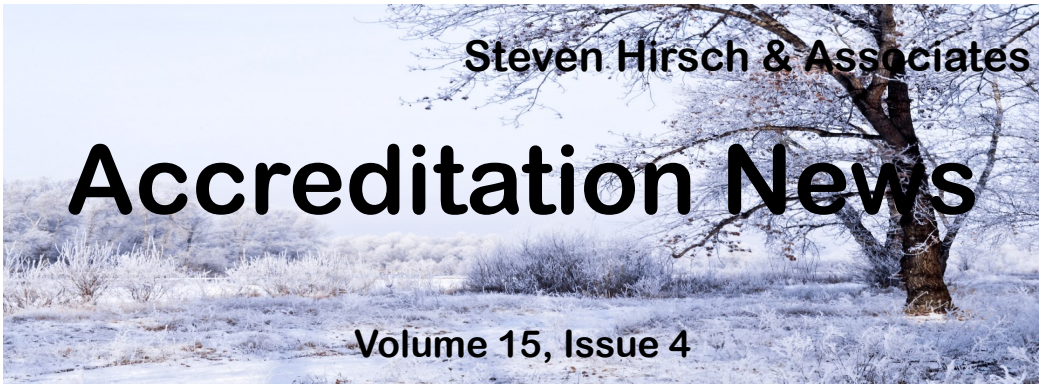

Winter 2023

Diversity, Equity, and Inclusion

By David Woodard, MSc, CIC, FSHEA and Steven Hirsch, MPA, FACHE

Diversity, Equity, and Inclusion (DEI) in the workplace focuses on how well organizations have integrated themselves into their community, how they provide services equitably, and how they will ensure that their workforce is reflective of the community they serve. Most industries have fully complied with the legal requirements of the Equal Employment Opportunity Act and other federal, state, and local laws regarding treating all individuals equally. However, the adoption of policies and procedures that support DEI is variable, with some organizations doing an excellent job, while others have implemented the bare minimum necessary to avoid legal exposure. It should be noted that multiple jurisdictions have implemented laws declaring DEI, or some parts, to be in violation of existing federal laws. Therefore, while we believe that this is an important discussion, your organization's implementation of DEI components should be executed with care using legal advice and counsel.

The Joint Commission, in Sentinel Event Alert #64 issued in November 2021***, introduced healthcare disparity as a significant risk to healthcare quality and safety. Several recommendations were made, including:

1. Collect and stratify quality and safety performance data specific to the communities your organization serves and develop communication channels that enable you to listen and learn.
2. Analyze stratified data and community feedback to identify health care disparities and opportunities for improvement.
3. Commit to achieving diversity and inclusion as an important step toward addressing health care disparities.
4. Undertake initiatives to rectify health care disparities by building sustainable business cases.

To better understand what DEI is, it is helpful to know how the federal government defines each term within the acronym.

Diversity

According to The White House Executive Order on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce*, *"The term "diversity" means the practice of including the many communities, identities, races, ethnicities, backgrounds, abilities, cultures, and beliefs of the American people, including underserved communities."* Most hospitals and healthcare settings have done a good job including race/ethnicity, but there may be other cultural or demographic characteristics that also need consideration, particularly as they relate to the underserved.

As an example, if one were to query the governing body of your hospital, how would the Chair respond to the question, "How have you evaluated and made an effort to make your facility more welcoming to the Native American population of the surrounding reservation (s)?"

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Diversity, Equity, and Inclusion

Continued ...

Does the hospital staff understand the diversity of the patients and visitors they serve? It is key in the process that staff recognize that while they may be "meeting the needs" of the "gall bladder in 46", there is a human attached to the gall bladder and just as importantly, a family member. It is also important to respect the cultural and ethnic sensitivities that patients have. Their impressions are critical to their understanding of quality care.

Equity

According to The White House Executive Order on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce*, *"The term "equity" means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment."*

Are employees trained to recognize the various customs/superstitions/beliefs of your patient population, whether they be Romani or Native American? How has your non-patient care staff been trained to address the issues of refugees or victims of violence, including diet, habits, and hygiene? What is your organization doing to recognize various holidays and celebrations? Do you recognize Juneteenth? Do all patients have the same access to care, treatment, and services based on their healthcare needs, regardless of payment source or setting in the organization?

Inclusion

According to The White House Executive Order on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce*, *"The term "inclusion" means the recognition, appreciation, and use of the talents and skills of employees of all backgrounds."*

Does your organization know and adapt to the prior work and background experience of all employees? With the influx of foreign-trained staff, it is important to listen to them and evaluate their ideas.

How is leadership trained to ensure that the entire organization understands the cultural mores in the patient populations served? Hospital leaders should ensure that during general orientation, there is a discussion around inclusion. The avoidance of cliques is an important tactic that can improve the overall perception of inclusion.

One of the benefits of having a DEI program is that it helps link the hospital with the community. Most hospitals are working to ensure that various ethnic and gender communities are reflected in their staff. Organizations must take the next steps to ensure that the local populations are included in the hospital and its delivery of care.

There are some components that, if properly integrated into the organization, can improve the health of the community. Strategists should be sure to look at the catchment area and evaluate overarching medical needs, as well as the special needs, customs, and wants of various minority populations and the medically underserved.

Investing in DEI programs is in the organization's best interest. Although DEI can bring value to the organization in many ways, it has a particularly positive impact on the following five aspects of organizational performance:

1. **Better alignment with the customer base**
2. **Greater accessibility to services offered by the organization**
3. **Improved compliance of patients with clinical recommendations and treatment, leading to improved health**
4. **An advantage in talent acquisition**
5. **Increased employee satisfaction**
6. **Improved decision-making and innovation**

R3 Report Issue 38: National Patient Safety Goal to Improve Health Care Equity **

Effective July 1, 2023, The Joint Commission Standard LD.04.03.08, which addresses health care disparities as a quality and safety priority, has been elevated to a new National Patient Safety Goal (NPSG), Goal 16: Improve health care equity, and moved to NPSG.16.01.01 for Ambulatory Health Care Organizations, Behavioral Health Care and Human Services Organizations, Critical Access Hospitals, and Hospitals. This National Patient Safety Goal is applicable to all institutions accredited by TJC.

The requirement is consistent with the usual structure of standards. The first element of performance requires that there be an individual appointed to oversee the program. The Standard is silent on any credential for the individual but does require that they are able to function across all disciplines in the organization, to improve health care equity.

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Diversity, Equity, and Inclusion

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The second element of performance is to assess the status of how equity is seen. This includes an assessment of health-related social needs (HRSNs). While under a different name, many organizations may have already started on components of this based on the evaluation of causes for readmission and addressing some of those factors, for example: failed blood glucose monitor, medication non-compliance, food and housing insecurity, transportation to follow-up appointments, etc. It might be of value to include data from current agencies that provide healthcare support, for example: "Meals on Wheels," medi-transport services, or VNA.

The third element of performance is to evaluate healthcare disparities based on various strata of patients based on income, accessibility, race, age, gender and disabilities. There is no prescription on which metrics are measured.

EP 4 and 5 then go on to require the codification of the findings into an action plan, and then to act when undesirable variation is identified.

Lastly, there is a requirement for development of an annual report that is provided not only to the Hospital but also to other stakeholders such as the local health department, faith-based organizations that develop and implement outpatient services, and any agency in the area that is responsible for supporting delivery of healthcare.

The most recent information from The Joint Commission revealed that frequent findings related to the Health Equity National Patient Safety Goal include:

- The organization had not identified an individual to lead activities to reduce health care disparities.
- The organization has not identified the socioeconomic characteristics of the patient population served for inclusion in the organization's analysis of "health-related social needs" in order to provide community resources and support.
- The organization did not have a process in place to collect data regarding the health-related social needs of its patients.
- Quality and safety data had not been stratified to reflect sociodemographic characteristics of the patient population served.
- There was no written action plan as to how the organization will address identified health care disparities.

As an initiative introduced by the Centers for Medicare and Medicaid Services and The Joint Commission, as well as other accreditation organizations, it is important to address health care disparities through organization specific quality improvement and safety activities. These activities should be high priorities as the health care organization conducts its strategic planning, so that adequate resources can be provided to address and reduce disparities, and increase access to healthcare services, ultimately improving the health of the communities served.

References

*Executive Order on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce, June 25, 2021, Sec. 2. Definitions. (b), (c), (d)

https://www.whitehouse.gov/briefing-room/presidential-actions/2021/06/25/executive-order-on-diversity-equity-inclusion-and-accessibility-in-the-federal-workforce/#:~:text=(b)%20The%20term%20%E2%80%9Cdiversity,American%20people%2C%20including%20underserved%20communities

**R3 Report Issue 38: National Patient Safety Goal to Improve Health Care Equity, National Patient Safety Goal to Improve Health Care Equity

https://www.jointcommission.org/standards/r3-report/r3-report-issue-38-national-patient-safety-goal-to-improve-health-care-equity/

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Key Points for Hospitals Participating in a Professional Graduate Education Program

By Joann Saporito, RN, MBA, HACP

If your organization is participating in a Graduate Medical Education Program, it is important to ensure that the facility is compliant with all of the Elements of Performance (EPs) as established by The Joint Commission in MS.04.01.01. This includes Residency and Fellowship training programs. There are a total of nine Elements of Performance, three of which have written documentation requirements.

The EPs in MS.04.01.01 that require **written documentation** from The Joint Commission are:

EP 1: "The organized medical staff has a defined process for supervision by a physician with appropriate clinical privileges of each participant in the program carrying out patient care responsibilities." This should be addressed within the Medical Staff Rules and Regulations or a Medical Staff approved document (such as a policy) specific to the Graduate Medical Education program. A defined process needs to be in place throughout the facility to assure that staff are able to identify participants in the Graduate Medical Education program (photographs) and the level of supervision or authorized independent practice for which they can function.

EP 2: "Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff." Note that Graduate Medical Education trainees (i.e., "Residents") should have specific functions and skills that they are permitted to perform depending upon their current level of training. Furthermore, there should be clear documentation of what the Resident is permitted to perform independently versus with supervision. These limitations should be readily available to staff in the locations where the Resident will be performing their duties, and should be routinely updated (such as quarterly). How the organization makes this available to staff is not specified by The Joint Commission, so a hospital will want to ensure that its employees can speak to this. **It is important to note that although MS.04.01.01 EP 3 does not have a written documentation requirement, this EP further clarifies that the written descriptions as required in EP2 must include information on how the supervising physician(s) and the graduate medical education program director will make decisions about the Resident's involvement in patient care activities, including criteria for practicing independently versus continuing to need supervision. If a facility is assessing its compliance with EP 2, EP 3 will need to be considered in that review.

EP 4: "Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician." This would most likely be located within the Medical Staff Rules and Regulations and hospital policies.

MS.04.01.01 EP 5 focuses on having established a clear, effective communication process between the committee (s) responsible for the professional graduate education program and the organization's medical staff and governing board. How this communication transpires may differ if the hospital being surveyed has an established residency program committee, such as a Graduate Medical Education Committee (GMEC), or rather is an affiliated hospital with a training program in a different hospital. In the latter case, the hospital being surveyed may only have a coordinator and not a GMEC and would need to be able to demonstrate to a surveyor how communication occurs with the hospital providing the training program. Regardless of the method, the communication might be found documented in various medical staff meeting minutes and governing board reports from the Medical Executive Committee.

MS.04.01.01 EP 6 elaborates on what is required to be communicated between the organization responsible for the GME program and the participating hospital. Whether the information is submitted to a coordinator or directly to a GMEC, material reported must include data related to the safety and quality of patient care, treatment, and services provided through the program, and the educational and supervisory needs of the program participants.

What about a resident working in a private physician's office or a local community clinic? MS.04.01.01 EP 7 requires that there is also a process for an appropriate person at these types of facilities to report directly to the GMEC. As with EP 6, this information should also include data regarding the quality of care, treatment, and services provided and educational needs of the participants.

MS.04.01.01 EP 8 requires that hospitals which sponsor a GME program have a GMEC report presented to the governing body that reflects information about the quality of patient care, treatment, and services provided and the educational needs of the program participants. A surveyor will likely review GMEC and governing body minutes to assess compliance with this EP.

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Key Points for Hospitals Participating in a Professional Graduate Education Program

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Finally, MS.04.01.01 EP 9 addresses residency review committee citations. In this case, a "citation" is defined by the Accreditation Council for Graduate Medical Education (ACGME) as "a finding of a Review or Recognition Committee that a Sponsoring Institution or program has failed to comply substantially with a particular accreditation or recognition requirement." Citations are most commonly related to program personnel and resources (such as program director and/or faculty responsibilities), evaluations (including program, faculty, or resident), and the education program (such as supervisory requirements, minimum hours per week, and scholarly activities). The organization must be able to demonstrate how it is compliant with any citations in order to comply with this EP.

In addition to the Professional Graduate Medical Education Program requirements, both The Joint Commission and the Accreditation Commission for Health Care (ACHC) also have requirements specific to surgical residents that must be followed (Joint Commission UP.01.02.01 EP 3 and ACHC 30.11.11).

It is worth repeating, that if your organization is participating in a Graduate Medical Education Program, it is important to ensure that the facility is compliant with all of the Elements of Performance (EPs) as established by The Joint Commission in MS.04.01.01. Though only three of the nine EPs "require written documentation," each of them will best be demonstrated via written verification. It is suggested that hospitals confirm that their Medical Staff Rules and Regulations, policies, and meeting minutes accurately reflect conformity.

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and

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