



Despite overall improvements in public health and medicine, disparities in health and healthcare persist. Disparities are differences caused by inequities that are linked to social, economic, and/or environmental disadvantages. Widespread recognition of health and healthcare disparities has prompted the U.S. Department of Health and Human Services (HHS) as well as many other organizations in the public sector and the private sector to prioritize health equity as a key component of healthcare quality improvement. Achieving health equity requires eliminating disparities in health outcomes by addressing social risk factors that adversely affect excluded or marginalized groups.

Performance measurement is an essential tool for monitoring health disparities and assessing the level to which interventions known to reduce disparities are employed. Measures can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality. Yet, there is no systematic approach for HHS and other stakeholders (e.g., providers, hospitals, health plans, etc.) to use measures for eliminating disparities and promoting health equity. To support this aim, the National Quality Forum (NQF), funded by HHS, convened a group of experts to develop a roadmap that demonstrates how healthcare performance measures, and associated policy levers, can be used to eliminate disparities.

NQF'S ROADMAP TO REDUCE DISPARITIES

The roadmap primarily focuses on ways the U.S. healthcare system (i.e., providers and payers) can use more traditional pathways to eliminate disparities; however, it also identifies areas where collaboration and community partnerships can be used to expand the healthcare system's role to better address disparities. Although the primary audience for the roadmap is public- and private-sector payers, achieving health equity will require a meaningful commitment and efforts from all stakeholders.

The roadmap lays out four actions, "Four I's for Health Equity," to promote health equity and reduce disparities:

- 1. Identify** and prioritize reducing health disparities
- 2. Implement** evidence-based interventions to reduce disparities
- 3. Invest** in the development and use of health equity performance measures
- 4. Incentivize** the reduction of health disparities and achievement of health equity

A Roadmap for Promoting Health Equity and Reducing Disparities



HOW THE DISPARITIES ROADMAP COULD BE USED

The actions presented in the roadmap allow multiple stakeholders to identify how they can begin to play a part in reducing disparities and promoting health equity. For example:

- Hospitals and/or health plans can identify and prioritize reducing disparities by stratifying performance measures that can detect and monitor known disparities and distinguish which they can address in the near, medium, and long-term.
- Clinicians can implement evidence-based interventions by connecting patients to community-based services or culturally tailored programs shown to mitigate the drivers of disparities. Healthcare organizations and

researchers can test new interventions to add to the current evidence base.

- Measure developers can work with patients to translate concepts of equity into performance measures that can directly assess health equity.
- Policymakers and payers can incentivize the reduction of disparities and the promotion of health equity by building health equity measures into new and existing healthcare payment models.

These are only a few of the many ways the roadmap can be implemented and only some of the stakeholders that can act on its recommendations.

IDENTIFY AND PRIORITIZE REDUCING HEALTH DISPARITIES

The volume of existing measures can make prioritization a challenge, but measures that can help to monitor and reduce disparities should be prioritized. Disparities-sensitive measures detect differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups. NQF's Disparities Committee recommended four criteria to help stakeholders identify and prioritize measures that can detect disparities:

1. Prevalence—How prevalent is the condition among populations with social risk factors?

What is the impact of the condition on the health of populations with social risk factors?

2. Size of the disparity—How large is the gap in quality, access, and/or health outcome between the group with social risk factors and the group with the highest quality ratings for that measure?

3. Impact of the quality process—How strong is the evidence linking improvement in performance on the measure to improved outcomes in the population with social risk factors?

4. Ease and feasibility of improving the quality process (actionable)—Is the measure actionable among the population with social risk factors?

TABLE 1. EXAMPLES OF DISPARITIES-SENSITIVE MEASURES

Measure Title	Description
NQF Measure 0018: Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of Hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
NQF Measure 0059: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
NQF Measure 0034: Colorectal Cancer Screening	Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer .
NQF Measure 0004: Initiation and Engagement of Alcohol and Other Drug Dependence	Percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received Initiation and engagement of alcohol and other drug dependence treatment
NQF Measure 0278: Low birth weight (PQI9)	The number of low birth weight infants per 100 births

IMPLEMENT EVIDENCE-BASED INTERVENTIONS TO REDUCE DISPARITIES

Many studies have documented interventions that reduce disparities; however, these interventions are rarely implemented in practice. A large body of evidence and guidance demonstrates how all stakeholders can play a role in reducing disparities. Clinicians and allied health professionals can work with communities to deliver culturally tailored lifestyle education programs and deploy community health workers. Provider organizations can ensure

that their workforce has the knowledge, attitudes, skills, and resources to advance health equity. Payers should incentivize and monitor the use of interventions to reduce disparities. Lastly, and most importantly, patients and families can and should be involved in the development and evaluation of interventions designed to reduce disparities. Although further investment in research and demonstration projects is needed, there is enough evidence for stakeholders to act now. Performance measures can then be used to monitor the extent to which these health promoting activities occur.

INVEST IN THE DEVELOPMENT AND USE OF HEALTH EQUITY PERFORMANCE MEASURES

The Committee recognized a need for both disparities-sensitive measures (i.e., measures that can detect disparities) and measures that directly assess whether interventions that promote health equity are employed (i.e., health equity measures). To guide the selection and development of health equity measures, the Committee identified five domains of measurement of health equity, which represent a prioritized set of goals that must be achieved for the U.S. healthcare system to promote health equity:

1. Adopt and implement a **culture of equity**. A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, the creation of environments where all individuals, particularly those from diverse and/or stigmatized backgrounds, feel safe in addressing difficult topics, e.g., racism, and advocating for public and private policies that advance equity.
2. Create **structures** that support a culture of equity. These structures include policies and procedures that institutionalize values that promote health equity, commit adequate resources for the reduction of disparities, and enact systematic collection of data to monitor and provide transparency and accountability about the outcomes of individuals with social risk factors. These structures also include continuous learning systems that routinely assess and the needs of individuals with social risk factors, develop culturally tailored interventions to reduce disparities, and evaluate their impact.
3. Ensure **equitable access to healthcare**. Equitable access means that individuals with social risk factors are able to easily get care. It also means care is affordable, convenient, and able to meet the needs of individuals with social risk factors.

4. Ensure **high-quality care** within systems that continuously reduces disparities. Performance measures should be routinely stratified to identify disparities in care. In addition, performance measures should be used to create accountability for reducing, and ultimately, eliminating disparities through effective interventions.
5. **Collaborate and partner with** other organizations or agencies that influence the health of individuals (e.g., neighborhoods, transportation, housing, education, etc.). Collaboration is necessary to address social determinants of health that are not amenable to what doctors, hospitals, and other healthcare providers are trained and licensed to do.

The Committee also identified measure concepts that measure developers can translate into performance measures to assess progress towards meeting the goals of the domains of measurement.

INCENTIVIZE THE REDUCTION OF HEALTH DISPARITIES AND ACHIEVEMENT OF HEALTH EQUITY

The increased use of performance measures offers numerous ways to incentivize the reduction of disparities. For instance, accountable care models can include health equity measures that are linked to payment to spur both improvement and innovation. Reporting the results of disparities-sensitive and health equity measures can provide transparency as well as help identify and address disparities. Public and private payers can adjust payments to providers based on social risk factors or offer additional payments for primary care or disease management programs (e.g., in-home monitoring of blood pressure). Acknowledging that leveraging payment models is only one way of incentivizing and supporting the achievement of health equity, the Committee developed a set of recommendations to provide the necessary support for reducing disparities and promoting health equity.

RECOMMENDATIONS

RECOMMENDATION 1:

Collect social risk factor data.

Data are the bedrock of all measurement activities; however, data on social risk factors are currently limited. As such, stakeholders must invest in the necessary infrastructure to support data collection. There is a general need for data collection related to social risks like housing instability, food insecurity, gender identity, sexual orientation, language, continuity of insurance coverage, etc.

RECOMMENDATION 2:

Use and prioritize stratified health equity outcome measures.

Stakeholders should first conduct a needs assessment to identify the extent to which they are meeting the goals outlined in the roadmap. The domains of measurement should be considered as a whole rather than aiming to make progress in only one area. Stakeholders must actively identify and decommission measures that have reached ceiling levels of performance and where there are insignificant gaps in performance.

RECOMMENDATION 3:

Prioritize measures in the domains of Equitable Access and Equitable High-Quality Care for accountability purposes.

Some measures within the domains of measurement are more suitable for accountability and others, for quality improvement. The majority of measures that fall within the domains of *Culture for Equity*, *Structure for Equity*, and *Collaboration and Partnerships* should be used primarily for quality improvement initiatives and are less appropriate for accountability. Measures that are aligned with the domains of *Equitable Access to Care* and *Equitable High-Quality Care* may be more suitable for accountability.

RECOMMENDATION 4:

Invest in preventive and primary care for patients with social risk factors.

Equitable access starts with unconstrained access to primary care. People with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system often rely on continuity with a trusted

primary care physician. Primary care's capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while providing resources and services to align with these needs is vital to improving health equity. Ultimately, incentives are needed to prioritize support for traditionally underfunded preventive activities.

RECOMMENDATION 5:

Redesign payment models to support health equity.

Payment models designed to promote health equity have the potential to have a large impact on reducing disparities. For example, health plans can provide upfront payments to fund infrastructure for achieving equity and addressing the social determinants of health. Health plans can also implement pay-for-performance payment models that reward providers for reducing disparities in quality and access to care. The Committee noted that purchasers could use mixed model approaches, combining payment models based on their specific goals (e.g., upfront payments and pay-for-performance to reduce disparities). Payment models can also be phased, using pay-for-reporting, then pay-for-performance incentives.

RECOMMENDATION 6:

Link health equity measures to accreditation programs.

Integrating health equity measures into accreditation programs can increase accountability for reducing disparities and promoting health equity. These measures can be linked to quality improvement-related equity building activities. Organizations like the National Committee for Quality Assurance (NCQA) and URAC have already aligned with this strategy.

RECOMMENDATION 7:

Support outpatient and inpatient services with additional payment for patients with social risk factors.

Social risk factors are like clinical risk factors in the sense that they require more time and effort on the part of providers in specific encounters to achieve the same results. If an office visit is more complex (and billed and paid at a higher level) because of clinical complexity in a patient, the same concept could extend to the incorporation of social

risk factors and “social complexity” as a payment concept.

**RECOMMENDATION 8:
Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.**

Payers should consider additional payments to assist organizations in developing the infrastructure to provide high-quality care for people with social risk factors. There is a need to adjust for social risk factors as well as stratify performance scores by social risk to ensure transparency and drive improvement. In addition, relevant stakeholders should prospectively monitor the financial impact of value-based purchasing programs on organizations caring for individuals with social risk factors.

**RECOMMENDATION 9:
Fund care delivery and payment reform demonstration projects to reduce disparities.**

The evidence base for many care delivery and payment reform interventions to reduce healthcare

disparities is still limited. There is a need to better understand what work is being done to reduce disparities, what interventions are effective, and how these interventions can be replicated in practice (e.g., implementation science). Future research and demonstration projects should be conducted in partnership with researchers to ensure they are rigorous and scientifically sound.

**RECOMMENDATION 10:
Assess economic impact of disparities from multiple perspectives.**

There is limited understanding of the economic impact of disparities. Quantifying the costs in terms such as lost productivity, quality adjusted life years, readmission rates, emergency department use, etc., could help organizations understand the imperative to invest in health equity.

The full NQF report, A Roadmap to Reduce Health and Healthcare Disparities through Measurement, can be accessed on the NQF website. To receive updates about NQF’s disparities-related work, please [sign up here](#).

GLOSSARY OF TERMS

Social risk factors: Economic and social conditions that may influence individual and group differences in health and health outcomes. These factors may include age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and many others.

Performance measure: an assessment tool that aggregates data to assess the structure, processes, and outcomes of care within and between entities—typically specifies a numerator (what/how/when), denominator (who/where/when), and exclusions (not).

Measurement Roadmap: A conceptual model to provide structure for organizing currently available measures. It identifies areas where gaps in measurement exist and prioritizes areas for future measure development by

organizing ideas about what is important to measure for a topic area and how measurement should take place (e.g., whose performance should be measured, in which care settings, and for which individuals).

Disparities-sensitive measure: A measure that detects differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups.

Domain of measurement: A domain of measurement is a categorization/grouping of high-level ideas and measure concepts that further describes the measurement roadmap, and a subdomain is a smaller categorization/grouping within a domain.

Health disparity: A health difference that is closely linked to social, economic, or environmental factors. A

healthcare disparity is a difference in the quality of healthcare that is not due to clinical factors.

Health equity measure: A performance measure that assesses the use of evidence-based interventions that reduce disparities in health or healthcare.

Measure concept: An idea for a measure that includes a description of the measure, including planned target and population.

Stratification: A process by which clinicians, providers, and other entities report measures by different groups of patients (male, female, African American, white, etc.) or combination of groups to find potential differences in care. An example is examining a measure of how many patients received routine mammography by how many African American women received the recommended care.

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