

Public Reporting of Provider Performance at a Crossroads in the United States: Summary of Current Barriers and Recommendations on How to Move Forward

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Abstract

Twenty-seven years after the first public release by the U.S. government of data on the quality of hospital care, public reporting for consumers has expanded substantially. Despite the growth in public reporting activities, there is limited evidence of their use by consumers in ways that significantly affect health care delivery. Support for public reporting continues, in part, because of the face value of transparency. The limited impact of reporting efforts is plausibly due to flaws in the content, design, and implementation of existing public reports rather than inherent limitations of reporting. Substantial work is still needed for public reports to achieve their potential for engaging and informing consumers. We present a vision statement and 10 recommendations to achieve this potential.

Keywords

consumer engagement in quality, public reporting, report cards, transparency, health care decision making

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Introduction

The year 2014 marks 27 years since the historic public release by the U.S. government of data on the health outcomes of patients treated at specific hospitals, the beginning of modern public reporting in the United States. William Roper, MD, who presided over the U.S. Health Care Financing Administration (HCFA, since renamed the Centers for Medicare and Medicaid Services [CMS]) during this milestone event, recently reflected on the environment then (Roper, 2011). He noted the critical work that had been completed in the 1970s and 1980s indicating gaps in quality of U.S. health care, especially evidence of significant geographic variation in the practice of medicine, findings that a large portion of medical services were unnecessary, and research indicating the lack of clear evidence for the effectiveness of many medical practices. On the heels of these seminal studies, HCFA's implementation of a new prospective payment for hospitals raised concerns in Congress that hospitals would have an incentive to discharge patients prematurely, potentially placing patients at risk (Chulis, 1991). To offset such incentives without heavy-handed regulation, in 1987, HCFA released its first public report for consumers.

Over time, public reporting of health care quality expanded substantially. While there are many types of reporting activities, in this article, the phrase "public reports" refers to comparisons that are: (a) publicly available, (b) intended for use by consumers, (c) name health care facilities, medical groups, individual physicians, or other clinicians, and (d) use predetermined standards of performance. Today there are at least 150 consumer-focused public reports on hospital and physician performance (Cronin, Damberg, Riedel, & France, 2011); there are more if one counts reports of other providers, such as nursing homes or limited-release reports produced by health plans exclusively for their own enrollees (Christianson, Volmar, Alexander, & Scanlon, 2010; O'Neil, Schurrer, & Simon, 2010). A review of 72 public reports found that more than 70% came into existence since 2005 (O'Neil et al., 2010). The growth in public reporting may accelerate in the next several years as federal regulations related to State Health Insurance Exchanges and accountable care organizations include new public reporting provisions, some of which may include provider-specific ratings.

There is low awareness, however, of the existence of public reports. For example, public reporting has been established in California for years, yet among a representative sample of Californians, only 17% had viewed publicly reported quality information on hospitals; of that group, only 1% changed their hospital selection based on the data (Teleki & Shannon, 2012). A survey of U.S. adults found that only 12% consulted online rankings or reviews of physicians or other clinicians; only 11% did so for hospitals and other medical facilities (Fox, 2011). Another survey found that only 7% of adults actually used information comparing hospitals to make health care decisions, and 6% did so regarding physician performance (Kaiser Family Foundation, 2008). An earlier study found that only 12% of cardiac surgery patients in Pennsylvania were aware of a prominent report on cardiac surgery mortality before undergoing surgery (Schneider & Epstein, 1998).

Despite this limited track record of demonstrable consumer engagement and impact, interest in public reporting has persisted. The premise remains attractive; transparency of quality performance has been posited as a fundamental consumer right—the right to know the extent to which one’s care or care options conform to objective standards of quality (President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998). Many agree that transparency of (at least some) provider performance information is essential to better-functioning health care markets (Sinaiko, Eastman, & Rosenthal, 2012). Whether one favors reliance on market forces or regulation to improve care, there is typically agreement on the value of transparency, accountability, and dialogue. As a result, public consumer-focused reporting on the performance of hospitals, physicians, and other providers has achieved what few other health care policies have—bipartisan support.

Public reporting may maintain its support because there are several reasons to believe its limited measurable impact has been due to flaws in report content, design, and implementation, rather than inherent limitations of the concept (Sinaiko et al., 2012). Lansky (2012) cautions policy makers not to draw the wrong conclusion from evaluation snapshots:

if we extrapolate too much from studies [of public reports] that are based on flawed measures deployed in flawed settings, we won’t get much insight on how to create a flow of information that provides value to the health care system we’re trying to encourage.

There is evidence that consumers would use reports for decision making if they were better designed and more relevant (Richard, Rawal, & Martin, 2005). Furthermore, some (but not all) public reporting has been associated with improved quality (Hibbard, Stockard, & Tusler, 2003; Totten et al., 2012).

In this introduction to a special issue on public reporting, we describe the public reporting landscape and how our nation is doing in terms of achieving consumer engagement with public reports. We then comment on policy options to advance the state of public reporting for consumers by drawing on the discussion among 125 participants in the 2011 Agency for Healthcare Research and Quality (AHRQ, 2011) Summit on Public Reporting for Consumers.

Public Report Landscape Circa 2014

Public Report Availability

Public reports are sponsored by the federal government, state governments, multi-stakeholder community quality collaboratives and business coalitions, professional associations, and the media. A recent analysis found that most are sponsored by state agencies (33%) and multistakeholder community collaboratives (24%; O’Neil et al., 2010). Virtually everyone in the United States has access to ratings of their local hospitals because the U.S. CMS publish an online national report of hospital quality, *Hospital Compare*. Some consumers can access a surprisingly large number of

hospital reports—12 in Minnesota, including health plan reports exclusively for their enrollees (Christianson et al., 2010). Physician reports, in contrast, are fewer in number and more locally based.

Public Report Content

Although public reports are widely available, there is little use by consumers of the information reported. Most consumers do not believe quality varies from hospital to hospital, clinic to clinic, or physician to physician. Only 35% of adults think there are big differences in the quality of care among their local hospitals (Kaiser Family Foundation, 2011). Three fourths of opinion leaders surveyed identified the public's lack of awareness of quality variation as a problem (Sinaiko et al., 2012). Many consumers opt to defer to doctors and are reluctant, when facing a medical crisis, to seek out independent information about performance (Krumholz, 2009). For many people, any medical intervention is anxiety producing, and to consider the uncertainty about the quality of individual providers makes a bad situation worse. Still others—especially those in rural areas or with insurance that provides coverage for only a narrow panel of participating providers—have limited provider options and see little reason to use reports.

For the subset of consumers who are motivated to review provider ratings *and* know that public reports exist, their information seeking may be derailed by the content and design of available reports. Few reports are well tailored to consumers' needs. There is a growing consensus that commonly reported measures are ill-suited to help consumers make informed health care choices (Sinaiko et al., 2012). Historically, with the exception of selected measurement initiatives like the Consumer Assessment of Healthcare Providers and Systems (CAHPS), measurement of development has been a function of data availability rather than well-planned approaches to meet an identified consumer need. The article in this supplement by Greaves, Millett, and Nuki reviews the approach taken by England's National Health Services to include measures meaningful to consumers by incorporating "anecdotal narratives" directly from patients into the National Health Service public reporting system.

Targeting patients known to be making health care decisions appears to promote the use of performance data. Of adults known to be seeking a new primary care physician, after minimal outreach 17% accepted the invitation to visit a website that provided performance data on primary care physicians (Fanjiang, von Glahn, Chang, Rogers, & Gelb Safran, 2007). But such targeting is rarely done. The article in this supplement by Shaller, Kanouse, and Schlesinger identifies and analyses four groups of consumers poised to seek out quality information about providers and likely receptive to targeting and outreach.

Another reason cited for the lack of consumer engagement is information complexity and consumers' difficulty in processing numbers and abstract ideas. The article in this supplement by Schlesinger, Kanouse, Martino, Shaller, and Rybowski explores ways in which report complexity may impair—rather than enhance—consumer decision making and discusses strategies to minimize complexity. A consumer's perceived

“cost” of obtaining provider performance ratings easily can outweigh the perceived value (Damman, Spreeuwenberg, Rademakers, & Hendriks, 2011). A recent review of 16 hospital public reports found that nearly all used fairly technical language, few provided user-friendly labels for performance measures, and only one organized the measures in a framework that conveyed key elements of quality (Bardach, Hibbard, & Dudley, 2011). Consumers want to know the performance of individual physicians, but most physician reports only rate physician groups.

Variation in Public Reports

There is very little uniformity in the existing pool of reports. Each reflects hundreds of decisions about what types of information to include, underlying data and methods considerations, and how to present the information to meet consumers’ needs—for example, whether to report process or outcome quality measures, and whether to report performance measures that are “negatively” focused (e.g., mortality) versus positive outcomes or success rates that consumers might be more drawn to (e.g., improved functional status). These report preparation options are well documented (Friedberg & Damberg, 2011; Romano, Hussey, & Ritley, 2010).

Variation in content and design may not only foster innovation in public reporting but may also contribute to low uptake by consumers. At a meeting of community quality collaboratives convened by AHRQ (July 2009 National Meeting of Chartered Value Exchanges), sponsors of public reports expressed concern that two organizations could each use the same underlying data set, but the two reports could well include diverging provider scores—as a result of differences in how a series of data, methods, and measure selection decisions are made. Several studies bear this out. Rothberg, Morsi, Benjamin, Pekow, and Lindenauer (2008) examined performance ratings from five different public reports of nine hospitals in a single metropolitan area. The reports failed to consistently agree on either top- or bottom-performing hospitals among the set of nine. Even when two reports simultaneously measured the same outcome (mortality), agreement was poor. In another study, Leonardi, McGory, and Ko (2007) also found that different reports of hospital quality showed inconsistent results.

Public Report Data and Methods

Some of the variation across reports is due to the different sources of data used to measure performance. Some reports use data collected by commercial health plans (or a specific commercial plan), and some rely on data from public programs such as Medicare or Medicaid. While each payer may have an interest in reporting only for its beneficiaries—or only have access to such data, other reporting entities may be interested in capturing care for a broader group of consumers. Some reports use data contributed directly by providers, which has the benefit of capturing care for all patients regardless of coverage. CMS’s new program to make Medicare data available to “qualified entities” that produce public reports using other private and public data

likely will broaden the extent to which reports reflect both Medicare and private insurance beneficiaries (CMS, 2011). But even where data exist and are accessible for use, they may not be sufficient to create measures meaningful to consumers; additional data elements may be needed to report improved functioning, reduced pain, reduced complications, care results for “patients like me,” specialists’ performance, physician-specific ratings, out-of-pocket costs, and more meaningful composite measures.

The extent of provider inclusion is another source of variation among reports. Public reports may not include all providers in the geographic area of interest. Participation by providers may be voluntary; for example, in The Leapfrog Group’s public report providers have the option to participate. For other reports, all providers within a report’s scope (e.g., clinic locations with four or more clinicians in a given metropolitan area) are included. Advocates of public reporting tend to support mandatory reporting, concerned that poor performers opt out under a voluntary system. Voluntary participation, however, is necessary if data cannot be obtained without the provider’s permission (McNamara, 2006).

Reports vary widely in terms of the number (from 1 to 261) of quality measures included (O’Neil et al., 2010), as well as the type(s) of measures featured—structure, process, outcome, or a combination (Rothberg et al., 2008). Even when two reports include what appears to be the same measure, there is no guarantee that the underlying measure specifications are the same (Rothberg et al., 2008).

Public reports also differ in other aspects of methodology, which are not always disclosed to interested parties. The article in this supplement by Damberg, Hyman, and France examines the extent to which public reports follow recommended best practices for disclosure of data sources and methods.

In summary, there are a variety of challenges to consumer engagement with public reports, including low public awareness of quality variation; variability in report content, underlying data and methods, and design; poor targeting of consumers’ needs; and information complexity. These factors—separately and together—undermine consumers’ use of performance ratings.

Commentary: Advancing the State of Public Reporting

Public reporting is at a crossroads. Reports have proliferated widely, but substantial work is still needed for public reports to achieve their potential for engaging and informing consumers. Do we as a country want to invest private and public funds and expend the political will needed to produce a public reporting enterprise that will engage consumers directly in decision making about the quality of their care? On the one hand, the challenges to successful consumer engagement are significant. On the other hand, increased consumer engagement could lead to improvements in the quality of physician and hospital care.

How would we move toward a public reporting enterprise that succeeds in engaging consumers? This question formed the motivation for and shaped the agenda of a 2011 National Summit sponsored by the U.S. AHRQ, which brought together 125 individuals—public reporting believers and skeptics alike. These individuals were

Table 1. Guiding Vision for Public Reporting for Consumers.

By 2025—or ideally much sooner—consumers will access and appropriately use health care provider performance information in selecting providers. Specifically, consumers in every community in the United States will have ready access to comparable, accurate, meaningful, and actionable performance information on primary care physicians, specialists, hospitals, and ultimately the full spectrum of providers to enhance the quality of their decision making. Consumers' use of this information will facilitate a positive relationship between providers and patients, drive consumer engagement and empowerment, and ultimately improve health system performance. To achieve these goals, the following are needed: coordinated national and local programs of consumer education and engagement; core performance measures and supporting information that matter to consumers; a network of robust, widely available data to support new measure development and U.S.-wide reporting; a consensus on standards for data and scoring methods and methods transparency; and an ongoing monitoring and feedback system to ensure that public reporting keeps pace and continues to meet the needs of consumers.

Source. Authors' synthesis of deliberations of 125 Summit participants.

selected to participate because of their policy experience or involvement with some aspect of the public reporting enterprise. The group included representation of consumers, providers, community quality collaboratives and other report hosts, national quality organizations, such as the AHRQ, the National Quality Forum, and the Quality Alliance Steering Committee, the CMS, other purchasers, health plans and technical experts.

Vision and Recommendations

Based on the discussions at the 2011 National Summit (AHRQ, 2011), the authors (who were involved in the planning and conduct of the Summit) developed a vision statement for public reporting (Table 1) and a set of 10 policy recommendations to advance public reporting (Table 2).

The 10 recommendations are grouped into three topic areas. Some are calls for public policy, some are for private sector action, and some are for organizations that fund and disseminate research. The first recommendation addresses “The Why” of public reporting. To counter the pervasive lack of awareness of significant variation in the quality and cost of care, and thereby strengthen demand for public reporting, this recommendation aims to build momentum for expanded use of public reports. Several ongoing efforts could provide the foundation for this recommendation, but further work is needed given the lack of awareness about variation in quality.

Recommendations 2 to 5 address “The What” of public reporting, including calls to change the content and format of future reports. These recommendations are motivated by the recognition that while many are working hard to make measures and reports more consumer-friendly, no one has yet found the optimal content, structure, and communication vehicle for successful engagement. To maximize value in public reporting, we need systematic and ongoing guidance from consumers. The recommendations

Table 2. Recommendations for Public Reporting Circa 2025.

Number	Recommendation	Require alignment or standardization?	Require new investments?	Type
The Why: Strengthening the demand for public reporting				
1	Policy makers, report sponsors, and consumer organizations should support and sponsor ongoing campaigns to raise awareness about variation in care quality	Alignment	New investment	Public and private sector policy; dissemination of best practices
The What: Changing the content and format of public reports				
2	Federal policy makers and report sponsors should engage consumers in identifying or developing, prioritizing, and testing a new generation of meaningful and scientifically sound measures that meet consumers' needs	Alignment	Refocus current measure development activity	Research and development; measure dissemination/ implementation
3	Report sponsors should use an agreed-upon core set of measures. Report sponsors may augment core measures with others of interest to their community	Standardization	No/minimal	Public and private sector policy
4	Federal policy makers and report sponsors should engage consumers in developing and testing how to effectively frame and present measure results so the information is accessible, understandable, and useful to consumers	Alignment	New investment	Research and development; dissemination of best practices
5	Report sponsors should explore alternative technologies to deliver comparative information to consumers at the point of their decision making	Alignment	New investment	Public and private sector policy Research and development
The How: Developing methods and data sources for public reporting				
6	Report sponsors should disclose fully the methods they used to produce performance ratings	Standardization	No/minimal	Public and private sector policy
7	Public and private policy makers should reach consensus on standards for data elements used in performance measures	Standardization	No/minimal	Public and private sector policy

Table 2. (Continued)

Number	Recommendation	Require alignment or standardization?	Require new investments?	Type
8	Public and private payers, plans, consumers, and providers should support the creation and maintenance of a secure nationwide health data infrastructure	Standardization	New investment	Public and private sector policy
9	Methods should be developed to allow secure linkage of patient-level data across sources for the purpose of developing reports	Alignment	New investment	Public and private sector policy and implementation
10	Public and private payers, through public policy and purchasing actions, should act in coordinated ways to financially support public reporting and collection of the underlying data	Alignment	New investment	Public and private sector policy and implementation

Source. Authors' analysis of deliberations of 125 Summit participants.

include increased consumer engagement in report development, standardization of performance measures, and exploration of alternative technologies to target and deliver reports to consumers.

Recommendations 6 to 10 address “The How” of public reporting, including recommendations for developing the methods and data sources needed to support the vision. These recommendations address the need for better approaches to measurement methodology and data sources in order to make reports widespread, useful, and trustworthy.

This set of recommendations calls for greater alignment and coordination of effort across public and private sectors, and across Federal, State, and regional initiatives. Four of the recommendations go further by calling for standardization. Historically, there has been a healthy tension between those who support a greater degree of alignment and standardization of decisions related to data, methods, measure selection and report design, and those who do not. In part, this may reflect relatively low support for standardized report *frameworks* in contrast to greater enthusiasm for standardized *data* (Sinaiko et al., 2012).

Proponents of greater alignment and standardization cite reduced provider burdens, efficiencies of scale, comparability of measures, more uniform deployment of evidence-based report designs and practices, and ultimately a more credible reporting enterprise that produces ratings useful to consumers. The U.S. National Quality Strategy (U.S. Department of Health and Human Services, 2012) reflects some of

these sentiments in identifying a “national plan for data collection, measurement and reporting” as one of three strategic opportunities. But other stakeholders, some leading truly innovative regional reporting efforts, may be reluctant to adopt a standardized approach that may represent a lower bar or upset the delicate political understanding they have worked hard to negotiate among providers, payers, plans, and consumers in their region.

Some, but not all, of the recommendations require additional investment. There is currently a lack of adequate and stable funding for ongoing data collection and cleaning, report generation, and consumer engagement. Public reporting of quality measures benefits society, individual consumers, and public and private payers. Information on provider performance is a classic public good, meaning that everyone can benefit from it, but no one wants to pay for it.

The *Postscript* by Damberg and McNamara takes a more detailed look at the next generation of needed investments in research, drawing in part from this and other articles featured in the supplement.

Conclusion

Public reporting has had a largely disappointing track record in engaging consumers and significantly improving U.S. health care. Our vision for public reporting is that by 2025—or ideally much sooner—consumers will access and appropriately use health care provider performance information in selecting providers and improving health system performance. Improving public reporting in order to achieve this vision will be a significant challenge. Without strong action to meet this challenge, health care consumers will continue to lack the information they need to effectively navigate the U.S. health care system and make good choices about their care.

Authors' Note

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