Reducing Disparities Requires Multiple Strategies

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Addressing disparities in care is a critical issue that requires multiple strategies to solve. We concur with Ms O’Kane that sharing best practices among providers and across healthcare organizations and stratifying results to spot differences are important actions.1 We applaud the steps that the National Committee for Quality Assurance is taking to report Healthcare Effectiveness Data and Information Set scores stratified by socioeconomic status (SES). We also agree that additional payments to providers who treat a disproportionate share of low-SES patients could help them make needed investments to support the delivery of high-quality care.

In prior work, we proposed that incentive programs consider adjusting incentive payments to mitigate the negative effects of redistributions of payments across providers with disparate patient populations.2 This approach categorizes providers based on a set of predefined patient or provider characteristics, such as percentage of low-income patients, and then sets the average incentive payout to be the same across provider categories. We found that this approach nearly doubled payments to disadvantaged physician organizations and greatly reduced payment differentials across physician organizations according to patients’ income, race/ethnicity, and region.

The National Academy of Medicine (NAM) identified 4 categories of strategies to account for social risk factors in public reporting and payment systems.3 Two of these categories include strategies mentioned by Ms O’Kane: public reporting stratified by patient or provider characteristics, and direct adjustment of payments through risk adjustment of payment formulas or stratification of payment benchmarks.

However, another category of strategies identified by NAM includes risk adjustment of performance measure scores for within-provider differences associated with social risk factors. Receipt of appropriate care is not entirely under the control of providers when performance is connected with social risk and its consequences.4 Failure to account for within-provider differences in performance associated with social risk factors that are beyond provider control risks disincentivizing providers to treat patients with social risk factors and mismeasuring care quality.5 The Categorical Adjustment Index (CAI) adjusts for within-plan disparities. As such, the CAI is not confounded by quality differences across plans.6 The focus on within-provider disparities is similar to current adjustments for differences in patient clinical complexity across providers, such as for patient-reported experience measures collected by Consumer Assessment of Healthcare Providers and Systems surveys.7

As noted in the NAM report, "The fact that some units (eg, providers) do well with socially at-risk populations does not imply that it is equally easy to do so on average, and such population differences may also affect the relationship between provider quality and observed provider scores. The standard for taking such factors into account should not be that it is impossible to provide optimal care, but that it is more difficult on average."8

Strategies to improve the measurement of quality can go hand-in-hand with other strategies, such as reporting stratified performance estimates, to address disparities in value-based purchasing programs.

REFERENCES