

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 36, Date June 20, 2022

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

New Requirements to Reduce Health Care Disparities

Effective January 1, 2023, new and revised requirements to reduce health care disparities will apply to organizations in the Joint Commission’s ambulatory health care, behavioral health care and human services, critical access hospital, and hospital accreditation programs.

- A new standard in the Leadership (LD) chapter with 6 new elements of performance (EPs) has been developed to address health care disparities as a quality and safety priority. Standard LD.04.03.08 will apply to the following Joint Commission–accredited organizations:
 - All critical access hospitals and hospitals
 - 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
- The Record of Care, Treatment, and Services (RC) requirement to collect patient race and ethnicity information has been revised and will apply to the following Joint Commission–accredited programs:
 - Ambulatory health care (Standard RC.02.01.01, EP 31)
 - Behavioral health care and human services (Standard RC.02.01.01, EP 26)
 - Critical access hospital (Standard RC.02.01.01, EP 25)
- The Rights and Responsibilities of the Individual (RI) requirement prohibiting discrimination (Standard RI.01.01.01, EP 29) will apply to all Joint Commission–accredited ambulatory health care organizations and behavioral health care and human services organizations.

Engagement with stakeholders, customers, and experts

In addition to an extensive literature review and public field review, The Joint Commission obtained expert guidance from the following groups:

- [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 reduce health care disparities will be available online until December 31, 2022. After January 1, 2023, please access the new requirements in the E-dition or standards manual.

Leadership 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 LD.04.03.08: Reducing health care disparities for 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.”¹ 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. There are many examples of successful efforts to reduce disparities.² 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.^{3,4,5} 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 address health care disparities 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, The Joint Commission's standards focus on fundamental processes that will help organizations start this journey (i.e., 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 equity.

The new standard states “Reducing health care disparities for patients is a quality and safety priority.” We have placed the new standard in the Leadership chapter (LD.04.03.08) because success demands leadership. Achieving health care equity will require commitment, vision, creativity, and sustained effort at all levels, including the C-suite and the Board.

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*Not a complete literature review.

Requirement

EP 1: The [organization] designates an individual(s) to lead activities to reduce health care disparities for the [organization's] [patients].

Note: Leading the [organization's] activities to reduce health care disparities 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."⁶ 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 reduce health care disparities 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 health care equity efforts.⁷⁻¹³

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*Not a complete literature review.

Requirement

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

Note 1: [Organizations] determine which health-related social needs to include in the [patient] assessment.

Examples of a [patient's] health-related social needs may include the following:

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

Note 2: Health-related social needs 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 upon the HRSNs and the specific intervention studied, a range of improvements have been observed in health outcomes (e.g., blood glucose levels), process measures (e.g., medication adherence), utilization (e.g., hospital admissions), and in the reduction/resolution of unmet social needs.¹⁴⁻¹⁶

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 (e.g., 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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*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 disparities identified in the scientific literature (for example, [Hospital/Critical Access Hospital: organ transplantation, maternal care, diabetes management; Ambulatory Health Care: kidney disease, maternal care, diabetes management; Behavioral Health Care: 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.¹⁷ 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.¹⁸⁻²⁰ 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 (e.g., experience of care, readmissions) or concentrate on a well-known area of persistent disparity (e.g., 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).²¹ 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.²²

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*Not a complete literature review.

Requirement

EP 4: The [organization] develops a written action plan that describes how it will address 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.²³⁻²⁵ The organization can then build on the lessons learned from that approach to address additional disparities in the future.

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Requirement

EP 5: The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities.

Rationale

It is important to assess progress and evaluate whether an organization's efforts to reduce health care disparities are successful. Reviewing quality and safety metrics, collecting feedback from patients about new services or interventions, or evaluating staff training and education needs demonstrate support for the organization's strategy to address health care disparities. These activities can also inform the organization if it should revise its action plan or provide additional resources.²⁶⁻²⁸

References:*

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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 reduce identified health care disparities.

Rationale

An organization's commitment to reducing health care disparities should be embedded throughout its culture and

practices. Leadership, practitioners, and staff need to be aware of the organization's initiatives to address health care disparities 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.²⁹⁻³¹

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*Not a complete literature review.

Record of Care, Treatment, and Services (RC) 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 RC.02.01.01: The [medical] record contains information that reflects the [patient's] care, treatment, and services.

Requirement

The [medical] record contains the [patient's] race and ethnicity.

Note: The EP numbers vary by program: ambulatory health care (Standard RC.02.01.01, EP 31), behavioral health care and human services (Standard RC.02.01.01, EP 26), and critical access hospital (Standard RC.02.01.01, EP 25).

Rationale

The collection of patient-level demographic data on race and ethnicity is a crucial component of the process to identify health care disparities. Collecting this information for each patient allows the organization to better understand the patient population as a whole and allow organizations to stratify key quality and safety measures to identify potential disparities in care.³²⁻³⁴

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*Not a complete literature review.

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