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How Report Cards On Physicians, Physician Groups, And Hospitals Can Have Greater Impact On Consumer Choices

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ABSTRACT **Public report cards with quality and cost information on physicians, physician groups, and hospital providers have proliferated in recent years. However, many of these report cards are difficult for consumers to interpret and have had little impact on the provider choices consumers are making. To gain a more focused understanding of why these reports cards have not been more successful and what improvements could be made, we interviewed experts and surveyed registrants at the March 2011 AHRQ National Summit on Public Reporting for Consumers in Health Care. We found broad agreement that public reporting has been disconnected from consumer decisions about providers because of weaknesses in report card content, design, and accessibility. Policy makers have an opportunity to change the landscape of public reporting by taking advantage of advances in measurement, data collection, and information technology to deliver a more consumer-centered report card. Overcoming the constraint of limited public funding, and achieving the acceptance of providers, is critical to realizing future success.**

In recent years, efforts to improve the quality and affordability of health care in the United States and abroad increasingly have looked to public performance reporting to guide consumer choice and stimulate delivery system improvement. Such public reporting, however, is hardly a new phenomenon. More than two decades ago, public agencies in New York and Pennsylvania began reporting cardiac surgical outcomes by surgeon and hospital. Other early initiatives to evaluate provider performance were launched by payer groups such as the Pacific Business Group on Health and the Buyers Health Care Action Group in Minnesota. Since then, many private purchasers, the federal government, and multistakeholder community groups have developed and disseminated their own report cards with quality and cost information on physicians, physician groups, and hospital providers at the community, regional, and state levels.

The evolution of, and experience with, consumer-directed public report cards is well-documented.[1–3] Publication of these report cards aims to encourage consumers to assess and include provider quality information in their health care decisions and to foster quality improvement among providers. However, research suggests that although consumers report that they value quality information about their providers, consumer-directed reports on quality have been difficult to understand and use and have had minimal impact on consumer choices of providers.[4–7]

Challenges associated with measuring performance at the individual physician level (for example, inadequate sample sizes and difficulty adjusting for severity of patients' medical conditions)[8] have resulted in group-level reporting and probably have limited the salience of report cards for consumers. Moreover, going forward, today's report cards will need to adapt to the fundamental changes in health care delivery on the horizon (such as accountable care organizations and efforts to assess provider quality based on episodes of care instead of individual procedures).

Rather than review the published literature on consumer-directed public reporting further, in this paper we start from the premise that the confluence of mixed experience and changing landscape presents a unique opportunity to collect and synthesize expert viewpoints on public reporting for consumers of provider (that is, physician, other professional, hospital, or other facility) performance data.

We sought to identify experts in the research community, and from each of the major stakeholder groups involved in public reporting efforts, to assess their perspectives on the history of public reporting to date and their perception of key objectives and strategies for public reporting initiatives in the future. These opinions are not intended to be representative of public opinion, but are the perspectives of individuals who have considerable experience—accumulated from different vantage points—with consumer-directed public reporting. We then aimed to translate these findings into implications that can help guide the path forward.

This paper was originally commissioned for, and its findings presented at, a National Summit on Public Reporting for Consumers in Health Care, sponsored by the Agency for Healthcare Research and Quality and held in March 2011. The summit was organized around this and six additional invited papers related to dimensions of public reporting for consumers.[9–14]

The summit brought together representatives from major stakeholders involved in consumer-directed public reporting—including consumer advocacy groups, providers, buyers of health insurance and health care (for example, employers/insurers), the government (for example, Centers for Medicare and Medicaid Services, Office of the National Coordinator for Health Information Technology, and Agency for Healthcare Research and Quality staff), local and national health care quality organizations, and researchers/technical experts—to stimulate discussion about alternative visions for public reporting in 2025.

Study Data And Methods

Two sources of data form the basis of the analyses presented in this paper. The first is a series of twenty-nine telephone interviews with leaders in the design and delivery of public reporting of provider performance information. The second is a brief survey of invited participants of the National Summit on Public Reporting described above.

Members of both groups of informants were not randomly selected; rather, they were chosen because of their significant experience with some aspect of consumer-directed reporting. Therefore, neither group provides a representative sample of public opinion or even of the general health policy community. Moreover, the sample size of both interviewees and survey respondents is small, a fact that should raise further cautions against extrapolation of findings. However, participants' responses, viewed collectively, represent and enable us to report on a broad range of opinions held across stakeholders as elicited during the data collection process.

Individuals invited for interviews were experts, who we identified as either having made a major contribution to the development and evolution of consumer-directed public reporting, or who are widely considered to be leaders of the stakeholder groups. No fewer than two interviewees represented each stakeholder perspective (Appendix Exhibit A).[15]

For the interviews, we developed a semistructured interview guide to garner opinions on past performance and future directions for consumer-directed report cards (Appendix Exhibit B).[15] Specifically, interviewees were asked about the effectiveness of report cards according to specific dimensions (for example, measures, presentation); the value of these efforts; key areas of focus to improve public reporting of quality information; how other health policy initiatives might affect public reporting; and strategies to overcome future challenges. Questions were framed as open-ended, with the exception of one closed-ended, multiple choice question.

Each interview lasted between thirty and forty-five minutes. Interviews were conducted by telephone between December 2010 and February 2011 and were recorded and transcribed.

Following the completion of these individual interviews, we developed and administered a brief online survey to the eighty-four registered participants of the National Summit on Public Reporting (Appendix Exhibit C).[15] Survey questions were structured to test for support among the conference participants for the themes and key findings elicited during the expert interviews.

The survey asked eleven closed-ended questions to ascertain agreement or disagreement about factors driving the successes and shortfalls of reporting efforts to date, how respondents would rank interviewee-suggested alternatives for making public reporting more effective, and agreement or disagreement with the challenges and priorities that interviewees identified for report cards going forward. Surveys were administered and responses submitted on the Internet in February and March 2011.

We received fifty-seven completed surveys for a response rate of 68 percent. Because the survey was administered anonymously, we are unable to identify which sets of responses are associated with individuals from particular stakeholder groups, thus we report results in terms of overall frequencies.

Study Results

INTERVIEW RESULTS Interviewee discussion about important, unmet needs for public reporting of provider performance information to consumers largely originated from the perspective of building on past efforts at reporting. Respondents were asked whether current consumer reporting programs: (a) should be abandoned, (b) need to be totally revamped, (c) need some modest changes, or (d) are more or less all right as they are.

Twelve of the twenty-nine interviewees thought current report cards either required modest changes or needed to be totally revamped; thirteen of the interviewee responses fell between these two options. The central tendency of respondents is best captured by one interviewee: “It’s not revamped, it’s substantially augmented or refined. Revamped suggests that there is something fundamentally defective about what we are doing. Where we’ve come from has been massively useful.” Several other interviewees echoed this sentiment.

When considering consumer-directed reporting initiatives to date, interviewees noted that placing performance information in the public domain has in some cases motivated providers to focus on their own quality improvement (for example, due to reputational concerns or in response to media reports or the attention of hospital boards) and has legitimized the notion that variations in provider quality exist. However, the majority of interviewees felt that consumers were unaware of the publicly available reports or unable to use the information provided.

In addition, six interviewees raised questions about consumers’ ability and willingness to make health care choices based on such reports because of high levels of trust in the opinions and recommendations of their own physician and the constraints imposed by health plan benefit designs. As one person said, “A lot of the time, the decision is made by the physician so that the patient doesn’t have any real shared decision making in it.”

Interviewees also felt that the content and presentation of consumer-directed report cards have hindered their usefulness. There was broad consensus, including a perspective offered by at least one representative of each stakeholder group, that the measures reported in current consumer-directed report cards are ill-suited to help consumers make more informed health care choices.

This poor match was attributed to limitations in the salience of measures to consumers or the quality of the data and analyses used to produce the measures. Many current report cards showcase measures based on administrative claims or hospital discharge data with the dual purpose of spurring quality improvement among providers and facilitating consumer decision making.

Interviewees said that they believed that these reports have failed to “match the product to [a consumer] audience” as they are not meaningful for consumers. Although seven interviewees (across research, consumer, government, and quality organization stakeholders) noted that academic research has made “incremental” progress in report design, eight individuals—including at least one from each stakeholder group—said they believed that presentation generally has not incorporated best practices from cognitive psychology and related disciplines. Rather, report cards have increased the cognitive burden placed on consumers by presenting too much information, using technical language, or being unduly difficult to navigate.

Exhibit 1 presents priorities for improving public report cards as identified by interviewees. There was strong support for refining the content and for presentation of quality information in report cards, specifically by offering more consumer-oriented measures and by enhancing clarity and accessibility.

Representatives from consumer groups and quality organizations also said that increasing the types of information made available (for example, including cost alongside quality information) and allowing for report cards that could be customized to report on specific conditions, procedures, or populations of interest to the patient should be priorities going forward. We identified support across the majority of stakeholders for efforts that would make report card information available to consumers at the time when they are most likely to use it (for example, when they are selecting a physician for the first time), and many suggested doing so using a web-based platform.

Increased consumer education around the existence of variation in provider quality and how to use report cards was also thought to be a critical priority going forward by most inter-

EXHIBIT 1

Priorities For Improving Public Reporting Efforts As Identified By Interviewees From Various Stakeholder Groups

	Raised by interviewee(s) from stakeholder group						
Priority area/action item	**H**	**C**	**G**	**P**	**Q**	**R**	**Interviewee recommendations**
CONTENT AND PRESENTATION OF QUALITY INFORMATION							
Report consumer-oriented measures	●	●	●	●	●	●	Suggested measures include functional status outcomes, patient-reported measures, physician- and hospital-specific measures, care for chronic conditions and nonemergent treatment episodes, composite/roll-up measures
Improve clarity and accessibility	●	●	●	●		●	Display summary scores with ability to drill down; order performance scores based on rank; use colors and symbols; employ nontechnical language; nest within a framework that explicitly describes and defines health care quality
Pair quality data with other consumer-relevant information		●			●	●	Include patient share of cost, logistical information, condition-related educational information
Make reports personalized or customizable		●			●		Integrate performance data with online personal health record; tailor dynamically, based on user-inputted information (for example, age, medical conditions, geographic location)
TIMING AND MODE OF DELIVERY							
Make performance data available via a robust, web-based platform	●	●	●		●	●	Make available within a searchable, online database; incorporate into an online provider directory; make accessible via mobile phone
Present to consumers proactively at decision-making points	●	●	●	●			Share data as a mandatory part of informed consent; present using a nonphysician health care navigator; send in preparation for visit to facilitate shared patient-provider decision making
CONSUMER AWARENESS OF QUALITY VARIATION AND INTEREST IN PERFORMANCE REPORTS							
Improve consumer health literacy and understanding of care quality		●	●	●	●		Use patient-centered medical home model to facilitate patient education; conduct surveys to determine population's baseline level of health literacy; then, formulate strategic initiatives
Conduct additional research and experimentation around consumer activation	●			●	●	●	Run focus groups and Plan-Do-Study-Act cycles; research what information consumers need and want to make health care decisions
Increase marketing and dissemination		●	●		●		Raise consciousness through a national consumer outreach campaign; target outreach to primed segments (for example, patients with chronic diseases)
CREDIBILITY OF REPORTS AND UNDERLYING DATA							
Improve underlying data quality	●	●	●	●	●	●	Publicly fund clinical data collection infrastructure; tie provider payment to provision of data; motivate consumers to enter clinical data into personal health records
Create accreditation standards to signal report quality			●	●	●	●	Make certification voluntary with an accreditation body; set federal-level regulatory standards and audit function (for example, model based on the Securities and Exchange Commission)

SOURCE Authors' analyses of semistructured interviews. **NOTES** Stakeholder group abbreviations are as follows: H is health insurance/health care buyers (that is, employers/purchasers and insurers). C is consumer advocate. G is government representative. P is provider. Q is quality organization representative. R is researcher.

viewees. Several individuals said that they thought that additional research in this area would be important to determine how to best pursue this aim.

Finally, interviewees from all the stakeholder groups said that inherent weaknesses in the quality of data on provider performance must be improved. Government, provider, and quality organization and research representatives all suggested that implementing some form of accreditation process for report cards might be an effective strategy to address this gap in current report cards.

Interviewees identified six significant challenges that could inhibit the ability of consumer-directed reporting initiatives to achieve their desired outcomes (Exhibit 2). Representatives from all stakeholder groups identified lack of consumer readiness and engagement to absorb and use the information provided in report cards as a major impediment to the success of public reporting.

Likewise, representatives from each of the stakeholder groups cited provider opposition as a critical obstacle. That opposition was said to stem from poor support for the idea that consumers should be evaluating provider performance in these ways and from skepticism of the quality of the performance data.

Several interviewees were concerned that a lack of funding and a weak business case for report cards would leave investments in these initiatives at suboptimal levels. Representatives from the government, from provider groups, from quality organizations, and from the research community also worried that political obstacles due to difficulties reaching consensus across stakeholder groups may hinder the future of consumer-directed reporting initiatives.

As a corollary to the need for improved data and measures identified in Exhibit 1, interviewees representing health care buyers, the government, and researchers suggested that some sort of national data infrastructure be constructed to assist with the capture of quality and performance information that is useful and actionable for consumers. Consumer and provider representatives expressed concerns about the inadequacy of the measurement science informing current data capture processes.

Interviewees also identified several health policy changes as intersecting in an important way with consumer-directed public reporting. The majority of interviewees said that they believed

EXHIBIT 2

Challenges Facing Public Reporting Efforts As Identified By Interviewees From Various Stakeholder Groups

	Raised by interviewee(s) from stakeholder group						
Challenge	**H**	**C**	**G**	**P**	**Q**	**R**	**Barriers**
Lack of consumer readiness and engagement	●	●	●	●	●	●	Poor consumer understanding of health care quality and the variation therein—with price and volume of care often serving as quality proxies, locus of control tilted toward a provider-centric model and lack of empowerment, diverse consumer community with different needs and preferences toward engagement, all information competes in an age of information overload
Provider opposition	●	●	●	●	●	●	Provider skepticism around reliability and accuracy of measures and methodology (for example, risk adjustment), insufficient recognition within provider community that consumers have both a right to access and use for performance data
Lack of funding		●	●	●		●	As yet, the payment system does not provide an incentive for provision of performance data; data collection is a public good, but uncertainty remains around who can or will fund
Political obstacles			●	●	●	●	Reaching consensus around a common vision for the future of public reporting and the path forward is difficult due to varied—and often opposing—stakeholder objectives; consumers do not have the organization or clout of other stakeholder groups at the table (for example, physician specialty groups)
Insufficient data infrastructure	●		●			●	Current measures draw heavily from administrative databases that are ill suited for this task; small provider groups have neither the financial nor human capital resources to invest in necessary health information technology, infrastructure for clinical data collection, and reporting
Inadequate measurement science		●		●			Measurement science has not evolved to produce measures salient for consumer decision making (for example, individual provider-level measures); measure development research pipeline is underfunded

SOURCE Authors' analyses of semistructured interviews. **NOTES** Stakeholder group abbreviations are as follows: H is health insurance/health care buyers (that is, employers/purchasers and insurers). C is consumer advocate. G is government representative. P is provider. Q is quality organization representative. R is researcher.

that accountable care organizations would probably increase demands from both patients and providers for quality data.

Half of the interviewees, including at least one person from each stakeholder perspective, said that they thought that widespread adoption of electronic health records had the potential to improve the content of reports by making richer clinical data available. Several interviewees, however, were more "cautiously optimistic" about electronic health records, noting that many of the current systems do not yet have the requisite reporting functionalities.

One-third of interviewees, but again at least one person from each stakeholder perspective, said that they thought that increasing consumer out-of-pocket costs through some form of tiered payments would be important in driving consumer demand for reporting in the future. As one interviewee put it: "[It] gives consumers an incentive to demand quality information about their providers and it's politically-feasible." However, not everyone thought additional policy changes were important. Three interviewees said that they thought that consumer-directed report cards were important, regardless of other policy determinants.

SURVEY RESULTS Results from the survey of registrants at the National Summit on Public Reporting provided information on the extent to which the wider community of individuals who work on consumer-directed public reporting initiatives agree with the opinions of our interviewed experts. Several questions explicitly asked for or allowed more than one response. For example, we asked respondents to indicate the three most important factors for the future success of consumer-focused, quality reporting. Select survey results are summarized in Appendix Exhibit D.[15,16]

The idea that the format and presentation of report card data should allow search and customization by consumers was clearly supported by the majority of conference attendees (74 percent). By contrast, support for published, fixed-format report cards was low (9 percent). Fewer than 10 percent of survey respondents said that they thought that delivery of report card data should be part of a patient's interaction with a primary care physician.

On the topic of improved measures, survey respondents offered support across the variety of types of consumer-oriented measures suggested by interviewees, including outcome measures (72 percent), cost-related measures (70 percent), composite measures by condition (54 percent), measures tailored to demographics or health status (49 percent), and functional status measures (40 percent).

We also asked about the optimal source for provider performance information. Survey respondents were more likely to indicate that an independent organization—such as *Consumer Reports* or Angie's List (40 percent) or a local multistakeholder coalition (33 percent)—should release this information, as opposed to a governmental entity (18 percent). Almost no survey respondents said that they thought that this information should come from employers or health plans.

The challenges to achieving the most desirable outcome for public reporting in the future identified by our interviewees were echoed by survey respondents. Nearly three-quarters of survey respondents said that they believed that lack of consumer understanding and appreciation of quality variation among providers was a significant impediment. Inconsistent methods, lack of all-payer databases and reports, and poor measurement science were selected as important obstacles by 53 percent, 39 percent, and 21 percent of survey respondents, respectively. Twenty-eight percent of survey respondents mentioned the need to overcome provider resistance toward reporting as a major obstacle to future success.

Lack of funding for public reporting initiatives is another major challenge identified by nearly half (46 percent) of survey respondents. When asked about who should financially support public reporting programs going forward, 77 percent of survey respondents thought public sources; 75 percent, health plans; 63 percent, private payers; 46 percent, providers; and 44 percent, private nonprofit groups. Thus, while no survey respondents said they thought that that health plans should release quality information, nearly three of four said that they believed that health plans should provide financial support for these initiatives.

The survey also provided a list of the priorities for improving public reporting efforts as identified by interviewees and asked respondents to rank the three they thought were most important to the success of consumer-focused quality reporting.

Development of consumer-focused measures was deemed important by a majority (65 percent) of respondents, and at least one-third of respondents selected increasing consumer awareness of public reporting (44 percent), development of personalized or customizable report cards (42 percent), and improved formatting and design (35 percent).

In contrast, initiatives that received less support from survey respondents (that is, those identified as one of the three most important initiatives by fewer than 20 percent of respondents) were the development of a standard framework for presentation of performance data (18 percent), improved credibility of measures (14 percent), increased consumer cost-sharing for lower-rated providers (14 percent), and creation of an accreditation program for public reporting programs (0 percent).

When asked about the importance of specific policy initiatives to encourage consumer-directed public reporting, the majority of survey respondents said that they thought that electronic health records (63 percent), provider payment reform (for example, pay-for-performance, global budgets—55 percent), new data on comparative effectiveness (52 percent), and shared decision making (53 percent) were "very important" to complementing or driving public reporting for consumers (Exhibit 3).

Policy trends for which the response option "very important" received a plurality of responses were delivery system changes (for example, accountable care organizations and medical homes—45 percent) and increased consumer cost sharing (for example, high-deductible plans or tiered networks—47 percent).

Discussion

Overall, data from our interviews with, and surveys of, individuals intimately involved with public reporting of health care quality data confirm that current efforts to disseminate provider performance information to consumers require significant changes if they are to realize their potential to inform consumer choices. To their credit, efforts to report provider performance information to consumers are perceived by a variety of stakeholders to have at times motivated providers to improve their own performance. Such efforts are also considered to be a critical step toward legitimizing the notion among consumers and providers that variations in provider quality exist and should be considered in decision making.

In contrast, other widely held perceptions are cause for concern. These include perceptions that current efforts to report provider-level quality data to consumers have missed the mark in terms of adequacy of quality measures (for example, measure content, the salience of the measures to consumers, or the quality of the data and analyses used to produce the measures); how report card data is formatted, presented, and delivered to consumers; and levels of consumer awareness and engagement in reporting initiatives.

In terms of the way forward, we encountered a diversity of perspectives on public reporting of health care quality and cost information to consumers. One important theme resonated with the vast majority of respondents, whether interviewed or surveyed: the need for personalized, tailored information that meets consumers where they are.

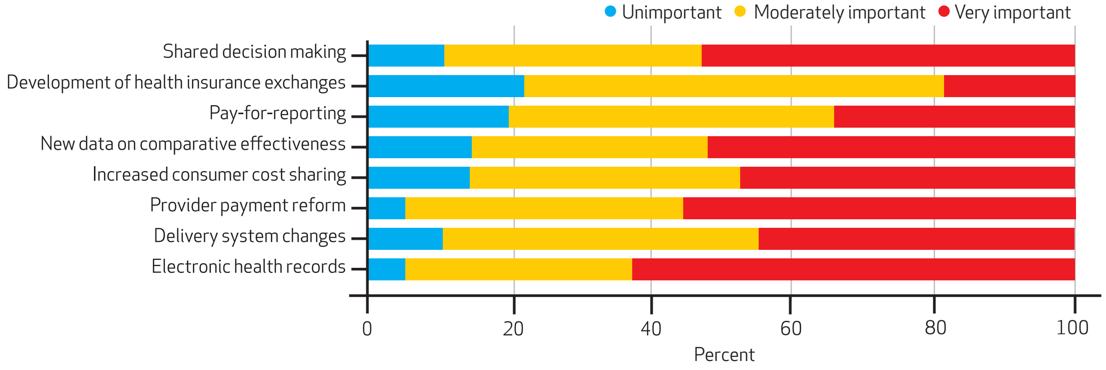
Nearly everyone agreed that the "one size fits all" approach to report cards should have little role in a more robust vision of public reporting. Rather, personalized, customizable reports would be easier to understand and could be coupled with other information that consumers find helpful (for example, cost, logistical, contact, or condition-related information).

Findings from academic research and best practices in other relevant domains (for example, as employed by *Consumer Reports*) could inform development of these reports. Providing higher-level, simplified reports does not preclude making more detailed information available to those consumers who want to drill down.

A second major theme identified by interviewees and confirmed by survey respondents was the

EXHIBIT 3

Perceived Importance Of Intersecting Policy Trends To The Success Of Public Reporting For Consumers: Survey Results



SOURCE Authors' analyses of survey fielded to AHRQ National Summit on Public Reporting for Consumers in Health Care registrants.

need for improvement in data and methods, particularly more salient, consumer-focused measures. We heard repeatedly that a report card providing improved information on outcomes (not just mortality, but also health and functionality), as well as consumer share of cost, composite measures by condition, and composite measures tailored to segments of the population by demographic and health status would offer a vast improvement over the much less robust, more generic report cards that are available today.

An important challenge to meeting this objective will be overcoming what our experts currently still view as inadequate and underfunded measurement science. The suggestions from experts to involve patients in measure development, to pursue construction of all-payer databases, and to create standard reporting frameworks (for example, such as those currently required in financial reporting) are all possible strategies that could improve measure development. However, lack of support for the idea of standardized reporting frameworks by survey respondents suggests that this idea is not as well accepted among the broader reporting community.

Respondents also deemed increasing consumer awareness of quality variation and interest in public reports critical to the success of public reporting. The need to overcome engrained constructs within our health care system (for example, that price and volume of care often serve as quality proxies, the fact of our provider-centric model) and consumer reliance on informal (for example, friend/family) recommendations when choosing providers make consumer engagement especially challenging.

However, future reporting initiatives that target less complex and nonemergent health care decisions and that start from the perspective of the consumer (for example, what information do consumers need and want to make health care decisions?) may be able to achieve this aim. Greater dissemination and marketing of reports, increased efforts to deliver reports at the time consumers need them, and more research and experimentation around consumer activation will also be important.

Although one interviewee noted that there remain major technical and governance challenges around creation of electronic, search-oriented report cards, the use of web-based and mobile tools as a platform through which to deliver personalized report card content to consumers was mentioned frequently by interviewees and will in all likelihood be very important going forward.

In contrast, a clear consensus on the role for providers as agents for the transmission of provider performance information is still lacking. Although proponents of provider involvement noted that providers could send reports to patients before a visit, discuss information during visits, or incorporate delivery of quality information into the informed consent processes, other interviewees were concerned that provider skepticism around report card initiatives and an inherent conflict of interest would create the potential for providers to present a biased view of the data. Survey findings that support release of provider performance information from independent organizations further suggest that the role for providers in report card dissemination, at least in the short term, may be limited.

The murkiest topic raised in our interviews concerned the business case for public reporting. A challenge associated with achieving needed improvements in consumer-directed public reporting is a lack of funding to build data collection infrastructure, accelerate measurement development, and create reports. Few interviewees had strong opinions about which stakeholders would demand improved public reporting. A few interviewees suggested that health plans stood to gain from these efforts, but only a quarter of survey respondents agreed with this notion.

Only one interviewee expressed a strong conviction on this topic: that consumers would demand better information and private markets would find a way to deliver it profitably. Even there, however, it was acknowledged that there is an inherent public good in the data collection and measurement aspects of reporting. By default then, our interviewees and respondents suggested that the public sector would be left, at a minimum, to finance and organize data collection and measure development.

Both federal and state policy makers have recently taken up this challenge. Most notably, the Affordable Care Act of 2010 calls for large investments to strengthen the quality infrastructure of the US health care system and will undoubtedly prove to be a vital driver in the reporting landscape. Reforms to improve the availability, depth, and dissemination of health care quality information figure prominently in several provisions of the health reform law.

Section 3011, for instance, charges the secretary of health and human services with the development of a national strategy to enhance health care delivery, patient outcomes, and population health. The National Quality Strategy that emerged from this charge identifies the refinement and expansion of public reporting as key to realizing priority initiatives.

Section 3013 mandates the identification of gaps in quality measures and the improvement of existing performance metrics on an ongoing basis. Measure development in the areas of health outcomes and functional status, coordination across care transitions, patient experience, meaningful use of health information technology, safety, and efficiency is prioritized.

Outlined in Section 10331, the Physician Compare website will serve Medicare enrollees as a joint physician directory and repository of performance information. The site is a component of the Physician Quality Reporting System, and reporting will become mandatory for physicians in the Medicare program in 2015. Although the federal government is the locus for most of the investment in quality measure development, many states—including Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Tennessee, Utah, and Vermont—have taken the lead in mandating and funding the creation of all-payer claims databases that would support public reporting and other value-based purchasing initiatives.[17]

Conclusions

Overall, our findings indicate that few stakeholders or experts doubt the value of past investments in public reporting made by the public sector and a wide range of private entities. Nevertheless, most agree that the public reporting to date has been disconnected from consumer decisions about providers.

At a time when cost control dominates the health policy agenda, it is more urgent than ever to engage patients as a force for improving value in health care. The challenge facing us today is to take advantage of advances in measurement, data collection, and information technology to deliver a more consumer-centered report card and to do so within the constraints of limited public funding and provider acceptability.

These tasks are further complicated by the simultaneous push by policy makers and payers for groups of providers to share financial accountability for episodes of care and populations, including the new accountable care organization arrangements under Medicare. Tensions will arise between the consumer tendency to focus on an individual physician as his or her salient choice for receipt of health care and the reality of the consequences that may flow from selecting a physician in the context of global payment.

The future of public reporting depends on its ability to become more relevant to consumers and help them navigate what, given these circumstances, is sure to be an increasingly complex delivery system. ■

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14 Shaller D, Kanouse D, Schlesinger M. Meeting consumers halfway: context-driven strategies for engaging consumers to use public reports on health care providers. Working paper commissioned for: AHRQ National Summit on Public Reporting for Consumers in Health Care; 2011 Mar 23; Washington (DC).
15 To access the Appendix, click on the Appendix link in the box to the right of the article online.
16 Full results of the survey are not shown but are available from authors upon request.
17 Love D, Custer W, Miller P. All-payer claims databases: state initiatives to improve health care transparency [Internet]. New York (NY): Commonwealth Fund; 2010 Sep [cited 2012 Jan 18]. (Issue Brief No. 1439). Available from: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Sep/1439_Love_allpayer_claims_databases_ib_v2.pdf

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In this month's *Health Affairs*, Anna Sinaiko and coauthors report on interviews with and survey data collected from registrants at the March 2011 National Summit on Public Reporting in Health Care, sponsored by the Agency for Healthcare Research and Quality. They note that public report cards on health care have not had the impact on consumers that had been anticipated, for various reasons. They reflect the views of those surveyed that report cards should now be redesigned to reflect advances in measurement, data collection, and information technology, increasing their usefulness to consumers in making their provider choices.

"No one felt public reporting efforts should be abandoned," says Sinaiko. But she and coauthors, colleagues at the Harvard School of Public Health's Department of Health Policy and Management, firmly believe that now is the time for stakeholders in consumer-directed health care quality reporting to come together and adjust their course.

Sinaiko has been a postdoctoral research fellow in the Department of Health Policy and Management at the Harvard School of Public Health since 2010. Her explorations of decision making in health care settings focus on the use of information and benefit designs to alter such consumer choices as provider selection. Sinaiko received her master's degree in public policy, with a concentration in health policy, from the Harvard Kennedy School and her doctorate in health policy, with a concentration in economics, from Harvard University.

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Meredith Rosenthal is a professor of health economics and policy in the Department of Health Policy and Management, Harvard School of Public Health. Her research examines the design and impact of health policy mechanisms intended to improve the efficiency of health care markets. She is particularly interested in the use of financial incentives, such as pay-for-performance, to alter provider and consumer behaviors. A member of the Massachusetts Public Health Council, which promulgates regulations and advises the state commissioner of public health on policy matters, Rosenthal completed her doctorate in health policy at Harvard University.