

HEALTH CARE QUALITY TRANSPARENCY: **IF YOU BUILD IT, WILL PATIENTS COME?**

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In recent years, significant energy has been invested in developing health care price and quality information in hopes of engaging consumers to be more active when making health care choices. Although research shows that provider quality can vary greatly, many Americans still rely on friends and family when choosing a physician or hospital. For public and private payers seeking to encourage consumers to use quality information when choosing physicians, hospitals and other providers, a critical first step is to raise consumer awareness of the existence and serious implications of provider quality gaps. Unlike price transparency, where consumer needs vary greatly depending on whether they are insured or not, and if they are insured, how their benefits are structured, theoretically all consumers can benefit from the same information on the quality of care provided by individual physicians, medical groups, hospitals and other providers. Until consumers are motivated to use quality information to choose providers, the main value of public quality reporting will likely be to motivate providers to improve their performance.

Raising Consumer Awareness of Quality Gaps

Turning passive patients into active consumers who factor cost and quality into decisions about which doctors or hospitals to choose or which treatment options to pursue is an elusive goal in the U.S. health care system. Despite well-intentioned efforts in recent years by government, employers, health plans and others to foster health care price and quality transparency, most Americans still choose doctors and hospitals based on recommendations from friends and families and physicians.¹

Despite extensive evidence that the quality of U.S. health care is uneven at best and that Americans pay more for health care—with worse results—than citizens in any other industrialized nation,² health care price and quality transparency in the United States for the most part remains a product in search of a buyer.

On the price front, insured Americans face few incentives to consider price when

choosing providers because they typically pay the same amount as long as they use an in-network provider. On the quality front, few consumers believe that quality differs significantly across providers. For public and private payers seeking to encourage consumers to use quality information when choosing physicians, hospitals and other providers, a critical first step is to raise consumer awareness of the existence and serious implications of provider quality gaps.³

If consumers believe that ignorance of provider quality can be hazardous to their health, then there will be a much firmer foundation on which to build transparency initiatives that help patients choose providers wisely and inspire physicians, hospitals and other providers to improve their performances.

Greater transparency in health care reflects the confluence of two major trends. One is a development throughout society that institutions need to operate in a more

open and accountable manner. The other is the health care consumerism movement, which envisions consumers assuming more responsibility for and control over their health and health care. To move from the vision of health care consumerism to reality will require credible and accessible information on a wide range of issues, from evidence on what diagnostic and therapeutic strategies are effective to how providers compare on dimensions of cost and quality.

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Meeting Consumer Needs

Effective quality reporting needs to reflect different consumer abilities to understand and use information. Sophisticated consumers may seek and understand more detailed and complex data, while others might be satisfied with less-detailed descriptions of provider quality.

A key aspect of presenting quality information is how much data aggregation to perform. The most aggregated data would be a simple binary score for a hospital or physician, such as “preferred” or “not preferred.” The opposite extreme would be specific quality information for each service provided. The virtue of highly aggregated information is the packaging of complex information into understandable and actionable concepts. For consumers with lower levels of health literacy and numeracy,⁴ visual cues, such as a star rating, or simple designations, such as “high performance,” may be useful. Research shows that comparative information on hospital quality can be presented in different ways “to ease the cognitive burden and highlight the meaning of important information.”⁵

The downside of aggregation is that condensing complex information into simple measures may not meet the information needs of all audiences. For example, a hospital might receive very different quality ratings for different types of patients or services. A hospital could have outstanding quality for cardiovascular surgery but be poor at treating congestive heart failure or performing hip replacements. So aggregating hospital quality into a single measure would mask variation, potentially concealing a great deal of information that could be valuable to consumers and others, such as physicians.

In summary, there is no single answer about whether presenting more or less aggregated data is more useful for consumers. In general, higher degrees of aggregation make information more accessible to consumers to assess quality broadly. But in many cases, too much aggregation can make the content less useful for consumers seeking information about specific facets of quality performance. The ideal degree of aggregation is likely to vary for different users, suggesting that layering information

may be the best way to meet different users’ needs. A key implication is that providing information in different forms, with different degrees of analysis, has the potential to derive the most value from collected performance information.

Measuring Hospital Quality

Meaningful outcome measures are often lacking in medical care, shifting the quality focus to measures of process—or how often patients receive recommended treatments associated with better results—provider credentials and patient satisfaction.

Hospital Compare, a Web site maintained by the Centers for Medicare and Medicaid Services (CMS), reflects the broadest effort to report hospital quality data. Based on Medicare patient data, Hospital Compare includes results of outcome, process and patient satisfaction measures for individual hospitals across the country. Additionally, Hospital Compare provides information about the number of Medicare patients treated, or volume, for particular procedures—research has linked higher volumes of procedures to better outcomes in some instances.

At this point, the process and outcome measures in Hospital Compare apply to a limited range of conditions and procedures. Process measures apply to surgical procedures—proper use of antibiotics and prevention of blood clots—and the following conditions: heart attack, heart failure, pneumonia and childhood asthma. Although not attempting to aggregate measures over these conditions into a single measure is probably wise, creation of a composite index for each condition might increase the value of the information to guide patients in choosing a hospital that performs well when treating a specific condition. For example, a single, indexed indicator of care for heart attacks might be more useful for consumers than the seven individual process measures now reported.

Until recently, Hospital Compare reported only one outcome measure—30-day risk-adjusted death rates for three conditions: heart attack, heart failure and pneumonia. But at this time, this outcome measure provides little guidance to patients because few hospitals are statistically significantly above or

below the national average.⁶ If 95 percent of all hospitals' mortality rates are presented as "no different than the U.S. national rate," then patients have gained little insight into most hospitals' performance. In July 2009, Hospital Compare added a second outcome measure: 30-day readmission rates for heart attack, heart failure and pneumonia patients.

Hospital Compare patient satisfaction ratings apply to all patient types. The 10 measures focus on dimensions that are likely to apply throughout a hospital, such as whether the nurses communicated well and whether the patient's room was clean. However, some measures, such as whether the patient would recommend the hospital, probably would be more useful if made available for different types of patients, such as medical, surgical and maternity patients.

Unlike Hospital Compare, which uses point estimates for each measure without identifying whether differences among providers are significant, CalHospitalCompare, a Web site that rates California hospitals, uses a five-point scale—based on multiple benchmarks—to characterize individual hospital's quality as Poor, Below Average, Average, Above Average or Superior. This approach provides consumers with a more informative scale to compare hospitals for a number of conditions, as well as patient experience with overall care, medical care, surgical care and maternity care.⁷

Health plans have focused limited attention on providing hospital quality information to enrollees.⁸ Plans often contract with outside vendors that analyze publicly available Medicare and state data on a range of conditions and procedures to allow plan enrollees access to hospital comparison tools. For example, WebMD's hospital comparison tool allows enrollees to prioritize various factors, such as a hospital's volume, complication rate and status as a teaching hospital, when comparing hospitals.

Measuring Physician Quality

Arguably, the most important choice a consumer faces is choosing a physician because that choice will likely influence other choices, such as what hospital to choose if the need arises. Physicians have long resisted public reporting of compara-

tive quality information. Few professionals in any field like to be judged—except those who are confident they will score favorably. So a strong case must be made to convince providers of data validity.

Public quality information on individual physician performance is the rare exception rather than the rule in the United States. New York has long publicly reported mortality rates for individual surgeons performing coronary artery bypass graft surgery and related cardiac procedures but not without controversy that public reporting may have prompted surgeons to not operate on riskier patients.

The National Committee for Quality Assurance (NCQA) has developed physician recognition programs to designate physicians who meet certain evidence-based quality standards for diabetes care, heart/stroke care and low back pain care. Physicians who meet the NCQA standards are sometimes highlighted in health plan provider directories, and NCQA maintains an online directory of the approximately 10,000 physicians nationally that participate in the recognition programs.

Nascent efforts are underway to report on physician quality at the group or practice level. One of the stated goals of the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) initiative is to foster increased public reporting of physician performance to both help inform consumer choices and motivate physicians to improve their performance. AF4Q's efforts to foster public reporting are guided by four core principles:

- transparency in the measurement process so both doctors and patients can trust the data;
- consumer and provider input into the process to help ensure that information is meaningful to consumers and fair to doctors;
- independent verification to provide assurances that programs are fair and valid; and
- nationwide consistency of measures so that "good health care" means the same thing across the country.

Many national health plans have developed physician ranking programs, or some



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type of narrow, tiered or high-performance provider network. The underlying premise of these initiatives is to measure physician performance based on quality and cost metrics that can be assessed using plans' claims data and making the results publicly available to enrollees. Most often, the results are used only to inform consumers; in some cases, consumers have incentives, such as reduced copayments, to use the higher-performing physicians.

In these programs, quality and efficiency improvements are achieved to the extent that patient volume shifts to higher-performing physicians as a result of changes in physician referrals and consumer choices and lower-performing physicians improving the care they provide. These initiatives have been limited by fragmentation in the insurance marketplace. With each health plan developing its own methods for classifying physicians and having only its own claims data to draw on, the effort has not been credible with physicians.⁹ The missteps by health plans highlight the importance of transparent and clear explanations about how quality data are measured, collected and analyzed to ensure both public and provider confidence in the data's integrity.

Policy Implications

Until consumers are motivated to use quality information to choose providers, the main value of public quality reporting will likely be to motivate providers to improve their performance. For example, CMS provides reporting hospitals with more detailed comparisons of their quality indicators to national norms than are available to the public. This is designed to support hospitals' use of quality data to improve quality.

The potential for providers to make use of quality data will expand in the future. For example, if reliable data were available on the quality of care of specialist physicians, primary care physicians would have a stronger basis for making referral recommendations. Health plans have begun to use quality data to support incentives for enrollees to choose among physicians in their network, but they could go much further with more useful quality data.

Providers also have the potential to influence consumers. If providers believe

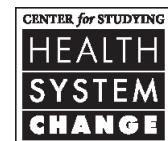
quality data or analyses are flawed, their communicating those beliefs to patients will undermine consumers' willingness to rely on the information.

Government can play an important role in promoting quality transparency because of its ability to induce or require reporting by providers. To date, CMS reporting of hospital quality data has probably had a much larger impact by spurring hospitals to improve quality rather than by fostering better consumer choices of hospitals.¹⁰ Indeed, we are already at the point where quality reporting is motivating and fostering self-improvement by providers, while likely years away from significant value to consumers. This should reinforce the strategy of having sunshine work to improve provider performance while pursuing the much harder job of motivating consumers and creating data that are meaningful to them. ■

Notes

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 3. Hibbard, Judith H., and L. Gregory Pawlson, "Why Not Give Consumers a Framework for Understanding Quality?" *Joint Commission Journal on Quality and Safety*, Vol. 30, No. 6 (June 2004).
 4. Numeracy refers to a consumer's ability to understand numbers and use them. Researchers have found that "highly numerate individuals appear to pay more attention to numbers, better comprehend them, translate them into meaningful information, and ultimately use them in decisions." Further, "the less numerate are informed less by numbers and more by other non-numeric sources of information." Peters, Ellen, "Numeracy and the Perception and Communication of Risk," *Annals of the New York Academy of Science*,
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 6. Hospital Compare uses a stringent two-standard-deviation rule to identify well- and poorly performing providers for its mortality estimates. This means that, typically, 95% of providers will be in the average category, and only 2.5% (or 1 in 40) providers will be in each of the superior and inferior categories.
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