

Emphasis on

public reporting of health care data



intensifies

by Julie Lewis, Quality Affairs Consultant



Advances in research and technology over the last few decades have altered how health care services are delivered, how many services are provided, and the cost. At the same time, surgeons and other health care professionals are functioning in a new environment where other stakeholders have an intense interest in increasing the transparency, the efficiency, and the quality of care provided. In an effort to achieve these goals, a number of initiatives, including public reporting of health care quality indicators, have been introduced in recent years.

As a signal of the increasing focus multiple stakeholders now place on transparency, the Agency for Healthcare Research and Quality (AHRQ) provides Web links to 221 health care reports available to the public via <http://www.talkingquality.gov/compendium/>. Audiences with particular interest in this information include payors, purchasers, patients (that is, organizations focused on patients' needs and interests), and policymakers.

As the name suggests, public reporting refers to any report that includes health care data made available to the public. The concept of public reporting is now embedded in the current health care culture of accountability and transparency. The debate over who, what, where, and how the data are best reported is still in progress.

To be truly meaningful, reports must give an accurate and complete depiction of the health care provider. Many factors may be examined to evaluate a provider, including the following:

- Structural indicators: accreditation, certification, and staffing ratios
- Volume: number of procedures performed by a provider
- Process: clinical quality indicators measured during the treatment process
- Outcome: risk-adjusted short-term, intermediate, and long-term
- Spending: cost of care provided, price, or resources used to provide care
- Efficiency/value: combination of cost and quality metrics
- Patient experience: patients' perception of the provider and care provided

Although it is unnecessary to make each of these factors visible to the public, provider ratings and rankings should take all of these factors into account. This goal can be achieved through provider report cards or composite scoring. Reports should also include data on all patients in a physician's practice or a representative sample of the practice. For instance, a report from "Insurance Company X" will not include data on the provider's patients insured by other payors or plans. The skewed sample can cause a misleading representation of the provider. This hurdle can be especially important to surgeons, who have a relatively small range of services or procedures to sample.

Limitations

Most public reports are still in their infancy, as is our understanding of what a meaningful public report should include and how it should be displayed. Many current reports are limited by the population included or by the type of information collected. Reports are often representative of small populations characterized by a specific disease or condition, geographic area, or single-insurer data. In addition, many reports provide only one aspect of health care decision making, such as cost, volume, or limited clinical quality metrics.

Surgeon-specific data are limited in current public reports, perhaps because much of the current focus is on chronic disease management or because the data are more difficult to collect from billing systems. Most meaningful surgical data reflect the system in which care is delivered. Data available on individual surgeons are often limited to education, liability claims, and structural measures, such as procedure volume and board certification.

It is important to note that many influential health care reports are unavailable to the public. Health insurers often provide data to their enrollees through a password-protected Web site, as do some nonprofit member organizations. In addition, many reports are strictly used for internal quality improvement and available only to the provider being measured.

Surgical specialty societies have some of the most sophisticated data available through programs like the American College of Surgeons

National Surgical Quality Improvement Program and the Society of Thoracic Surgeons National Cardiac Database. Both databases collect process and risk-adjusted outcomes data for a hospital or practice. Currently, the vast majority of the data collected in these programs consist of system-level measures, are used for internal quality improvement, and are only available to the participating hospital or practice. There is a strong push from other stakeholders to use these robust databases to enhance the quality of data available to the public.

Pros and cons

The concept of public reporting has enthusiastic opponents and proponents. Advocates of public reporting believe that the practice will create a more informed and accountable health care system by promoting competition and increasing incentives for physicians to comply with evidence-based guidelines. With quality and cost data available to the public, insurers could make better decisions about preferred provider networks and benefit plan structure, purchasers could choose health plans for their employees more wisely, and consumers could use the information to make informed decisions about their health care.

Challengers of public reporting cite the limited ability to collect accurate information as a major barrier to success. The release of superficial or poor information could have significant consequences. Inappropriately categorizing providers could lead to adverse health care decisions by other stakeholders. The narrow ability of many organizations to accurately adjust for patient risk factors can lead to some physicians avoiding performing procedures on the sickest patients. In addition, the method used to evaluate health care professionals is a concern. The top 10 percent cannot care for the entire population. The demand for medical and surgical services must be taken into account, as well as quality improvement strategies to improve performance among lower-scoring professionals.

Standards

Concerns about public reporting are valid and must be considered in designing a meaningful program. Many organizations have developed

principles to guide organizations interested in publicly reporting health care data. The AQA (formerly known as the Ambulatory Care Quality Alliance) has developed a set of principles for public reports, including the following:

- Standardized measures should be used when available
- A contextual framework should accompany the report
- Measures, methods, and performance targets should be transparent
- Reports should be timely and constantly evaluated

In addition, the Commonwealth Fund's Commission on a High Performance Health System studied public reporting efforts and cited the following lessons learned:

- Public reporting adds value
- Reports must be carefully designed
- Collaboration is essential
- Regional efforts are successful
- Active research and evaluation are critical
- Automated data collection is necessary

The current state of reporting

The medical and surgical communities continue to educate themselves on successful public reporting efforts. Public reports are continually being improved and refined, but it is important to understand the current state of reporting. The reports come in many shapes and sizes and can be roughly categorized by the type of organization releasing the report. Examples of these organizations and reports are as follows.*

For-profit businesses. The publication of health care data has become a profitable business. Companies such as HealthGrades (www.healthgrades.com) and Consumers' Checkbook (www.checkbook.com) offer information on providers. HealthGrades charges approximately \$20 to \$50 for a quality report and, for an additional fee, offers its customers the opportunity to perform a liability search and receive information about what physicians are paid. Consumers' Checkbook uses a slightly different strategy and charges customers \$24.95 for two years of

*Information provided on each type of organization involved in public reporting is meant to serve as an example of the current environment and should not be considered representative of all organizations functioning in the category.

“The medical and surgical communities continue to educate themselves on successful public reporting efforts. Public reports are continually being improved and refined, but it is important to understand the current state of reporting.”

unlimited access. HealthGrades has become a popular site with many providers publicly advertising their “grade” and consequently providing HealthGrades with free advertising. Both Web sites include data on surgeons.

Federal government. Over the last few years, the U.S. Department of Health and Human Services (HHS) has increased the amount of data publicly available. Through the HHS Web site, beneficiaries can access a variety of tools, including Nursing Home Compare and Hospital Compare, to search for providers and make decisions about their care. Hospital Compare includes performance measures on surgical site infection, acute myocardial infarction, heart failure, and pneumonia. The measures used in the surgical site infection module have strong multistakeholder support. The measures are included in the Surgical Care Improvement Project, approved by the National Quality Forum, and adopted by the Hospital Quality Alliance.

In 2007, the Centers for Medicare and Medicaid Services (CMS) launched the Physician Quality Reporting Initiative (PQRI), which allows individual providers to submit quality data to CMS

and receive a 1.5 percent bonus payment. The PQRI has a design similar to the Hospital Compare program, but CMS has stated that provider-specific data will not be publicly reported.

State governments. There is a wide spectrum of involvement by state governments in health care data transparency initiatives. Some states, such as Florida and California, have been particularly active and have developed Web sites for health care consumers. However, most states make no or limited data available to the public.

Business groups on health and purchaser coalitions. As the cost of health care services and insurance has risen, so has the purchasers' interest in obtaining information about the quality and cost of care. Many purchasers have formed city, state, or regional coalitions to address their concerns regarding health care costs. Groups in California and Colorado have made data publicly available, whereas initiatives like QualityCounts in Wisconsin make data available to member organizations only.

For-profit companies, free reports. *About.com's* UCompare is an example of a company providing free health care information to consumers. The site includes data on both individual physicians and hospitals and allows patients to view providers' ratings on designated performance metrics. Physician data are limited to structural measures, such as education, board certification, and disciplinary action. These Web pages appear to be financially supported by a plethora of sponsors whose advertisements appear throughout the sites. Established Internet-based companies have the benefit of understanding Web design, and the information is often displayed in an easily understandable manner.

Health insurance companies. As discussed previously, some health insurance companies keep quality and cost information in password-protected Web sites and release the information to enrollees only. Some insurers, such as Blue Cross and Blue Shield of Louisiana and Blue Cross and Blue Shield of Tennessee, post their reports on publicly available Web pages. Much of the data are limited to hospital structural measures such as staff ratios and volume, as well as cost information.

Consumer-oriented not-for-profit organizations. With a specific focus on the consumer,

many not-for-profit organizations publicly report health care data. These organizations, however, often have financial constraints. As a result, the information provided is extremely limited and the Web sites are basic and difficult to navigate. Sites that include information on surgical care often must use volume as a proxy for quality and do not include specific information on quality or cost metrics.

Regional value exchanges. Formal collaborations among health care stakeholders by geographic area are a relatively new phenomenon. In 2006, the AQA chose six of these sites as pilots for collection of physician quality data. The Quality Alliance Steering Committee—a collaborative effort involving the AQA, Hospital Quality Alliance, and HHS—will be certifying community value exchanges in the coming months. The commonality of these initiatives is in their multistakeholder approach, their regional focus on quality, and cost improvement through public transparency. These value exchanges will focus on providing regional improvements with their reports to the public and an educational program for patients and the purchasers of health care. The Wisconsin Collaborative for Healthcare Quality, California Cooperative Healthcare Reporting Initiative, and Massachusetts Health Quality Partners are examples of these collaborative efforts that make health care data available on their Web sites. Most of the information is currently limited to chronic disease management and primary care physicians.

Conclusion

Most reports are still in early stages of development and will require additional research. Public reporting will continue to be enhanced and expanded as stakeholders learn more about which reports are successful. Only through active collaboration can all stakeholders ensure that meaningful, accurate information is available to patients for health care decision making. □