Title: Pay-For-Performance Programs to Reduce Racial/Ethnic Disparities: What Might Different Designs Achieve?

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I. Background:
Definition: Pay for Performance is a strategy to improve health care delivery that relies on the use of market or purchaser power.

Pay for Performance (P4P), depending on the context, refers to financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payer, and improved quality and patient safety.

Most P4P programs are interested primarily in improving quality, they tend to rank providers by overall quality, and then reward high performers.

II. Objective/Hypothesis of the study
The objective of the study was to examine the potential impact on national hospital disparities using P4P programs and alternative ranking methods.

III. Methods
Retrospective design.
Years: 2005 and 2006.
Data from over four million patients
Hospitals = more than 4,500 hospitals participating in the Hospital Quality Alliance (HQA).

Analyzed what might occur if measures of overall quality, disparities, or both, were used to rank hospitals to determine incentive rewards.

Questions:
1. How might overall national-level quality and disparities be affected by different methods of ranking hospitals for P4P purposes?
2. Do hospitals with the highest quality also have the lowest disparities? and
3. how do U.S. hospitals with the highest quality and lowest disparities treat minority patients compared with how they treat White patients?

Intervention
Pay for Performance program
Outcomes
Quality of care measure
Racial and Ethnic Disparity

Analysis
Hospitals were ranked using two metrics:
(a) based on magnitude of overall quality of care (quality rank); and
(b) magnitude of the hospital level disparity score - defined as the quality of score for Whites minus the quality of score for the combined minority group (disparity rank)

50th percentile (median) value was used to categorize hospitals into High and low performing hospitals.

Agreement between top performing groups for quality and disparity was analyzed Kappa statistics.

IV Results
(1) Many hospitals has low disparity score AND low overall quality score.
(2) Many hospitals had high disparity score AND high overall quality core
(3) Within hospital disparities varied substantially across hospitals.
(4) National composite quality scores in 2005–6 were 82.4% for AMI, 60.6% for HF, and 48.5% for pneumonia (Table 3). National disparity scores, that is, the difference in scores between Whites and minorities, ranged from about 4–6 percentage points for Blacks, 7–10 percentage points for Hispanics, 2–9 percentage points for Asians, and 5–7 percentage points for the combined minorities group, depending on the condition.

V. Authors conclusions
To maximize both improvements in quality and reductions in national disparities, P4P programs should consider an approach that incorporates both overall quality and reductions in disparities when setting incentives.

VI. Reviewers Critique
Overall, informative and excellent study.

VII Summary for practice implications
1. Difficult to implement.
2. Coming up with appropriate incentives is challenging.
3. Issues related to treatment heterogeneity remains.
4. It would be interesting to further analyze the impact of P4P program intervention on outcomes such as readmissions, mortality and overall cost.