

PERSPECTIVE

Consumers And Quality-Driven Health Care: A Call To Action

Five action principles to improve the effectiveness and impact of public reporting of health care quality.

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ABSTRACT: A key strategy for driving improvements in health care quality is providing comparative quality information to consumers. This strategy will not work, and could even be counterproductive, unless (1) consumers are convinced that quality problems are real and consequential and that quality can be improved; (2) purchasers and policymakers make sure that quality reporting is standardized and universal; (3) consumers are given quality information that is relevant and easy to understand and use; (4) the dissemination of quality information is improved; and (5) purchasers reward quality improvements and providers create the information and organizational infrastructure to achieve them.

IN THE PAST TEN YEARS improving health care quality has become a major focal point of health care reform efforts. A key component of this activity is the development of ways to collect and publicly compare performance information from health care providers.

We believe that consumers will use health care quality measures to assess and choose health plans, providers, caregivers, and health facilities, but only if that information is relevant to their concerns and packaged and disseminated so they can easily obtain, trust, understand, and apply it. We also believe that “industrial-strength” quality improvement

will not occur until consumers are engaged and informed partners in the work and until providers and plans have the knowledge and tools to respond to an increasing public demand for quality.¹

Given emerging information and communication technologies, the potential for producing, packaging, and disseminating comparative health care quality information is greater than ever. However, it is unfair to expect consumers and patients, the least knowledgeable and supported group in health care, to bear the entire burden (and risk) of creating an effective, efficient, and equitable system.²

In this brief report we synthesize our re-

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search and that of others, as well as our experience and perspectives, to offer five action principles and related recommendations for making public reporting initiatives more effective and forceful.

Principle 1: Convince Consumers

Consumers must be convinced that health care quality problems are real, that they have serious consequences, and that quality can and should be improved. Here we face a conundrum. On the one hand, many consumers care about health care quality, would like to have objective data, recognize its value, and are increasingly involved in making decisions about their own care.³ On the other hand, few have used clinical quality or other provider performance data in making care decisions.⁴

There are two main reasons for this, both requiring immediate attention. First, the public lacks understanding of what quality does and does not include. Second, few available quality measures resonate with the public, because they do not speak directly to what consumers and patients care most about: individual physicians, hospitals, and nursing homes.

■ **Understand quality.** Given how long it has taken for experts to build any consensus about health care quality, we should not be surprised that consumers do not fully understand what is meant by “quality” and “quality measurement.” When asked to identify aspects of quality in health plans, most consumers name freedom to choose one’s own doctor; physicians’ qualifications; costs; and covered benefits.⁵ This fairly limited concept of quality makes sense to consumers and reflects the limited information available. In testing reports with consumers, we observe that what people do not understand, they tend to view as less important.⁶ So how do we help consumers understand and value truly meaningful quality concepts and measures?

Research demonstrates that if people have a framework for understanding a concept or the “big ideas,” they are more likely to understand the “little ideas” and integrate new information.⁷ Current quality reports tend to give people all of the little ideas without an organizing

framework. This makes it less likely that individual facts (such as a score on a particular quality measure) will have meaning. An overarching framework will help consumers better understand and value quality information and will avoid exposing them to disparate and confusing concepts that undermine comprehension, engagement, and trust.

■ **Recommendation.** We recommend that leaders in the quality movement (1) build consensus on the most appropriate framework and (2) ensure that all major parties in the public and private sectors use that framework repeatedly both in communication campaigns about quality in general and in all comparative quality reports.

Several such frameworks have been tested with consumers. These include a modified version of the framework from the Institute of Medicine (IOM) report *Crossing the Quality Chasm* and a framework developed and tested by the Foundation for Accountability (FACCT).⁸ Indeed, the IOM report *Envisioning the National Health Care Quality Report* recommends using a matrix that incorporates both IOM and FACCT frameworks.⁹ Formative research has demonstrated that these frameworks help consumers understand and value key aspects of clinical and service quality.

As we communicate the framework, we must also (1) specify how and where consumers can act to improve the quality of their care (2) appeal to emotions as well as reason, since we must both motivate and educate; and (3) recognize our nation’s diversity on key factors such as trust in health professionals, health status, health literacy, culture and language, and socioeconomic circumstances.¹⁰

■ **Improve relevance and usefulness.** If we want to be heard and understood by consumers, we must heed their quality concerns. Specifically, we need to increase the number of consumer-oriented, publicly disclosed measures that assess the performance of the clinicians, hospitals, and other service delivery organizations that consumers believe are really responsible for the quality of their care. This does not mean that we stop reporting consumer-oriented measures of health plans.

As the *Quality Chasm* report makes clear, quality depends not just on the behavior of providers but on the systems that support them.¹¹

The development of consumer-oriented provider measures has already begun. For example, the second phase of the Consumer Assessment of Health Plans (CAHPS) initiative, originally begun by the Agency for Healthcare Research and Quality (AHRQ) to develop standardized methods for surveying consumers about their experiences with health plans, has expanded to include individual providers, medical groups, hospitals, and, if possible, nursing homes. Other initiatives also have or are developing provider-specific clinical quality measures.¹² However, data using such measures are only rarely publicly available, although the rate of public reporting is increasing.

We also need more measures that reveal real differences in quality and performance. If the only measures on which consensus is reached ensure that all providers look alike, we undermine attempts to show consumers that there is meaningful variation in quality. Simultaneously, we must refine and implement mechanisms to adjust for patient risk and severity of illness, so we fairly compare providers' performance and assure that plans and providers do not avoid sicker consumers who may be more difficult and costly to treat.

■ **Recommendation.** We recommend that groups with influence over key measurement sets give priority in measurement development and selection to (1) the need for publicly available service and quality measures at all levels of the health care system; and (2) the need for precise risk-adjusted measures that discriminate effectively.

Principle 2: Standardization

Quality measurement and reporting to consumers must be standardized and universal. Many quality reporting initiatives are still designed primarily to support payers' choice of health plans and quality improvement among plans and providers, not consumer awareness and choice. Most remain voluntary, and many plans and providers do not provide data on their performance or quality of care.

It is time to be more assertive. The number of plans and providers who measure and publicly report their performance on consumer-oriented quality dimensions must increase. This will only happen if the organizations paying the bills—and thus wielding the clout—either require this or use strong financial incentives that ensure it happens.

■ **Recommendation.** We recommend that payers—government and private industry, and particularly large employers—implement both mandatory and voluntary approaches over the next decade and monitor progress to determine which approach works better to ensure that consumers have access to comprehensive and standardized quality data. Every large business, public employer, and health insurer can be involved in a voluntary initiative— Independently or through a coalition or other group—to measure quality and report results to the public. Consumers should sit on the steering committees of all such initiatives. These efforts should avoid duplication that imposes costly administrative burdens on providers. If the voluntary approach does not work, we must move toward strong legislation mandating the collection and public reporting of consumer-oriented quality information.

Early experience indicates that voluntary models tied to incentives, such as potential growth in market share, are promising. The Leapfrog Group, a coalition of more than 130 of the nation's large businesses and public entities buying health benefits, launched a high-profile health quality initiative in 2000.¹³ In July 2001 Leapfrog members began inviting hospitals in particular markets to respond to a voluntary online survey to report their progress in implementing three recommended safety practices. To date, 57 percent of hospitals across eighteen markets have participated, including all hospitals in the Rochester (N.Y.), Savannah, Seattle, and Wichita areas, and results have been shared with enrollees and posted on Leapfrog's Web site, www.leapfroggroup.org. The Pacific Business Group on Health (PBGH) has incorporated the findings into its consumer Web site as well, while the East Tennessee coalition has issued a *Consumer*

Guide to Hospital Care for its members.¹⁴ Efforts will be under way to collect information from hospitals in additional regions in 2003.¹⁵

Voluntary programs have yet to achieve universal provider participation. Indeed, such participation may require a government mandate. Models for such programs exist in Pennsylvania (the Health Care Cost Containment Council), New York (the State Department of Health Statewide Planning and Research Cooperative System), and Rhode Island.¹⁶

However, the greatest pressure for public disclosure can and should come from the federal government, the single largest U.S. purchaser of health care. The Centers for Medicare and Medicaid Services (CMS) now collects CAHPS survey information on all Medicare managed care plans and from beneficiaries in the original Medicare program and has publicly reported selected results to consumers.¹⁷ More recently, the Bush administration has taken initial steps to require providers serving Medicare beneficiaries, such as nursing homes and dialysis centers, to collect quality information for public release. It is also pursuing collection and reporting of standardized quality information on the nation's hospitals.

Making quality measurement and reporting to consumers universal will be expensive. However, plans and providers already spend enormous sums to collect myriad unrelated and uncomparable data sets. If these resources were directed in a standardized and more coordinated fashion, as described further below, the cost burden would be minimized.

Principle 3: Ease Of Use

Information given to consumers must be easy to understand and use. Many current reports are hard for laypersons to understand and even harder for them to use in making decisions, and they often contain more information than most people can effectively process. When faced with information overload and burdensome tasks, people tend to take shortcuts, such as making a choice based on one or two more familiar factors. This can lead consumers to make choices based solely on something concrete, like cost, instead of consider-

ing quality as well.¹⁸

We can make health quality data more usable. Computerized decision aids can reduce cognitive burden and increase the likelihood that the option chosen fits personal preferences. Print documents can present data so that it is easier to identify better and worse options—for example, by rank-ordering choices or using other visual cues or labels to identify high performers.¹⁹ Recent controlled experiments found that consumers were more likely to use quality data when data presentation made evaluating choices easier.²⁰

If we produce reports simply as a symbolic gesture, clear presentation will likely give way under providers' resistance. It is easy to present data in a way that makes it difficult to determine how well a particular provider is doing or to compare providers. If we really want consumers to understand and act upon information, we have to use what we know works.

■ **Recommendation.** We recommend that the design of consumer-oriented quality reports be based on evidence and that quality movement leaders develop and disseminate standards of data collection and presentation to ensure that consumers get accurate and easily understood information about both absolute and comparative performance.

The evidence in this field is growing; our understanding will change and deepen in the years to come. This is no excuse for not using the evidence we already have. AHRQ has recently launched a Web site for sponsors of performance measurement and reporting efforts, www.TalkingQuality.gov, that will be updated regularly to reflect new evidence.

Principle 4: Dissemination

To reach diverse groups of consumers—especially the most vulnerable—we must work with and through organizations and individuals they trust. Comprehensible and usable reports must also be disseminated effectively so they are received when needed; are considered as objective, trustworthy, and authoritative; and reinforce the value and relevance of the information. Dissemination of quality information is haphazard and often ineffective. Issues

of language, literacy, region, priority health concerns, and decision context must all be taken into account.

For audiences comfortable with Web-based information, decision-support tools can improve accuracy and help minimize the cognitive decision-making burden. These tools typically can be personalized to respond to individual priorities and presentation preferences. Nevertheless, for many people these “high-tech” approaches alone are unlikely to work. Groups with lower literacy, those whose first language is not English, those less familiar with the complexities of health care, and those with serious health care problems will likely need to receive information in person from a known and trusted source.²¹

The best way to provide personal assistance is to use the wide range of public and private organizations that do, or could, help consumers with quality information.²² We have invested little in supporting such potential partners to date. Without dedicated, well-supported resources of this kind, consumers now turn to close friends and family members, who are often as ill informed as they are, or to physicians and other health care providers, who may be somewhat better informed but often have conflicts of interest.²³

Few studies have assessed whether it is feasible and effective to use community-based and voluntary agencies in this role.²⁴ Few organizations can take on this role without earmarked funding, and many will themselves need to understand better the importance of quality and its variations. Partners must be carefully selected to ensure that they serve and are trusted by target groups and that they are neutral in how they present choices to clients.²⁵ Partners will need not only access to evidence-based reports, but also training, technical support, and Internet access (surprisingly absent for many groups).

If this sounds expensive, it is, although probably not as expensive as are media campaigns addressed to the nonexistent “average” consumer. Policymakers are correct in noting that the evidence is lacking that this approach will work. Not only have we invested little

money in dissemination, we have invested almost nothing in dissemination research.

■ **Recommendation.** We recommend that public and private funders jointly support and evaluate a set of demonstration projects that use various dissemination strategies to reach a series of distinct audiences, to find out what works. These demonstrations could build on existing activities or be designed from scratch using all we know about social marketing, cross-cultural communication, and community-based organizations.

Principle 5: Reward Improvement

Consumers alone cannot improve system quality. The system and all its stakeholders must be willing to reward and support quality improvement, or it will not happen.

■ **Role of purchasers.** Prevailing provider reimbursement systems not only fail to reward quality adequately, they often undermine quality by paying doctors and hospitals more when they perform unnecessary and potentially harmful procedures.²⁶ Efforts to improve quality will not succeed unless providers and plans are rewarded economically for doing the right thing, even if that means performing fewer services.

■ **Recommendation.** We recommend that all purchasers, public and private, begin now to design and implement incentive programs that reward providers and plans for improving quality of care. Purchasers can use several types of incentives to reward quality, including increased market share and higher payments. Both General Motors (GM) and the Buyers Health Care Action Group (BHCAG) have steered employees to higher-quality plans and providers, either by setting lower employee contributions for plans with higher quality scores (GM) or by disseminating reports that clearly identify plans in three cost tiers that do and do not perform well.²⁷

On the higher-payment front, “pay for performance” programs are emerging among both public and private payers. Several large health plans in California recently announced a system for paying providers bonuses for achieving specified quality levels and avoiding medical errors.²⁸ The PBGH has developed its own

method of linking medical-group reimbursement to a combination of three quality weights. The Central Florida Health Care Coalition plans to set payments to individual physicians according to their performance on a combination of patient survey scores and clinical quality measures.²⁹

■ Role of health plans and providers.

Even if providers get incentives to improve, they cannot do so without the information systems and training needed to implement continuous quality improvement programs.

■ Recommendation.

We recommend that health plans and providers act now, with appropriate policy and funding support, to make sizable investments in building capacity for quality improvement and a health care information infrastructure that is up to the task. Information systems that support consumer choice and those that support quality improvement are now on entirely different tracks. This nonalignment of measures, data collection approaches, and reporting systems contributes to both financial and administrative waste. Furthermore, information systems are located at specific sites of care and do not support data collection across a consumer's episode of care.

We can design both measures and information systems that support clinical decision-making and improvement processes while providing at least some of the data elements needed to construct consumer-oriented quality measures.³⁰ For example, information obtained at the point of care in the treatment of a chronic condition such as diabetes can be combined with other patient data to develop risk-adjusted indicators of provider performance. Data such as these can be used for clinical care management, quality improvement, accountability, and consumer choice, thus reducing the cost and burden of reporting.

IF THE PRINCIPLES and recommendations offered in this paper are acted on, consumers and patients armed with accurate, standardized, timely, and relevant information can indeed be a potent force for driving the health care system to higher levels of

quality and accountability. However, if all stakeholders do not provide adequate information and support and respond to consumers' demands for quality, many consumers may be left bearing the burden of rising costs and uncertain, highly variable levels of quality and access. These principles and actions also will require new political will and bipartisan support among policymakers in the face of growing consumer distrust and cynicism, provider discontent, and health care industry pressures to maintain power and profits. Working together, we believe that we can and must all do our part to shape a quality-driven health care system.

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NOTES

1. M.J. Coye, "No Toyotas in Health Care: Why Medical Care Has Not Evolved to Meet Patients' Needs," *Health Affairs* (Nov/Dec 2001): 44-56.
2. With forty-one million uninsured Americans and many others having little or no choice of providers or plans, only a subset of consumers has the luxury of choice and any opportunity to drive system quality.
3. Henry J. Kaiser Family Foundation, *National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information* (Menlo Park, Calif.: Kaiser Family Foundation, 2000); and Deloitte and Touche, *Consumer Demand for Clinical Quality: The Giant Awakens* (Irving, Tex.: VHA, 14 December 2001).
4. A.M. Epstein, "Public Release of Performance Data: A Progress Report from the Front," *Journal of the American Medical Association* 283, no. 14 (2000): 1884-1886; and M.N. Marshall et al., "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evi-

- dence," *Journal of the American Medical Association* 283, no. 14 (2000): 1866–1874.
5. Kaiser Family Foundation, *National Survey*.
 6. J.H. Hibbard and J.J. Jewett, "Will Quality Report Cards Help Consumers?" *Health Affairs* (May/June 1997): 218–228.
 7. D. Carmine, "Diverse Learners and Prevailing, Emerging, and Research-Based Educational Approaches and Their Tools," *School Psychology Review* 23, no. 3 (1994): 341.
 8. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academy Press, 2001); and D. Lansky and C. Bethell, "Empowering Consumers to Make Informed Choices," in *Connecting with the New Healthcare Consumer: Defining Your Strategy*, ed. D.B. Nash (New York: Aspen Publishers, 2001).
 9. IOM, *Envisioning the National Health Care Quality Report* (Washington: National Academy Press, 2001).
 10. C. Molnar, "Reporting Health Care Quality to Minority Populations: Issues and Challenges" (Paper for National Quality Forum Working Group on Minority Healthcare Quality Measurement and Reporting, July 2001); and S.F. Jencks et al., "Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels," *Journal of the American Medical Association* 284, no. 13 (2000): 1670–1676.
 11. IOM, *Crossing the Quality Chasm*.
 12. C. Bethell et al., "Assessing Health System Provision of Adolescent Preventive Services: The Young Adult Health Care Survey," *Medical Care* (May 2001): 478–490; and C. Bethell et al., "Assessing Health System Provision of Well-Child Care: The Promoting Healthy Development Survey," *Pediatrics* (May 2001): 1084–1094.
 13. E. Lovern, "'Wave of the Future': Leapfrog's Release of Hospital Information Sets Off Swell of Activity," *Modern Healthcare* 32, no. 3 (2002): 4–7.
 14. Pacific Business Group on Health, "How to Use HealthScope," www.healthscope.org (15 November 2002).
 15. Leapfrog Group, "The Leapfrog Group Expands Patient Safety Improvement Initiative into Twelve New Regions," Press Release, 25 April 2002, www.leapfroggroup.org/news.htm (15 November 2002).
 16. Pennsylvania Health Care Cost Containment Council, "Agency Spotlight," www.phc4.org (15 November 2002); and J.K. Barr et al., "Public Reporting of Hospital Patient Satisfaction: The Rhode Island Experience," *Health Care Financing Review* 23, no. 4 (2002): 51–70.
 17. Centers for Medicare and Medicaid Services, "Medicare Health Plan Compare," www.medicare.gov/MPHCompare/Home.asp (15 November 2002).
 18. J.H. Hibbard et al., "Increasing Informed Consumer Decisions in Health Care," *Milbank Quarterly* 75, no. 3 (1997): 395–414.
 19. A. Tversky et al., "Contingent Weighting in Judgment and Choice," *Psychological Review* 95, no. 3 (1988): 371–384.
 20. J.H. Hibbard et al., "Strategies for Reporting Health Plan Performance Information to Consumers: Evidence from Controlled Studies," *Health Services Research* 37, no. 2 (2002): 291–313.
 21. Barents Group of KPMG, *Report to HCFA: Consulting, Development, and Testing of Medicare Quality Performance Materials for Hispanic/Latino Beneficiaries and Intermediaries Serving Them* (McLean, Va.: Barents Group of KPMG Consulting, Inc., December 2001); California HealthCare Foundation, *Voices of Experience: Case Studies in Measurement and Public Reporting of Health Care Quality*, March 2001, www.chcf.org/documents/quality/VoicesOfExperience.pdf (4 September 2002); and Molnar, "Reporting Health Care Quality to Minority Populations."
 22. S. Sofaer, "Informing Older Consumers about Health Care Quality: Issues in Implementing a Research and Action Agenda," in *Informing Consumers about Health Care Quality: New Directions in Research and Action*, ed. D.I. Lewin (Rockville, Md.: AHRQ, 2002).
 23. Kaiser Family Foundation, *National Survey*.
 24. S. Sofaer, "The Feasibility of Involving Community Based Organizations in Providing Information and Support to People on Medicare" (Paper presented at the American Public Health Association Annual Meeting, Boston, November 2000).
 25. Physicians are often cited as a trusted source of health care information. See Kaiser Family Foundation, *National Survey*. We should encourage doctors to refer patients to appropriate information sources when they cannot personally provide assistance.
 26. IOM, *Crossing the Quality Chasm*.
 27. Milbank Memorial Fund, *Value Purchasers in Health Care: Seven Case Studies* (New York: Milbank Memorial Fund, 2001).
 28. R.D. White, "A Shift to Quality by Health Plans," *Los Angeles Times*, 14 January 2002.
 29. M. Freudenheim, "Florida Employees Will Offer Incentives to Doctors," *New York Times*, 16 November 2001.
 30. U.S. Department of Health and Human Services, *Information for Health: A Strategy for Building the National Health Information Infrastructure*, 15 November 2001, ncvhs.hhs.gov/nhiilayo.pdf (4 September 2002).