

EDITORIAL

# Achieving Health Care Equity Requires a Systems Approach

David W. Baker, MD, MPH, FACP

Of all the challenges facing health care, achieving health care equity may be the most complex and daunting. Hundreds of studies have documented suboptimal care for many different patient subgroups, including racial/ethnic minorities, people with limited English proficiency, women, older adults, members of the LGBTQ+ community, and those with low health literacy.<sup>1</sup> Health-related social needs (HRSN) are often not routinely identified by providers, which can lead to unsafe or lower quality care and worse health outcomes.<sup>2</sup> Finally, many people face problems with access to care and may not even be able to receive care at all, including people who lack health insurance and those in rural areas or health professional shortage areas. Our health care delivery system was not designed to achieve the goal of equal access, quality, safety, and outcomes for all.

So, how do we make major strides forward on the journey to achieving health care equity? The current approach to tackling healthcare inequities seems to be following the old aphorism on how to eat an elephant: one bite at a time. Although addressing disparities one issue at a time may be a practical path to valuable improvements, especially for organizations new to addressing disparities, I don't think this will achieve the large, lasting changes in healthcare equity that we need.

Unlike the elephant analogy, healthcare disparities are not a single large problem. To achieve equity, we must grapple with a large herd of unruly, poorly understood problems. For this, health care organizations need to shift from tackling one disparity at a time to taking a systems approach based on a clear framework. Several organizations have created frameworks to help organizations.<sup>3</sup> The Joint Commission's framework and systems approach is represented by its accreditation<sup>4</sup> and health care equity certification standards.<sup>5,6</sup> The frameworks typically address leadership; collaboration with patients, families, caregivers, and community organizations; routine data collection from patients, staff, and the communities served; stratification of performance measures to identify disparities; improved care delivery through workforce diversity, staff training; improved communication for people with language barriers and communication difficulties; and implementation of actions to

meet the needs of special populations (e.g., those with HRSNs and disabilities).

The call for papers on healthcare equity we published earlier this year did not ask specifically for articles on systems approaches. Nevertheless, many of the papers submitted for this special issue offer insights into systems approaches to specific healthcare equity challenges. Of course, this might have occurred by chance. But I think it suggests that the cutting edge thinking in healthcare equity has shifted toward systems approaches. We hope this issue of the *Journal* comes at the right time as organizations move in this direction.

## USING INCIDENT REPORTING SYSTEMS TO IDENTIFY AND ADDRESS DISPARITIES

Data collection and analytics systems are fundamental for organizations to understand current and emerging disparities and measure the success of interventions. One potential data source is incident reporting systems (IRSs). Alfred and colleagues examined two years of incident reports extracted from their hospital's IRS and used these to investigate factors in systems and clinical environments that may have contributed to adverse outcomes and racial and ethnic disparities.<sup>7</sup> They found that Non-Hispanic Black patients had a higher risk of a reported adverse incidents, and they identified variations in care that were associated with adverse outcomes and increased length of stay. These findings can directly inform safety and equity efforts in intrapartum care, and they show the potential value of using IRS data to identify and address disparities.

However, most organizations do not capture patient demographics in their reporting systems,<sup>8</sup> which greatly limits the usefulness of IRSs for evaluating disparities. In addition, the value of IRSs for advancing equity can be limited by how often events are reported and the presence of bias in what gets reported. Hoops and colleagues conducted a scoping review of published, peer-reviewed literature that discusses patient safety event reporting and differences by age, gender, race, and socioeconomic status.<sup>9</sup> Their review showed that patients from minoritized groups may be less likely to have events reported but be more likely to suffer serious events. In addition, reporting may vary by provider gender. Thus, analyses of disparities based on IRS data must be interpreted cautiously. In a separate commentary, Gandhi provides a broader perspective on the limitations of

IRs and suggests six actions that organizations should take to embed equity into safety reporting.<sup>8</sup>

## OVERCOMING COMMUNICATION BARRIERS

Understanding and addressing populations with special needs is another way that healthcare providers can take a systems approach to equity. Overcoming communication barriers, including meeting the needs of patients with limited English proficiency (LEP) or hearing impairments, is a prime example. The *Journal* has published many studies of interpreter use and ways to improve interpreter services (see Table 1). But interpreters are often limited and expensive. So, when health care organizations are thinking systematically about how to improve communication with patients with LEP, they should also establish policies and procedures about how to use bilingual clinicians. Yet there are few studies of how to efficiently and effectively assess non-English language (NEL) proficiency. To address this gap, Alarcon and colleagues compared a longer NEL proficiency assessment tool, the Clinician Cultural and Linguistic Assessment (CCLA), to a shorter assessment tool, the Interagency Language Roundtable (ILR) for medical trainees or independent clinicians who used NEL skills for direct patient care.<sup>10</sup> They found a strong positive correlation between the original ILR and CCLA ( $\rho = 0.61, p < 0.0001$ ), suggesting that the briefer ILR may be adequate. Moreover, all participants who self-identified as a native speaker in a language were found to perform at the highest level of the CCLA, suggesting that these individuals can be considered competent without testing. It is also worth noting that although all participants said they used their NEL skills for direct patient care, many did not achieve a passing score on the CCLA. This finding shows the need for organizations to formally test and confirm clinicians' NEL skills before allowing them to communicate directly with patients without an interpreter.

## ADDRESSING HEALTH-RELATED SOCIAL NEEDS

A third area that must be addressed to achieve health care equity is HRSNs. HRSNs are critically important on their own, but they also frequently contribute to racial/ethnic differences in outcomes.<sup>1</sup> Therefore, mitigating the effect of HRSNs is doubly important.

Two articles in this issue report on system-level approaches for HRSN screening and interventions to meet HRSNs. Angah and colleagues at Yale New Haven Health System aimed to standardize data collection at one multi-specialty medical practice and seven hospitals using a screening questionnaire designed in alignment with the Accountable Health Communities model and the Connecticut Hospital Association.<sup>11</sup> Plan-Do-Study-Act cycles were used to determine automated messaging through the web-based patient portal for the ambulatory prac-

tice and to develop in-person collection methods for inpatients. Annual screening rates increased by 15.5 percentage points in ambulatory settings and approximately 66 percentage points for inpatients. In addition, List and colleagues report the efforts of the Veterans Health Administration's Office of Health Equity's ACORN project (Assessing Circumstances and Offering Resources for Needs).<sup>12</sup>

These two new reports on addressing HRSNs add to the evidence base from previous articles we have published on this topic and those in other journals (see Table 1). It is clearly possible (albeit expensive) to collect self-reported HRSNs and refer patients to have their needs met. The question now is whether HRSNs can be mitigated and outcomes improved. This will be the *Journal's* focus as we consider publication of articles going forward.

## IMPROVING CARE FOR PEOPLE WITH DISABILITIES

Improving access to care, quality of care, and safety for people with disabilities should be another key part of the overall vision of health care equity. People accessing care should be screened for disabilities; if present, patients should be asked whether accommodations are needed and, if so, what specific accommodations. To understand the experience of those working toward this goal, Morris and colleagues conducted qualitative interviews with HCOs who had active or past initiatives to implement systematic collection of disability status in the electronic health record (EHR).<sup>13</sup> They stated that the main purpose for collection of disability status and accommodation needs was to prepare for patients with disabilities. Because of this focus, participants believed (1) collection should occur prior to patients' clinical encounters, (2) this information should be collected regularly, (3) standardized language should be used, and (4) the results should be available in a highly visible location in the EHR.

The article by Buning and colleagues<sup>14</sup> dovetails well with the article by Morris and colleagues. Buning et al. developed a Disability Accommodation questionnaire to screen for disability status and to determine types of disability and self-reported accommodation needs. Approximately 13% patients in their primary care clinic reported a disability, and 54% indicated at least one needed accommodation (e.g., presence of an ASL interpreter, assistive listening devices, inclusion of a support person during care decisions, and assistance with transfers). There was substantial heterogeneity in patients' needed accommodations, even for those who had the same type of disability.<sup>14</sup> This study supports the need for and feasibility of routine screening for disabilities and the accommodations needed. Future studies are needed to show how having these data can lead to improved processes of care and outcomes.

**Table 1. Past Articles Relate to Healthcare Equity Published in *The Joint Commission Journal on Quality and Patient Safety***

Title	Author	Year of Publication
Social Determinants of Health Screening and Management: Lessons at a Large, Urban Academic Health System	Peretz et al. <sup>17</sup>	2023
Extending Maternal Care After Pregnancy: An Initiative to Address Health Care Disparities and Enhance Access to Care After Delivery	Nelson et al. <sup>18</sup>	2023
An Infrastructure to Provide Safer, Higher-Quality, and More Equitable Telehealth	Kobeissi and Hickey <sup>19</sup>	2023
Lack of Association Between Race and Ethnicity and Timely Treatment of Severe Peripartum Hypertension	Ozimek et al. <sup>20</sup>	2022
Mi Plan: Using a Pediatric-Based Community Health Worker Model to Facilitate Obtaining of Contraceptives Among Latino Immigrant Parents with Contraceptive Needs	Caballero et al. <sup>21</sup>	2022
Preferences and Perceptions of Medical Error Disclosure Among Marginalized Populations: A Narrative Review	Olazo et al. <sup>22</sup>	2022
Equity, Where Art Thou? Opportunities to Improve Safety Culture Measurement	Etchegary and Thomas <sup>23</sup>	2022
Improving and Promoting Social Determinants of Health at a System Level	Imran et al. <sup>24</sup>	2022
Prioritizing Child Health: Promoting Adherence to Well-Child Visits in an Urban, Safety-Net Health System During the COVID-19 Pandemic	Garg et al. <sup>25</sup>	2022
Increasing Telehealth Access to Care for Older Adults During the COVID-19 Pandemic at an Academic Medical Center: Video Visits for Elders Project (VVEP)	Chu et al. <sup>26</sup>	2022
Changes in Rates and Modality of Interpreter Use for Pediatric Emergency Department Patients in the COVID-19 Era	Hartford et al. <sup>27</sup>	2022
Disparities After Discharge: The Association of Limited English Proficiency and Postdischarge Patient-Reported Issues	Malevanchik et al. <sup>28</sup>	2021
Use of Accessible Weight Scales and Examination Tables/Chairs for Patients with Significant Mobility Limitations by Physicians Nationwide	Iezzoni et al. <sup>29</sup>	2021
Implementation of Collection of Patients' Disability Status by Centralized Scheduling	Morris et al. <sup>30</sup>	2021
Health System Leaders' Role in Addressing Racism: Time to Prioritize Eliminating Health Care Disparities	Austin et al. <sup>31</sup>	2021
Using Electronic Health Record and Administrative Data to Analyze Maternal and Neonatal Delivery Complications	Huennekens et al. <sup>32</sup>	2020
Systematic Collection of Sexual Orientation and Gender Identity in a Public Health System: The San Francisco Health Network SO/GI Systems-Change Initiative	Rosendale et al. <sup>33</sup>	2020
Surgical Residents as Certified Bilingual Speakers: A Quality Improvement Initiative	Solomon et al. <sup>34</sup>	2020
A Model for Improving Health Care Quality for Transgender and Gender Nonconforming Patients	Ding et al. <sup>35</sup>	2020
Hospital and Health System-Level Interventions to Improve Care for Limited English Proficiency Patients: A Systematic Review	Taira et al. <sup>36</sup>	2019
Audio-Recorded Discharge Instructions for Limited English Proficient Parents: A Pilot Study	Lion et al. <sup>37</sup>	2019
Hospital Leadership Diversity and Strategies to Advance Health Equity	Herrin et al. <sup>38</sup>	2018
Using Health IT to Coordinate Care and Improve Quality in Safety-Net Clinics	Kranz et al. <sup>39</sup>	2018
Development of Patient-Centered Disability Status Questions to Address Equity in Care	Morris et al. <sup>40</sup>	2017
Examining Racial and Ethnic Differences in Nursing Home Quality	Hefele et al. <sup>41</sup>	2017

## BUILDING EQUITY ROUTINELY INTO IMPROVEMENT

Lastly, healthcare organizations can take a systems approach to advancing health care equity by building equity into all improvement efforts rather than focusing on just a few high priority health equity targets. If quality improvement projects do not consider DEI and social determinants of health (SDOH)/HRSN, they can sometimes paradoxi-

cally create disparities when none existed at baseline—some groups may improve while others do not because their special needs were not identified and addressed in the improvement intervention.

Toward this end, Ganz-Lord and colleagues<sup>15</sup> describe how they developed a novel quality improvement toolkit that ingrains issues of diversity, equity, and inclusion (DEI) and SDOH into the Institute for Healthcare Improvement's

tools. The tools prompt quality improvement teams to evaluate DEI and SDOH at each step of the journey, including an updated charter and stratified baseline tool, a new fishbone diagram for the discovery phase that includes a “tail” to include DEI and SDOH, and additions in the Study and Act sessions of the PDSA worksheet to address these issues.<sup>15</sup>

After development and dissemination of this toolkit, Ganz-Lord and colleagues conducted a pre-post analysis of projects conducted by Performance Improvement (PI) fellows in their institution. They found that prior to introducing the new toolkit, 23% of projects from 2016 to 2021 incorporated DEI/SDOH into any stage of the PI process. After implementing the amended tools, this increased to 83% in the 2022 fellowship. These results show that this simple approach can hardwire consideration of DEI and SDOH into improvement projects.<sup>15</sup> However, more research is needed to understand whether using these reminder tools leads to modifications of improvement interventions to ensure that all patients benefit.

Moyal-Smith and colleagues examined equity for a very different improvement issue: designing hospital incident command systems for responding to emergencies and disasters.<sup>16</sup> They conducted a systematic review of the peer-reviewed and gray literature for articles that referenced incident command system (ICS) and equity. Based on 29 articles included in their thematic analysis, they identified three themes: (1) including equity specialists in the ICS, (2) modifying systems to promote equity, and (3) sensitivity to the local community (e.g., integration with public health agencies, bidirectional communication with the community, providing needed resources). This article brought home to me the full circle of community engagement and partnership, ranging from collecting population data and listening to the community to understand their needs and concerns, to work together to improve care, and finally, to ensure that emergency management plans serve the community during their times of greatest need. The latter proved to be sorely lacking during the COVID pandemic.

## LOOKING BACK, MOVING FORWARD

The editorial team at the *Journal* is proud of our longstanding commitment to publish papers that address the many aspects of health care equity.<sup>17–41</sup> Table 1 lists some of the key articles we have published on health care equity so our readers can look back on the lessons of the past and use these as tools for the broader challenges ahead. We look forward to sharing more articles about the innovative work organizations are doing to embrace a vision of health care in which equity is embedded into all we do.

**David W. Baker, MD, MPH, FACP**, is Executive Vice President for Healthcare Quality Evaluation, The Joint Commission, Oakbrook Terrace, Illinois, and Editor-in-Chief, The Joint Commission Journal on Quality and Patient Safety. Please address correspondence to David W. Baker, [dbaker@jointcommission.org](mailto:dbaker@jointcommission.org).

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