



AMERICA'S ESSENTIAL HOSPITALS

April 8, 2014

**Ref: Risk Adjustment for Socioeconomic Status or Other
Sociodemographic Factors.**

Dear Dr. Cassel,

America's Essential Hospitals appreciates the opportunity to comment on the National Quality Forum's (NQF) draft report, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. As essential hospitals, our more than 220 member organizations fill a safety net role in their communities, serving the uninsured and patients covered by public programs. Our members provide a disproportionate share of the nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients, most of whom are low-income and struggle with social issues, such as food or housing insecurity. Also, more than half of our hospitals' patients are of minority racial or ethnic origin.

For the following reasons, America's Essential Hospitals supports the recommendations of the expert panel.

The report follows a large body of emerging evidence that sociodemographic factors, a term NQF uses to explain a variety of socioeconomic (e.g., income, education, occupation) and demographic factors (e.g., age, race, ethnicity, primary language), can influence health outcomes. These studies have shown the impact adjusting for sociodemographic factors has on readmissions rates and, by extension, provider penalties. Inclusion of sociodemographic factors into the risk adjustment models of outcomes measures, when there is conceptual and empirical evidence to do so, will improve the science of performance measurement. Including sociodemographic factors in risk adjustment methodologies will increase the

precision of the measures and allow providers, payers, and the public to have more accurate information.

Including risk adjustment for sociodemographic variables will help level the playing field for providers assessed by such measures. No one class or one type of provider will be advantaged or disadvantaged by the inclusion of sociodemographic factors in risk adjustment. Rather, a more accurate picture of performance will come to light. Indeed, current accountability model risk adjustment, which does not include sociodemographic factors, may inaccurately report outcomes of hospitals that treat a disproportionate share of vulnerable patients.

Although some have argued that adjusting for sociodemographic factors will mask disparities, this is not the case. Risk adjusting for sociodemographic factors does not mask disparities any more than risk adjusting for a clinical factor negates the importance of that medical comorbidity. For example, including hypertension in a risk-adjustment model for acute myocardial infarction does not lead anyone to believe that hypertension is no longer relevant to heart disease. Researchers have numerous tools at their disposal for analyzing disparities, including stratification and other statistical techniques. Work will continue to uncover disparities in health care and mitigate their impact, and that work will continue independent from a change in the risk-adjustment methodology of any particular quality measure.

The current lack of sociodemographic data should not be a reason for their exclusion. In fact, these recommendations will further fuel efforts already underway to collect this data on patients. Adjusting for sociodemographic factors in risk models will not be easy. But simply because it is hard work does not mean we should back away from it. It would be a mistake to only value that which is most easily measured. Collecting data and building empirical models that show the impact of sociodemographic factors on outcomes will take time; however, adjusting for these factors is the first steps to reducing disparities.

In summary, we support the recommendations of the expert panel and the use of sociodemographic factors in risk models. This is an important work. Risk adjustment for sociodemographic factors will allow for true quality comparisons. Just like the adjustment for clinical presentation factors, adjusting for sociodemographic factors improves the fit of risk models and improves the accuracy of quality measures used for public reporting and accountability. It advances the accuracy of accountability models, benefits payers by improving accuracy of performance metrics, and benefits

consumers by providing them with better information with which to choose providers. We also recognize and agree with the expert panel's explanation that risk adjustment for sociodemographic factors should not apply to all performance measures.

America's Essential Hospitals' comments on each of the report's specific recommendations follow below.

Recommendation 1 from Report:

"When there is a conceptual relationship (i.e., logical rationale or theory) between sociodemographic factors and outcomes or processes of care that is not primarily mediated by quality of care, and empirical evidence that sociodemographic factors affect an outcome or process of care reflected in a performance measure, the analytic method should differ based on the purpose as follows:

- *For purposes of accountability* (e.g., public reporting, pay-for-performance), those sociodemographic factors should be included in risk adjustment of the performance score (using accepted guidelines identified in #3) unless there are conceptual reasons or empirical evidence indicating that adjustment is unnecessary or inappropriate; and
- *For purposes of identifying and reducing disparities*, performance measures should be stratified on the basis of relevant sociodemographic factors when used in analysis by individual providers, policymakers, researchers, and the public working to reduce disparities."

Comments on Recommendation 1:

America's Essential Hospitals supports recommendation 1 as currently written. Some factors that influence outcomes are beyond the control of health plans and providers, no matter how dedicated and caring they are, how culturally sensitive they are, and how much they try to ameliorate the effects of those factors. Adjustment for sociodemographic factors provides a clearer, more accurate picture by accounting for all aspects of a patient's situation.

We agree with the panel that sociodemographic factors, outside the control of the provider, should be included in risk adjustment models used in accountability models, such as pay for performance. There is a growing body of evidence that sociodemographic factors affect health outcomes, such as readmissions. Adjustment will improve these models, making the scores reflect true performance, and better align financial incentives with quality.

Sociodemographic adjustment may not apply to all performance metrics. We recognize this is true for certain measures, such as central line-associated bloodstream infection (CLABSI), where procedural protocols greatly impact outcomes. However, there are many measures where adjustment does apply across all metrics. The panel appropriately recognizes the need for empirical or logical reasons for making the adjustment based on sociodemographics.

We strongly believe that researchers have many tools at their disposal to continue to find and uncover disparities where they can—stratification, for example. We agree with the expert panel’s recommendations to continue using these techniques. However, we caution against the use of stratification in public reporting for its unintended consequences of suggesting different quality standards depending on strata. It is important that there be only one level of quality we all seek to achieve. There should be one standard set for the highest performance of all providers. We should not allow displays of stratified data to create different quality standards for hospitals that treat patients of differing sociodemographic characteristics.

Recommendation 2 from Report:

“The NQF criteria for endorsing performance measures used in **accountability applications** (e.g., public reporting, pay-for-performance) should be revised as follows to indicate that patient factors for risk adjustment include both clinical and sociodemographic factors:

*2b4. For outcome measures and other measures when indicated (e.g., resource use, some process): an evidence-based risk-adjustment strategy (e.g., risk models, ~~risk stratification~~) is specified; is based on patient factors (including clinical and sociodemographic factors) that influence the measured outcome (but not primarily mediated by the quality of care factors related to disparities in care or the quality of care) and are present at start of care;^{14,15} and has demonstrated adequate discrimination and calibration **OR** rationale/data support no risk adjustment/ ~~stratification~~.*

14. Risk factors that influence outcomes should not be specified as exclusions. 15. Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care, such as race, socioeconomic status, or gender (e.g., poorer treatment outcomes of African American men with prostate cancer or inequalities in treatment for CVD risk factors between men and women). It is preferable to stratify measures by race and socioeconomic status rather than to adjust out the differences.”

Comments on Recommendation 2:

America's Essential Hospitals supports recommendation 2 as currently written. Risk adjustment for socioeconomic factors allows for true quality comparisons.

America's Essential Hospitals has been a longtime supporter of the NQF endorsement process. Our members have served on NQF panels, including this expert panel, and have been engaged as stakeholders and participated actively in the consensus-building process.

We believe this recommendation will strengthen the endorsement process and will, if approved, advance the science of performance measurement.

Recommendation 3 from Report:

The same guidelines for selecting clinical and health status risk factors for adjustment of performance measures may be applied to sociodemographic factors and include the following:

- Clinical/conceptual relationship with the outcome of interest
- Empirical association with the outcome of interest
- Variation in prevalence of the factor across the measured entities
- Present at the start of care
- Does not represent the quality of care provided (e.g., treatments, expertise of staff)
- Resistant to manipulation or gaming
- Accurate data that can be reliably and feasibly captured
- Contribution of unique variation in the outcome (i.e., not redundant)
- Potentially, improvement of the risk model (e.g., risk model metrics of discrimination, calibration)
- Potentially, face validity and acceptability

Comments for Recommendation 3:

America's Essential Hospitals supports recommendation 3 as currently written. Appropriate inclusion of sociodemographic factors will improve risk adjustment and maintain valuable and meaningful measures. Just as clinical factors for risk adjustment have been carefully reviewed before endorsement, so, too, should sociodemographic factors. This recommendation will be especially helpful to developers of performance measures. It provides general guidance developers can use as they build the risk adjustment models used in their measures. This allows for transparency and continues to ensure the quality of the endorsement process.

Recommendation 4 from Report:

“When there is a conceptual relationship and evidence that sociodemographic factors affect an outcome or process of care reflected in a

performance measure submitted to NQF for endorsement, the following information should be included in the submission:

- A detailed discussion of the rationale and decisions for selecting or not selecting sociodemographic risk factors and methods of adjustment (including a conceptual description of relationship to the outcome, empirical analyses, and limitations of available sociodemographic data) should be submitted to demonstrate that adjustment incorporates relevant sociodemographic factors unless there are conceptual reasons or empirical evidence indicating that adjustment is unnecessary or inappropriate.”

Comments for Recommendation 4:

America’s Essential Hospitals supports recommendation 4 as currently written. As with recommendation 3, this recommendation provides guidance to the measure developer community and makes developers responsible for selecting or not selecting sociodemographic data risk factors when submitting measures for NQF endorsement. We are concerned that developers may use “data limitations” as a reason for not selecting demographic factors. The lack of data on sociodemographic factors should not be reason alone to not employ these factors in a risk-adjustment model. Without data, you cannot prove the empirical relationship exists or does not exist. This could cause circular reasoning.

If the expert panel recommendations are accepted, there will be a vigorous push toward the collection of sociodemographic data, which is already underway at many hospitals. This will aid in the further identification of health care disparities and the development of solutions for them.

Recommendation 5 from Report:

“When performance measures are used for accountability applications such as public reporting and pay-for-performance, then purchasers, policymakers and other users of performance measures should assess the potential impact on disadvantaged patient populations and the providers serving them to identify unintended consequences and to ensure alignment with program and policy goals. Additional actions such as creating peer groups for comparison purposes could be applied.”

Comments for Recommendation 5:

America's Essential Hospitals supports recommendation 5 as currently written and its desire to assess the unintended consequences of accountability measures on essential hospitals serving disadvantaged populations. However, similar to our concern about stratification, peer

grouping can create a perception that there are different classes of hospitals. It is important that there be only one level of quality we all seek to achieve.

Recommendation 6 from Report:

“NQF and/or others such as CMS, Office of the National Coordinator (ONC) for Health Information Technology, and the Agency for Healthcare Research and Quality (AHRQ) should develop strategies to identify a standard set of sociodemographic variables (patient and community-level) to be collected and made available for performance measurement and identifying disparities.”

Comments for Recommendation 6:

America’s Essential Hospitals supports recommendation 6. We strongly support the collection of standardized, uniform, and well-defined sociodemographic data on all patients. Our Essential Hospitals Engagement Network (EHEN), under the CMS Partnership for Patients project, has focused attention on the standardized collection of race, ethnicity, and language (REAL) data across all of our hospitals as part of our health equity action plan.

America’s Essential Hospitals, along with Association of American Medical Colleges, American College of Healthcare Executives, American Hospital Association, and the Catholic Health Association of the United States, launched the National Call to Action in 2011 to end health care disparities through increased collection and use of REAL data, increased cultural competency training, and increased diversity in governance and leadership.

We suggest that NQF fulfill this recommendation by leveraging work already underway by the National Call to Action partners. We would value a multi-stakeholder discussion.

Recommendation 7 from Report:

“NQF should consider expanding its role to include guidance on implementation of performance measures. Possibilities to explore include:

- guidance for each measure as part of the endorsement process;
- guidance for different accountability applications (e.g., use in pay-for-performance versus pay-for-improvement; innovative approaches to quality measurement explicitly designed to reduce disparities).”

Comments for Recommendation 7:

America's Essential Hospitals believes this recommendation as now written is out of the scope of NQF’s current activities, but deserves consideration by the NQF board. Providing guidance on how a measure should be

implemented or used as part of the endorsement process would be an important contribution to the field. It seems like a logical next step in the NQF endorsement process.

Recommendation 8 from Report:

“NQF should make explicit the existing policy that endorsement of a performance measure is for a specific context as specified and tested for a specific patient population (e.g., diagnosis, age), data source (e.g., claims, chart abstraction), care setting (e.g., hospital, ambulatory care), and level of analysis (e.g., health plan, facility, individual clinician). Endorsement should not be expanded without review and usually additional testing.”

Comments for Recommendation 8:

America's Essential Hospitals supports recommendation 8 to make this explicit.