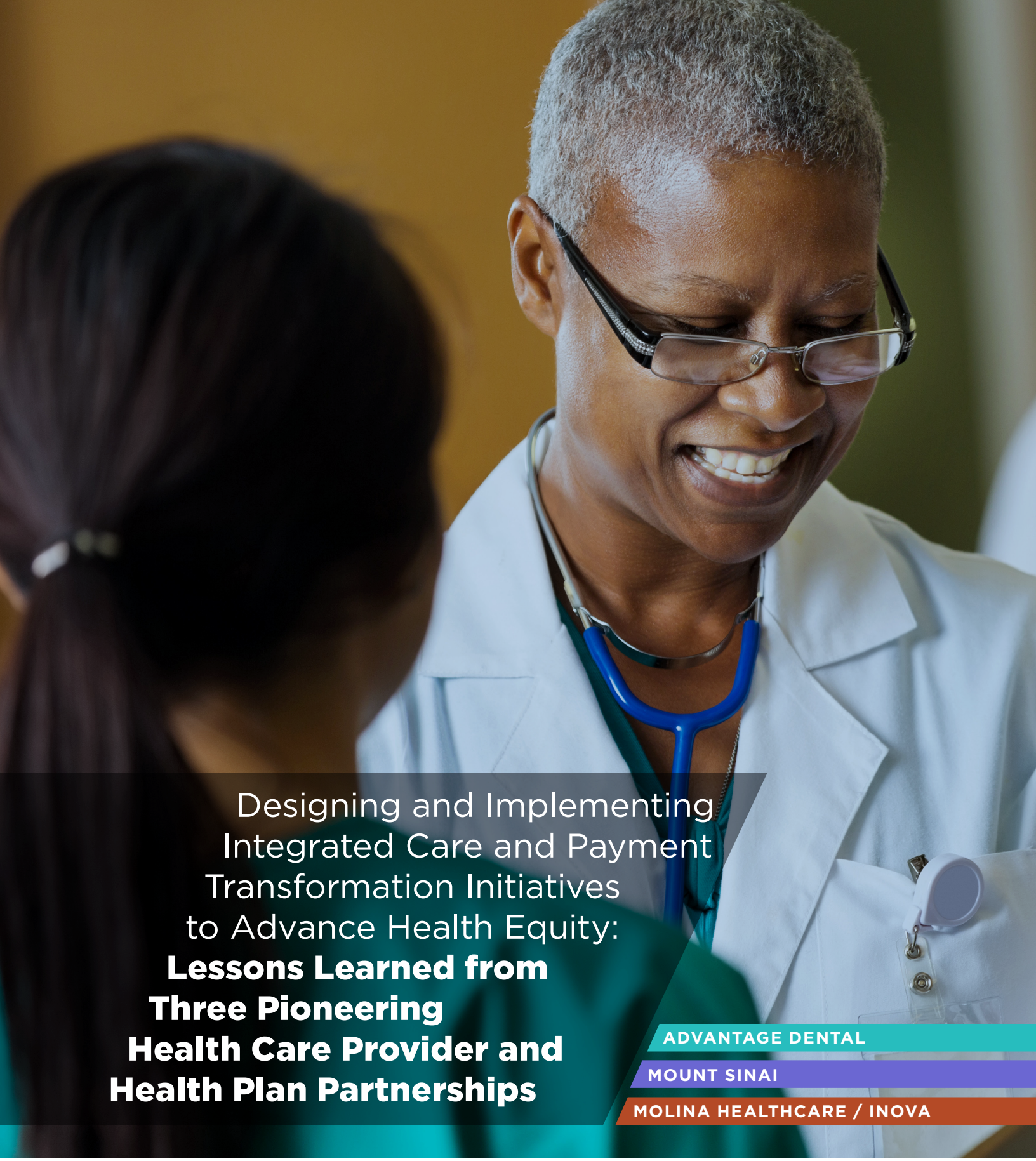

Designing and Implementing Integrated Care and Payment Transformation Initiatives to Advance Health Equity: **Lessons Learned from Three Pioneering Health Care Provider and Health Plan Partnerships**

ADVANTAGE DENTAL

MOUNT SINAI

MOLINA HEALTHCARE / INOVA

AHE Advancing Health Equity
Leading care, payment, and systems transformation

Designing and Implementing Integrated Care and Payment Transformation Initiatives to Advance Health Equity:

Lessons Learned from Three Pioneering Health Care Provider and Health Plan Partnerships

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EXECUTIVE SUMMARY

In 2014, *Advancing Health Equity: Leading Care, Payment, and Systems Transformation*, a national program of the Robert Wood Johnson Foundation (AHE; formerly known as Finding Answers), launched a national call for proposals designed to discover best practices for achieving equity by integrating payment and delivery system reforms.

Three grantees in Virginia, New York, and Oregon that committed to the cutting-edge work of exploring different payer and provider partnerships in order to glean lessons learned and to identify best practices were funded. Each of them experienced clear successes and also challenges designing and implementing their initiatives.

PARTICIPANTS

VIRGINIA

Molina/Inova Healthcare, Fairfax County, VA, and George Mason University (Evaluation Partner)

Improving screening and disease management for diverse, multilingual patients at safety-net clinics in northern Virginia using team quality improvement incentives.

NEW YORK

Mount Sinai Health System, Healthfirst, and Icahn School of Medicine (Evaluation Partner)

Ensuring postpartum care for Medicaid-covered, high-risk, mostly minority women in a New York City health system through physician incentives and coordinated care.

OREGON

Advantage Dental Services and University of Washington (Evaluation Partner)

Community-based oral health care for mothers and children in rural Oregon using expanded-practice dental hygienists, global budgeting and a team payment incentive.

Several key lessons emerged about attempts to reduce disparities and advance health equity through integrated health care and payment reforms. In addition, some of their experiences emphasized and reinforced lessons demonstrated by previous grantees whose work focused solely on health care transformation efforts that were not paired with an equity-focused payment model.

- **Integrated health care and payment reforms must be tailored.** Designing and implementing effective financial incentives to reduce disparities has potential but is more complex than anticipated. Financial incentives are information technology intensive to implement, and an incorrectly designed financial incentive system can have little impact or can even discourage staff. Integrated payment and delivery reforms to address disparities need to be tailored to the patient population, community, organizations and settings. There is no one-size-fits-all answer.

- **Incentivizing the whole care team has potential advantages.** Team-wide incentives can encourage integrated care management as team members strive toward a common goal. At the same time, in contrast to financial support for delivery system improvements, designing and implementing individual or team behavior change incentives to improve quality can be more challenging. Team-wide incentives require multifaceted and nuanced consideration of how the financial incentives may interact positively or negatively with other types of internal and external motivations that impact behavior.

- **Data management is critical.** Revealing and combating health and health care disparities requires sustained collection, integration and reporting of key demographic data, such as race, ethnicity and language (REL).

- **There are factors other than money that health care teams find motivating**. Seeing positive movement in reduction of a disparity and related quality of care measures, for example, may be more motivating to some health care team members than a financial incentive.

- **Patient navigators, community health workers, social workers and others in similar positions can make a big difference in disparities—if their positions are funded.** This is especially true if the positions are held by peers who share language, identity, or community with a vulnerable group. Flexible funding models and high-level commitment are necessary to ensure their success. Much work remains in changing policy and practice so that payers cover peer-based models.

- **Institutions, leaders, individual team members, and patients must not only buy-into the program, but also be key participants in its design.** Policy change and value-based payment systems can encourage health care leaders to prioritize disparities reduction in a sustained way—and make it financially viable to do so. They can also incentivize the hard work of culture change necessary to address disparities. In addition, patients and front-line health care providers such as nurses, medical office assistants, patient registration staff, and community health workers have critical insights into the unique local causes of disparities in health and health care and ideas for eliminating them that middle- and upper-level managers and leaders do not.

- **It is important to share data illuminating health and health care inequities with the entire care team.** While providers and other health care team members are often surprised to discover disparities in their patient care, they are highly motivated to do something about it once they find out. New financial models might make it more possible for them to take action, especially when aligned with state Medicaid programs and federal policies.

EXECUTIVE SUMMARY **RECOMMENDATIONS**

This section contains high-level recommendations for health systems, payers and policymakers regarding the use of health care payment reform to promote disparities reduction. The full report contains detailed lessons learned and recommendations important for designing and implementing integrated care and delivery transformations to advance health equity. Top-line recommendations are as follows:

- In many cases, payment reform for equity initiatives must incentivize the organization as a whole, including its leaders and investors, not just the practitioners within the organization. While some disparities interventions may save payers or providers money in the long run, measuring, reporting and reducing disparities requires immediate commitment, infrastructure, experimentation and staff time. Initiatives must be designed from the earliest stages to not only support the resources needed initially, but also with in-depth knowledge of what organization leaders view as key metrics to monitor and measure that will inform and encourage long-term sustainability.

- To help justify the organizational investments by providers, payer organizations—especially large payers such as state Medicare and Medicaid administrations—could prioritize disparities reduction in their requirements for health plans. Because safety-net systems often bear the costs of health and health care disparities, a focus on disparities reduction would likely prove to be both mission-driven and financially responsible. Future efforts must explore ways to incorporate disparities-reduction guidelines without negative side effects, such as placing additional burdens upon safety-net health systems.

- Because there is no one answer that works to reduce all disparities, incentive systems should be flexible and allow for experimentation and rearranging the care system in whatever way is most effective.

- At every level, improved data collection and management are necessary for the wider adoption of disparities-reduction efforts.

The Report

HOW TO USE THIS DOCUMENT

The document is divided into six sections and two appendices:

1. **Introduction and Background**
   Review this section if you want to learn more about the three health care organization - health plan partnerships that constituted the Finding Answers program and a brief summary of the equity-focused health services research behind their work. This section includes details about each partnership's priority patient populations and the health care delivery transformations they undertook to promote health equity. It also describes the payment reform mechanisms utilized to support and/or incentivize those transformations.

2. **Design Care Delivery Transformation**
   Review this section to familiarize yourself with some key issues involved in transforming care for patients experiencing health and health care disparities.

3. **Design Payment Mechanisms**
   Review this section for guidance on how to utilize payment reform mechanisms to bring about and maintain equity focused care delivery changes.

4. **Engage Patients as Partners**
   Review this section if you want real-world examples of how to integrate the patient voice into your intiative.

5. **Obtain and Maintain Stakeholder Buy-In**
   Review this section to gain greater insight into why obtaining stakeholder buy-in is crucial to success and how to work to maintain buy-in throughout your initiative.

6. **Anticipate Data Challenges**
   Review this section to prepare yourself for common obstacles related to data collection, analysis, and evaluation that initiatives may encounter when integrating care delivery and payment transformations to advance health equity.

7. **Appendix A**
   Contains a glossary with definitions of key terms utilized throughout the report.

8. **Appendix B**
   Contains a description of the *Roadmap to Advance Health Equity*, a model for how policy makers, payers, and health care provider organizations can work together to design integrated equity-focused care and payment transformation initiatives.

INTRODUCTION AND BACKGROUND

Finding Answers: Solving Disparities Through Payment and Delivery System Reform (Finding Answers), a predecessor to the Advancing Health Equity: Leading Care, Payment, and Systems Transformation program (AHE), was a leader in driving the United States from merely documenting health disparities to implementing solutions from 2005-2014.[1]

During this same period, governmental and organizational policy efforts were accelerating a shift from payment models that incentivize volume to those that incentivize improving value. Examples include penalties for avoidable hospital acquired infections and readmissions, alternative payment models such as those associated with risk-bearing accountable care organizations, and bundled payment. However, consideration of health equity was largely absent from these initiatives. While these efforts sought to improve cost-effective high quality care, there were potential unintended consequences related to disparities.

In 2012, the Finding Answers program created *The Roadmap to Advance Health Equity* (Roadmap), with guidelines and best practices for health care organizations and policymakers to address health disparities through care delivery transformation efforts. However, there remained a need to marry those care transformation efforts with emerging experiments in payment reform. To meet this need, Finding Answers issued a new call for proposals in 2014 with the goal of exploring best practices for achieving equity by integrating payment and delivery system reform interventions.

Finding Answers ultimately funded three grantees that committed to exploring different payer and provider partnerships in order to glean lessons learned and to identify best practices. Each of the grantee initiatives transformed care delivery to target specific health and health care disparities and then integrated supporting payment reform strategies into the initiative design. The grantees each utilized two payment components in their integrated payment and health care delivery reform models: financial support for care delivery transformations that are typically not reimbursable, as well as financial incentives for specific behavior changes.

1 The Finding Answers program had different program names, determined by the primary focus of the program, during the following time frames: 2005-2012, Finding Answers: Disparities Research for Change; 2012-2016, Finding Answers: Reducing Health Care Disparities Through Payment and Delivery System Reform; and 2016-2018, Finding Answers: Solving Disparities Through Payment and Delivery System Reform. The program is currently named Advancing Health Equity: Leading Care, Payment, and Systems Transformation. All programs were funded by the Robert Wood Johnson Foundation.

When Finding Answers began working with these initiatives, the partnering organizations had already carried out some components of the Roadmap. Hence those components, "Identify a Health Equity Focus", "Diagnose Root Causes with an Equity Lens", "Prioritize Root Causes", and much of "Design Care Delivery Transformation" are not covered in the report. Appendix B contains a detailed description of the Roadmap.

The following is a description of the three grantee initiatives.

THREE PAYER AND PROVIDER PARTNERSHIPS FOCUSED ON EQUITY

VIRGINIA
Molina/Inova Healthcare, Fairfax County, VA, and George Mason University (Evaluation Partner)

At safety-net clinics belonging to Fairfax County, Virginia's Community Health Care Network (Fairfax County CHCN), Hispanic patients were more likely to receive "high performance" care for cervical cancer screening, diabetes control, and hypertension control than non-Hispanic patients. The non-Hispanic patients at Fairfax County CHCN were individuals and families from diverse communities who primarily spoke languages not spoken by care team members. Fairfax County and its clinical partner Molina Healthcare/Inova introduced an incentive system to improve the quality of care to its non-Hispanic population for these three conditions.

Molina Healthcare/Inova operated under a capitated system with a global budget and paid all clinic staff a salary-percentage bonus for meeting care targets aimed at disparities reduction in cervical cancer screening, hypertension control, and diabetes control. Molina Healthcare/Inova:

- Funded incentives for monthly team-based relative value unit (RVU) productivity and processes of care;
- Used incentive metrics aimed at health condition targets instead of reductions in disparities;
- Provided mid-month metric reports to allow teams to make adjustments to meet monthly incentive targets;
- Provided team members with financial incentives up to 3% of their salary.

Activities that promoted greater disparities reduction for target conditions (e.g. identifying a patient in need of cervical cancer screening AND getting them screened the same day) were assigned a higher RVU. The payment incentive was incorporated into Molina's clinical care team compensation scheme and was budget-neutral. When operation of the Fairfax County CHCN clinics came under the management of Inova Healthcare in 2016, Inova maintained this same incentive structure through the life of the initiative.

NEW YORK
Mount Sinai Health System, Healthfirst, and Icahn School of Medicine (Evaluation Partner)

Postpartum follow-up care is critical to ensuring that maternal and child health needs are properly addressed. Yet staff and researchers at Mount Sinai Hospital found that only 58% of Medicaid-covered women who delivered at the hospital received timely postpartum care. The rate was even lower among mothers on Medicaid with hypertension (46%) or diabetes (50%). The rates of timely post-partum care for this primarily non-white population compared negatively to national averages of commercially insured, low-risk, white women who receive timely care at a rate of 80 to 90%.

Mount Sinai and Healthfirst implemented an initiative to improve the quality and frequency of postpartum care for Medicaid patients with or at high risk for gestational diabetes, depression, and/or hypertension. In the proposed intervention model, obstetrics/gynecology physicians would receive a small bonus payment for every Healthfirst enrollee who received a timely postpartum visit. Clinical support staff, including a care coordinator and a social worker, screened mothers for depression and educated women about health conditions, important health behaviors, and common postpartum symptoms. They focused on teaching women self-management skills, enhancing social support, and connecting postpartum patients with appropriate medical care and community resources. A cost-sharing arrangement between Mount Sinai and Healthfirst covered the costs of these additional staff positions.

OREGON
Advantage Dental Services and University of Washington (Evaluation Partner)

Low-income mothers and children in Oregon have low rates of preventative dental care, and as a result, rates of tooth decay in children are higher than the national average. Advantage Dental (Advantage), a for-profit dental service organization, launched the PREDICT pilot initiative, a community-based dental care model aimed at increasing dental care utilization and decreasing the incidence of oral health problems among Medicaid- and Children's Health Insurance Program-enrolled (Oregon Health Plan) mothers and children in rural areas. PREDICT employed expanded practice permit dental hygienists (EPPDHs) to screen and treat patients in community settings including schools, offices for the Special Supplemental Nutrition Program for Women, Infants, and Children, and Head Start offices. The new EPPDH-administered assessment utilized a unique risk-based algorithm that prioritized evidence-based care in the community for moderate and high-risk individuals while referrals were made within the system for clinic care that required a primary care dentist. Case managers coordinated care for patients with immediate needs to

facilitate dental clinic visits, and to ensure patients were re-assessed at appropriate intervals. Regional manager community liaisons (RMCLs) coordinated community outreach and partnerships, including community education initiatives.

Advantage employed a global budgeting capitation model which pooled the per-patient, per-month payments. Research and development funds were used to fund the new mobile delivery system, associated central management, and information technology changes. Of the approximately $6.9 million allocated to Advantage through the Oregon Health Plan (Medicaid), the company directed a little over 2% into a bonus pool that is disbursed to the county-based teams (EPPDHs, regional managers, and dentists) for reaching goals of increased numbers of risk assessments, mobile treatment of at-risk patients, and follow-up care. It also disbursed the incentive to the case managers and RMCLs if the participating counties that they supported met the targets. Incentives targeted a reduction in care access disparities and the use of evidence-based care strategies.

More details and an infographic about each of the three grantee initiatives are available here. Each grantee experienced multiple implementation successes and obstacles throughout the lives of their initiatives. This report shares lessons learned based on their experiences and those of other organizations that have worked with Finding Answers.

LESSONS LEARNED

Design Care Delivery Transformation

The AHE Roadmap advises stakeholders to identify a health equity focus, diagnose root causes of health and health care disparities with an equity lens, and prioritize which of those causes to address with an equity-focused care delivery transformation. Stakeholders should also identify key process and outcome metrics to monitor progress.

LESSON 1: Consider a sequential design to reach the goal of reducing disparities between two groups of patients.

The choice of a particular outcome measure will depend on whether the goal is to focus solely upon improving health outcomes for those patients experiencing the identified disparity (even if the disparity is not ultimately reduced), or reducing the disparity between the groups. The former may be the most expedient or achievable goal initially. However, always remember that the end goal of any equity-focused integrated health care payment and delivery reform should be eliminating or reducing the targeted health disparities between groups. A two-stage approach may be appropriate in situations where reducing disparities between groups appears unobtainable due to resource or time constraints. In such cases, the design of the initiative can evolve over time to match the goals of each stage.

Early on, the Fairfax County CHCN leadership responded to physicians' concerns that disparities reduction was beyond their scope. The initiative began by incentivizing improvements in quality and/or health outcomes for the population experiencing the disparity, while monitoring the gap between groups. They hoped to build off initiative success by later transitioning to disparities-focused metrics.

LESSON 2: Involve all applicable individuals in the design of your care delivery transformation.

Having selected the health outcome that will serve as the basis for transforming care delivery to advance health equity, stop and list all of the individuals who will be involved, including patients. Then, work to ensure that your initiative design activities will capture input from all of them. While including physicians and nurses may seem obvious, involving patient registration staff and their supervisors may be just as important. For example, these individuals could voice concerns about changes to patient flow at registration, but they also have the expertise to suggest solutions. Care coordinators, social workers, care managers, behavioral health providers, pharmacy staff and technicians are other members of the care team who can contribute critical insight at early points in the initiative's design. See the Design Payment Mechanisms section on page 19 for related advice to include billing, coding, revenue, and IT staff when designing payment reforms that will support the care delivery transformation.

Make concrete plans for continuing these stakeholder conversations to continue throughout the initiative.

In addition to meeting regularly with clinic leadership and front-line employees to obtain their input regarding the new care delivery transformation, the Fairfax County CHCN Medical Director met regularly with them during daily huddles and other meetings after initial implementation. This daily interaction helped ensure that critical adjustments were made to address both challenges and opportunities encountered during implementation.

LESSON 3: Identify the specific individual and organizational behavior change(s) that will lead to the intended outcome(s).

Having created a process to include all relevant staff in the design phase, use their expertise to understand the current barriers to eliminating or reducing disparities for patients experiencing the disparities. Create staff/patient process maps to document each step of the targeted care processes or pathways. Process maps not only help reveal the details of quality problems, but can illuminate appropriate solutions[2] by making it easier to identify specific behaviors and activities that the initiative should target. Logic modeling, another useful design tool, can help clearly depict current problems, how proposed changes in specific behavior and activities will address those problems, and how those changes will lead to the desired result.

2 Trebble TM, Hansi N, Hydes, T, et al. Process mapping the patient journey: An introduction. BMJ. 2010;341:c4078. https://doi.org/10.1136/bmj.c4078

[Note: See the Design Payment Mechanisms section for related advice on identifying specific payment reform strategies that will support and/or incentivize those changes.]

Mt. Sinai, Fairfax County CHCN, and Advantage Dental each created logic models before implementing their initiatives. The models depicted their hypotheses about how their proposed payment and health care delivery reform interventions would impact care processes and behaviors to reduce and eliminate their targeted disparities.

Iteratively create and review process maps and logic models with clinical staff, support staff, and patients to ensure their ongoing accuracy and relevance.

LESSON 4: Think ahead to the implementation phase and avoid intervention designs that will place undue burden on key stakeholders whose support is necessary for initiative's success.

Another important reason to actively engage all key stakeholders is to minimize potential resistance to the initiative if it is perceived as being too burdensome once implemented. Analyze potential responses to the initiative from stakeholders at each of the following levels: patient, provider, microsystem, organization, community, and policy, to anticipate real or perceived burdens attributed to the care transformation initiative. For example, patients may feel burdened by having to provide new demographic screening information as the organization attempts to collect higher-quality data to stratify their quality metrics. Individual clinical providers may feel burdened by requirements to follow new documentation procedures or to undergo training. Other care team members may feel burdened by new activities required by the initiative, such as IT staff having to spend extra time extracting new data sets from the electronic health record. Community organizations may resent being expected to overlook historical neglect or mistreatment of the community by a local health care system seeking to establish new community-based partnerships. State policymakers might feel frustrated by a health system advocating for the expanded licensure and credentials required to implement a new model of coordinated care given other demands for the state's attention and resources.

The Advantage Dental initiative offers a good example of an initiative operating in a complex system wherein implementation depended on successful interaction with stakeholders at all levels. As described below, initiative planners did not sufficiently anticipate – and therefore did not successfully avoid – negative reactions to their initiative at many of those levels. Their experience demonstrates why conducting such an analysis up front can help designers proactively avoid threats to their proposed care delivery transformation.

At the patient level: The ability of Advantage Dental expanded practice dental hygienists to assess and treat children in schools and community settings required parental consent. The staff had unexpected difficulty obtaining paper consent due both to the consent form's cumbersome design and to challenges distributing the forms to parents.

At the provider level: The primary care dentists involved in the Advantage Dental initiative needed to learn new systems for processing referrals for office-based care. Uptake of the new procedures varied, with providers being less likely to fully engage with the changes if they had a mixed patient population that included both Advantage and non-Advantage covered patients.

At the micro-system level: The design of the Advantage Dental initiative required extensive modification to the company's IT system, creating a significant drain on IT department resources that delayed the launch of the initiative. The implementation time-pressures also resulted in programming errors and, at times, inaccurate monitoring data.

At the community level: The goal of the Advantage Dental initiative was to shift the prevailing model of dental care away from the existing school oral health programs that based the provision of treatment on school demographics, using the proportion of students qualifying for the federal free or reduced lunch program as a proxy for risk. Instead, Advantage wanted to promote a new system that assessed children for individual risk and then treated children based on their risk. Advantage encountered difficulty gaining access to some schools due to resistance to an unfamiliar model of care.

At the state level, oral health incentive metrics within state Medicaid contracts centered on treatment approaches that contrasted sharply from the Advantage model. Negotiating changes with the state delayed implementation of the Advantage initiative.

Reviewing the challenges encountered by the Advantage Dental initiative sheds light on how negative perceptions by key stakeholders can significantly hamper efforts to advance health equity. Thus, a key design strategy involves 1) thinking ahead to actual implementation and 2) making design decisions that help reduce or avoid negative reactions from individuals whose cooperation is necessary.

LESSON 5: Anticipate initiative disruption.

Reducing and eliminating health disparities requires a significant time investment, and both internal and external initiative disruptions will occur regularly during the course of the program's design and implementation. Examples of internal disruption include high-level leadership turn-over and the subsequent loss of institutional support and buy-in, changes in vendors or contractors essential to initiative operations (e.g., adoption of a new electronic health record platform that drops key reports or metrics needed by the initiative), organization restructure or merger, turnover of key information technology staff supporting the initiative, provider group or payer contracts being eliminated or significantly altered, and staffing reductions.

Mount Sinai Health System was part of a hospital merger in the early- and mid-stages of their initiative that impacted their timeline as some key stakeholders needed to direct resources and attention to merger-related activities. Advantage Dental experienced initiative disruption when the state chose to reduce expenditures by cutting the number of Medicaid enrollees. The accompanying loss of revenue for Advantage Dental increased pressure on the PREDICT dental hygienists to increase cash flow by meeting state-designated incentive goals for application of dental sealants that contradicted the PREDICT care delivery transformation.

Proactively plan for such potential disruptions to the initiative. Work to keep multiple high-level leaders knowledgeable about, and supportive of, the initiative over time. Establishing supportive relationships with high-level leaders from the outset is more effective than attempting to establish them in the midst of unanticipated challenges. Actively nurture initiative champions not just at the senior level, but throughout all levels of the organization. When potential disruptions do become apparent, develop contingency and recovery plans as soon as possible.

Fairfax County CHCN experienced a significant transformation when Fairfax County contracted with a new clinical provider, Inova Healthcare Services, to operate the network's three health centers. The equity-focused initiative at Fairfax County CHCN survived and thrived in large part due to Fairfax County and Inova leadership consistently communicating with key stakeholders at all partner organizations about the initiative and its benefits. They established these relationships before the initiative started and maintained them throughout.

LESSONS LEARNED

Design Payment Mechanisms

Drawing upon the lessons described above can greatly enhance the ability of a care transformation effort to reduce health and health care disparities. However, initiating and sustaining such transformations requires sufficient financial resources. The Advancing Health Equity Roadmap relies on the design and utilization of payment models that will support and incentivize the identified care transformations.

Designing and implementing effective payment mechanisms to reduce disparities and advance health equity is a complex endeavor. Remember that there are many things other than money that care teams find motivating and an incorrectly designed payment model (e.g., financial incentives) can discourage them. It is informative to look at how others have designed value-based payment models, but integrated payment and delivery reforms to advance health equity require tailoring to specific organizations and settings. There is no one-size-fits-all answer.

Mt. Sinai, Fairfax County CHCN, and Advantage Dental each utilized at least two major payment components in their integrated payment and health care delivery reform models (see "Background" on Page 9): financial support for care delivery transformations that are typically not reimbursable and payment incentives for meeting performance targets ("pay for performance" or P4P). Fairfax County CHCN and Advantage Dental utilized the flexibility of capitated payments to finance operational support for non-reimbursable expenses while Healthfirst provided Mt. Sinai a direct grant to fund delivery system improvements. Examples of non-reimbursable expenses include the addition of case managers to the care team and infrastructure expenses to deploy expanded practice permit dental hygienists into schools and other community settings. The three sites reported very few challenges designing and implementing this aspect of their payment reforms.

The second major component of the grantees' financial reform models consisted of payment incentives for specific behavior changes. In contrast to financial support for delivery system improvements, the grantee initiatives discovered that designing and implementing individual or team behavior change incentives to improve quality was challenging, and they experienced mixed results with this aspect of their models.

Health services researchers have developed recommendations to guide the use of financial incentives to improve the quality of care and patient outcomes[3,4,5]. However, as Joynt Maddox et al. noted in their 2017 review of Medicare value-based and alternative payment models, "Each choice [in the design of a financial incentive program] has distinct pros and cons that impact program efficacy. Unfortunately, there are scant data to inform which incentive design choice is best."[6] Below, we describe lessons learned from Mt. Sinai, Fairfax County CHCN, and Advantage Dental's experiences designing financial incentives to improve equity.

As noted in Lesson 2 on Page 15, ensuring that all involved parties have a voice in the design process is critical to success. In addition to the personnel mentioned in Lesson 2, decisions about payment incentive design must include non-clinical personnel. For example, information technology staff are critical for how new metrics will be retrieved from the electronic health record. Coding, finance and accounting staff are essential for directing incentive payments to the correct team members.

Another important reason to include multiple voices at the early stage of payment incentive design is to verify with patients, community members, and staff if incentives can motivate behavior change enough to advance health equity. In many cases, staff members may already be highly motivated to deliver quality care that will reduce or eliminate health disparities, but they are stymied by lack of resources and/or gaps in necessary infrastructure. In that case, organizational leadership may need to set their sights on payment reform strategies that can increase operational support, as described above.

LESSON 6: Identify first any non-financial factors that might motivate individuals and organizations to adopt the behaviors needed to support the care delivery transformation.

Because the use of payment incentives should complement other drivers of staff behavior, it's important to understand all factors that might encourage the behavior changes sought by the care transformation initiative. Using a mix of incentive types creates a multi-pronged approach to transforming care.

3 Blumenthal DM, Song Z, Jena AB, Ferris T. Guidance for Structuring Team-Based Incentives in Health Care. The American journal of managed care. 2013;19(2):e64-e70.

4 Custers T, Hurley J, Klazinga NS, et al. Selecting effective incentive structures in health care: A decision framework to support health care purchasers in finding the right incentives to drive performance. BMC Health Services Res. 2008;8(66):1-14.

5 Van Herck P, Annemans L, De Smedt D, et al. Pay-for-performance step-by-step: Introduction to the MIMIQ model. Health Policy. 2011;102(1):8-17. https://doi.org/10.1016/j.healthpol.2010.09.014.

6 Joynt Maddox K, Sen AP, Lok WS, Zuckerman RB, et al. Elements of Program Design in Medicare's Value-based and Alternative Payment Models: a Narrative Review. J Gen Intern Med. 2017 Nov;32(11):1249-1254. doi: 10.1007/s11606-017-4125-8. Epub 2017 Jul 17.

In some circumstances, simply having the necessary resources to do a good job motivates people to perform at a high level.

Part of the collaboration between Mount Sinai Hospital and Healthfirst included a cost-sharing arrangement for the salaries of a social worker and a bilingual care coordinator. These team members were primarily responsible for the initiative's success in increasing the postpartum visit rate. The clinic physicians reported feeling that access to these ancillary staff empowered them to provide better care to postpartum mothers.

Health care workers often report that seeing data about inequities in their organization motivates them to make equity-focused quality improvement changes. This common response should allay any concerns organizational leaders might have that revealing such disparities within their patient population will lead to controversy or to low morale.

When Community Health Care Network leaders shared their disparities data with employees, the response was healthy and productive. First, the staff were surprised and concerned. However, they immediately moved into a mode of problem solving and were highly motivated to discover and implement solutions. This response was facilitated by being informed that health and health care disparities are a national problem and can be found in virtually every care organization. In addition, they were motivated by the fact that their organization is on the leading-edge of taking the responsibility to create a culture of equity, which requires looking for disparities within their own patient population and making a commitment to eliminating them.

Friendly competition between teams, units, or clinics may also motivate staff members to change behavior, as they compare their progress on disparities-focused quality performance metrics to others. Non-financial incentives for winning performance competitions could be directed towards staff, patients, the workplace (e.g. training or equipment), or even to a designated charity.

Recognition for high performance was utilized in the Mount Sinai initiative. Announcements via emails, residency lectures, and at clinical grand rounds reviewed the initiative and progress to date. Employees in the three clinics that make up the Community Health Care Network found that viewing bi-monthly payment incentive metric reports for all clinics resulted in friendly and fun competition between them to see which clinic teams could achieve the highest scores. While not identical, the care processes, staffing, and quality infrastructure at each clinic were similar enough that the unofficial competition between them felt fun and fair.

Over-reliance on competition in the context of financial incentives should be avoided, as it may lead to undesired results.

Teams at Advantage Dental worked with a variety of community based organizations across large geographic settings (e.g., counties) with wide variability in the organizations, resources and cultures across communities. As a result, the teams encountered significant differences in how easy or hard it was to reach their quality metric goals and earn their incentives. This experience at times was de-motivating for team members who struggled to meet metric goals and earn their incentives in keeping with their counterparts on other teams.

Basing the targets required for earning incentives on improvement from individual team performance baselines instead of reaching common performance targets may have enhanced the perceived fairness of the incentive model.

LESSON 7: Assess how the type and quality of partner relationships will inform your proposed payment reform model.

Shared-ownership or partnership arrangements among health plan and health care organizations can promote collaboration on payment reform efforts.

Healthfirst is a nonprofit health insurance company sponsored by multiple hospitals and health care systems in New York, including the Mount Sinai Health System, the provider partner. This financial arrangement contributed to alignment of goals at both organizations around reducing disparities among postpartum women.

Not only does the nature of the payer/provider organization relationship matter, but also the number of those relationships that must be navigated. When health care organizations interact with multiple payers, it can lead to competing or confusing payment reform or quality improvement programs. This can result in mismatched quality improvement metrics for the same health condition (e.g., different HbA1c targets for diabetes), or different incentive structures to meet the same metrics. Health care organizations (or staff members) may place less value in an equity focused initiative that involves just one payer in a setting with many other payers, or if the payer's share of the patient population is relatively small. In contrast, if a payer organization is the dominant payer of a health care provider's services, it will be easier for front line and clinical staff to respond to a single or small number of incentive programs.

At Mt. Sinai, although there was alignment between payer and provider at the organizational level as discussed above, the situation was less clear at the level of the clinicians. Mount Sinai Hospital System interacts with numerous Medicaid managed care and private/commercial insurance plans, but Healthfirst was the only Medicaid managed care plan trying to incentivize postpartum care transformation. The payment reform targeting care for Healthfirst patients exclusively had less influence over individual clinician behavior compared to the payment incentives at Fairfax County CHCN and Advantage Dental where the payer was the sole or dominant funder of the provider organization.

LESSON 8: Structure your incentive to target the staff and metrics most critical to your initiative's success.

Incentives designed to motivate individual or organizational behavior change can look very different depending on the context in which the desired changes should occur. The questions below provide a guide for thinking about how to structure incentives to match initiative needs.

Will you reward for improvement, achieving specific targets, or both?
Holding all staff accountable to the same targets may work best when staff work in very similar contexts. If staff face differing levels of challenges and difficulties based on variation in patient population, work setting, or geography, consider establishing tailored targets. One option is to consider setting targets that reward and incentivize improvement over time. See Lesson 12 on page 28 for more details.

Will the incentive be individual or team-based?
Individual incentives might be the best choice when behavior change is needed, specific to a single type of position. However, it is crucial to ensure that the right member of the care team is being incentivized. For example, if the desired outcome is to increase effective referrals to community based agencies, incentivizing social workers in the organization might be more effective than incentivizing the entire health care team.

Mount Sinai Hospital's initiative incentivized physicians to improve postpartum visit rates as they are the medical provider that conducts the postpartum visit. In practice however, the social worker and clinical care coordinator were better able to establish connections with high-risk women and influence their likelihood of returning for a postpartum visit. Incentives targeting these front line staff would have had a greater impact than those aimed at the clinical providers.

A team-based performance metric may be beneficial when the initiatives's outcome metric is impacted by multiple staff, such as multidisciplinary, team-based models of care for patients with chronic conditions. For example, patients dually-diagnosed with HIV and diabetes might need the assistance of a nurse care manager, social worker, pharmacist, and physician at different points in time for their health outcomes to improve. An incentive model that impacts all team members might work better than one that only targets physicians. Moreover, physicians with higher reimbursement rates or salaries may not be sufficiently motivated by the available payment incentive. In contrast, medical office assistants might be highly motivated by the available incentive and proactively initiate changes to standard work designed to make it easy for physicians to identify and carry out incentivized patient care activities.

At the Fairfax County CHCN, their team-based pay-for-performance initiative created a dynamic where lower compensated staff in the clinics were more motivated to earn the additional financial incentives. These staff were able to identify and utilize strategies to effectively drive physician behavior in the desired direction.

Who will be eligible to receive the incentive?

When deciding whether to use individual or team-based metrics, consider the many different types of staff members who play a direct role in meeting quality-related performance metrics (e.g., interns, residents, specialists, social work, behavioral health, locums). Incentive systems may fail to achieve their desired outcomes if they are directed at only a subset of the team members who could play a role in reaching the desired outcome.

When the provider contract for the Fairfax County CHCN was granted a new organization mid-initiative, the network utilized temporary staff during the transition period. Unlike other members of the team, these temporary staff were not eligible to receive the incentives. The potential motivating impact of the incentives was blunted because a portion of the staff were unable to receive them.

If the incentive model targets more than one metric, how will each metric contribute to the total payment incentive?

Consider a program designed to improve performance on three quality metrics; A, B, and C, through the establishment of a maximum payment incentive. Achieving target performance on each individual metric could result in receiving one-third of the payment, up to the maximum amount (A and/or B and/or C). With an alternative "all-or-nothing" strategy, staff could be required to hit the target performance on all three metrics in order to earn the payment (A and B and C). Finally, the same performance metrics might be combined into one composite "score" (either weighted or unweighted) and tiered payments could be allotted to staff according to their particular score (A + B + C).

Advantage Dental designed an incentive model built around team-based performance on each of three metrics related to utilization, appropriateness of referral to higher levels of care, and timeliness of acute treatment. Over the course of initiative implementation, initiative leaders made several adjustments to the incentive payout based on proportion of the three metrics achieved each quarter. These adjustments were made to balance motivation to achieve set targets with the need to maintain staff morale (i.e., that failure to meet all three metrics every quarter did not leave staff feeling that earning an incentive was beyond reach.)

It is also possible to combine different types of metrics addressing more than one organizational goal.

The leadership of the Fairfax County CHCN and Fairfax County health officials worked together to develop an incentive formula to address disparities that required both quality and productivity metrics be met in order to earn an incentive. By combining measures into one formula, they sought to ensure that efforts to improve care quality did not negatively impact productivity, nor vice versa.

Ultimately, the choice of how to incorporate more than one metric into a payment incentive model will depend on the relative importance of each metric to achieving the desired care transformation, how staff will perceive any additional complexity, and the resources required to track performance. If each metric is critical to initiative goals, be careful not to structure the payment incentive in a way that staff can perform poorly on one, but still receive the maximum reward.

LESSON 9: Analyze competing motivators that may act as barriers to bringing about desired individual and organizational behavior change.

Incentive models rely on the understanding that individuals and organizations will change their behavior to gain a reward. Yet, that same behavior change can cause them to lose out on other benefits. The designers of a new incentive model risk creating potential unintended consequences that may undermine success if they do not conduct a thorough analysis of the differing, and sometimes competing, motivations of all stakeholders.

Some organizations may have income, profit, productivity, quality, or other types of goals for leadership or management. Consider how these goals might lead administrators and/or managers to intentionally or unintentionally hinder their staff members' focus on any new incentive program, especially if the performance metrics and incentive structures of the two programs are not fully aligned.

Prior to the implementation of the PREDICT initiative, Advantage Dental had an existing pay-for- performance program in place that incentivized different metrics. As a result, staff sometimes had to balance the demands of two contradictory programs.

Competing motivations (time constraints, a need to reduce stress, other performance incentive programs, etc.) may distract staff from the initiative's goals.

The Mount Sinai postpartum initiative required that information technology and revenue management staff members at Mount Sinai invest time to update the clinic's use of the hospital's electronic health record. However, these staff members also had multiple competing organizational priorities involving larger patient populations and payer contracts. As a result, the postpartum initiative experienced substantial implementation delays.

At Advantage Dental, the administrative and IT staff were overwhelmed by the schedule for rolling out community-based care across a large number of counties. Supervision of field staff was divided and poorly coordinated, resulting in initiative delays and failures.

Identifying such competing motivators can aid in the development of incentive models that are complementary and synergistic with other influences on stakeholder behavior.

LESSON 10: Consider staggering implementation of the care transformation and the new payment incentive.

Comprehensive and simultaneous payment and delivery system changes can be overwhelming for staff, including IT staff. However, if they are too spread out, the delivery system reform effort may not be bolstered by the motivating factor of the new incentive. Therefore, if you do stagger the roll-out, consider using other non-financial motivators such as appealing to internal motivation to improve health outcomes, or education and training while waiting to implement payment reform.

The launch of the Mt. Sinai postpartum initiative occurred in the midst of a merger with other hospital systems that required significant attention from operations staff. Initiative leaders chose to initiate the care transformation changes while waiting for the IT and revenue management staff to have enough capacity to launch the supporting payment incentives. In the meantime, other supports such as provider education and funding for the social work position were utilized to facilitate needed transformations in care until the payment incentives could be put into place.

LESSON 11: Consider the frequency and timing of incentive reporting and payouts.

Performance reports need to arrive in time for staff members to review them and enact any necessary changes to improve their performance and earn an incentive by the end of the period.[7,8] The frequency of financial payout may influence motivation and long-term sustainability. Regardless of how often the financial incentive is paid out, consider regular, interim performance reports so staff members get feedback early and often.

Initially, the Fairfax County CHCN initiative paid their teams incentives on a monthly basis. Mid-month, team members would receive reports of their progress so they could identify any needed improvements in time to meet the monthly targets. When the CHCN network began operating under new sponsorship, administrative and technical issues related to the transition disrupted the production of those reports and eventually resulted in the move to a quarterly incentive payout. The increased length of time between team members' actual behavior and the receipt of any payment risked decreasing the incentive's influence on performance.

LESSON 12: After implementation, consistently monitor the strategies stakeholders use to meet incentive targets and work with them to adjust the strategies to maximize progress.

You may need to increase or decrease incentive metrics to adequately impact process-of-care or health outcome measures.

After six months of operating their incentive model, the Fairfax County CHCN found that the care team was easily meeting the minimum threshold to achieve incentives. To continue improving quality rather than simply maintaining it, they raised the target threshold required to earn the incentive.

Conversely, some teams at Advantage Dental were working hard and making progress, but had difficulty reaching the quarterly targets required to receive an incentive. The difficulty reaching the targets resulted in poor morale among staff. In the second year of the initiative, the target metrics were decreased, making the goals and the incentives more achievable for the teams to reach.

7 Van Herck P, Annemans L, De Smedt D, et al. Pay-for-performance step-by-step: Introduction to the MIMIQ model. Health Policy. 2011;102(1):8-17. https://doi.org/10.1016/j.healthpol.2010.09.014.

8 Kondo KK, Dambert CL, Mendelson A, et al. Implementation processes and pay for performance in healthcare: A systematic review. J Gen Intern Med. 2016 Mar;31(Suppl 1);s61-69. doi:10.1007/s11606-015-3567-0.

Communicate proactively about these potential changes to the model from the beginning. Staff members who have been meeting incentive targets for a significant amount of time may perceive changes to the model design or structure that make it harder to meet incentive goals as a loss of income (versus a loss of "extra" incentive funds).

LESSONS LEARNED

Engage Patients as Partners

To reduce disparities across patient groups, health care organizations must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their patient population. An essential element of successful initiatives that reduce disparities and advance health equity is ongoing meaningful engagement with patients and communities living with the identified disparities who have critical insights into why the disparities exist and what might be the best way to address them.

LESSON 13: Engage patients during the initiative's design phase to anticipate implementation barriers.

The experience at Advantage Dental demonstrates the difference that patient engagement can make when implementing a new initiative.

As described on page 17, the PREDICT extended practice dental hygienists encountered obstacles obtaining the signed consent forms required for them to conduct dental screenings, a key performance metric, in school settings. Feedback obtained through participation in community meetings and through the patient advisory board of a partnering organization made clear that, among other concerns, the design of the written consent form was cumbersome. Some parents/guardians did not realize the signature line was located on the back of the form, so they returned the form without signing. School personnel also advised Advantage Dental that consent would be easier to obtain if their form were part of the packet of forms that parents/guardians receive at the beginning of the school year, many of which were in digital form. To resolve these and other issues with the consent form, Advantage streamlined the form's design to fit on one page and also worked to launch a digital version in time for the beginning of the following school year.

LESSON 14: Engage patients throughout the life of the initiative to enhance continuous quality improvement efforts.

At Fairfax County CHCN, efforts to engage patients were not initiated until after implementation.

As part of performance improvement, initiative leaders conducted a two-phase effort to identify the root causes of the disparities in health and health care quality that the initiative sought to reduce (diabetes control, blood pressure control, and cervical cancer screening). In the first phase, managers utilized a fishbone diagram tool with internal staff to surface possible causes of each disparity, including patient, provider, organizational, and community level factors. The second phase of the analysis involved hosting focus groups with CHCN patients with the intent of further elaborating the relationship between these factors and patients' use of and satisfaction with CHCN services. While patients reported high levels of satisfaction, the focus groups highlighted barriers related to difficulties obtaining appointments that had not been noted by internal staff.

Examining disparities in partnership with patients allows organizations to understand differences in how patients experience care. Ensuring that patients', care-givers', and community members' points of view are represented, either through an advisory panel or some other mechanism with a genuine and sincere desire to learn and incorporate their perspectives will improve understanding of the potential reasons for the disparities. This engagement can make a significant difference not only during the design phase of an initiative, but as a continuous improvement feedback mechanism.

LESSONS LEARNED

Obtain and Mantain Stakeholder Buy-in

Do not assume that stakeholders will provide sustained buy-in for the life of the initiative. To ensure that relationships are sustained, directly involve all people whose work could be impacted by the initiative—this will include people from the lowest to highest levels of the partner organizations. The AHE website has multiple recommendations for securing buy-in and for maximizing sustainability of any disparities-focused initiative.

LESSON 15: Dedicate ample time and resources to establish and maintain positive relationships with external partners.

Initiatives that rely on external partners (e.g., community-based social service organizations, churches, schools, departments of public health) must devote time and resources to establishing and maintaining positive partner interactions. Learn about the relationship and cultural dynamics between the organizations and systems that will need to work together during the initiative. In addition to positive relationship dynamics, longstanding (e.g., years or decades) negativity, rivalries, competition, and distrust may exist between organizations. Work to minimize any potential perceived threats to one or more partners' usual ways of doing business.

When Advantage Dental encountered community stakeholders reacting negatively to their initiative they began attending community meetings at potential partner organizations. This allowed them to hear first-hand some of the concerns being expressed and to make adaptations to their model in response. Additionally, faced with conflicting incentives between the Advantage Dental initiative and the state's quality metrics, Advantage leadership sought to meet with state oral health officials to argue for the adoption of evidence-based indicators more in keeping with the Advantage initiative.

LESSON 16: Plan for long-term sustainability during the design phase.

Identify at the very beginning of your initiative those individuals and groups who will have the decision-making authority and the resources to support your initiative for the long term. Examples include, but are not limited to: boards of directors, chief executive officers, chief financial officers, chief medical officers, managed care leadership, and population health leadership. Invite their input at the beginning, keep them updated, and work with them throughout the intervention.

Strive when possible to align the interests of more than one of these stakeholders. Some might be highly motivated to address specific patient populations or health conditions that result in high cost outlays for the organization. Others may be highly motivated to address patients who are suffering from one or more health disparities. For example, a proposed initiative might address patient populations that are high-cost for the organization and who also suffer from significant disparities in care quality or health outcomes.

Mount Sinai Health System and Healthfirst were both motivated by desires to improve timely HEDIS postpartum visit completion rates, reduce hospitalization, readmission, and emergency department utilization rates, improve patient satisfaction, and the ability to link postpartum women to a primary care provider. Due to these motivators, both organizations were dedicated to participating in the care delivery and payment transformation initiative.

LESSON 17: Select initiative outcomes that will engender long-term support from key stakeholders. Monitor outcomes over time and report out to key audiences.

Ascertain the bottom-line metrics that organizational leaders or others able to invest in the initiative will need to see to to sustain it over the long-term. Make sure to get specifics on what information would be of value. For example, “The initiative should reduce costs” is too vague. Which costs? How much of a reduction (e.g., a certain percentage of the budget or an absolute figure?) Over what period of time? Will initiative costs be incorporated in this calculation? Understanding this level of detail will often necessitate conversations about who will receive the mid- and long-term benefits that result from early outlays of resources.

Mount Sinai tracked a number of key metrics on postpartum mothers, but due to resource constraints could not collect cost and utilization data on their newborns. Mount Sinai senior leadership had identified postnatal care as a priority area for value-based quality improvement. However, the Mt. Sinai initiative was unable to make a case that they had contributed to lower costs for the newborns because of the lack of data. This lack of a business case presented an obstacle to gaining leadership buy-in to sustain the initiative. Anticipating leadership information needs more accurately at the outset may have enabled the initiative to shift resources and begin collecting data to meet those needs.

One way to maximize a initiative's support is to ensure the disparities targeted by the initiative align with current national, state, and local health care priorities. Examples include state and local public health department programs, private payers' quality improvement initiatives, the Centers for Medicare and Medicaid Services quality programs, public reporting programs, etc).

At Mount Sinai Hospital, postpartum women at high risk for health complications was a priority population in New York. Their payer partner, Healthfirst, recognized the importance of improving the percentage of Healthfirst patients who had a timely postpartum visit. Additionally, New York State was focused on improving postpartum care outcomes and had utilized the HEDIS timely postpartum visits measure to assign star ratings to Medicaid programs. Because these three organizations all shared a focus on access to care for this priority population, the timing was right to collaborate on designing an integrated payment and health care delivery reform initiative to address women's health that had the potential for ongoing support. In contrast, Advantage Dental had difficulty getting buy-in from key community dental health partners due to differing priorities from the State Health Department. While Advantage Dental wanted to focus on risk-stratified dental care, the Oregon State Health Department focused on increasing sealants for all children, regardless of risk status.

Another question to consider when selecting a initiative outcome is whether there would be potential secondary benefits to other stakeholders, as such choices might encourage support of the initiative for reasons beyond advancing health equity.

For example, the early and intensive management of tooth decay implemented by the Advantage initiative could have a secondary benefit of avoiding hospitalization and the use of general anesthesia in young children. Hospital-based care uses excessive resources for a small number of children, denying others care, and general anesthesia can result in developmental and cognitive deficits that can compromise future learning. These are potential motivators for key stakeholders.

LESSONS LEARNED

Anticipate Data Challenges

Each of the grantees, and the vast majority of care organizations with whom we have worked in the past, experienced significant and unanticipated challenges in collecting, analyzing, and utilizing data. The following recommendations are based upon their experiences and will be made more effective by directly involving front-line staff members, finance, and billing departments in all aspects of data collection, analysis, and interpretation.

The clinical care experiences of front-line staff will often reveal inconsistencies in data reports, logic mistakes in electronic health record report programming, or inaccurate assumptions behind data calculations. For example, nurses or dental hygienists can identify problematic approaches to data collection or interpretation that are easily overlooked by physicians, dentists, IT staff members, and administrators. Thus, it is important to include front-line staff members (e.g., nursing, registration staff) in data audits.

LESSON 18: Assess the accuracy of the baseline data needed to operate your initiative.

Accurately measuring change over time, requires high-quality baseline data on subgroups. With the exceptions of age, payer status, and biological sex, existing demographic data in electronic health records have a high chance of being inaccurate and/or incomplete.

LESSON 19: Analyze potential sources of inaccurate data and develop strategies to counteract.

Data entry inconsistencies—e.g., different staff members entering similar data into different fields or areas of the electronic health record—may result in inaccurate pay for performance metrics. Failure to capture data accurately may result in claims data being sent to the payer that are partial or incomplete compared to the actual care provided. This may be more likely for newly generated billing/care codes that have been introduced for your initiativee. Work directly with front-line staff members to ensure that procedures for inputting data are not too burdensome or confusing.

The Mount Sinai Hospital team worked with the Healthfirst Clinical Quality staff and identified that clinicians were not selecting the correct billing codes for postpartum services in the electronic health record. This gap in selecting the appropriate postpartum visit incentive code persisted despite education provided to clinicians about the billing codes.

Allocate sufficient resources for training staff members on new data collection procedures. This includes sufficient time to onboard new staff who start work mid-initiative and to provide booster training for existing staff.

Advantage Dental realized that risk assessments being entered by different EPPDHs were inconsistent and at odds with anticipated data. This required retraining throughout the company.

Staff members might benefit from ongoing reminders regarding data entry and standardization.

In some cases, procedures to ensure accurate data exist but are not adequately monitored or maintained.

IT staff at Advantage Dental were operating under multiple organizational priorities that placed significant demands on their time and could not implement EHR updates required for adequate data monitoring. These constraints eventually led to inaccurate performance reports and obstacles administering the incentive model.

LESSON 20: Be aware of potential gaps in data regarding services or treatment received by the initiative's priority populations.

It may be difficult to identify all care that specific patients received, or all care that providers delivered, due to data collection and reporting limitations, such as:

- Patients moving in and out of specific payer status (e.g., Medicaid eligibility) and resulting loss of claims data.

The Mount Sinai Hospital initiative experienced difficulties using claims data to track women before and after delivery due in part to Medicaid "churn." Churn refers to patients moving in and out of enrollment status usually due to changes in eligibility or gaining alternative insurance. Mount Sinai patients also experienced fluctuating coverage due to the State of New York's Emergency Medicaid program which provided for otherwise uninsured pregnant women to receive emergency Medicaid during their pregnancy and for the following 6 weeks. As a result, women who delivered at Mount Sinai could lose health insurance coverage during the postnatal period. The turnover in coverage led to difficulties using Medicaid claims to calculate postpartum visits, upon which the incentive payment was based.

- Boundary crossing - patients receiving care in different or neighboring geographic regions (e.g., outside of an accountable care organization/coordinated care organization boundary to which they are assigned), multiple locations within larger health systems, or from different health care organizations over time. For example, incentive model metrics for staff members may be impacted by patients accessing care in different organizations or regions over time (e.g., receiving preventive services at one organization with the incentive program, but the incentive-related health outcomes being measured at another organization not participating in the incentive program). Similar issues can arise for providers working in different organizations or regions over time.

At Advantage Dental, staff earned incentive payments based on the performance of county teams. However, tracking their contribution towards each county team became difficult because the expanded practice permit dental hygienists were occasionally deployed to work in more than one county.

- Lack of post referral follow-up:

Attempts by the Community Health Care Network to track a patient's receipt of cervical cancer screening ran into difficulties when clinic providers referred patients to other providers for the exams. Under those circumstances, the staff had difficulty both accurately assessing and documenting that a screening had taken place.

LESSON 21: Ensure that initiative leadership can access data to inform ongoing initiative operations and respond to stakeholder concerns.

Data collected in electronic health records or claims databases may not be accessible (via data queries or reports) in the manner required by your initiative. Additionally, extracting data from the electronic health record system may be significantly more difficult and time-consuming than entering it.

The Community Health Care Network discovered that despite having collected race and ethnicity data on patients for some time, there were no existing reports in their electronic health record that stratified performance metrics by race and ethnicity. They needed extra time and resources to create them.

Fully develop and test run data reports before initiating the initiative to ensure that data can be accessed and retrieved as needed. Additionally, build a system to audit all data reports regularly throughout the initiative. Do not minimize or underestimate the critical need for adequate IT skills and resources.

Advantage Dental's initiative changed the focus of its customer service department to provide greater case coordination and follow-up with patients, and documented these services using open text fields within the data management system. Managers came to discover that data formatted in this fashion is difficult to run queries on for the purposes of reporting. As a result, administrators faced difficult choices about whether to use limited financial resources for fixing the IT deficits. Instead, the initiative chose "work-arounds", like having trainers monitor recordings of care managers' phone calls with patients.

In addition, current billing and reimbursement systems may not be configured to easily link payment incentives to individuals or teams within a specific health care organization.

Mount Sinai found it challenging to create coding and billing systems to document and track incentivized activities for reporting to Healthfirst and to track and direct incentive funds from the payer through the health care organization's accounting and finance systems to specific teams or providers. This can be particularly difficult in larger health systems with multiple payers, hospitals, and clinics. Work closely with the data and financial teams at both the payer and provider organizations to anticipate and minimize these challenges.

LESSON 22: Ensure that disparities gaps do not lessen due to care processes or outcome measures worsening for the originally advantaged group.

Initiative leadership at the Community Health Care Network closely monitored care outcome changes between Hispanic and non-Hispanic patients throughout the duration of the initiative. Prior to the start of the initiative, Hispanic patients had better outcomes than non-Hispanics. The outcomes measured between these two groups were monitored carefully to ensure that disparities reductions were due to quality improvement among non-Hispanic patients, and not a decrease in the quality of care received by Hispanic patients.

CONCLUSION

The work required of health care organizations wishing to identify and eliminate disparities is neither quick nor easy and cannot be achieved via one-time or siloed equity-focused quality improvement efforts.

Health care organizations need a solid business case for the nation to successfully reduce health and care disparities on a large scale. The Finding Answers grantee experiences described in this document provide additional evidence that reducing and eliminating health and health care inequities via integrated payment and care delivery transformations is possible. It is a journey that requires active engagement and coordination across the teams at both care delivery organizations and health plans.

APPENDIX A

Glossary

- **Health Equity**: Everyone having a fair and just opportunity to be as healthy as possible. This requires improving access to the conditions and resources that strongly influence health. Health equity for those groups who have been excluded or marginalized requires a focused commitment to eliminating health disparities.

- **Health Disparities**: Differences in health or its key determinants such as health care, education, safe housing, and freedom from discrimination.

- **Health Inequity**: Disparities in health that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.

- **Advance Health Equity**: To reduce a disparity within a health care process or health outcome between a less socially advantaged population and a more socially advantaged population. Importantly, the disparity reduction is due to the improvement of health outcomes in the less advantaged group, not a worsening of health outcomes of the more socially advantaged population.

- **Care Delivery Transformation**: A reform to the current care delivery process in order to provide high-quality care and engage patients to improve care, address disparities in health care processes and/or outcomes, and ensure culturally competent care.

- **Payment Transformation:** Design and implement value-based payment mechanisms that support and incentivize one or more care delivery transformations to reduce health and health care disparities.

- **Value-based Payment Models:** Activities that move away from the traditional fee-for-service payment system that rewards volume, to payment models that incentivize high-quality, cost-effective care.[9]

- **Root Cause Analysis:** A process to assess why a health or health care disparity exists among a particular patient population. A root cause analysis is a tool to understand and map out the chain of multiple, inter-related causes of health disparities that begin with broad systemic oppression and discrimination that plays out over time and geography.

9 1. Bailey M, Matulis R, Brykman K. Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations. Center for Health Care Strategies. Published September 9, 2019. Accessed December 14, 2020. https://www.chcs.org/resource/behavioral-health-provider-participation-in-medicaid-value-based-payment-models-an-environmental-scan-and-policy/

- **Member:** A person receiving health insurance. Medicaid members are referred to as patients throughout this document.

- **Patient:** A person receiving care from a health care organization.

- **Medicaid Managed Care Organizations (MCOs):** Health care systems that integrate the financing and delivery of appropriate services to Medicaid covered individuals. MCOs arrange with selected providers to furnish a comprehensive set of health care services. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are two examples of MCOs.[10]

- **Culture of Equity:** The culture of an organization consists of the behaviors and beliefs built up by the group and transmitted from one to another over time. An organizational culture of equity is defined by employees openly acknowledging the existence of health inequities, being motivated to reduce and eliminate them, and knowing their role in the process. Health care organizations (e.g., providers, payers, state Medicaid agencies) with a strong culture of equity take steps to reduce inequities not only in their patient populations, but also those that exist between employees in different levels of the organizational hierarchy and between different demographic groups of employees.

- **Equity Lens**: A reflective process to examine who experiences the benefits and burdens of policies, programs, and other types of action or intervention. Using an equity lens can help to identify the basis for differential experiences in health care and health outcomes and can also reduce the chances of inadvertently creating new inequities or exacerbating existing inequities in quality improvement activities.[11]

- **Process measures:** Health care quality measures that are used to demonstrate a health care contribution to positive health outcomes (e.g., whether providers engage in patient counseling).[12]

- **Outcome measures:** Health care quality measures that are used to demonstrate the effect of health care (e.g., laboratory test results, total cost savings, and readmission rates).[13]

10 Glossary of Medicaid Terms Related to Public Health. Expanded Glossary of Medicaid Terms As They Relate to Public Health. Accessed December 14, 2020. https://www.astho.org/Health-Systems-Transformation/Glossary-of-Medicaid-Terms-Related-to-Public-Health/

11 Pertillar T, Ann Pobutsky P, Gail Brandt E, et al. An Assessment of Funding and Other Capacity Needs for Health Equity Programming Within State-Level Chronic Disease Programs. Journal of Health Disparities Research and Practice. 2017;9(6). https://digitalscholarship.unlv.edu/jhdrp/vol9/iss6/7

12 Glossary of Medicaid Terms Related to Public Health. Expanded Glossary of Medicaid Terms As They Relate to Public Health. Accessed December 14, 2020. https://www.astho.org/Health-Systems-Transformation/Glossary-of-Medicaid-Terms-Related-to-Public-Health/

13 Glossary of Medicaid Terms Related to Public Health. Expanded Glossary of Medicaid Terms As They Relate to Public Health. Accessed December 14, 2020. https://www.astho.org/Health-Systems-Transformation/Glossary-of-Medicaid-Terms-Related-to-Public-Health/

APPENDIX B

The Roadmap to Advance Health Equity

Advancing Health Equity: Leading Care, Payment, and Systems Transformation, a national program of the Robert Wood Johnson Foundation, has been on a 15-year journey to learn—and teach others—what works to reduce health and health care disparities. Through comprehensive reviews of interventions taking place across the United States and abroad, and the lessons learned by our 36 grantee partners, we developed core lessons for health care systems that wish to tackle disparities in the care they give and their patients' health outcomes. We created the Roadmap to Advance Health Equity, with detailed steps health care providers can follow. Yet one problem came up again and again: conflicting priorities. Health care practitioners at all levels face a wide variety of quality metrics, assessment systems, accreditation and institutional requirements. It is difficult for them to devote the required attention and resources to disparities reduction efforts in the midst of these many other demands.

During this same period, governmental and organizational policy efforts were accelerating a shift from payment models that incentivize volume to those that incentivize improving quality while reducing costs. Examples include penalties for avoidable hospital acquired infections and readmissions, and alternative payment models such as those associated with risk-bearing accountable care organizations and bundled payment. However, equity is largely absent from these initiatives. While these efforts may seek to improve cost-effective quality care, there are potential unintended consequences related to disparities. A great need exists to improve our understanding about how to develop and implement successful programs to explicitly achieve equity in health care quality and outcomes by aligning payment and delivery system reform. To make equity rise to the top, we must make a business case for it. The Roadmap to Advance Health Equity provides guidance for how health care payers and providers can work together to design equity-focused and integrated care and payment transformation initiatives.

Figure 1 on page 48 is a high-level overview that depicts the Roadmap to Advance Health Equity. The activities of the Roadmap can be categorized in four ways:

1. Foundational Activities

- A Team Charter and Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis should be implemented at the initiative's outset and updated at regular intervals because they will undergird and strengthen the work.

2. Components

- The six components of designing an equity-focused integrated payment and delivery system reform initiative are each comprised of multiple activities. The activities will vary depending on the particular stakeholder organizations involved and the particular initiative being planned.

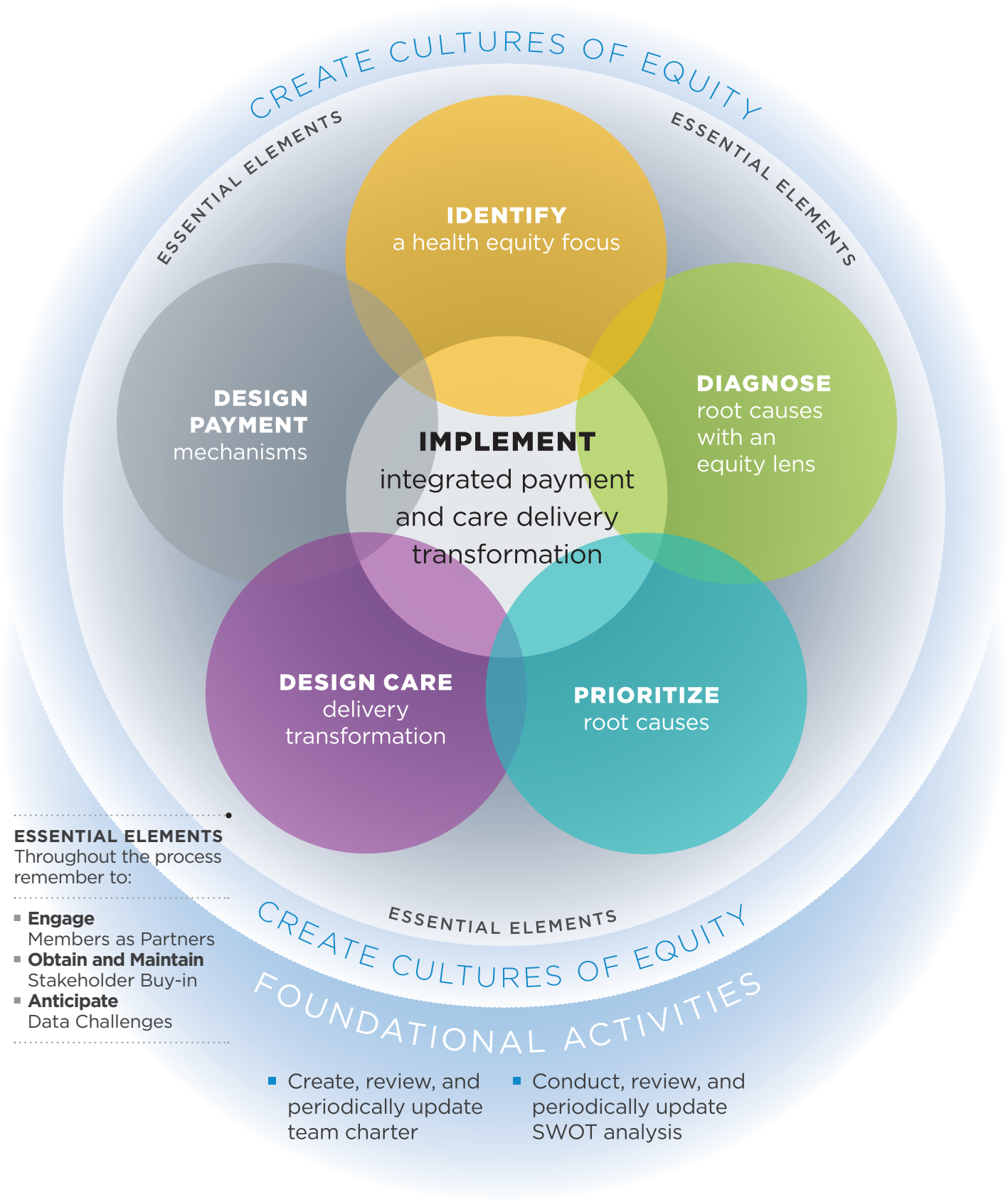
3. Essential Elements

- Unlike the components that structure the activities, essential elements represent characteristics of activities that will be critical to the success of the initiative. Throughout the design process, initiative leaders should seek to ensure they have planned activities that will engage patients, obtain or maintain stakeholder buy-in, and anticipate (and respond to) data challenges.

4. Create Cultures of Equity

- The activities of the Roadmap ideally occur within a context of each participating organization also changing core aspects of its culture in ways that provide staff members the skills to identify and mitigate key aspects of structural and organizational oppression and discrimination. Doing so increases the chances of successfully designing and implementing initiatives to reduce health and health care disparities in their patient populations. See the glossary and the AHE website for additional information and resources regarding cultures of equity.

Figure 1: The Roadmap to Advance Health Equity



AHE Advancing Health Equity

Leading care, payment, and systems transformation

ABOUT AHE

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