

# TRANSPARENCY AND PUBLIC REPORTING AS QUALITY DRIVERS



Introduction

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# Session Overview

- ◆ Preview of presentations
  - ◆ A range of stakeholder perspectives
  - ◆ What's behind these perspectives
    - ◆ Professional orientation and training
    - ◆ Self-interest
    - ◆ Evidence
  - ◆ Listen carefully; ask us all tough questions

# Public Reports and Quality Improvement: The Theory(ies)

- ◆ The theory of consumer choice and market share as drivers of quality
- ◆ Key assumptions:
  - ◆ If consumers get comparative quality information they can and will use it to make choices
  - ◆ This will lead to significant shifts in market share
  - ◆ Plans and providers will respond

# Public Reports and Quality Improvement: The Theory(ies)

- ◆ There is limited evidence to support this theory – just a few reasons why
  - ◆ Most public reports have been poorly designed
  - ◆ Almost no public reports have been effectively disseminated or promoted
  - ◆ Much current data is hard to translate into clear choices
  - ◆ Consumer/patient choices are often highly constrained

# Public Reports and Quality Improvement: The Theory(ies)

- ◆ Two alternative perspectives:
  - ◆ Public reporting is about accountability as an end in itself in the context of a democratic society
  - ◆ Public reporting affects quality improvement efforts through the “reputational” pathway

# Public Reports and Quality Improvement: The Theory(ies)

- ◆ Accountability as an end in itself
  - ◆ What possible justification is there for a sector of society that spends over 15% of GDP to have its performance “under wraps”?
  - ◆ Even if “micro” level decisions are not affected by public reporting, “macro” level policy decisions should focus on the presentation and carefully analysis of performance information

# Public Reports and Quality Improvement: The Theory(ies)

- ◆ The reputational pathway
  - ◆ Public reports that show performance deficits upset plans and providers because they value their “reputation” – even when there is little or no evidence of shifts in market share
  - ◆ Evidence is growing that a well-designed public report gets the attention of providers (especially hospitals) and leads not only to grousing but to attempts to improve scores

# Implications

- ◆ The measures we choose make a huge difference in any of these scenarios
  - ◆ Consumers won't pay attention to reports on measures they don't understand or care about
  - ◆ If we create a “Tower of Babel” of measures that don't say much about fundamental provider performance we won't see or respond to patterns

# Implications

- ◆ We have to use what we know about designing effective and usable reports
- ◆ We have to learn more about report design
- ◆ We have to **START** learning about report dissemination and promotion

# TRANSPARENCY AND PUBLIC REPORTING AS QUALITY DRIVERS



Conveying Transparent Information  
to Consumers

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# OVERVIEW

- ◆ Criteria for assessing comparative health care quality reports for consumers
- ◆ Where are we?
- ◆ What's missing?

# CRITERIA

- ◆ Four areas of criteria
  - ◆ The nature of the comparative data provided
  - ◆ How clearly the data are presented
  - ◆ The presence of material that frames the data to reveal the benefits of using it
  - ◆ The presence of tools that make it easy to use appropriately

# CRITERIA

- ◆ Nature of the data provided
  - ◆ Does it speak to aspects of quality consumers care about?
  - ◆ Do the measures reveal (or mask) underlying differences in performance?
  - ◆ Are we using measures (of individual phenomena) or indicators (of more fundamental characteristics)?
  - ◆ Are the data “actionable” by consumers?

# CRITERIA

- ◆ What's wrong with this woman?? She hasn't mentioned:
  - ◆ Validity
  - ◆ Reliability
  - ◆ Risk or severity adjustment
  - ◆ The need for hierarchical modeling!
- ◆ Why? Because everyone always talks about those issues, and rarely addresses seriously the ones I raised!

# CRITERIA

- ◆ How clearly are the data presented?
  - ◆ Easy to understand language and graphics
  - ◆ “Evaluable” presentations that make it very easy to identify high and low performers
  - ◆ Avoidance of too many data points
  - ◆ Avoidance of too many caveats
  - ◆ Avoidance of too many details that clutter up the main point

# CRITERIA

- ◆ Framing the data to reveal benefits
  - ◆ This implies that we want people not only to look at the data and understand it, but use it
  - ◆ Consumers don't "automatically" know why they should use quality data or how to use it
  - ◆ Negative v. positive framing: while most people want a report that accentuates the positive, consumers actually pay attention to reports that point out risks and threats

# CRITERIA

- ◆ Framing the data to reveal benefits
  - ◆ There may well be exceptions to this rule, e.g. nursing homes are so universally feared and presumed to be lousy that we may need “positive” framing to get consumers to engage with quality information
  - ◆ Personal stories/narratives have real promise in terms of both humanizing and framing quality data

# CRITERIA

- ◆ Tools to make appropriate use easy
  - ◆ Quality improvement often means making it easy to do the right thing; incorporating effective decision support tools makes it easy for people to interpret and use comparative data appropriately
  - ◆ More fundamentally, we need to give people explicit guidance about MULTIPLE ways to use reports

# CRITERIA

- ◆ Other issues to remember:
  - ◆ Most consumers want more than quality information when they make choices – that means we have to be willing and able to incorporate it
  - ◆ An effective report that is not well disseminated and promoted won't be looked at or used

# WHERE ARE WE?

- ◆ The numbers: data from the AHRQ “Report Card Clearinghouse” which is currently in development cover 201 reports identified in an exhaustive search. Of these
  - ◆ 85 present data on health plans; 70 on hospitals; 22 on medical groups and only 10 on individual physicians

# WHERE ARE WE?

- ◆ More data from the clearinghouse:
  - ◆ 158 reports have data on clinical quality; 112 have patient experience data; 26 have other kinds of quality data
  - ◆ 77 have both clinical quality *and* patient experience data; 21 have both clinical and other quality measures; 19 have patient experience and other quality measures; 14 have all three kinds of measures

# WHERE ARE WE?

- ◆ More data from the clearinghouse:
  - ◆ 98 are sponsored by a government agency; 24 by purchasers; 18 by health care quality organizations; 15 by health plans; 14 by private vendors; 11 by a collaboration of multiple groups; and only 5 by providers
  - ◆ 175 of the 201 are available on the web
  - ◆ 18 are available in a language other than English

# WHERE ARE WE?

- ◆ Some reports have been tested “formatively” to make sure they resonate with and are comprehensible to the target audience
- ◆ But few reports have been systematically evaluated, especially “summatively” so we have little “hard” data on effectiveness

# WHERE ARE WE?

- ◆ The available evidence is mixed in terms of the effectiveness of reports in increasing knowledge, supporting “better” choices or increasing satisfaction with choices made
- ◆ This is disturbing since the reports subjected to this kind of systematic research are among the most carefully designed one out there

# WHERE ARE WE?

- ◆ There is fairly consistent evidence, however, that effectively designed public reports encourage quality improvement, especially among low performers (who also complain the most about reports)
- ◆ This evidence better supports the “reputational” rather than the “choice” pathway, at least at this stage

# WHERE ARE WE?

- ◆ It is still rare for public reports to
  - ◆ Use available evidence about what works vis a vis “evaluable” design
  - ◆ Make sure reports are appropriately disseminated and promoted
  - ◆ Create incentives for the use of reports to choose better plans and providers (e.g. active v. passive enrollment, lower premium share for higher quality plans)

# WHERE ARE WE?

- ◆ So it is not clear we have given public reporting for choice an adequate test
- ◆ Further, it may take a while before the public “gets it” about the use of quality reports
- ◆ And finally, people may use reports in ways we didn’t think of (e.g. for reassurance or to be generally better informed)

# WHERE ARE WE?

- ◆ Some historical perspective:
  - ◆ We have worked literally for decades to get physicians to change their behavior by providing them with feedback that is not public
  - ◆ We keep doing this even when it is clear that feedback may be necessary but is far from sufficient
  - ◆ Vis a vis consumers, we need both perseverance and a steeper learning curve!

# WHAT'S MISSING?

- ◆ Understanding of how to communicate about quality to ordinary people (not us)
- ◆ For example, many people
  - ◆ Don't realize/believe that quality varies much in ways that are consequential for health/safety
  - ◆ Don't want to realize/believe that their current providers are less than “the best”

# WHAT'S MISSING?

## ◆ More examples

- ◆ The vast majority of Americans have very limited numeracy, e.g. they don't understand averages, yet we load them down with numerical and even statistical details
- ◆ The potential ways to use quality data are not self-evident to many people – they will need ideas that are realistic given their circumstances

# SOCIAL MARKETING IDEAS

- ◆ Benefits: Many consumers and patients don't clearly see any benefits from looking at or using quality reports, probably because we have designed reports *we* think are valuable rather than reports *they* will find valuable

# SOCIAL MARKETING IDEAS

## ◆ Barriers:

- ◆ We have made so many reports hard to understand, navigate and apply
- ◆ We have done virtually nothing to promote reports
- ◆ We have done virtually nothing to provide personal support for the use of reports, especially by more vulnerable and lower literacy groups

# SOCIAL MARKETING IDEAS

- ◆ We have serious competition:
  - ◆ Trust your doctor
  - ◆ Ask your neighbor
  - ◆ Don't worry! be happy!

# AND THEN THE POLITICS!

## ◆ Forces *within health care*

- ◆ Consciously or unconsciously reinforce current consumer/patient attitudes/beliefs either that they don't have real choices or that they don't have to worry about quality
- ◆ In the name of “transparency” and “accuracy” create reports that are opaque and unusable

# AND THEN THE POLITICS!

## ◆ Some examples:

- ◆ Fighting against presentation strategies that make it easy to see differences
- ◆ Insisting on providing detailed information on methodology that clutters up the main message and creates uncertainty about whether the data are to be trusted

# AND THEN THE POLITICS!

## ◆ More examples:

- ◆ More fundamentally, fighting public reporting per se, with such disingenuous arguments as that the public will never understand the nuances
- ◆ More subtly, creating systems for selecting measures that give very limited voice to consumers and patients

# THE TOUGHEST PROBLEM OF ALL

- ◆ How do we help consumers find, within a report, what they really need?
- ◆ This, of course, depends on what they need
- ◆ Most “consumers” want summary assessments of a plan, provider or facility
- ◆ Patients, on the other hand, typically want more fine-grained, often condition specific information

# THE TOUGHEST PROBLEM OF ALL

- ◆ So what's the problem? We can always “layer” a report so people can find what they want, can't we? Yes, but
- ◆ We are really NOT in a position to provide meaningful summary measures about plans and providers because there is so little correlation across measures, either within or across conditions or domains of quality

# THE TOUGHEST PROBLEM OF ALL

## ◆ Examples:

- ◆ Recent NEJM articles note that hospitals that do well in one area don't necessarily do well in another
- ◆ Recent analyses of nursing home quality measures derived from the MDS show virtually no correlation

# THE TOUGHEST PROBLEM OF ALL

- ◆ The challenge, therefore, is to think strategically about how to identify more robust and fundamental measures of plan, system and provider performance, so that we are in a position to provide truly interpretable data to the public
- ◆ If it ain't interpretable, it ain't transparent!