

# Measurement for Health Equity: Data, Performance Metrics, VBP

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# Agenda

- / Introduction
- / Impact Assessment and Value-based Payment
- / Q&A
- / Wrap-up

# A Roadmap to Advance Health Equity

[advancinghealthequity.org](http://advancinghealthequity.org)

Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) is a national program supported by the Robert Wood Johnson Foundation and based at the University of Chicago. AHE's mission is to discover best practices for advancing health equity by fostering payment reform and sustainable care models to eliminate health and healthcare inequities.

 You Are Here!

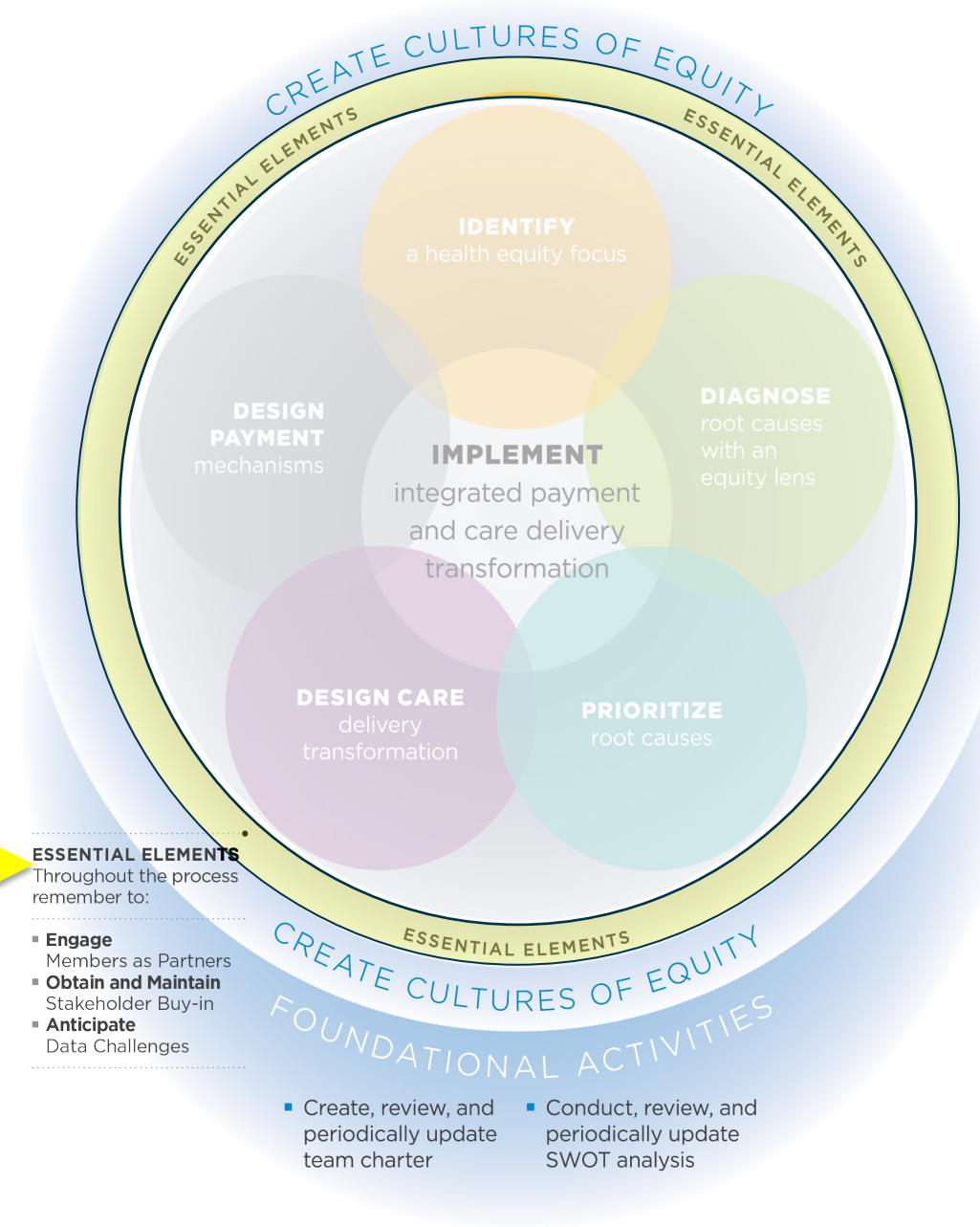
**ESSENTIAL ELEMENTS**

Throughout the process remember to:

- **Engage**  
Members as Partners
- **Obtain and Maintain**  
Stakeholder Buy-in
- **Anticipate**  
Data Challenges

- Create, review, and periodically update team charter

- Conduct, review, and periodically update SWOT analysis



# Lessons from Advancing Health Equity: Cross-Cutting Success Factors

|                    |  |
|--------------------|--|
| <b>Root Causes</b> |  Analyze root causes of disparities, including structural racism, explicit/implicit bias, and historic underinvestment and neglect            |
| <b>Partnership</b> |  Partner with individuals with Medicaid and communities, community-based organizations, and care teams to identify causes and craft solutions |
| <b>Language</b>    |  Establish shared definitions of health equity, health disparities, and related concepts  |
| <b>Data</b>        |  Strengthen quality, completeness, and use of data to more accurately measure health disparities, engage providers, and assess progress      |
| <b>Culture</b>     |  Cultivate an internal culture of equity to strengthen approaches so colleagues understand the need to advance health equity                |



# Measuring Impact of Health Equity Interventions: **Selecting Metrics**

- / Outcomes or processes that reflect your health equity goal(s)
- / Intermediate process changes that reflect care transformation activities and designed to help achieve the health equity goal, for example:
  - Screening for and addressing health-related social needs
  - Attending primary care visits, broadly defined (e.g., CHW contact, care manager)
  - Support or coaching by a community health worker or care manager
  - Number of patients prioritized for engagement and number successfully engaged
- / Individual experiences with care that may relate to root causes of the disparity
  - Trust
  - Communication



# Measuring Impact of Health Equity Interventions: **Data Sources**

- / Existing plan enrollee/claims/encounter data
- / Electronic health records
- / Patient screening tools
- / Care management software
- / Patient or care team surveys
- / Member satisfaction surveys
- / Community health needs assessments



# Measuring Impact of Health Equity Interventions: **Improving the Data**

- // Assess quality and completeness of demographic information reflecting:
  - Race, ethnicity, language preferences, and disability status (RELD)
  - Sexual orientation and gender identity (SOGI)
- // Evaluate and improve data intake processes to prioritize individual self-identification
- // Consider and clarify intended uses of data
- // Partner with community leaders, enrollment assisters, providers



# Leveraging VBP to Support Your Health Equity Efforts

- ✓ Avoids unintentionally increasing disparities, when developed with an intentional equity lens
- ✓ Provides direct financial resources and rewards to successfully address disparities by:
  - Transforming care delivery
  - Addressing health-related social needs
  - Targeting resources
- ✓ Aligns health equity with existing high-priority activities related to payment reform
- ✓ Indirectly supports investments in data to identify disparities





# VBP & Health Equity Resource



**Articulate health equity goals**



**Assess current VBP and care transformation activities**



**Select performance metrics reflecting the equity goals**



**Set performance targets to stimulate transformation and improvement**



**Design the payment approach**



**Address operational issues**

Patel, Shilpa; Smithey, Anne; Tuck, Kim; McGinnis, Tricia. *Leveraging Value-Based Payment Approaches to Promote Health Equity: Key Strategies for Health Care Payers*. Accessed February 9, 2023. Available at: [https://www.chcs.org/media/Leveraging-Value-Based-Payment-Approaches-to-Promote-Health-Equity-Key-Strategies-for-Health-Care-Payers\\_Final.pdf](https://www.chcs.org/media/Leveraging-Value-Based-Payment-Approaches-to-Promote-Health-Equity-Key-Strategies-for-Health-Care-Payers_Final.pdf)

**What care transformation activities are most important to incentivize in order to achieve your health equity goals?**

**What organization and individuals are primarily responsible for those actions?**

**What available metrics best reflect these processes or outcomes?**

**How will success be measured to reflect health equity goals?**

**How might payment be structured to reward successful processes and outcomes as well as the infrastructure and capacity needed to achieve goals?**

## **Payment Design Decision Points**



# Building Off of Impact Assessment: Performance Targets for VBP

- ✓ Establish impactful measures
- ✓ Determine a comparison population and measurement approach
- ✓ Implement processes for data collection

## **What types of targets will be used for performance-based payment?**

- // Improvement-based performance: rewarding for improvement relative to baseline
- // Improvement-based performance, narrowing disparities: statistically significant improvement compared to the reference group
- // Absolute performance for the priority population: achieving equitable outcomes



# Other Health Equity Payment Approaches

- // Provide upfront PMPM funding for community-based care team (e.g., community health workers, peer navigators)
- // Invest in data capacity to stratify data by race, ethnicity, language, and disability status (RELD) and sexual orientation and gender identity (SOGI), and share results with provider organizations
- // Incentivize partnerships with trusted community stakeholders (e.g., community-based organizations, faith organizations)
- // Focus on engaging providers serving a large proportion of diverse patients and communities
- // Incentivize robust partnership with individuals with Medicaid and communities
- // Require incentives to “flow down” to care team



# Example: Reducing Health Disparities in Post-Partum Care

Mount Sinai Hospital teamed with Healthfirst to improve maternal health outcomes for Latina and Black postpartum individuals with high-risk conditions.

## **Payment Model:**

- // Physicians received small annual bonus for individuals who received timely postpartum visit
- // Plan/Provider jointly funded a social worker and bilingual case manager to support individuals
- // Individuals received small financial incentive for visit