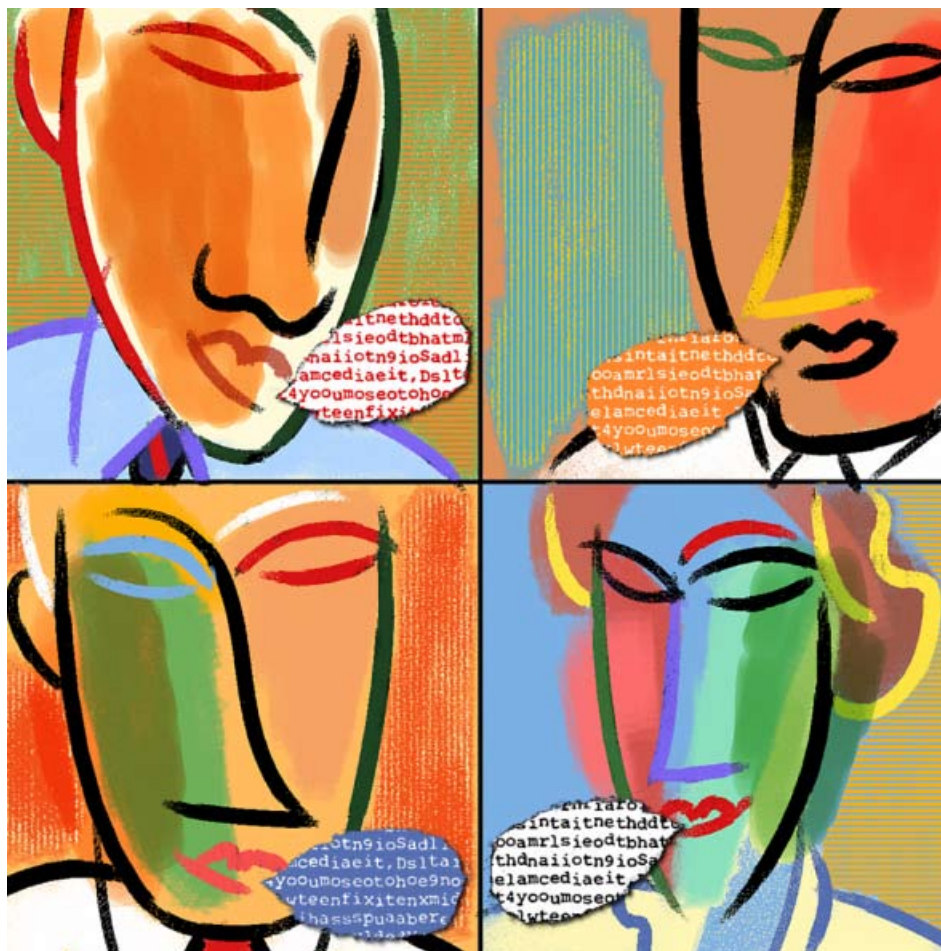




CALIFORNIA  
HEALTHCARE  
FOUNDATION



## Consumers' Priorities for Hospital Quality Improvement and Implications for Public Reporting

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# Consumers' Priorities for Hospital Quality Improvement and Implications for Public Reporting

*Prepared for*

CALIFORNIA HEALTHCARE FOUNDATION

*by*

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## About the Authors

Marjorie Ginsburg is the executive director and Kathy Glasmire is the associate director of the **Center for Healthcare Decisions (CHCD)**.

CHCD is a nonprofit, nonpartisan organization whose purpose is to advance health care that reflects the values and priorities of an informed public. CHCD specializes in designing and conducting deliberative processes to identify the societal perspective when health care resources are limited and trade-offs are inevitable.

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## About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at [www.chcf.org](http://www.chcf.org).

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# I. Introduction

WHAT ARE CONSUMERS' PRIORITIES IN TERMS of hospital quality, and does the public have a role in driving quality improvement efforts? These questions were posed in early 2010 by leaders working in the California hospital quality improvement arena. Since 2007, performance data from California hospitals have been publicly available on a Web site under the direction of a multi-stakeholder collaborative, the California Hospital Assessment and Reporting Taskforce (CHART).<sup>1,2</sup> Its goal is to improve the quality of care by motivating hospitals to take corrective actions in quality areas that are below par, and by prompting consumers to use the information when choosing a hospital.

Although public reporting of quality measures has been undertaken by various entities in the wake of the 2001 Institute of Medicine (IOM) report "Crossing the Quality Chasm," the public's use of hospital report cards has been minimal.<sup>3,4</sup> The authors of "Choosing a Health Care Provider: The Role of Quality Information," found no studies that "link the dissemination of information to consumers choosing higher quality providers."<sup>5</sup>

To help CHART leaders evaluate the usefulness of its work to consumers, the Center for Healthcare Decisions (the Center) conducted a study to:

- (1) determine how Californians view the relative significance of four IOM quality domains; and
- (2) identify the characteristics within these domains that are most important to consumers. The four domains studied are clinical effectiveness, patient safety, responsiveness to patients, and efficiency.

While there has been valuable research on how individuals experience hospital care and what is important to them, there is little information on how people as community members rank the different quality domains.<sup>6-8</sup> Peter Pronovost and Ruth Faden underscored the relevance of community input in a 2009 *JAMA* commentary. Writing about patient safety, they said "public engagement is essential to form effective and legitimate public policies that involve moral values and social tradeoffs."<sup>9</sup>

The study described in this paper was intended to help close the gap in information about how the public—in their dual roles as potential hospital patients and as community members—thinks about and uses quality information. The results are intended to help providers set priorities for corrective action and to provide new insights for those involved in public reporting. Following is a summary of the methodology and data summary, findings, and conclusions of the research.

## II. Research Methodology and Data Summary

THE CENTER CONDUCTED 11 DISCUSSION groups between June and September 2010 throughout California. Participants were asked to consider the two study priorities from two different vantage points:

- From the perspective of individual consumers; and
- From the perspective of the general public concerned about hospital services in their community.

A two-hour interactive small-group process that incorporated ranking exercises was used to understand how consumers prioritize quality indicators. The process focused on four of the IOM quality domains: clinical effectiveness, patient safety, patient experience, and efficiency.<sup>10</sup> The first three were reported on CalHospitalCompare.org and were typically components of other Web sites as well. For the project, the domain of “efficiency” was added at the request of purchasers and health plans concerned that hospitals do not necessarily demonstrate a higher quality of care that would justify higher-than-average costs.

The researchers created examples of hospital-based patient care that illustrated the different domains of quality. The exercise of ranking patient care problems from least to greatest concern was used to prompt participants to weigh competing priorities and then to explain their choices to others in their group.

To make sure the examples were easy to grasp to those with no hospital experience, cognitive testing sessions were conducted with two separate groups.

Based on this testing, the names of the quality domains were revised to be more accessible to a lay audience. The domain known as clinical effectiveness became Treatment Skill, efficiency became Good Value, and the patient experience was renamed Responsive to Patients.<sup>11</sup> The term patient safety did not change.

### Data Collection and Analysis

The discussion groups of eight to 12 people each were conducted in diverse locations in California: Chico, Fresno, Los Angeles, Oakland, Sacramento, San Diego, and Sunnyvale. Of the 108 participants, half had recent inpatient hospital experience. Health care workers were excluded. Recruiters aimed to include individuals of diverse ethnicity, education, and income. One session was conducted in Spanish with Hispanic residents; one with Medicaid beneficiaries; and one with individuals age 65 and older on Medicare. Participants received stipends ranging from \$75 to \$100, varying by custom and location. Nine were held in formal focus group facilities and the others in community settings.<sup>12</sup> The demographic characteristics of all participants are shown in Table 1 on the following page.

Experienced facilitators conducted the sessions and took detailed notes; the sessions were also audiotaped and transcribed. Project leaders analyzed the qualitative data by consolidating the meeting notes according to subjects and themes, validated by reviewing the transcriptions. The written responses to the ranking exercises provided the quantitative data for analysis.

**Table 1. Demographic Characteristics of Discussion Group Participants** (n=108)

AGE GROUP	PERCENT	HOSPITAL PATIENT IN THE PAST YEAR?	PERCENT
18 to 29	1%	Yes	51%
30 to 39	26%	No	49%
40 to 49	23%	<b>ETHNIC BACKGROUND</b>	
50 to 59	23%	African-American	18%
60 and older	27%	Asian/Pacific Islander	7%
<b>GENDER</b>		Caucasian	46%
Male	50%	Hispanic or Latino	25%
Female	50%	Other (Native American)	4%
<b>EDUCATION LEVEL COMPLETED</b>		<b>HOUSEHOLD INCOME</b>	
Less than high school	6%	Less than \$20,000	26%
Some high school	4%	\$20,000 to \$40,000	18%
High school graduate	27%	\$40,000 to \$60,000	25%
Some college	33%	\$60,000 to \$80,000	20%
4-year college degree	19%	\$80,000 to \$100,000	3%
Post graduate	11%	\$100,000 or more	8%

### Discussion Group Process

The three-part sessions were designed to gradually shift participants from thinking about hospital quality from their own experiences to considering quality priorities from the perspective of community members.

The facilitators began by asking participants to indicate the importance of hospital choice if they were to be a patient. The responses they gave (Table 2) became the basis for a semi-structured open-ended discussion about the hospital attributes they think about while describing why hospital choice is or is not an important feature of their health care.

**Table 2. Importance of Having a Choice of Hospital**

*Question: Imagine you need to be admitted to a hospital for tests and possibly treatment. Though this is not an emergency, you'll be in the hospital for a few days. Since there are several hospitals in your community, how important is it to you to have a choice about where you are admitted? (n=108)*

- 72%** If I were given a choice, I would request a certain hospital (or avoid a certain hospital).
- 26%** Choice of hospital is important to me but not essential.
- 2%** Choice of hospital is not important to me at all.

At the end of this discussion, participants reviewed short written descriptions of the four quality domains that would be the focus of the remainder of the session. These descriptions were:

- **Responsive to patients.** Does hospital staff meet patients' individual needs with clear communication, personal respect, and timely pain relief?
- **Patient safety.** Does hospital staff protect patients from harmful mistakes and avoidable accidents?
- **Good value.** Since patients sometimes pay part of the hospital bill, are the hospital charges reasonable compared to other hospitals?
- **Treatment skill.** Do doctors and nurses treat patients' medical problems in ways that medical experts have determined to be most successful?

### Prioritizing Quality Domains

Facilitators provided participants with a handout with each of the four quality domains illustrated by a patient vignette. Each participant ranked them in the order in which they would be of greatest concern if they or a family member were going to be in a hospital. Patient-specific examples were used to make it easier to visualize how these domains could actually affect individuals. The goal was to make the domains seem real and not simply an abstract concept.

The vignettes described examples of poor quality rather than high quality care, so that participants would understand how quality problems can be manifested in a hospital setting and what the consequences to patients might be. Participants completed their individual rankings on their handouts and then indicated their choices using an electronic audience response system. This approach provided an immediate composite ranking for each quality example, shown on a projection screen. Results were a visual indication of the relative importance of each of the four domains when evaluated by all the participants in that session (see Table 3). Participants then discussed their rankings.

### Table 3: Composite Results of Prioritizing the Four Quality Domains

*Instruction: Imagine that these examples were about you or someone in your family. Rank these types of hospital quality problems in the order of greatest concern to you (1 is highest, 4 is lowest). (n = 108, The numbers below represent the mean scores; the lower the score, the higher the priority.)*

#### 2.5 RESPONSIVE TO PATIENTS

George was 68 years old and in the hospital for serious kidney problems. Worried that he might lose all kidney function, he and his wife were frustrated when the doctors and nurses gave them no information about his condition, even though they asked repeatedly. They felt "invisible" and that no one there cared.

#### 1.9 PATIENT SAFETY

Joyce was an active 75 year-old who had her broken hip repaired. The surgery went well, but before she could go home, she developed a life-threatening infection because her urinary catheter had not been taken care of properly by the nurses. Transferred to the ICU, it took two weeks to recover. This slowed her recovery from the hip surgery.

#### 3.7 GOOD VALUE

33 year-old Barbara delivered her first baby, and everything turned out fine. But she was dismayed when she received her part of the hospital bill. She learned that this hospital regularly charges 25 percent more than other hospitals even though the medical care is the same. She will have to pay \$1,000 more than if she had been in another hospital.

#### 2.0 TREATMENT SKILL

49 year-old Frank suddenly was very weak on his left side. Rushed to the hospital, doctors said he had a stroke. After several delays, he received an IV that may reverse the stroke. But this hospital had a "poor" rating last year because there were frequent delays in stroke treatment. So Frank is less likely to recover from this stroke than are patients at other hospitals.

### Prioritizing Within Domains— "Drill-Downs"

In the last step of the process, participants had a chance to look more closely at the individual domains. This part of the session was intended to get a more nuanced understanding of the aspects of individual quality domains that were especially troublesome. It helped isolate quality characteristics that could be the basis for improvement activities. To adhere to the limited time available, each group



did the drill-down exercise with just two of the four quality domains. The four drill-downs were coupled in different ways among the groups. Table 4 shows all four of the drill-down exercises. Each one has three examples that participants ranked from 1 (highest priority) to 3 (lowest priority).

In the introduction to this task, participants were asked to imagine that the mayor appointed them to a local committee that is making recommendations to improve hospital care in their community. Their role was to advise on the order in which various quality problems should be tackled, keeping in mind the needs of everyone in the community.

**Table 4. Drill-Down Rankings of Problems, by Domain**

*Instruction: The mayor appointed you to a local committee that is making recommendations to improve hospital care in your community. This committee will help hospitals decide which quality issues should be tackled first. Read the three examples below and rank them 1, 2, and 3 in the order that you regard them as a priority for improvement, with 1 being highest priority. (The numbers below represent the mean scores; the lower the score, the higher the priority.)*

**RESPONSIVE TO PATIENTS (n=50)**

- 1.6 **Adding to patients' discomfort:** Hospital stays are usually difficult for patients when, for example, the patient's room is noisy, staff is slow to help patients who need assistance, or when pain medication is needed.
- 1.6 **Communicating poorly:** Sometime doctors, nurses, or other staff do not always keep patients or families well informed about their treatment, do not involve them in decisions about their care, or do not give clear information to help patients understand what is happening.
- 2.8 **Ignoring family needs:** Some hospitals know the importance of family presence and provide services to make it easier—such as an available cafeteria, a place to sleep if needed, convenient parking. When hospitals do not provide such basic services, it can make a stressful time even worse.

**PATIENT SAFETY (n=60)**

- 2.3 **Wrong meds:** Medication errors happen in different ways—the doctor writes the wrong dose; the pharmacist puts the wrong drug in the bottle; the nurse gives the wrong drug to the wrong patient. Some errors cause no harm or are easy to fix, but some cause lasting injury or death.

- 2.0 **Surgery mistakes:** Mistakes often occur in operating rooms due to inattention to detail. Surgical tools are left inside the patient, or a surgeon operates on the wrong part of or even the wrong patient. Mistakes are usually caught before harm is done, yet the impact on some may be significant.
- 1.7 **Preventable infections:** Patients can be exposed to infection in the hospital when equipment is not cleaned properly, when rooms are not carefully cleaned between patients, and when staff fail to wash their hands before and after they visit each patient.

**GOOD VALUE (n=48)**

- 1.5 **Delays and stalls:** Some hospitals do not provide care in an organized, efficient manner, e.g., the lab only runs certain tests once a day or communication is slow due to paper medical records. The result is wasted time, longer hospital stays, and higher costs, but without better patient care.
- 1.9 **Unnecessary treatment:** In some hospitals, doctors order more tests, scans, and procedures than are needed for excellent patient care, e.g., back surgery often does not get good results for seniors. Going through a needless operation may be wasteful, dangerous, and contribute to increased costs of health insurance for everyone.
- 2.6 **Pricey but not better:** Hospital charges vary considerably; in one a hip replacement may cost \$25,000 and another may charge \$40,000. If medical care is no better and results no different, these higher prices are not a “good value” for individuals who pay part of the cost or for companies that pay for health insurance for their employees.

**TREATMENT SKILL (n=58)**

- 1.9 **Diabetes complications:** Diabetes can lead to severe infections, requiring hospital care to prevent amputations. While some hospitals provide highly skilled diabetes care, not all hospitals control these infections, resulting in more patients having amputations that permanently affect their activities.
- 1.2 **Heart problems:** When patients with long-term heart problems need intensive medical treatment or surgery, some doctors and nurses are better than others in giving the correct treatments at the right time. When hospitals do not perform as well, their patients may develop worse heart problems or have a greater chance of dying.
- 2.9 **Knee replacements:** Knee replacement can make a big difference in controlling pain, allowing patients to walk normally, and be athletic again, yet not all hospitals perform at the same high standard. Patients with less-expert surgeons or not enough rehab therapy may have to get another operation or live with more limitations.

### III. Findings

WHEN PARTICIPANTS TALKED ABOUT HOSPITAL quality during the opening discussion of why choice of hospital is important, they presented a variety of hospital characteristics based on their personal experience. They mentioned issues such as clean patient rooms, thoughtful staff, close to home, good food, nurses who keep them informed, reasonable waiting times in ERs, attentive care, respect, and medical treatment that worked well. Most started with the assumption that physician care would be good; there were few references to patient safety problems that could threaten their health or to efficiency measures (good value) that could affect their pocketbooks. While all four domains were referenced in some fashion, the dominant themes of their experiences were those that were in the Responsive to Patients domain.

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*I assume the government is going to do their job, and shut them down if they're really bad.*

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As shown in Table 3, the quality domains of highest priority were Patient Safety and Treatment Skill, and many participants voiced how difficult it was to decide which of these two were more important. By contrast, Responsive to Patients was commonly the third choice, and Good Value was rarely deemed important. The descriptions below include the predominant reasons that participants

gave for ranking these four as they did, as well as the reasons for their priorities in the drill-down exercise (Table 4).

#### Patient Safety

Participants ranked the Patient Safety domain as the highest priority. Participants viewed safety, first and foremost, as “life or death.” While patient safety was rarely mentioned during participants’ initial discussion of hospital choice, once presented as a quality domain, it generated considerable discussion. It is one thing to have the doctor provide less-than-ideal care, but consumers did not want to come out of the hospital worse than when they entered. Those who gave safety the highest ranking tended to believe that more harm could come to patients from mistakes than from poor treatment skill and that there were more opportunities for safety measures to “go wrong.” Participants also saw this as an area where they had very little control, which intensified their conviction that these problems must be mitigated as quickly as possible.

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*You know, if something's wrong, and they're on the road to recovery, and something else becomes wrong because of somebody screwing something up? No! That is really, really not okay with me.*

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*But the reality is you can get over bad feelings, you can get over paying extra money. The ones where it has long-term, possibly, permanent ramifications, to me, are the most serious. They must rank top.*

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When Patient Safety was examined during the drill-down exercise, the three types of safety problems (see Table 4) brought intense debate. The scores were very close because participants regarded all three as dangerous and saw the potential for any patient to be affected. Although Patient Safety seemed to be a novel concern for most of them, participants grasped the significance of these problems more easily than they did, for example, Treatment Skill. While participants debated which of the three types of safety problems were most harmful, there was considerable consistency in the characteristics they regarded as problematic. The high-priority problems were those that 1) can have a devastating impact on the individual patient; 2) can affect a large number of patients; 3) are those over which patients have little control or influence; and 4) are easily correctable.

For example, preventable infections were on average a higher priority than wrong medications because participants believed they had greater potential for harming more people. Although surgical mistakes were sometimes viewed as potentially more catastrophic to the individual patient than the other examples, participants also thought they probably happened less often than other safety problems.

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*The surgery mistakes sound like they're the most preventable by just following the damn stupid checklist.*

*But surgical mistakes, that's more human error. There's a lot of hands that have to travel through for someone to receive wrong meds— from one end to the other.*

*Preventable infections, kind of acts like a pyramid. If one person gets it, that person is going to spread it on to several other people. Whereas the other two, it really only affects that individual.*

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### **Treatment Skill**

Some saw Patient Safety and Treatment Skill as closely aligned, even inseparable, and participants struggled over which one was the higher priority. Those who viewed Treatment Skill as higher commonly noted that it is the main reason a person goes to the hospital, thus it is always the aspect of hospital care that has highest priority. Others who ranked this one higher felt poor Treatment Skill had a greater (and more lasting) impact on the patient's medical well-being than the other domains, and without good skill nothing else seemed important. When it was not highest priority, it was because they

regarded Treatment Skill as the responsibility of the doctor, not the hospital.

Although the examples describe Treatment Skill as a medical team responsibility, most study participants still assumed it was the individual physician who controlled this. While some participants knew specific examples of low-quality Treatment Skill, this domain did not have the intensity of discussion of others. As one person put it, “we don’t always know when the skill isn’t good.” Thus, although Treatment Skill was critically important, it may not be what worried them the most. As many participants noted, “We start with the assumption that we will get good medical care.” A number of people regarded poor Treatment Skill as more likely to be a result of simple human error and thus more forgivable. This was in contrast to Patient Safety where they regarded these errors as a function of sloppy, inattentive actions that should be easy to correct.

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*I rate Treatment Skill first, and Patient Safety second.... I feel like Treatment Skill is dealing with what you have, so that’s a concrete thing, “I have this problem, I’m going to the hospital for it.” Now, Patient Safety, to me, seems like accidents. Maybe I’ll have an accident, maybe I won’t. It’s more of a risk assessment for me.*

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The participants that addressed the Treatment Skill drill-down were far more in agreement about priorities than were those assessing the Patient Safety examples. As shown in Table 4, the heart example ranked highest. Participants were quite consistent in their belief that the heart was the key to life and that everything else was subsidiary. They also believed that hospitals’ most important function was to save lives, and since heart problems were often emergency situations—when patients had no choice of hospital—this was their highest priority. The other medical scenarios were usually elective and patients had time to shop around. With a heart attack, patients had to hope that the closest hospital was capable of handling their medical crisis.

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*Death, dismemberment, and discomfort.*

*You’ve got to go in the right order.*

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Yet 21 percent of participants gave diabetes complications the highest ranking. Their reasons included that diabetes was just as life-threatening as heart disease; it leads to many other health problems; they believed it affects more people; and many with lower socio-demographic characteristics are impacted. By comparison, knee replacements were deemed virtually inconsequential. While acknowledging the frequency of this operation, participants viewed this nonetheless as an optional service; patients would not die if treatment skill was not optimal; and patients had responsibility for researching which doctors and hospitals provide good quality care.

## Responsive to Patients

Study participants commonly mentioned problems related to this domain in the initial discussion about choice of hospital, yet they ranked this domain third (out of four) in importance. They still regarded this domain as a high priority, but it did not rise to the same level as Patient Safety and Treatment Skill — both of which had a tangible impact on the physical health and well-being of patients.

Nevertheless, those who ranked it at or near the top often had particularly vivid stories of poor care. Typical comments: “This is what you remember about being in the hospital, when they treat you like cattle;” “If I can’t ask the doctor questions, how am I going to have confidence?”; and “I go to the hospital for treatment; I don’t want to be put in the corner and ignored.” Despite their strong familiarity with the topic, most still ranked it lower than skill and safety and acknowledged they were doing so. “You have some control over this — you can scream and jump up and down — but you have no control over Treatment Skill or Patient Safety.”

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*I put down number 3 on Response to Patients, but that bothers me more than the other things. Now, it’s not more important, but if I’m not treated with respect, that bothers me more than anything.*

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The three types of problems shown in Table 4 elicited a debate about physical and emotional well-being and their relevance to patients. Whereas many believed that physical discomfort has a great impact on patients’ ability to recover quickly, others were just as passionate that communication is key to patients feeling they are in control of the situation. For many, the inclusion of timely pain medication in the example of patient discomfort brought this problem to the top of their list. Many viewed physical needs as more important than other forms of discomfort. Although the Patient Safety discussion elicited the most animated concern regarding the well-being of patients, Responsive to Patients brought forth many examples and experiences that clearly had long-standing impact on the individuals affected.

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*You never hear so much about all the good experiences. But when somebody’s had a bad experience, you remember that hospital.*

*It’s hard to describe when you haven’t been in that position. Because exactly what (he) is describing, when the little things don’t work for you, then you don’t trust the system.*

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There was little doubt that the needs of the family were secondary to those of the patient. Even those who had extensive experience as family members of hospitalized patients felt strongly that all the effort should be put towards helping the patient get well, not “coddling” the family.

One interesting observation was that participants in the Spanish-language and Medicare sessions ranked Responsive to Patients higher than did other demographic groups. This domain perhaps speaks to the particular vulnerability of these populations in the hospital environment.

### Good Value

With only a few exceptions, participants ranked Good Value the lowest of the four quality domains in terms of importance to them as patients and consumers. Even those who had experience with high out-of-pocket expenses believed that this is much less important than the other three domains. Common comments were, “You can’t compare life with money” and “It doesn’t matter how much you pay if you get good treatment.” One participant complained, “Why is this even on the list? We are talking about life and death, not talking about money!” Some believed that higher costs were associated with better care or that there might be justifiable reasons that the hospital had to charge more. In particular, they put the responsibility on the patients to research the cost question in advance.

Yet not all participants were dismissive of this domain. Recognizing that some people may not have generous health plans, an individual’s share of cost might be very important to them. Noted one participant wryly in reference to affordability, “The quality of the care isn’t going to matter if you are not getting treated.” While the Spanish-speaking Hispanic group also agreed that this was a lower priority than the other domains, these participants

had the most examples of problematic cost-sharing as a factor in choosing a hospital.

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*And it’s easy to say [not to consider the expense] if we’re privileged enough to not have to worry about paying for anything. Or that I can go anywhere and receive the best quality care. But, in this area, and across the country, there are a lot of people that don’t get that option.*

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When given the opportunity to look at specific examples of Good Value problems, participants did not disregard these as meaningless. Yet the rationale for their rankings of these examples continued to be oriented to patient care rather than unjustified costs.

The problem “pricey but not better” was the lowest priority because its impact was solely related to the cost of the care, with no obvious clinical detriment to the patient. Both “delays/stalls” and “unnecessary treatment” suggested that patients may be adversely affected by these examples of poor value, and these were the issues that concerned participants the most. Interestingly, “unnecessary treatment” was the only one that explicitly cited examples of possibly harmful care—yet “delays/stalls” ranked higher. While some participants provided testimony of the wastefulness and potential harm of unnecessary treatment, others voiced skepticism that “too much treatment” is a bad thing, and they

would rather risk too much care than not enough. It was clear, however, that the main aspect that participants focused on was the effect the examples had on patients' health and well-being. Financial considerations alone were not of high interest.

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*When it says, for example, back surgery*

*“often does not get good results....”*

*But you know what? I'm suffering!*

*I'll use this just as an example:*

*Veterinarians. I have two vets by my house. One charges about triple what the other one charges for everything.*

*But they both do fine work.*

*The more costly the hospital, the greater chance of better care.*

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Although Good Value was consistently the area of lowest concern, most participants still felt it was appropriate to have hospitals improve this quality domain. While many with health insurance will not regard this as a critical element for their decisionmaking, patients without insurance (or with high deductibles or coinsurance) may find reporting on this domain useful.

## Study Limitations

It should be noted that the research had certain limitations due to the small sample size, relatively brief duration of sessions, and difficulty that a small minority of participants had in understanding the domains. Nevertheless, the vast majority understood what was being asked and responded with clarity, consistency, and logic. The discussions were animated, relevant to the issues, and reflected considerable consumer interest.

The sessions' two-hour time frame meant that many of the nuances of what constitutes an important quality problem—such as how often these problems actually occur, the extent to which problems result in significant patient harm, and populations that are disproportionately affected—were not presented to participants in the descriptions. Detailed in-depth deliberative discussions would likely require a multi-session format with community members over a longer period.

## IV. Conclusions

LIKE ALL HEALTH CARE STAKEHOLDERS, hospitals must decide where to put their time and resources to measure and improve quality. The priorities voiced in the research groups have implications for those developing quality improvement standards and those whose role is to share quality information with the public at large. Following are some conclusions and suggestions for hospitals and reporting organizations.

### Target Improvement Efforts to High Priority Domains

In establishing their priorities for QI, hospitals should keep in mind the two domains that the public regards as highest priority: patient safety and clinical effectiveness. Particularly important within those two domains are: emergency, life-saving clinical care; safety problems that may affect many patients; and clinical or safety problems that could have a devastating impact on individuals. Consumers are particularly concerned about those quality issues where they feel there is little they can do as patients to control them (such as hospital infections).

While the patient experience ranked lower in priority, it is the quality domain that patients know about personally, and it affects their perception of the total quality of care. It may not be as important as patient safety and clinical effectiveness, but it is the most visible domain and should be carefully tracked.

### Spotlight Patient Safety

Reporting organizations should emphasize the significance of patient safety by reporting it as a separate and distinct quality domain, underscoring that it is as relevant to good patient care as is clinical

effectiveness. Hospitals may not be anxious to put a spotlight on patient safety, but helping consumers appreciate the importance of this domain means giving it the attention that is warranted.

### Use the Term “Quality” with All Domains

While the IOM specified that quality care has six attributes, many reporting organizations’ Web sites and communications only use the term “quality” in association with clinical effectiveness. We found that, like the IOM, consumers regard the domains of clinical effectiveness, patient safety, and responsive to patients all as quality issues; Web sites and other communications should do so as well.

### Consider Efficiency Carefully

While consumers seemed least enthusiastic about the efficiency domain (and do not consider it a “quality” issue), purchasers and health plans are not likely to ignore it. If rising health care costs increase patients’ hospital cost-sharing burden dramatically, this quality domain may gain greater consumer attention. Discussion group participants also suggested that efficiency information is more valuable at the time of open enrollment; bringing potential cost-sharing issues to consumers at that time might have a bigger impact.

### Elicit the Public’s Voice

This study sheds light on consumer priorities across hospital quality domains, but there are foundational issues that also need a deliberative public process. As health care costs continue to soar, identifying priorities for QI must take into account the relative



costs and benefits of alternative approaches. State or national organizations with a broad focus on QI will need to take the lead in eliciting public input on some of the more nuanced trade-offs such as: How to balance great harm to a few versus lesser harm to many; how to remedy quality problems that disproportionately affect certain populations; how to weigh very costly remedies against other needs in terms of resource use. The public should be key participants in conversations about these ethical and societal health care dilemmas.

## Endnotes

1. CHART is a nonprofit organization formed by leaders from health plans, hospitals, purchasers, and consumer organizations with initial funding from California HealthCare Foundation. It reports hospital quality measures on the Web site [www.calhospitalcompare.org](http://www.calhospitalcompare.org).
2. For the most part, the hospital data shown on the Web site are gathered from state and national sources. CHART has responsibility for what is collected and how it is collected, following widely accepted standards for accuracy and objectivity. The Web site—[www.calhospitalcompare.org](http://www.calhospitalcompare.org)—is operated by the California HealthCare Foundation in collaboration with CHART.
3. Institute of Medicine, “Crossing the Quality Chasm: A New Health System for the 21st Century,” see [www.iom.edu](http://www.iom.edu).
4. Kaiser Family Foundation, Agency for Healthcare Research and Quality. “Update on Consumers’ Views on Patient Safety and Quality Information, 2006.” Available at [www.kff.org](http://www.kff.org).
5. Harris, K.M., M.B. Buntin. “Choosing a health care provider: The role of quality information,” The Robert Wood Johnson Foundation. Research Synthesis Report 14, May 2008. pg.11 [www.rwjf.org](http://www.rwjf.org).
6. Sofaer, S., C. Crofton, E. Goldstein, E. Hoy, J. Crabb. “What do Consumers Want to Know about the Quality of Care in Hospitals?” Health Research and Educational Trust, DOI: 10.1111/j.1475-6773.2005.00473.x
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9. Pronovost, P.J., R.R. Faden. “Setting Priorities for Patient Safety: Ethics, Accountability and Public Engagement.” *JAMA*. 2009; 302 (8):890–91.
10. According to the IOM report, health care must also be timely and equitable.
11. This domain directly reflects patients’ responses to their hospital care. Hospital ratings on this are based on a national standardized survey called Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), conducted under the auspices of the Agency for Health Care Research and Quality. See [www.cms.gov](http://www.cms.gov).
12. When sessions are held outside the geographic territory of the recruitment firm, community organizations are used to find appropriate participants and to host the sessions.



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