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Promoting Health Equity And Eliminating Disparities Through Performance Measurement And Payment

ABSTRACT **Current approaches to health care quality have failed to reduce health care disparities. Despite dramatic increases in the use of quality measurement and associated payment policies, there has been no notable implementation of measurement strategies to reduce health disparities. The National Quality Forum developed a road map to demonstrate how measurement and associated policies can contribute to eliminating disparities and promote health equity. Specifically, the road map presents a four-part strategy whose components are identifying and prioritizing areas to reduce health disparities, implementing evidence-based interventions to reduce disparities, investing in the development and use of health equity performance measures, and incentivizing the reduction of health disparities and achievement of health equity. To demonstrate how the road map can be applied, we present an example of how measurement and value-based payment can be used to reduce racial disparities in hypertension among African Americans.**

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Health and health care disparities in the United States are long standing and pervasive. In the Institute of Medicine's seminal report *Crossing the Quality Chasm*,[1] equity was identified as a key domain of quality. However, although there has been a meteoric rise in the use of quality measurement tied to payment and public reporting, the use of measures that directly target disparities reduction has not expanded.[2] To date, major payment programs such as the Hospital Value-Based Purchasing Program and the Merit-Based Incentive Payment System (MIPS) do not include equity as a domain of performance measurement. Quality improvement initiatives without a focus on disparity reduction have had mixed results in influencing disparities and, in some instances, have the potential to widen disparities.[3,4] Pay-for-performance programs have mostly been designed for the general population, and systematic reviews indicate that these incentives have usually not improved disparities.[5] In addition, bundled payment and accountable care organizations have also not directly incorporated disparities reduction into incentives.[6] In one of the few payment initiatives specifically designed to advance equity, the Massachusetts Medicaid program tried to decrease disparities through financial incentives, but this effort was unsuccessful because of limited racial/ethnic diversity in many hospitals, statistical issues, and insufficient quality improvement processes.[7]

To ensure that equity is front and center in these efforts, the health care system needs a road map for reducing disparities that includes specific recommendations regarding the use of quality measurement and payment as potential levers to reduce disparities and drive equity in health and health care.[8] The National Quality Forum (NQF) convened a multistakeholder group of experts to develop such a road map. As detailed

in the online appendix,[9] the road map specifies four elements to achieve health equity: identify and prioritize areas to reduce health disparities, implement evidence-based interventions to reduce disparities, invest in the development and use of health equity performance measures, and incentivize the reduction of health disparities and achievement of health equity.

This article illustrates how the equity road map can be used to reduce disparities through value-based payment. To demonstrate the linkage of the proposed equity road map to evidence-based approaches to reducing disparities, we use as an example hypertension—a major source of morbidity and premature mortality among African Americans.[8]

This example illustrates the power of a deliberate and comprehensive approach to the identification and eradication of disparities through measurement and payment. Though it focuses on racial disparities, the approach is applicable to a broad range of disparities, including those based on gender, income, language, sexual orientation, gender identity, disability, geographic location, and other social risk factors. This article provides examples of strategies that aim to reduce disparities in the prevention and control of hypertension among African Americans. This work builds on a literature review of evidence-based practices, an environmental scan of measures, and key-informant interviews with experts in cardiovascular disease disparities.

Action 1: Identify And Prioritize Reducing Health Disparities

A health care organization, insurer, or policy maker must identify whether disparities exist among the racial and ethnic groups it serves and identify specific areas that should be prioritized for disparities reduction. Organizations can use standardized clinical performance measures, such as NQF Measure 0018: Controlling High Blood Pressure from the National Committee for Quality Assurance (NCQA). This measure captures the percentage of patients ages 18–85 with a diagnosis of hypertension and with adequately controlled blood pressure ($<140/90$ mmHg) during the measurement period. Though all quality measures could be considered through the lens of disparities, four criteria can identify the measures that warrant a specific focus on disparities by assessing the prevalence of the target condition, the size of the disparity, the strength of the evidence for strategies to reduce the disparity, and the ease and feasibility of improvement. These criteria—discussed next—assist in prioritizing a set of measures for monitoring disparities and can be customized based on specific needs. However, not all criteria must be met for prioritization.

PREVALENCE In this example, the question is how prevalent hypertension is among African Americans. The American College of Cardiology defines hypertension in two stages: Stage 1 is systolic 130–139 or diastolic 80–89 mmHg, and stage 2 is systolic ≥140 or diastolic ≥90 mmHg.[10] According to the American Heart Association, more than 40 percent of African Americans have high blood pressure, hypertension, or both.[11] African Americans are also more likely to develop hypertension earlier in life, and it is usually more severe.[12]

SIZE OF THE DISPARITY This criterion aims to measure the gap in the prevalence or control of hypertension between African Americans and groups with the lowest rates of hypertension. African Americans have higher rates of hypertension than any other racial/ethnic group in the US. The National Center for Health Statistics reported that in the period 2011–14, among adults ages twenty or older, 43.0 percent of non-Hispanic African Americans, 34.5 percent of non-Hispanic whites, 25.0 percent of Asians, and 22.0 percent of Hispanics or Latinos had hypertension.[13] The American Heart Association found that African Americans have rates of stroke and heart failure that are two times higher than those of non-Hispanic whites, and a rate of end-stage renal disease that is four times higher. Half of the cardiovascular mortality disparity between African Americans and whites is directly attributable to the prevalence and control of hypertension.[14]

STRENGTH OF THE EVIDENCE FOR REDUCTION STRATEGIES This criterion explores how strong the evidence is that links reduction or management of hypertension to improvements in the African American population. Providers can intervene to reduce hypertension in African American communities and prevent complications. However, implicit bias may lead to clinical inertia—the failure of providers to treat hypertension in some groups.[15] African Americans have higher rates of nonadherence to antihypertensive medications, which is a modifiable factor that should be addressed to reduce racial disparities in blood pressure control.[16] Other studies have linked attitudes and beliefs about hypertension to disparities among African Americans.[17] Improving self-efficacy for managing hypertension is also associated with significant improvements in blood pressure control.[18–20] Policy interventions, such as efforts to reduce salt in fast food, could also reduce disparities in hypertension.[21]

EASE AND FEASIBILITY OF IMPROVEMENT This criterion addresses the extent to which providers

This article illustrates how the equity road map can be used to reduce disparities through value-based payment.

or health plans can reasonably improve on the reduction of disparities in hypertension. Many providers have improved the prevention and control of hypertension among African Americans using evidence-based interventions. For example, 81 percent of African Americans in a program of the Philadelphia Veterans Affairs Medical Center who received monthly counseling and drug changes and adjustments by a pharmacist had controlled hypertension by the end of six months.[22] In addition, standardized measures for hypertension are used in many public and private payment programs. For example, NQF Measure 0018 is currently used in MIPS and several other public reporting and accountability programs.[23] Since this measure is already built into clinical practice, it can be prioritized to monitor disparities in hypertension among African American patients.

Action 2: Implement Evidence-Based Interventions To Reduce Disparities

Evidence-based interventions to reduce disparities can be organized into the following two categories: those that aim to address differences in hypertension between African Americans and the group with the lowest rates of hypertension, and those that aim to reduce overall rates of hypertension within African American communities. The road map employs a modified socioecological model , which describes the levels of health systems that play a role in individual health outcomes. Using this framework, interventions to reduce disparities in hypertension can be applied at the patient-family, provider, organization, community, or policy level, or some combination of these. Multilevel and multisectoral interventions are needed to fully address the complex societal causes of disparities in hypertension.[24,25]

Over the past decade, dozens of studies have documented evidence-based interventions that health care organizations can use to address disparities in hypertension among African Americans. These interventions have primarily focused on lifestyle modification to prevent or control hypertension. A systematic review of interventions among communities of color by Andrew Davis and coauthors found that interventions were primarily nonpharmacologic and focused on changing the behavior of patients or families through education.[14] The majority of the interventions target diet, exercise, and stress. Interventions at the provider and organization level that involve clinic reorganization or multidisciplinary teams of health care providers have produced beneficial effects for multiple outcomes, including blood pressure control in patients with hypertension and glucose control in patients with diabetes.[26] Other studies have corroborated these findings and provided further evidence for the use of disease management programs, peer coaches, and community health workers to reduce disparities in hypertension among African Americans and other communities of color.[27–29]

Leading health care organizations have demonstrated promising findings using interventions designed to reduce disparities between different groups and improve the care and outcomes of at-risk populations. For example, Aetna collaborated with the Morehouse School of Medicine and Health & Technology Vector Inc. to implement a high-intensity, multimodal, culturally competent disease management program for African Americans insured by Aetna to achieve and maintain blood pressure control. The intervention consisted of telephonic lifestyle and diet counseling by trained nurses, along with the use of home blood pressure monitoring devices. The program increased the frequency of self-monitoring for African Americans and improved systolic hypertension control by 50 percent. The program could likely be applied to African Americans enrolled in other private health plans.[30]

In addition, Kaiser Permanente implemented a disparities intervention through its Equitable Care Health Outcomes Program, which uses a population care management, team-based approach to address racial disparities in hypertension control. Kaiser implemented the following four strategies: a physician-led educational program on treatment intensification, medication adherence, and consistent use of clinical practice guidelines; care teams with defined roles and responsibilities for hypertension management; redesigned care delivery to expand access; and culturally tailored communication tools for self-management.[31] The program reduced disparities in hypertension between African American and white patients by 71 percent between 2009 and 2016.[32] Kaiser Permanente received the Ameri-

can Hospital Association's 2017 Equity of Care Award for this achievement.

These are only a few of the many evidence-based interventions that health care organizations can implement to reduce disparities in hypertension among African Americans.[33,34] Health care organizations are in a unique position to implement interventions at multiple levels within health systems and beyond. For example, *Communities in Action: Pathways to Health Equity*, a 2017 report by the National Academies of Sciences, Engineering, and Medicine, recommended that hospitals and health care systems focus their community benefit dollars to pursue long-term strategies to promote health equity, such as changes in laws, policies, and systems.[35] These strategies should build healthier neighborhoods, promote healthy lifestyles, drive economic development, and advance upstream initiatives aimed at eradicating the root causes of poor health. An extensive literature documents how individual and institutionalized racism contributes to the prevalence of hypertension in racial/ethnic minority groups through increased allostatic loads.[36] Multisectoral efforts such as those in housing, food security, and the criminal justice system can help address the institutional manifestations of this racism that exacerbate hypertension.

MIPS could provide rewards for implementing many of these community and quality improvement activities, and more health care organizations would be likely to address fundamental determinants of health if the determinants were measured and rewarded in value-based purchasing programs.[37] The outcomes of these initiatives should be routinely monitored, using measures stratified by social risk factors to detect relative and absolute improvement among groups.

Action 3: Invest In The Development And Use Of Health Equity Performance Measures

Health equity performance measures can drive reductions in disparities by incentivizing providers to investigate their own practice and community, use interventions known to reduce disparities, and try new processes or interventions to improve equity. Eliminating disparities will require the sustained use of evidence-based interventions by stakeholders at all levels of the health care system. Performance measurement offers the opportunity not only to identify disparities but also to assess the use of effective interventions to eliminate disparities in care.

Advancing equity means improving both access to and quality of care, and no single intervention will eliminate disparities. The road map includes five domains of health equity measurement.

The domains represent the core processes, structures, and outcomes that must be measured to achieve equity with prioritized goals for the health care system. The domains are described next.

The first domain entails building collaborations and partnerships to address factors outside the direct control of the health care system that can contribute to racial and ethnic disparities in hypertension. Measures can be implemented that assess the degree to which such partnerships occur.[38] To reduce racial disparities in hypertension, health care providers will need to work with other sectors to help patients address non–health care factors. Measures could assess the degree to which providers connected patients to resources in their communities—such as stable housing, healthy food, and safe places to exercise—to help them control their blood pressure.

The second domain entails creating a culture of equity that prioritizes the reduction of disparities and responds to the needs of the individual. For example, measures could assess the use of culturally competent care, which has been shown to reduce racial and ethnic disparities in hypertension.[29] Equity training could also emphasize issues such as structural racism and the intersectionality of multiple dimensions of disadvantage, such as race/ethnicity and poverty.

The third domain entails creating structures that enable equity, such as team-based care and disease management programs.

The fourth domain entails ensuring equitable access to health care such as by measuring the affordability of medication—operationalized as the ability to pay for treatment, which can affect adherence.

The fifth domain entails ensuring that care is of high quality by using evidence-based interventions and assessing whether they actually reduce disparities in hypertension.

For hypertension, many evidence-based interventions will require linkages between communities and health systems, such as self-management and disease-monitoring programs that connect providers to patients outside the provider's office setting. One example of a health equity measure is the degree to which a health care organization reaches out to its African American population. Outreach could involve prevention education, blood pressure screening, and hypertension reduction projects in the community. Another key component is financial investment in community organizations that can facilitate preventing hypertension through behavioral health counseling, lifestyle change

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programs, or connecting patients to "enabling" services that address social risk factors by providing or making referrals for people to food, income, housing, transportation, and language support programs.[39] A hypertension control performance measure (such as NQF Measure 0018: Controlling High Blood Pressure) could then be stratified by relevant patient or population subgroups and used to monitor the reduction of disparities.

Measure stratification can be used to provide feedback to providers on equity within their practice or geographic area. Ideally, the subgroups of patients by which measures are stratified will correspond to known disparities in quality and outcomes. However, data quality and sample size issues may limit the granularity of subgroups (for example, racial/ethnic groups) for which stratified scores can be calculated. Measurement of disparities should be paired with overall performance measures to ensure that equity is not achieved by decreasing the quality of care received by the advantaged group.

Action 4: Incentivize The Reduction Of Health Disparities And Achievement Of Health Equity

Reducing racial and ethnic disparities may also require changing incentives.[40] Fee-for-service models limit the ability to address the non–health care factors that may contribute to a person's outcomes. The shift to value-based purchasing and alternative payment models represents an opportunity to realign incentives. Payment and reporting remain underused levers to reduce disparities and offer opportunities to advance equity in multiple ways.

Payers can consider adjusting payment and performance scores for a patient's social risk where appropriate and can report the results of stratified performance measures to promote transparency and help identify and address disparities. Moreover, the shift to value-based purchasing represents a chance to reward providers for reducing disparities or using effective interventions to achieve equity. Both of these approaches might not only lead to greater uptake of interventions known to reduce disparities but could also prompt providers to develop new interventions. Additionally, newer innovative approaches to incentives could include payment that rewards combinations of improving outcomes, attaining absolute thresholds of performance, and reducing disparities.

Promisingly, equity was recently included as a MIPS practice improvement activity, and the Centers for Medicare and Medicaid Services, in the most recent inpatient payment rule, is considering requiring providers to report certain outcome measures stratified by dual eligibility status.[41] The shift to global payment, capitated payment, and bundled payment—part of the movement toward value-based payment—could support the infrastructure for interventions that reduce disparities. However, these payment approaches must be coupled with explicit incentives to address social determinants of health and reduce disparities.

Finally, social and population health measures can be used to ensure that resources are allocated to counteract these drivers of disparities. For example, Medicare currently collects reliable data on beneficiaries' eligibility for Medicaid, geographic location (that is, rural versus urban location), and country of origin. These measures can be used to identify providers who disproportionately serve populations with social risk factors such as these and allocate additional resources based on need.[42]

Alternatives to fee-for-service payment offer opportunities to incentivize the reduction of disparities. Increased payment for primary and preventive care could improve disease management and promote behavioral and lifestyle interventions that have been shown to reduce disparities in hypertension. Strong primary care systems improve population health and reduce disparities.[43]

New payment models could also support infrastructure and upstream services necessary to reduce the burden of chronic disease. They can also incentivize reducing disparities as part of efforts to transform care. For instance, a recent Department of Veterans Affairs (VA) pay-for-performance program improved blood pressure control and appropriate response to uncontrolled blood pressure in African American patients. Every four months clinicians received audit and feedback on their blood pressure performance measures, as well as $9.10 for each target outcome the clinician or practice

achieved.[44] Although the VA is both a provider and single-payer system, which makes integrated payment and care delivery reform easier, it offers important lessons about how a pay-for-performance model could help reduce disparities.

Conclusion

To drive meaningful improvement in the health of the United States, health care stakeholders must use evidence-based approaches to reduce health care disparities and achieve health equity. For many years, policy makers and professional organizations have recommended stratifying clinical performance measures by social risk factors such as race and ethnicity to identify disparities and motivate change.[42] However, the uptake of such approaches has been modest at best; this suggests competing priorities, such as the initiation of value-based purchasing programs, that have not explicitly included equity performance measures. A key recommendation of the road map presented in this article is to tie stratified performance measures to payment incentives and financial supports. Creation of a stronger business case for equity can encourage the leadership of health care organizations to prioritize equity and invest in the data infrastructure necessary for stratifying performance measures. Ultimately, leaders must truly value reducing health disparities and encourage the payment and care delivery reforms necessary to incentivize, support, and sustain health equity efforts.[45]

Decades of experience have demonstrated that a general "rising tide lifts all boats" philosophy of quality improvement will not eliminate disparities. To achieve equity, health care stakeholders must identify disparities, implement evidence-based interventions to reduce them, invest in equity measurement, and incentivize the achievement of equity. As demonstrated in the hypertension example, this four-part strategy can and should be part of our quality efforts. Equity will not be achieved unless it is woven into the fabric of quality and payment in our health care system. ■

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