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Public reporting of hospital quality shows inconsistent ranking results



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ABSTRACT

Background: Evidence from the US has demonstrated that hospital report cards might generate confusion for consumers who are searching for a hospital. So far, little is known regarding hospital ranking agreement on German report cards as well as underlying factors creating disagreement.

Objective: This study examined the consistency of hospital recommendations on German hospital report cards and discussed underlying reasons for differences.

Methods: We compared hospital recommendations for three procedures on four German hospital report cards. The agreement between two report cards was determined by Cohen's-Kappa. Fleiss' kappa was applied to evaluate the overlap across all four report cards.

Results: Overall, 43.40% of all hospitals were labeled equally as low, middle, or top performers on two report cards (hip replacement: 43.2%; knee replacement: 42.8%; percutaneous coronary intervention: 44.3%). In contrast, 8.5% of all hospitals were rated a top performer on one report card and a low performer on another report card. The inter-report card agreement was slight at best between two report cards ($\kappa_{\max} = 0.148$) and poor between all four report cards ($\kappa_{\max} = 0.111$).

Conclusions: To increase the benefit of public reporting, increasing the transparency about the concept of – medical – “quality” that is represented on each report card seems to be important. This would help patients and other consumers use the report cards that most represent one's individual preferences.

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1. Introduction

Over the last decades, several public reporting instruments have been developed and introduced in the US and other industrialized countries [1–4]. Those instruments generally provide structural information and display

the adherence to clinical guidelines [5]. In addition, some report cards also include patients' experience scores; while some use the results of standardized offline surveys (e.g., HCAHPS; Hospital Consumer Assessment of Healthcare Providers and Systems), others allow users to rate hospitals online (e.g., RateMDs) [6]. The key aim of public reporting is to improve healthcare quality by both stimulating quality improvement on the provider level (“Improvement Through Changes in Care”) but also help patients and other consumers select the ‘right’ provider (“Improvement Through Selection”) [7]. While the published literature

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has confirmed the potential of public reporting to induce changes in clinical practice [8–10], little to no impact on the selection of healthcare providers has been demonstrated [9–11]. Regarding the latter, the literature has provided several reasons such as the lack of awareness about quality information, that the information is not what patients need or value, is not available when patients need it, or is not presented in a comprehensible way [4,9,12,13].

Recent studies have drawn attention to another challenge for consumers when using (multiple) report cards by demonstrating a low correlation between hospital ranking results from different report cards [14–17]. Instead of helping consumers find the best hospital, contradictory information might rather lead to confusion. These contradictions will likely lead to alienated, frustrated, and misdirected patients as well as referring physicians who search for hospital quality information. Also, it creates challenges for payers, since conflicting ratings make it difficult to recognize high-performers for purposes such as selective contracting. From a hospital leadership perspective, differences across rating systems also complicate decisions regarding the focus of quality improvement efforts [14,16]. It is therefore important to gain a scientific understanding of the magnitude of this phenomena, to learn more about the underlying reasons, as well as to derive recommendations for health policy makers on how to deal with this challenge.

In contrast to the US where public reporting has begun in 1984 when the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), began to publicly report the hospital mortality rates of Medicare patients [18], public reporting in Germany has a shorter history. The origin of public reporting here can be dated back to the year 2005, since when German hospitals have been required to publish structured quality reports (QR) at regular intervals. Those QRs contain information regarding hospital structure but also performance data as well as data from so-called German external quality assurance (see also Ref. [19] for a brief overview). Here, hospital treatment for selected interventions is documented for each patient based on a set of in-house related quality indicators. Currently, the assurance system comprises 400 quality indicators within 30 different clinical areas [20]. These data are then transmitted to a central external agency (AQUA Institute) or the corresponding state offices for quality assurance purposes. Performance results are fed back to each hospital so that they can assess their own quality outcomes against other hospitals in order to improve quality of care. Besides other objectives, these data can be used for public reporting purposes [19,21,22]. A recently published study could identify 18 report cards which publicly report on these quality data [23]. Besides this, other report cards (e.g., the AOK-Krankenhausnavigator) present hospital quality information based on routine data which enable a long-term perspective after hospital discharge (e.g., up to 365 days in prostate cancer treatment) [23,24]. So far, there is very scarce literature available on the effects of public reporting in Germany. For example, one recently published study has demonstrated an impact of public reporting on the quality of care by stimulating immediate and acceler-

ated quality improvement [19]. This study aims to narrow this gap of research.

In this article, we (1) determined the consistency of hospital recommendations for three medical procedures on four German hospital report cards. This means that we determined high, middle and low performers for each rating system and examined the overlap among those reporting systems (as suggested, our analysis expanded a smaller-scaled pioneer study which compared the hospital recommendations for hip replacement on three different report cards [16]). (2) Based on previous findings we hypothesized an inconsistency in hospital recommendations on different hospital report cards. Consequently, we presented possible underlying reasons and discussed from a health policy perspective whether and how to intervene.

2. Methods

Our investigation consisted of five steps: *First*, in line with the study by Austin et al. [14] we aimed at comparing hospital recommendations on those report cards which provide performance information by means of a summary score. We therefore conducted a systematic search procedure and subsequent analysis of German hospital report cards (not shown here in detail). Based on this, we included the following four hospital report cards in our analysis: AOK-Krankenhausnavigator, Qualitätskliniken, Weisse Liste, and Find The Best. Most of these report cards are non-profit, do not charge hospitals for being listed but provide different quality information about hospitals (Table 1). All report cards provide information from the German hospital quality reports (see above).

Second, in line with previous literature [17], this study focused on hospital recommendations of report cards for three non-emergency procedures that are both standard for public reporting initiatives as well as included in German hospital quality reports: hip replacement, knee replacement, and PCI (percutaneous coronary intervention), hip replacement (with 1229 hospitals listed in the German hospital quality report performing this procedure [20]), knee replacement (1.160), and PCI (percutaneous coronary intervention) (1053), respectively. Besides, hospital ranking results for the US were available for these procedures as well [17]. Other non-emergency procedures that are included in German hospital quality reports, like coronary artery bypass surgery (CABG) or Aortic valve surgery are less common (121). *Third*, we assigned hospitals on each report card into three performance groups (i.e., low performer, middle performer, and top performer) to evaluate the consistency of hospital recommendations between different report cards. For AOK-Krankenhausnavigator and Qualitätskliniken, a high performer is defined as a hospital given three life trees and three Qs, respectively. Analogously, hospitals with one life tree or one Q are identified as a low performer and those with two life trees or two Qs as a middle performer. As presented (Supplementary file 1), the Weisse Liste presents its results as the number of fulfilled quality criteria in relation to the total number of criteria, however, without categorizing the hospitals according to their performance. For our purpose, we defined top and low performers as those hospitals which are displayed in

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