

Technically Compliant Can Still Be Inequitable

Why procedural completion is not the same as meaningful access

Research Brief No. 1

Dr. Tonica Robinson

September 2026

ABOUT THIS BRIEF

This evidence-informed research brief synthesizes published evidence and offers an applied leadership framework. It does not report original empirical findings and is not legal advice. The phrase “technically compliant” is used as practical shorthand for satisfying a stated procedural or operational requirement; it is not a legal conclusion about compliance.

A NOTE ON VOICE

Selected 1990s-2000s hip-hop lyric fragments appear throughout this brief as cultural epigraphs. They provide interpretive framing, not evidentiary support; the research claims rest on the cited literature.

Systems • Policy • Institutional Practice • Research

Executive Summary

“Things done changed.”

- The Notorious B.I.G., “Things Done Changed” (1994)

Health and behavioral health systems often monitor whether required actions were completed: a referral was placed, an appointment was offered, a notice was sent, an outreach attempt was documented, or a telehealth option was made available. Those process markers matter. They can support accountability, consistency, and regulatory readiness. But they do not, by themselves, establish that a person was able to use the service or that the process achieved its intended purpose.

The distinction is especially important when access depends on factors outside the four walls of a program. Healthy People 2030 defines access in terms of timely use of services to achieve the best possible outcomes and identifies transportation, availability, affordability, and other barriers as contributors to delayed or forgone care.[1] In a nationally representative 2022 survey, 21.7% of U.S. adults reported delaying or not receiving medical care because of at least one of five selected nonfinancial barriers. Among the specific reasons, 12.5% cited work or other commitments, 10.6% could not obtain an appointment when needed, 4.6% could not get to a provider when open, 4.4% had difficulty finding a provider compatible with their insurance, and 2.4% said travel took too long.[2]

The implication for leaders is not that standards should be abandoned or that every unsuccessful encounter reflects inequity. It is that process completion and meaningful access are different constructs. A system can perform a required action correctly while the design or implementation of that action creates different levels of burden for different people. Equity-oriented review therefore asks a second set of questions: What happened after the process was completed? Who carried the burden of making it work? Were the barriers foreseeable? Did a uniform rule have uneven effects? What could the system reasonably do differently?

CORE THESIS

Compliance matters. Standards matter. Documentation matters. But when review ends with whether a required action occurred, organizations may stop before examining whether the action produced meaningful access or the outcome it was intended to support.

1. Procedural Completion and Meaningful Access Are Not the Same

A process measure answers one question: Did the organization perform the specified action? An access or outcome measure answers another: Could the person actually obtain and use the service, and what followed? Both are important, but they are not interchangeable.

Consider a behavioral health referral. A referral may be entered correctly, transmitted to the designated provider, and documented within the required timeframe. From a procedural standpoint, the workflow may be complete. Yet the referred person may still encounter a six-week wait, a provider who is not accepting new patients, a schedule that conflicts with hourly work, a location that cannot be reached when the clinic is open, a technology requirement that assumes broadband access, or a language barrier that makes the next step difficult to navigate. The original action can be valid while the pathway remains functionally inaccessible.

This distinction is consistent with broader evidence on health care access. Healthy People 2030 emphasizes that insurance coverage alone does not remove all barriers to care.[1] The National Academies similarly documents persistent inequities in access and use across health care settings and identifies appointment availability, insurance acceptance, infrastructure, geography, and other system conditions as contributors.[3] In behavioral health specifically, recent National Academies work notes that common access measures are often clinician- or network-focused and may fail to capture the patient’s experience of navigating care, finding appropriate services, or overcoming barriers that prevent full benefit from treatment.[4]

2. Systems Can Transfer Work to the Person Seeking Care

Many health care processes require patients to perform substantial nonclinical work: identify the correct provider, understand eligibility, call during business hours, repeat information across organizations, complete forms, obtain records, appeal denials, coordinate between offices, monitor referrals, or determine what to do when a process stalls. This work is often invisible in organizational performance dashboards because it occurs after the organization has marked its own task complete.

A 2025 scoping review of 63 U.S. studies describes this phenomenon as patient administrative burden: the nonclinical administrative work people must do to use the health care system. The review organizes burden across the patient journey - seeking care, receiving care, and resolving care-related issues - and highlights learning costs, compliance costs, and psychological costs associated with navigation.[5] Importantly, the framework treats many burdens as features of system and policy design rather than as deficits in the patient.

That distinction changes the leadership question. Instead of asking only whether people followed instructions, organizations can examine how much work the process requires, whether that work is necessary, and whether the same requirement is realistically navigable across different circumstances. A process that is easy for a salaried worker with broadband, reliable transportation, English proficiency, paid leave, and flexible childcare may create a very different burden for someone without those resources.

3. Consistent Implementation Does Not Automatically Mean Equitable Impact

Standardization can be valuable. Clear and consistent rules can reduce arbitrary decision-making, support safety, and improve accountability. But applying the same procedure to everyone does not guarantee that everyone encounters the same burden or has the same opportunity to benefit.

The 2022 National Health Interview Survey illustrates why. The prevalence of specific nonfinancial barriers varied across sociodemographic groups. For example, publicly insured adults were more likely than privately insured adults to report being unable to obtain an appointment when needed, and difficulty reaching a provider when open varied by income, race and ethnicity, insurance, and other characteristics.[2] These findings do not prove that any particular organizational rule is inequitable. They do show that the practical conditions surrounding access are not evenly distributed.

Federal and national equity frameworks increasingly reflect this broader view. The CMS Framework for Health Equity emphasizes access, language, health literacy, culturally appropriate care, data, and organizational capacity.[6] The National Academies has likewise argued that equitable care requires attention not only to whether services exist, but whether care is comprehensive, affordable, accessible, timely, respectful, and culturally appropriate.[7]

4. Repeated Barriers Are System Information

“Men lie, women lie, numbers don’t.”

- JAY-Z, “Reminder” (2009)

A single missed appointment or incomplete referral does not, by itself, establish a system problem. People make choices, circumstances change, and individual responsibility remains relevant. But recurring patterns deserve a different level of analysis.

If the same barrier appears repeatedly at the same step - for a particular service, payer, geography, language group, clinic schedule, referral type, or population - leadership has information about how the process is functioning. At that point, treating every instance as an isolated individual failure can obscure an operational pattern.

Equity-oriented quality improvement does not require assuming that every difference is caused by discrimination or that every standard must be individualized. It requires measuring where people drop out of a process, identifying

whether burdens cluster in predictable ways, engaging people who experience the process, and testing whether reasonable changes improve access without undermining legitimate standards. This is consistent with national recommendations emphasizing better data collection, person-centered measures of access, and community-informed approaches to system design.[3,4,6]

5. Five Questions Behavioral Health Leaders Should Ask Beyond Compliance

“How you gon’ win when you ain’t right within?”

- Lauryn Hill, “Doo Wop (That Thing)” (1998)

Leadership question	What to examine
1. What happened after the requirement was met?	Move beyond “completed,” “offered,” “sent,” or “referred.” Examine whether the next step occurred and whether the intended pathway became usable.
2. Who carried the burden of making the process work?	Identify which tasks remained with the individual: repeated calls, transportation, scheduling, documentation, digital access, coordination, language navigation, or follow-up.
3. Were the barriers foreseeable?	When the same obstacle appears repeatedly, it should no longer be treated as an unexpected exception. Repetition can signal a design or implementation problem.
4. Does the same rule produce different experiences for different people?	Consistent implementation is not the same as identical burden. Examine differences in completion, wait time, drop-off, and access across relevant populations and settings.
5. What could the system reasonably do differently?	Equity is not the absence of standards. It includes testing whether standards can be implemented in ways that reduce avoidable burden while preserving safety, integrity, and accountability.

From a Compliance Dashboard to an Access Dashboard

Organizations do not have to choose between compliance and equity. The more useful approach is to pair process measures with measures that show what happens next. A referral-completion rate can be paired with successful scheduling, first-contact, attendance, or service-initiation rates. An outreach-attempt count can be paired with connection rates by contact method and time of day. A telehealth-availability metric can be paired with data on modality used, failed connections, audio-only reliance, and whether technology requirements affect particular groups. A network-adequacy measure can be paired with appointment wait times and the percentage of callers who can actually secure care.

The point is not to create endless measurement. It is to identify the few transition points where the organization can mistake internal completion for external access. Those are the places where a second measure can change the interpretation of performance.

For behavioral health leaders, this matters because engagement is often treated as evidence of motivation, readiness, or adherence. Context complicates that interpretation. A person may decline care, miss an appointment, fail to complete paperwork, or stop responding for reasons that include individual choice. The same observable behavior may also occur when a pathway demands time, transportation, technology, literacy, coordination, or flexibility that the person does not have. Good leadership does not erase accountability; it improves the accuracy of the attribution.

Implications for Leadership and Continuous Quality Improvement

A practical equity review can begin without a new department or a large research initiative. Leaders can identify one high-volume pathway, map the steps from organizational action to actual service connection, and examine where people are lost. The most useful data may include wait time, failed contact, referral closure reason, appointment availability, payer acceptance, transportation or scheduling barriers, language needs, digital modality, and repeat referrals. Quantitative patterns should be paired with qualitative input from people who use and deliver the service.

The goal is not to guarantee identical outcomes. Health systems cannot control every condition that shapes access, and individual agency remains central. The goal is to distinguish what the organization can reasonably influence from what it cannot - and to avoid describing a process as successful merely because the organization completed its own portion of the workflow.

Conclusion

Compliance is necessary for safe, accountable, and reliable systems. But procedural completion is not the same as meaningful access. A referral can be made without becoming a connection. An appointment can be offered without being realistically usable. A notice can be sent without being understandable. A telehealth service can exist without being accessible. A rule can be applied consistently while creating unequal burdens in practice.

The leadership task is therefore not to choose between standards and equity. It is to examine whether standards are producing what they were designed to produce, for whom, under what conditions, and at what burden.

CLOSING QUESTION

The question is not whether standards matter. It is whether our review stops too soon.

References

1. Office of Disease Prevention and Health Promotion. (n.d.). Access to health services. Healthy People 2030, U.S. Department of Health and Human Services. <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services>
2. Ng, A. E., Adjaye-Gbewonyo, D., & Dahlhamer, J. M. (2024). Sociodemographic differences in nonfinancial access barriers to health care among adults: United States, 2022. National Health Statistics Reports, No. 207. National Center for Health Statistics. <https://www.cdc.gov/nchs/data/nhsr/nhsr207.pdf>
3. National Academies of Sciences, Engineering, and Medicine. (2024). Ending unequal treatment: Strategies to achieve equitable health care and optimal health for all. National Academies Press. <https://doi.org/10.17226/27820>
4. National Academies of Sciences, Engineering, and Medicine. (2024). Expanding behavioral health care workforce participation in Medicare, Medicaid, and Marketplace plans. National Academies Press. <https://doi.org/10.17226/27759>
5. Kyle, M. A., Feng, K. Y., Wade, C. G., & Yaver, M. (2025). Patient administrative burden: A scoping review. Health Affairs Scholar, 3(11), qxaf216. <https://doi.org/10.1093/haschl/qxaf216>
6. Centers for Medicare & Medicaid Services. (2022). CMS framework for health equity 2022-2032. <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>
7. National Academies of Sciences, Engineering, and Medicine. (2023). Federal policy to advance racial, ethnic, and tribal health equity. National Academies Press. <https://doi.org/10.17226/26834>
8. Office of Disease Prevention and Health Promotion. (n.d.). Access to primary care. Healthy People 2030, U.S. Department of Health and Human Services. <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care>

Cultural Epigraphs

The Notorious B.I.G. (1994). "Things Done Changed." Ready to Die. Bad Boy Records.

Lauryn Hill. (1998). "Doo Wop (That Thing)." The Miseducation of Lauryn Hill. Ruffhouse/Columbia.

JAY-Z. (2009). "Reminder." The Blueprint 3. Roc Nation/Atlantic.

Suggested Citation

Robinson, T. (2026). Technically compliant can still be inequitable: Why procedural completion is not the same as meaningful access. Behavioral Health in Context Research Brief No. 1.

Author

Dr. Tonica Robinson is a behavioral health executive, scholar, researcher, and educator whose work examines behavioral health in context - including the systems, policy, history, social conditions, and institutional practices that shape behavior, access, experience, and outcomes. Black American behavioral health is one of her deepest areas of scholarship.

drtonicarobinson.com