Finding Answers
Solving Disparities Through Payment and Delivery System Reform

Integrating Payment and Delivery System Reforms to Solve Disparities: Recommendations from Finding Answers Grantees

Robert Wood Johnson Foundation

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Background

Finding Answers: Solving Disparities Through Payment and Delivery System Reform (Finding Answers) is a national program of the Robert Wood Johnson Foundation and has been a leader in driving the United States from merely documenting health disparities to implementing solutions. From 2005 to 2013 our program team managed Finding Answers: Disparities Research for Change and produced 12 systematic reviews of the literature and awarded 33 grants to health care organizations with innovative interventions to identify best practices for reducing racial and ethnic disparities in care and outcomes. Based on these findings, we created *The Roadmap to Reduce Disparities* (*Roadmap*), with guidelines and best practices for health care organizations and policymakers to address disparities through quality improvement efforts. Finding Answers staff members also utilized the Roadmap and associated program products and tools to help health care practices within Aligning Forces for Quality (AF4Q) communities to successfully incorporate equity into their ambulatory quality improvement activities. This and our other technical assistance activities made clear that most organizations need a strong business case to justify the time and energy needed to address disparities in patient care and health outcomes.

Finding Answers Focuses on Integrating Payment and Health Care Delivery Reforms to Solve Disparities

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 re-admissions, 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 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. Compared to previous calls for proposals focused only on health care delivery reform, there were a limited number of applicants, and many were not responsive to the selection criteria[1]. Payers and health care organizations were unsure how to design payment models that build-in a financially-supported focus on equity. 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.

[1] DeMeester RH, Xu LJ, Nocon RS, et al. Solving disparities through payment and delivery system reform: A program to achieve health equity. Health Affairs. 2017;36(6):1133-1139.

Each of our grantee projects utilized two major payment components in their integrated payment and health care delivery reform models. They utilized financial support for delivery system improvements that are typically not reimbursable, as well as financial incentives for specific behavior changes. The following is a description of our three grantee projects.

Three Payer and Provider Partnerships Focused on Equity

George Mason University, Molina/Inova Healthcare, and Fairfax County, VA

Hispanic patients at safety-net clinics in Fairfax County, Virginia were more likely to receive "high performance" care for cervical cancer screening, diabetes control, and hypertension control than non-Hispanic patients. Fairfax County and its clinical partners—originally Molina Healthcare and now Inova Health System—wanted to extend the same quality of care to the diverse, multilingual non-Hispanic population.

Molina Healthcare, which originally operated clinics for Fairfax County's Community Health Center Network, paid all members of the clinic staff a salary-percentage bonus for meeting care targets aimed at disparities reduction in cervical cancer screening, blood pressure control, and diabetes control. Physicians and within-clinic specialists treat patients; referral specialists make sure patients see in-house specialists as soon as possible; enrollment staff members help patients sign up for care; and the county public health liaison ensures patients have access to other County resources such as food stamps.

Fairfax County and Molina (and later Inova) agreed on a capitated system with a global budget. Molina decided how and where to spend the money in running the clinics and paying care teams. They funded incentives for monthly team-based relative value unit (RVU) productivity and processes of care; used incentive metrics aimed at overall health condition targets instead of reductions in disparities; provided midmonth metric reports to allow teams to make adjustments to meet monthly incentive targets; and provided incentives of up to 3% of salary for team members. Activities that promoted disparities reduction for target conditions—for example, identifying a patient in need of cervical cancer screening and getting her 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.

Icahn School of Medicine at Mount Sinai and Healthfirst, New York City

Postpartum follow-up care offers a chance to influence maternal and child health for vulnerable populations. Yet staff and researchers at Mount Sinai Hospital found that a sample of Medicaid-covered women—most of them Hispanic or Black—received timely postpartum care only 58% of the time compared with national figures that suggest a rate of 80% to 90% for low-risk white, commercially insured women. The rate was even lower among mothers on Medicaid with hypertension (46%) or diabetes (50%).

Mount Sinai implemented a program to improve the quality and frequency of postpartum care for low-income patients with or at high risk for diabetes, depression or hypertension, through a combination of physician and patient incentives. In the proposed intervention model, ob/gyn physicians would receive a small bonus payment from Healthfirst (via Mount Sinai) for every Healthfirst enrollee who received a timely postpartum visit; they would also receive continuing medical education on quality care for chronic diseases. Clinical staff, including a care coordinator and a social worker, helped to connect women to care, follow up with them, screen for depression and other issues, and educate patients

on the importance of postpartum visits. There was a cost-sharing arrangement between Mount Sinai and Healthfirst to cover staff and provide clinician education.

University of Washington and Advantage Dental Services, Oregon

Low-income mothers and children in Oregon have low rates of dental care, and rates of tooth decay in young children are higher than the national average. Advantage Dental, a cooperatively owned dental care network, changed its payment and delivery model in order to extend service to disadvantaged mothers and children in rural areas.

Advantage utilized a capitated system with a global budget to increase dental care utilization and decrease the incidence of oral health problems among Medicaid- and Children's Health Insurance Program-enrolled (Oregon Health Plan) mothers and children. They employed expanded-practice dental hygienists (EPDHs) to screen and treat patients individually in community settings including schools and offices for the Special Supplemental Nutrition Program for Women, Infants, and Children and Head Start. Case managers coordinated care for patients with immediate needs to make sure they were seen by a primary care dentist or clinic, and 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 per-patient global budgeting capitation model and pooled the fixed payments it received per patient for pay-for-performance incentives rewarding efficient and coordinated patient care. This enabled funds to be directed toward their innovative care model. 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 team (EPDHs and dentists) for reaching goals of increased screening, in-field treatment of at-risk patients, and follow-up care in target counties. It also disbursed the incentive to the care coordinators and RMCLs if all participating counties met the targets. Some dentists were also shareholders in the company. Incentives targeted overall improvement within counties instead of reduction in disparities.

You can read more details and see an infographic about each of the three grantee projects here. Each grantee experienced multiple implementations successes and also encountered multiple obstacles throughout the lives of their programs. What follows are lessons to consider based on their experiences. When reviewing the considerations please remember that the Finding Answers Roadmap provides additional valuable information for organizations wishing to integrate healthcare payment and delivery system reforms to identify and eliminate disparities in health care and outcomes.

Identifying Goals and Objectives

When designing integrated disparities-focused payment and health care delivery programs, we recommend establishing close collaboration between the payer and the health care organization upfront. Directly involving key stakeholders at both organizations will account for the different perspectives and approaches that are needed for success. The topics in this section include important negotiation topics for the partnering organizations and recommendations related to program planning and design.

Clearly identify the desired outcomes.

- Do you want to *improve* the quality of care or health outcomes for one or more disadvantaged groups? Or do you want to reduce disparities in quality of care or health outcomes *between* two groups? The former may be the most expedient or achievable goal initially. However, it will be important to continue monitoring the disparity in care or outcomes between the two groups and ultimately take steps to reduce the disparity.
- Does your desired outcome align with current national, state, and local health care priorities and regulations? Examples include state and local public health department programs, private payers' quality improvement initiatives, the Centers for Medicare and Medicaid Services quality programs, Healthcare Effectiveness Data and Information Set measures, public reporting programs). Does it align with your organization's current quality or payment reform priorities?
    - Alignment with existing priorities will nurture buy-in and, potentially, sustainability.
    - Are there potential secondary benefits that might encourage sustainability and support of the program? For example, improving postpartum visit rates may improve child health care metrics or may create opportunities to engage women at high risk for chronic health conditions in preventive care or treatment.

Identify the specific behavior change(s) that will bring about the intended outcome.

- Create logic models and staff/patient process maps to document the steps of the targeted healthcare processes or pathways to illuminate the details of quality problems and their solutions. Doing so will make it easier to identify specific behaviors and activities that should be targeted to achieve your desired result. Create and review logic models and process maps with clinical staff and patients to ensure their accuracy and relevance.

Identify all staff involved in the behavior change and include all of them in the design phases of your disparities program(s).

- For example, when designing an intervention to improve care quality for patients with low health literacy, many implementers focus on the buy-in and training of physicians and nurses. However, part of your intervention might include screening patients for low health literacy when they check in or register for services: don't forget to obtain buy-in from the patient registration staff and their supervisors. Incorporate their needs and concerns into the overall design of the intervention. They may have concerns about increased workload or changes to patient flow at registration, explaining the purpose of screening forms, correctly communicating or documenting the screening results, or properly training future or new patient registration staff members.
- Another example is a payment reform which includes a financial incentive for individual physicians. Do not forget to obtain buy-in and solicit concerns, questions and recommendations from other members of the healthcare team. For example, information technology staff are critical for how new metrics will be retrieved from the electronic health record. Finance and accounting staff are essential for directing incentive payments to the correct providers.

Analyze what might motivate organizations and staff members to perform the desired behaviors. They might be motivated by factors other than money.

- Staff members often become motivated to make equity-focused quality improvement changes when they are shown quality or health outcome disparities data stratified by key demographic variables (e.g., race/ethnicity, age, sex), or when shown that a subset of their patient population is suffering from disparities in outcomes or quality of care. Having access to regularly updated performance metrics illustrating the gradual effects of their efforts can help maintain their motivation.
- Friendly competition between teams, units, or clinics may also motivate staff members as they compare progress on disparities-focused quality performance metrics. Incentives for "winning" (in whatever format) may not need to directly benefit staff personally, but could instead provide resources for patient care, the workplace (e.g., training, new equipment), or even designated charities.
- Staff members may also face competing motivations that can diminish performance (time constraints, burnout, other performance incentive programs, etc.). It is important to identify these competing motivators and ensure that the disparity-focused program incentives are strong enough to counteract them or, preferably, are complementary and synergistic.
- Payers can financially support or incentivize the infrastructure necessary to integrate equity efforts into the existing quality improvement activities (e.g., via capitated payment models or cost-sharing). They might help provide staffing resources, employee or patient training, and information technology software.

Do not underestimate the time and energy needed to build and sustain the relationships necessary for your program's success.

- Carefully consider the following types of positions at each partner organization. Do not assume that they will provide sustained buy-in for the life of the project. Instead, beginning with the initial design phases of the project, directly involve anyone who will be required to do something different in the course of their standard activities, from the lowest to the highest levels of the organization hierarchy. Example position types include:
  - Administrative
  - Clinical
  - Information technology
  - Finance/revenue
  - Communications/Marketing

Start Planning for long-term sustainability immediately.

- Identify at the beginning the individuals and groups who will have the decision-making authority and the resources to support your program for the long term, should pilot testing and implementation prove successful.
  - 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.

  - Ascertain their key, bottom-line metrics for determining whether they would devote the resources to sustain the program over the long-term.
    - Get to the details. For example, “The program should reduce costs” is too vague. Which costs? By how much (e.g., a certain percentage of X budget)? Over what period of time? Will program implementation 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.
- Determine how to best align the interests of key stakeholders critical for sustainability. 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 high-need patients who are suffering from one or more health or health care disparities. Consider how the motivators of different stakeholders could be aligned. For example, a proposed program might address patient populations that are high-cost for the organization and who also suffer from significant disparities in care quality or health outcomes?
- Ensure that your program has the capacity to collect the data needed to inform any bottom-line sustainability metrics, such as effectiveness, efficiency, or return on investment.
- The Finding Answers Roadmap has multiple recommendations to maximize sustainability of any disparities-focused program. Design your program from the beginning with them in mind.

Anticipate program disruption.

- Acknowledge from the beginning that reducing and eliminating disparities in care and health outcomes takes time. Hope for the best and proactively plan for the worst regarding potential disruptions to the program.
  - Examples include high-level leadership turn-over and the subsequent loss of institutional support and buy-in, changes in vendors or contractors essential to program operations (e.g., adoption of a new electronic health record platform that drops key reports or metrics needed by the program), organization restructure or merger, turnover of key information technology staff supporting the program, provider group or payer contracts being eliminated or significantly altered, and staffing reductions.
- Develop contingency and recovery plans as soon as you become aware of a potential disruption.
  - Work to keep multiple high-level leaders knowledgeable about, and supportive of, the program over time and actively nurture program champions at all levels of the organization.

Designing and Implementing a Payment System Reform

Each of our grantee projects utilized at least two major payment components in their integrated payment and health care delivery reform models. See page 4 and the Finding Answers website for more information about each of the grantee projects. First, they utilized financial support for delivery system improvements that are typically not reimbursable, which was an essential component underlying the success of their models. Two of the grantees utilized the flexibility of capitated payments and the third utilized direct payment from the payer to the healthcare provider organization to fund delivery system improvements. Examples included adding case managers to the care team and deploying expanded-practice dental hygienists into schools and other community settings. The two grantees utilizing capitated payments to financially support delivery system improvements involved healthcare organizations and payers that had prior experience operating such models. They 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 financial incentivizes for specific behavior changes. In contrast to financial support for delivery system improvements, the grantee projects 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[2][3][4]. 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 program design choice is best. While no one approach is clearly superior to another, the variability contained within these programs provides an important opportunity for Medicare and others to learn from these undertakings and to use that knowledge to inform future policymaking."[5] We next describe the lessons learned and recommendations based on the experience of our grantees in designing financial incentives to improve equity.

[2] 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.
[3] 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.
[4] 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.
[5] 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.

Consider the timing of introducing delivery system reform and financial incentive programs.

- Comprehensive and simultaneous payment and delivery system changes can be overwhelming for staff, including information technology 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.
- 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.
- ▪ Strongly consider piloting any incentive program before rolling it out fully.

If you choose to provide financial support for delivery system reform:

- In addition to following the recommendations in this resource document, utilize the Finding Answers Roadmap which provides extensive information, tools, and resources to guide disparities-focused health care delivery system reform. The grantee descriptions earlier in this document describe this aspect of their payment reform models.

If you determine that a financial incentive would be an appropriate mechanism to motivate participation in your program:

- Before proceeding, verify with patients, community members, and front-line non-physician staff if a stand-alone financial incentive is sufficient to achieve the desired disparity elimination goals. In many cases, staff members in the health care system or organization(s) might need infrastructure support. Or, for example, patients might report needing ongoing peer-based counseling and navigation support from a community health worker if they are to change behavior to improve their health.
- Identify all incentive programs currently in place and consider how they will influence perceptions of, and reactions to, the proposed program.
    - For example, some organizations have income, profit, productivity, quality, or other types of goals for leadership or management. Consider how these goals might lead leaders/managers to intentionally or unintentionally hinder their staff members' focus on a proposed quality-focused incentive program, especially if the performance metrics and incentive structures of the two programs are not fully aligned.
- Prepare all stakeholders from the beginning about what might happen in the future when the program succeeds or needs adjustments. Here are some examples of program changes that you should help stakeholders anticipate.
    - *Program beginning*. Will the program start off with easier-to-reach incentive targets that gradually increase in difficulty after staff members become comfortable with the program? Or will the program start off with more challenging incentive targets? Involving all stakeholders during the program design stages will help you understand how the different options for setting incentive targets might impact motivation.
    - *Program adjustments*. You might find that staff members easily earn incentives at the beginning of a program or that progress toward quality or health outcome

targets begins to plateau. As a result, you may need to alter or increase incentive metrics to adequately impact process-of-care or health outcome measures. Similarly, consistently monitor the strategies stakeholders use to meet incentive targets and work with them to adjust the strategies to maximize progress. Finally, staff members who have been meeting incentive targets for a significant amount of time may perceive changes to the program design or structure that make it harder to meet incentive goals as a loss of income (versus a loss of "extra" incentive funds). Communicate proactively about these potential changes from the beginning.

- The end goal of any equity-focused integrated health care payment and delivery reform program should always be eliminating or reducing the targeted disparities in quality of care or health outcomes.
    - However, at least at the beginning, there may be legitimate reasons to focus on improving quality or health outcomes for the patient population experiencing the disparity, rather than outright incentivizing a reduction in the disparity between groups. For example, stakeholders might perceive disparities reduction as overly ambitious or unattainable if it requires the patient to make behavioral changes.
    - A two-stage approach might work in these situations. The program can begin by incentivizing improvements in quality and/or health outcomes for the population experiencing the disparity, while monitoring the gap between groups. After experiencing some initial successes, the program can transition to incentivizing closing the disparities gap.
- Additional things to remember:
    - To accurately measure change over time, you need high-quality baseline data on subgroups.
    - Make sure that disparity reduction goals are not met by reducing health care process or outcome measures of the group initially experiencing better care and/or outcomes.

Understand the various ways incentives can be structured and choose the features that will work best for your program. Here are some questions to get you started:

- Will the incentive be individual or team-based?
    - Individual incentives might be the best choice when a behavior change specific to a single type of position can achieve the desired outcome. For example, incentivizing social workers in the organization might be more effective than incentivizing the entire health care team if the desired outcome is to increase effective referrals to community based agencies that address social determinants of health.
    - A team-based performance metric may be beneficial when:
        - Physicians with higher reimbursement rates or salaries may not be sufficiently motivated by the available payment incentive. Other staff members with lower incomes may be more motivated by the potential incentive and effectively drive physician behavior in the desired direction. For example, patient registration and call center staff could search for and identify prevention screenings, lab tests that need to be ordered, and other health care needs of patients every time they call or walk-in for an appointment. In this way, they could proactively schedule the correct

appointments and care instead of waiting for patients or providers to identify the need first. Medical office assistants might proactively initiate the necessary care processes at the beginning of a shift to make it easy for physicians to identify and carry out incentivized patient care activities.

  - The clinic or hospital utilizes a multidisciplinary, team-based model. For example, for health outcomes to improve, patients with multiple chronic illnesses might need the assistance of a nurse care manager, social worker, pharmacist, and physician at different points in time. An incentive program that impacts all team members might work better than one that only targets physicians.
  - A team-based model is desired and it could provide the impetus to develop a functional team.

- Who will be eligible to receive the incentive?
  - When deciding whether to use individual or team-based metrics, don't overlook the many different types of staff members who play a direct role in meeting quality-related performance metrics, particularly in training settings (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, or if a significant portion of team members are on short-term training or rotation assignments.
- Will the incentive program target one quality metric or multiple quality metrics?
  - If it is targeting multiple quality metrics, will the incentive be structured by measuring success regarding each separate metric or will it have one composite measure with multiple metrics within it? For example, a program might be comprised of three quality metrics; metric A, metric B, and metric C. Each metric could, for example, contribute one-third of the total incentive available. Thus, a team may earn none of the incentive (if they don't meet any of the three metrics), 1/3, 2/3, or the entire incentive during each measurement period.
  - Alternatively, the same incentive metrics might be combined into one composite and staff members could be required to achieve a minimum goal during the incentive period. For example, if it is possible to earn a maximum of three points for each of the three metrics, an all-or-none incentive could be triggered by achieving a goal of 5 or more out of the possible 9 points in each reporting period (i.e., 5 or more total points on a composite measure of Metric A + Metric B + Metric C earns the incentive).
  - Monitor performance on the individual components of composite incentive metrics over time because it may reveal useful patterns regarding the strategies staff use to meet the target threshold of the composite metric (e.g., by focusing more on some components of the composite than others).
- Will the incentive component of your larger payment reform model address both quality and productivity, or only quality?
- 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 targets that are more or less difficult based on context.
    - Consider setting targets that reward and incentivize improvement over time.

Consider the frequency and timing of incentive reporting and payouts.

- 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. 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.

Collecting and Managing Data

Each of the grantees, and the vast majority of healthcare organizations that have partnered with Finding Answers in the past, experienced significant and unanticipated challenges in collecting, analyzing, and utilizing data. The following recommendations are based upon their experiences.

Anticipate and address the following issues, before establishing baseline data and during data collection:

- 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.
- Extracting data from the electronic health record system may be significantly more difficult and time-consuming than entering it. Do not minimize the critical role of information technology skills and resource costs in these efforts.
- It may be difficult to identify all care that specific patients received due to a lack of post-referral follow-up in records, care received at other organizations, patients moving in and out of a specific payer status (e.g., Medicaid eligibility), and other factors.
- Staff members might need intervention, training, and reminders regarding data entry and standardization. Data entry inconsistencies—e.g., different staff members entering similar data into different fields or areas of the electronic health record—may result in:
    - Claims data 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.
    - Inaccurate pay-for-performance metrics.
- Current billing and reimbursement systems are not configured to easily link payment incentives to individuals or teams within a specific health care organization.
    - It is challenging to create coding and billing systems that document and track incentivized activities for reporting to the payer. It is also difficult to track and direct incentive funds from the payer, through the health care organization, to specific teams or providers. This can be particularly difficult in larger health systems with multiple payers and multiple hospitals and clinics. Work closely with the data and

financial teams at both the payer and provider organizations to anticipate and minimize these challenges.

- 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 program 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, but the related health outcomes being measured at another for purposes of earning the incentive).
    - Similar issues can arise for providers working in different organizations or regions over time.

Reduce data problems.

- Allocate sufficient resources for training staff members on new data collection procedures. This includes sufficient time to onboard new staff who start work mid-project and to provide booster training for existing staff.
- Work directly with front-line staff members to ensure that procedures for inputting data are not too burdensome or confusing. Continue to monitor this throughout the project.
- Fully develop and run project reports before rolling out the project to ensure that data can be retrieved as needed.
- Build a system to regularly audit all system reports. Include audits by front-line staff members (e.g., nursing, registration staff) in addition to physicians, administrators, and information professionals.
- Directly involve front-line staff members in all aspects of data collection, analyses, 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 sometimes identify problematic approaches to data collection or interpretation that are easily overlooked by physicians, dentists, information technology staff members, and administrators.
- Remember that data can be used to gain buy-in in addition to documenting and tracking disparities (e.g., highlighting successes, communicating the value of investing in disparity-focused processes and systems).

Organizational Complexity and External Partnerships

The Finding Answers Roadmap to Reduce Disparities defines six levels of the health care system: Patient, Care Team Member/Provider, Microsystems (within the health care organization), Health Care or Payer Organization, Community, and Policy. The following recommendations address various levels.

Be aware that people at different levels may have different perceptions of, responses to, and impact upon integrated payment and delivery reform programs to address disparities.

- What real or perceived burdens do you anticipate stakeholders at each of the six levels will attribute to your program? How will the program address these burdens? How are the perceived burdens balanced by perceived benefits? Examples of potential burdens include:
  - Patients may feel burdened by having to complete a new demographic profile as the organization attempts to collect higher-quality race and ethnicity data or begins collecting sexual orientation or gender identity data to stratify their quality metrics.
  - Specific care team members may feel burdened by extra training required by the program or new documentation procedures required to collect accurate data for the program.
  - A microsystem or team within the health care organization may feel burdened by new activities required by the program, such as information technology staff having to spend many hours or days extracting new data sets from the electronic health record.
  - Other nonprofit organizations may be reluctant to partner with a hospital on a community-based intervention if the hospital has historically neglected or imposed its desires on the community (e.g., an academic medical center buying a large tract of land for facilities expansion that was being used by the community for another valued purpose).
  - State policymakers might feel burdened by a health system seeking any expanded licensure and credentials required to implement a new model of coordinated care.

Consider how the number and size of payer and healthcare organizations, and the nature of the relationships between them, might inform your proposed payment reform program. For example:

- A specific payer organization will typically have more influence over a provider or health care organization if it is the main payer.
- A smaller payer organization may be strongly motivated by one of its larger health system owners to implement and sustain a provider-focused pay-for-performance intervention or to help create the infrastructure necessary to implement a disparities-focused quality improvement program.

- Different payers may have competing or confusing payment reform or quality improvement programs, resulting in different quality improvement metrics for the same health condition (e.g., different HbA1c targets), or different incentive structures to meet the same metrics.
- The health care organization (or staff members) may place less value in an integrated program to address disparities if the project involves just one payer in a setting with many other payers, or if the payer's share of the patient population is relatively small.
- Market forces and antitrust regulations could influence the buy-in and necessary cooperation of programs involving multiple payers and/or healthcare organizations. For example, if payer and health care organization partners wish to partner with community based social service organizations to address social determinants of health, high market saturation by them will decrease the chances that other organizations will simultaneously attempt to engage the same social service organizations with competing or conflicting initiatives.

Consider how the number and size of payer and healthcare organizations, and the nature of the relationships between them, might inform your proposed payment reform program. For example:

Typically, the core relationships will be between the payer and healthcare delivery organizations. However, many programs will engage and work directly with other types of organization partners (e.g., community-based social service organizations, churches, schools, departments of public health). These relationships also require time and effort to establish and maintain over the life of the program. Consider the following:

- Include input from all organization partners in the program design phase.
- Recognize additional burdens that your program may impose, and make a good-faith effort to accommodate partner concerns.
- Find out if other organization partners promote and use a different model of payment or care. How might this impact the reception to, and perceptions of, your new integrated model? Also:
    - State-level health care and payment policies may be especially influential. Will the new integrated model complement, support, or contradict existing policies?
    - Learn about the long- and mid-term relationship and cultural dynamics between the organizations, systems, and geographic regions that will need to work together in the program. In addition to positive relationship dynamics, longstanding (e.g., years or decades) negativity, rivalries, competition, and distrust may exist between organizations and/or community groups. Know about and proactively address these in advance. Analyze and prepare for:
        - Potential turf battles between partners.
        - Perceived threats to one or more partners' usual ways of doing business.