Best Practices in Public Reporting No. 2: Maximizing Consumer Understanding of Public Comparative Quality Reports: Effective Use of Explanatory Information

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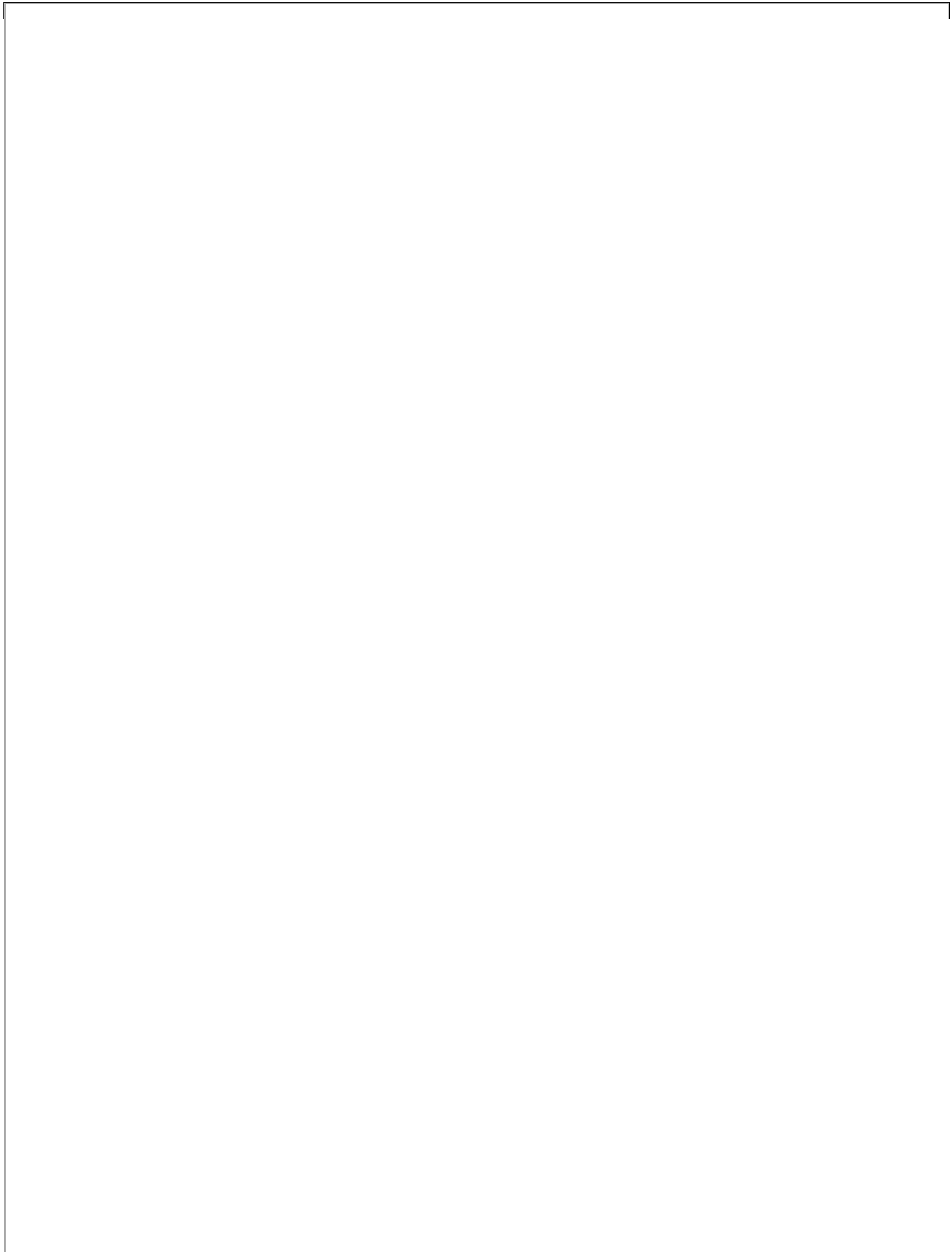
Since this is not a “real” report, it does not have a graphic theme or “look.” Its intent is to convey the content and language of a report. The key points include:

- A brief definition of quality in consumer-oriented language
- The reasons for publishing comparative data on hospital quality
- Several reasons an individual should look at this information
- A brief summary of the information in the report

Subheads and bullets break up blocks of text. A link at the bottom of the page immediately takes the user to the data. The rest of the report contains a lot more explanatory information, which is either wrapped around the data presentations or



If reporting a full complement of measures, a report sponsor may opt to organize provider ratings into these three categories:

1. Section on “care that protects patients from medical errors and does not cause harm,” which would include measures such as surgical infection rates or injuries from falls.
2. Section on “care that is proven to work,” which would include measures such as percentage of diabetes patients who receive all five recommended tests regularly.
3. Section on “care that is responsive to a patient’s needs and preferences,” which would include measures such as patient experience.

For more information about this framework, refer to Best Practices in Public Reporting No. 1

If the report is sponsored or published by a CVE, the organization or name may not be familiar to consumers. Even if a CVE is not well known, some of its members

Establish credibility by demonstrating fairness

The public wants to know that reports are fair to those being rated. Focus group researchers have heard repeatedly that a specific measure is not entirely the sole responsibility of the entity or individual being assessed. Some consumers say that the responsibility is broader—the patient's, or another health professional's, or shared by multiple professionals.

For example, when older women were asked about the inclusion of a mammography rate in an early HEDIS (Healthcare Effectiveness Data and Information Set) measurement set used to compare health plans, they thought that either the woman herself or her doctor was responsible for whether she had a mammogram, not the health plan.[5] In response to this feedback, explanatory information was added to the presentation of these data in an early version of Medicare Compare. This information acknowledged that patients and physicians affect a health plan's mammography rate but also specified exactly how health plans can act to ensure that more women get needed mammograms.

Another way to demonstrate fairness is by describing key aspects of the sponsor's interactions with the providers who are rated. While it is a good idea to make clear that you are at arm's length with providers, it also can help to: (1) conduct a dry run of data collection and aggregation, which is reported only to providers, prior to the actual public report; and (2) give providers an opportunity to comment on the findings. If you take these steps, tell the public about them, briefly and in plain language.

Provide the right level of detail to ensure credibility

Many report designers believe that for the public to trust a report, they need to know a lot of the technical details about how the data were collected and how the scores were generated. In particular, report designers think people need to know the extent to which differences between those rated are statistically or substantially significant. Because of this concern, some designers address statistical significance by including details (e.g., confidence intervals in graphs or highly technical presentations of data) in the main body of the report.

Such complex data presentations are unlikely to be either read or understood. In fact, consumers may see information about adjustments to the data as a sign that someone is "messing with the information." Therefore, it is important to find the right balance between technical details and summary information.

This challenge can be addressed by providing technical details in a special section toward the back of the report (after the measures or ratings). Links to this information should be provided early, however, to signal that the details are available to anyone who wants them. It is appropriate to have links like this throughout the report (e.g., via a tab at the left or on the top of the screen, for an online report) to reinforce the continuous availability of this information, as it is hard to predict when a given individual may want to look at it. Realistically, health professionals are more likely to look at this information than consumers are, but it must be made available to all. Most important, it must be wr1 9 to eny003c -0.0tte alnormacle al15 TI detst; un itf5(t)s

Technical details provided with the data display should include information about the time period covered by the data and data sources, including mention of whether data provided by the providers or health plans being rated are validated or audited in some way. When survey information is reported, people want to know that the sample was random and reasonably large. They also want to know that the surveys were conducted and scores generated by an independent entity.

Explain how scores were generated

Scoring can make a big difference in the effect comparative data have on consumers' understanding of quality information. For example, when Hospital CAHPS® data are presented on the Hospital Compare Web site, graphs show the percentage of patients in each hospital who gave the best possible rating for a given experience. However, when a composite of several measures is reported (such as, for example, communication between patients and their nurses) the graphs show the percentage of patients in each hospital who gave the best possible report on ALL items in the composite.

From a consumer-engagement perspective, it is a good thing if the information shows variation, because it reinforces the idea that there is variation in quality. On a more fundamental level, it makes people more interested in the information and more likely to think it can help them make a good choice. However, these scoring decisions need to be made clear, both in the individual data presentations and in the technical details.

Another aspect of scoring is risk adjustment or, in some cases, "smoothing" of data through hierarchical modeling when some of the entities being rated are substantially smaller than others.[6,7] These strategies involve complex statistical techniques, and they cannot be presented in public reports using language one might use in a graduate (or even undergraduate) course. The language must be as simple as possible but not so simplistic that the steps taken to ensure accuracy and fairness of the data are unclear.

The authors have found through research that people tend to understand adjustments based on age or severity of illness but react negatively to adjustments based on social factors such as education level. To the extent that a report sponsor plans to stratify data by race, ethnicity, or income level, the authors caution that this will have to be done carefully so that consumers do not see it as a manipulation of the "real" data or discrimination against racial, ethnic, or income groups.

Recommendation No. 4: Provide information about the importance, meaning, and interpretation of specific measures

In addition to providing a broad framework that defines different aspects of quality, reports need to offer simply stated explanations around their graphic presentations of data. They need to describe how the measures relate to quality and, sometimes, how to interpret the graphic.

Use terms consumers understand

Many reports justify using technical terms by including a glossary. People rarely use glossaries, however, and are not likely to examine information they do not understand. If technical terms are used, they must be defined immediately in everyday language that will be understood by individuals at an eighth-grade reading level or lower. An even better strategy is to use a common term (e.g., breast cancer screening test), with the technical term (e.g., mammography) in parentheses.

Ideally, the measures reported will have been vetted previously with consumers to see if they find them important, relevant, and appropriate to the providers or health plans being rated. If a measure has not been formally vetted, it may be necessary to conduct focus groups to obtain input on how to present it. Focus groups were conducted before finalizing the Hospital CAHPS survey, for example. They helped determine which items stayed in the survey and helped inform decisions about the contextual information needed.[8] For more information about testing, refer to "Recommendation No. 9: Test the report with consumers before going live" later in this report.

Explain different types of measures

The explanatory information needed depends on the type of measure, because consumers' interest in and level of understanding of the different types of measures will vary. When developing such information for public reports, consider the following key points about each type of measure:

- Patient experience measures, such as those derived from CAHPS surveys: People seem to naturally understand this kind of measure. Most, but not all, people value and will use rating information from other patients and consumers.
- Outcome measures: These measures are just beginning to be included in reports. Early testing on these measures with consumers indicates a range of responses to them:
  - Patient safety measures, such as measures of the frequency of infections, falls, and other negative consequences of care delivery: Once explained in plain language, these measures seem to resonate with many consumers. It appears important when presenting safety measures to emphasize that specific bad outcomes can be prevented by providers.
  - Mortality measures: These elicit a wide range of responses from consumers. Some say they do not want to read or think about the potential of death when they seek medical care. O8 Tc65 -1.15 Tdmeasw 12 0 0 5 d[t/of death w 5 -25.14 - 0 10.00 1r

Clinical process measures: It is almost always necessary to explain these kinds of measures. Clinical processes are not familiar to many consumers, and they rarely know the evidence of how a particular process supports a desirable outcome. The report must use plain language to describe the process, so that the importance is clear (e.g., patient given right medication at right time). The label should help people make the connection between the process and the outcome.

For example, the HEDIS assessments of health plans include a mammography measure as a key effectiveness indicator. When this measure was introduced, mammography rates were considerably lower than they are now. At that time, many women did not know the

Figure 3. A Plain Language Explanation Helps Consumers Interpret Data Quickly

The second common belief is that price, as with most consumer goods, is a reasonable proxy for quality. That is, when consumers are not getting a clear message about quality, they are likely to use cost as a proxy for quality. This can result in counterproductive choices.

Beginning to address these misconceptions in public reports is a first step in communicating about resource use issues. Keeping these misconceptions in mind as sponsors create approaches for reporting on resource use measures will be essential.

Composite scores, common in survey-based measures, can be helpful in reducing the total number of data points in a report, but they do not help as much as summary or "roll-up" scores. Unlike composite scores, summary or "roll-up" scores combine a large number of specific measures that may or may not be highly related to one another statistically. They relate to a single provider or facility. Consumers often say they want summary or "roll-up" scores, which can make it easier for consumers to evaluate choices and make decisions.

Two issues must be addressed in developing and reporting summary or "roll-up" scores, however. First, it is important not to wash out any variation across providers—something that will make it harder for consumers to make a decision. Summary scores that reveal that some providers and facilities are better across the board can be extremely helpful to consumers.

Second, care must be taken in weighting items in summary scores (i.e., giving more weight to some measures than to others). For example, it might seem obvious on the face of it to assign greater weight to a measure of the number of patients who die from central-line infections versus another measure of how quiet a hospital is at night. It is not clear, however, what the right weighting would be for any number of measures, and it is inevitable that different consumers will weight a set of measures differently.

3. Call out key differences in performance (i.e., pointing out places where differences in scores are particularly large).
4. Provide examples of specific ways consumers can use information, not just for making personal health care choices, but also to learn more about what kind of care is high quality, to help loved ones make a decision, or to begin a conversation with their physician or other provider. Stories and testimonials can illustrate how information can be applied (e.g., including first-person statements by consumers about how using the report made a difference in their choices, health, or finances).
5. Make explicit what actions consumers can take to protect themselves from poor-quality care. The most obvious step consumers can take is to avoid choosing and using poor-quality providers. Sometimes, as we know, consumers have little or no choice of health plans or hospital. One step a consumer might take in this case would be to talk about the issue of poor hospital quality with his or her physician.

   In recent research, physicians were asked how they would respond if patients expressed concerns about hospital quality information they had seen in a public report.[12] While many physicians said they would try to reassure their patient about the quality of the hospital, many also said they would alert the involved specialist about the patient's concerns, be vigilant about specific concerns while on rounds, or speak to the nursing

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