

# R3 Report

## REQUIREMENT, RATIONALE, REFERENCE

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*Published for Joint Commission-accredited organizations and interested health care professionals, R3 Report provides the rationale and references that Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, R3 Report goes into more depth. The references provide the evidence that supports the requirement. R3 Report may be reproduced if credited to Joint Commission. Sign up for [email](#) delivery.*

### National Patient Safety Goal to Improve Health Outcomes for All

Effective July 1, 2023, Standard LD.04.03.08, which addresses health care disparities as a quality and safety priority, will be elevated to a new National Patient Safety Goal (NPSG), Goal 16: Improve health outcomes for all, and moved to NPSG.16.01.01 for ambulatory health care organizations and behavioral health care and human services organizations.

The NPSG standard and 6 elements of performance (EPs) increases the focus on improving health outcomes for all as a quality and safety priority, but the requirements for accredited organizations are not changing. While some of the original language from Standard LD.04.03.08 and its EPs were revised to focus on improving health outcomes for all rather than reducing health care disparities, the intent behind the standard and associated EPs remains the same. Organizations will still be required to do the following:

- Identify an individual to lead activities to improve health outcomes for all
- Assess the patient's health-related social needs
- Analyze quality and safety data to identify disparities
- Develop an action plan to improve health outcomes for all
- Take action when the organization does not meet the goals in its action plan
- Inform key stakeholders about progress to improve health outcomes for all

As with the original requirement, NPSG.16.01.01 will apply to the following Joint Commission-accredited organizations:

- Ambulatory health care organizations providing primary care within the "Medical Centers" service in the ambulatory health care program (the requirements are not applicable to organizations providing episodic care, dental services, or surgical services)
- Behavioral health care and human services organizations providing "Addictions Services," "Eating Disorders Treatment," "Intellectual Disabilities/Developmental Delays," "Mental Health Services," and "Primary Physical Health Care" services

## Engagement with stakeholders, customers, and experts

Because the content hasn't changed from LD.04.03.08 to NPSG.16.01.01, the existing literature review, public field review, and engagement with expert guidance continues to apply. The following groups previously provided expert guidance:

- [Technical Advisory Panel \(TAP\)](#) of subject matter experts from various health care and academic organizations and professional associations.
- [Standards Review Panel \(SRP\)](#) comprised of clinicians and administrators who provided a "boots on the ground" point of view and insights into the practical application of the proposed standards.

The prepublication version of the requirements to improve health outcomes for all will be available online until June 30, 2023. After July 1, 2023, please access the new requirements in the E-dition or standards manual.

## National Patient Safety Goal Chapter

*Note: The terms included in brackets in the following requirements will vary depending on the accreditation program. For example, the behavioral health care and human services program uses the term [individual served] in place of [patient].*

**Standard NPSG.16.01.01:** Improving health outcomes for all the [organization's] [patients] is a quality and safety priority.

### Introduction

Almost twenty years ago, the Institute of Medicine (now the National Academy of Medicine) published "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." The report reviewed the voluminous literature on differences in quality of care and use of services by racial and ethnic minorities and concluded, "A large body of published research reveals that racial and ethnic minorities experience a lower quality of health services and are less likely to receive even routine medical procedures than are white Americans."<sup>1</sup> Although racial and ethnic differences in care have received the most attention, studies have also shown disparities in care for women, older adults, people with disabilities, and other historically marginalized groups.

Although health care disparities are often viewed through the lens of social injustice, they are first and foremost a quality of care problem. Like medication errors, health care-acquired infections, and falls, health care disparities must be examined, the root causes understood, and the causes addressed with targeted interventions in order to improve health outcomes for all. There are many examples of successful efforts to improve health outcomes for all.<sup>2</sup> Unfortunately, most of these efforts have been done as special projects, often with limited external funding, and were not sustained or spread across organizations. A different approach is needed. Organizations need established leaders and standardized structures and processes in place to detect and address health care disparities. These efforts should be fully integrated with existing quality improvement activities within the organization like other priority issues such as infection prevention and control, antibiotic stewardship, and workplace violence.

Health-related social needs (HRSN) are frequently identified as root causes of disparities in health outcomes.<sup>3,4,5</sup> We use the term HRSN instead of social determinants of health (SDOH) to emphasize that HRSNs are a proximate cause of poor health outcomes for individual patients as opposed to SDOH, which is a term better suited for describing populations. Understanding individual patients' HRSNs can be critical for designing practical, patient-centered care plans. A care plan for tight control of diabetes may be unsafe for someone with food insecurity, and outpatient radiation therapy may be impractical for someone who lacks reliable transportation to treatment. Many health care organizations have taken up this challenge and are implementing routine screening for HRSNs and referring patients to community resources as a part of their treatment plan.

While the introduction of specific standards to improve health outcomes for all is an important step in prioritizing this quality and safety issue, it should be acknowledged that health care is still learning how best to do this effectively and efficiently. For these reasons, Joint Commission's standards focus on fundamental processes that will help organizations start this journey (that is, identifying a leader, understanding patients' HRSNs, stratifying key measures, and developing a plan to address one or more target); the standards provide flexibility in their scope and focus to accommodate organizations at different stages on the path forward. For example, while it would be ideal for all patients to have their HRSNs assessed so these can be addressed directly or indirectly through a modified treatment plan, the standards do not require screening all patients; our requirement (EP 2) allows organizations to assess HRSNs for a representative sample of their patients rather than all patients. This will allow organizations to understand the value of screening and identify the resources most needed by the people they care for. These standards will serve as a foundation for future work to address health care disparities and achieve excellent health outcomes for all.

## **References:<sup>\*</sup>**

1. Smedley, B., Stith, A., & Nelson, A. (2003). *Unequal treatment: confronting racial and ethnic disparities in health care*. Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington, D.C.: National Academy Press.
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<sup>\*</sup>Not a complete literature review.

## **Requirement**

**EP 1:** The [organization] designates an individual(s) to lead activities to improve health outcomes for all the [organization's] [patients].

Note: Leading the [organization's] activities to improve health outcomes for all may be an individual's primary role or part of a broader set of responsibilities.

## **Rationale**

Leadership is an essential component of quality improvement activities. "Beyond any specific set of leader behaviors, team clarity regarding leadership is associated with clear team objectives, higher levels of engagement to promote excellence and greater innovation."<sup>6</sup> Management-level leadership, physician leadership, and team leadership have been consistently associated with successful quality improvement projects, and the lack of such leadership is frequently linked to the failure of quality improvement efforts. Identifying an individual to lead the organization's activities to improve health outcomes for all establishes clear lines of accountability and ensures that staff have the support necessary to implement successful initiatives. Multiple organizations and individual experts recommend having a designated leader for efforts to improve health outcomes for all.<sup>7-13</sup>

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\*Not a complete literature review.

## Requirement

EP 2: The [organization] assesses the [patient's] health-related social needs (HRSNs) and provides information about community resources and support services.

Note 1: [Organizations] determine which HSRNs to include in the [patient] assessment. Examples of a [patient's] HSRNs may include the following:

- Access to transportation
- Difficulty paying for prescriptions or medical bills
- Education and literacy
- Food insecurity
- Housing insecurity

Note 2: HRSNs may be identified for a representative sample of the [organization's] [patients] or for all the [organization's] [patients].

## Rationale

A growing body of research, including results from randomized controlled trials, systematic reviews, and well-designed observational studies, supports the value of identifying and addressing specific health-related social needs (HRSNs). Depending on the HRSNs and the specific intervention studied, a range of improvements have been observed in health outcomes (for example, blood glucose levels), process measures (for example, medication adherence), utilization (for example, hospital admissions), and in the reduction/resolution of unmet social needs.<sup>14-16</sup>

Organizations may determine which data to collect and whether data are collected for a sample of patients or routinely for all patients. It would be ideal for all patients to have their HRSNs assessed so these can be addressed directly by referral to community resources or indirectly through a modified treatment plan. However, organizations vary in their capacity to do this, so the standards do not require screening all patients. EP 2 allows organizations to assess HRSNs for a representative sample of their patients rather than all patients. For example, organizations could survey a sample of high-risk patient populations (such as those with diabetes, pregnant women, or oncology patients facing high out-of-pocket costs).

We encourage organizations to assess the most common HRSNs listed as examples in EP 2. However, due to differences in patient populations served, availability of community resources, and health care organization capacity, it is acceptable for organizations to focus on the social needs that are most practical and relevant for their unique situation. Similarly, the organization may determine what information about the potential interventions, services, and resources in their community are needed to address the HRSNs of its patients.

In summary, organizations have the flexibility to determine which patients to target for assessment of HRSNs and which HRSNs to assess and connect to resources.

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<sup>\*</sup>Not a complete literature review.

## Requirement

EP 3: The [organization] identifies health care disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].

Note 1: [Organizations] may focus on areas with known health care disparities identified in the scientific literature (for example, [Ambulatory Health Care: kidney disease, maternal care, diabetes management; Behavioral Health Care and Human Services: treatment for substance abuse disorder, restraint use, suicide rates]) or select measures that affect all [patients] (for example, experience of care and communication).

Note 2: [Organizations] determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following:

- Age
- Gender
- Preferred language
- Race and ethnicity

## Rationale

Health care disparities are ubiquitous for members of racial/ethnic minorities, people who prefer to speak a language other than English, women, older patients, people with disabilities, and other historically marginalized groups.<sup>17</sup> Therefore, it is essential for organizations to conduct analyses to understand the specific disparities that may exist at their institution. This process begins with stratifying existing measures.<sup>18-20</sup> Organizations may also wish to measure differences in care processes, procedure use, and outcomes for high-risk topics where research has shown disparities are common and substantial. If stratified analyses show differences across groups, organizations should work to understand the root causes of the differences and develop actions to address disparities when they are identified (see EP 4).

Organizations may differ in the patient information they collect, the quality and safety measures they use, and their ability to perform data analyses. Organizations may focus their analyses on measures that affect all patients (for example, experience of care, readmissions) or concentrate on a well-known area of persistent disparity (for example, diabetes, blood pressure control). Understanding which processes and outcomes vary by sociodemographic characteristics allows an organization to explore the possible root causes of a health care disparity and to tailor interventions to improve care. Stratified measurement also enables organizations to track their progress toward reducing health care disparities as interventions are implemented. A classic study by Sehgal and colleagues stratified data on dialysis quality for Blacks and whites and found large disparities. The disparities were nearly eliminated by addressing patient-specific barriers, including health-related social needs (HRSNs).<sup>21</sup> More recently, a study by Garg and colleagues at UMass Memorial Health stratified data on pediatric wellness visits and found that Black/African American and Hispanic/Latinx children were much less likely to have visits than whites during the COVID-19 pandemic. They were able to reverse this with a targeted, multi-faceted intervention.<sup>22</sup>

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\*Not a complete literature review.

## Requirement

EP 4: The [organization] develops a written action plan that describes how it will improve health outcomes for all by addressing at least one of the health care disparities identified in its [patient] population.

## Rationale

Addressing health care disparities often involves the coordination of efforts across multiple departments and programs (including quality and safety) and may result in the development of technology solutions, staff training and education activities, new or modified processes, and improvements to the organization's ability to help address patients' health-related social needs. It can be overwhelming for an organization to address disparities for the first time. Therefore, we only require organizations to address one topic, even if they identify multiple disparities.

The organization should develop an action plan that defines the health care disparity and the specific population(s) of focus, the organization's improvement goal, the strategies and resources needed to achieve the goal, and the process that will be used to monitor and report progress.<sup>23-25</sup> The organization can then build on the lessons learned from that approach to address additional disparities in the future.

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\*Not a complete literature review.

## Requirement

EP 5: The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to improve health outcomes for all.

## Rationale

It is important to assess progress and evaluate whether an organization's efforts to improve health outcomes for all are successful. Reviewing quality and safety metrics, collecting feedback from patients about new

services or interventions, or evaluating staff needs for training and education demonstrate support for the organization's strategy to improve health outcomes for all. These activities can also inform the organization if it should revise its action plan or provide additional resources.<sup>26-28</sup>

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\*Not a complete literature review.

## **Requirement**

EP 6: At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health outcomes for all.

## **Rationale**

An organization's commitment to improving health outcomes for all should be embedded throughout its culture and practices. Leaders, practitioners, and staff need to be aware of the organization's initiatives to improve health outcomes for all and be informed of their potential role in those initiatives. It is also important to receive updates about the challenges and successes of the organization's efforts to improve care for all patients.<sup>29-31</sup>

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