CHCI Policy Brief

Establishing a Transparent and Representative Evidence-Based Health Care System: Using Equity-Focused Performance Measurements to Reduce Health Disparities and Improve Patient Care

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Executive Summary

Current healthcare performance measurements allow substandard care for people of color. This is because performance measurements are not designed to identify the gaps between people that are affected by social risk factors, yet don't receive appropriate and quality health care. This policy issue analysis evaluates two distinct alternatives as possible solutions to the problem regarding the use of performance measurements to promote health equity, which is achieved when people have an equal opportunity to reach their full health potential regardless of socially determined circumstances.[1] Each alternative is evaluated based on three criteria: efficiency, sustainability, and political feasibility. The first alternative, "Require and Incentivize Collection of Social Risk Factor Data," requires the establishment of an electronic medical record (EMR) infrastructure to collect and store social risk factor data. The second alternative, "Prioritize Equitable High-Quality Care Measures To Create Accountability," stands out as the best option to address this policy issue. Although both policy alternatives present valid arguments and aim to strengthen equity-focused performance measures, the second alternative demonstrates a stronger data-collection foundation and promising development of

measures to ensure a transparent and representative evidence-based health care system. As a result, implementing the second alternative would result in the most efficient, sustainable, and politically feasible way to assess disparity reduction and patient care improvement through the use of equity-focused performance measurements.

Background

Performance measurements, which are used to identify health disparities, target resources and interventions, and monitor the improvement or worsening of those disparities, are not designed to promote health equity among people of color.

Attaining the highest possible standard of health should be a fundamental right for every human being regardless of race or socioeconomic status. The World Health Organization (WHO) recognizes the importance of building a transparent and representative evidence-based health care system to reduce health disparities and improve patient care.[2] While there have been significant improvements in understanding the impact social determinants have on health outcomes, disparities persist. In 2015, the Centers for Disease Control and Prevention (CDC) reported significant health and health care disparities in leading causes of death such as cardiovascular disease,

chronic kidney disease, diabetes, and mental illness.[3] In addition, the 2016 National Healthcare Quality and Disparities Report highlighted that racial and ethnic minorities, individuals with disabilities, and those who have low-incomes are more likely to receive lower quality of care.[4] In fact, Hispanics, African Americans, American Indians, and Alaska Natives received worse care than whites for about 40 percent of performance measurements whereas Asians and Pacific Islanders received worse care for about 30 percent of these measurements.[5]

Performance measurements are an essential, yet underused tool for advancing health equity.[6] They make it possible to monitor health disparities and assess the level to which interventions, that are known to reduce disparities, should be employed.[7] Performance measurements allow policymakers, legislators, hospital administrators, hospital delivery systems, community advocates, patient advocate groups, and providers to assess the impact of these interventions in improving patient care. Moreover, these measurements can help identify the gaps where people affected by social risk factors don't receive appropriate and quality health care.[8] Furthermore, the National Quality Forum (NQF) Committee directed an investigation to assess the current landscape of perfor-

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mance measurements that can be used to assess progress towards achieving reduced health disparities and improved patient care. This investigational analysis resulted in the finding of 886 performance measurements, which align with the equitable high-quality care and equitable access to care domains outlined in the 2017 NQF report.[9]

To be an effective tool for advancing health equity, performance measurement must be incorporated in a way that specifically accounts for disparities based on age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and other social risk factors. Stratifying performance data based on this criteria demonstrates the importance of cultural competence, community engagement, and cross-sector partnerships to reduce disparities and improve patient care.[10] It is important to note that multiple major operational performance data sets in Medicare, Medicaid, and commercial insurances do not stratify based on this criteria although the Affordable Care Act (ACA) requires population health surveys in national health insurance programs to collect and report stratified data.[11] Consequently, health care organizations and providers who participate in reporting performance measures to value-based programs (Medicare, Medicaid, and some commercial insurers) should be required to organize their data based on the given criteria.[12] This would play a key role in establishing a transparent and representative evidence-based health care system for people facing health disparities and inadequate patient care.

Policy Alternatives

Alternative Policy One – Require and Incentivize Collection of Social

Risk Factor Data

The collection and reporting of data serves as a foundation for equity-focused performance measurements particularly as it pertains to social risk factors such as housing instability, food insecurities, gender identity, sexual orientation, language barriers, and continuity of insurance coverage.[13] Data on social risk factors that affect people of color is limited and lacks complete representation of at-risk community groups such as Hispanics, African Americans, American Indians, Alaska Natives, Asians, and Pacific Islanders. The lack of transparent and representative evidence-based data makes it difficult to reduce health disparities and improve patient care. As a result, establishing an infrastructure that collects and stores social risk factor data would be ideal. One way to require and incentivize data collection would be to provide additional payment for the use of electronic medical records (EMR) that store recorded data.[14] The use of ICD-10 codes, which are used by physicians and other health care providers to classify and code all medical diagnoses, symptoms and procedures, would make it possible to determine the health status and services received by at-risk community groups.[15] These codes capture social risk factors such as education, socioeconomic status, employment, social environment, upbringing, and family circumstances.[16] Considering that many performance measures rely on insurance claims data, they are often not statistically representative of individuals who are unable to maintain consistent enrollment in a health insurance plan.[17] On the other hand, because ICD-10 codes are used regardless of continuous enrollment, the data collected from the analysis of these codes would be representative of most at-risk community groups that seek medical

care. Performance measurement data from ICD-10 codes would ultimately bridge the gap between people affected by social risk factors and the attainment of appropriate and quality health care.

Alternative Policy Two – Prioritize Equitable High-Quality Care Measures To Create Accountability

Although performance measurements play a significant role in creating accountability and establishing a transparent and representative evidence-based health care system, they lack the ability to promote health equity among people of color. This discrepancy creates a level of uncertainty in the accountability to reduce disparities and improve patient care among Hispanic, African American, American Indian, Alaska Native, Asian, and Pacific Islander communities. Prioritizing equitable high-quality care measures establishes a level of responsibility and ensures that community groups, at greatest risk for suboptimal care, receive the highest quality medical attention.[18] Equitable high-quality care measures include culturally tailored interventions, patient-centered communication skills, and cultural competency training.[19] Like equity-focused performance measurements, these measures are effective community interventions that play a key role in reducing disparities and promoting health equity among people of color. However, according to the NQF, few measures are currently used to directly assess disparities for accountability purposes. As a result, further research and measure development is needed to establish measures that assess whether stakeholders are employing interventions that are known to reduce disparities. Potential measures that could be developed for accountability purposes are measures for effective patient-provider communication and

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patient-centered care.[20] Measures that address equitable high-quality care to create accountability would face fewer data collection challenges. The clinical nature of quality-of-care measures requires traditional data sources such as claims data, which makes data collection more feasible.[21]

Assessing the Tradeoffs

Efficiency

Performance measurements should promote health equity to establish a transparent and representative evidence-based health care system that reduces health disparities and improves patient care. The second alternative, "Prioritize Equitable High-Quality Care Measures To Create Accountability," is the most efficient policy option to ensure that performance measurements become equity-focused and continue creating accountability in our health care system. Prioritizing existing quality-of-care measures doesn't require the establishment of a new administrative infrastructure nor is it contingent on additional payment requirements, which makes it increasingly efficient. According to the NQF, which reported 755 total measures of high-quality care, equitable high-quality care measures don't lack representation of at-risk community groups and they are not limited.[22] This means that numerous quality-of-care measures can be efficiently utilized to develop an equity-focused approach to performance measurements. Further, the transparent and representative measures to create accountability in the second alternative yield significant data collection advantages that enhance its efficiency compared to the first alternative.

Sustainability

More than being an efficient policy option, the second alternative possess-es characteristics that make it significantly more sustainable when compared to the first alternative, which would require and incentivize the collection of social risk factor data. By using effective community interventions, such as patient-provider communication and patient-centered care, quality-of-care measures in the second alternative would not rely on only populations that seek medical care. With data that is dependent and limited on the accuracy of reported ICD-10 codes, which don't always capture every social risk factor in at-risk community groups, the first alternative lacks depth in sustainability and patient representation. The use of equity-focused performance measurements requires the integration of a policy that prioritizes equity-based measures to monitor and assess how interventions are implemented. Therefore, the ability to sustainably reduce disparities and improve patient care is dependent on the second alternative, which creates accountability through the promotion of equitable high-quality care measures. Although few measures are currently used to directly assess disparities for accountability purposes, the feasibility of data collection and existing quality-of-care measures project its long-term sustainability.

Political Feasibility

Political feasibility analysis is used to predict the likelihood that distinct alternative solutions will resolve a policy problem, such as the restructuring of performance measurements to promote health equity among people of color. The political feasibility of the preferred second alternative rests on the fewer data collection and stratification challenges it needs to overcome compared to the first alternative. More specifically, the lack of infrastructure makes it increasingly difficult to obtaining reported data based on age, gender, income, race, ethnicity, nativity, language, sexual orientation, and gender identity. Beyond lacking political feasibility, these challenges pose a significant threat to the identification of health disparities among at-risk community groups. Furthermore, it's unfeasible to expect that social risk factor data will be reported and stratified based on specific criteria. In fact, operational performance data sets in national insurance programs, such as Medicare and Medicaid, don't stratify based on this criteria although the Affordable Care Act requires them to collect and report stratified data.[23] Although the first alternative is not impossible, the overarching challenge of standardizing insurance program data reporting schedules (annual, bi-annual, quarterly) make it politically unfeasible.

Recommendation

The use of equity-focused performance measurements, to reduce health disparities and improve patient care, undoubtedly leads to the establishment of a more transparent and representative evidence-based health care system. Having the capacity to measure performance allows health care systems to assess, support, and incentivize the reduction of disparities and achievement of health equity among people of color.[24] Furthermore, based on the three criteria that each alternative was equally evaluated on, the second alternative is the best option to address this policy problem. The preferred alternative would be a highly effective and sustainable policy that can be implemented with moderate administrative complexity, depending on the level of accountability needed to ensure that stakeholders are implementing the interventions needed to reduce disparities and improve patient care.

Endnotes

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