

A Lack of Standardization: The Basis for the Ethical Issues Surrounding Quality and Performance Reports

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EXECUTIVE SUMMARY

Consumers in the United States are taking advantage of the proliferation of publicly available, internet-based performance reports and quality appraisals of health plans, healthcare organizations, hospitals, and physicians to aid in their healthcare decision making. However, these appraisal practices have given rise to controversy and debate over certain distinctive ethical issues. This article advocates a standardized ethical framework to guide current and future development and implementation of performance reports. This framework, which would resolve a number of the major issues, includes the following ethical principles to guide the practice of public reporting on the Internet and facilitate enhanced quality improvement in the healthcare industry: legitimacy, data integrity and quality, transparency, informed understanding, equity, privacy and confidentiality, collaboration, accountability, and evaluation and continuous improvement.

For more information on the concepts in this essay, please contact Ms. Suchy at kbv22@unh.edu. Ms. Suchy is the first-place winner of the undergraduate division of the 2010 ACHE Richard J. Stull Student Essay Competition in Healthcare Management. For more information on this competition, please contact Reed L. Morton, PhD, FACHE, at (312) 424-2800.

PREAMBLE

Though public disclosure of performance reports plays a role in improving the quality of healthcare and strengthening patient autonomy, such reports are criticized for lacking standardization and using inaccurate data. Yet, no matter how high the competing arguments rank in the hierarchy of the nation's ethical obligations, improving healthcare quality generally remains the primary goal of advocates and critics alike. As this is also the goal of quality improvement (QI) tools such as performance reporting and similar quality measuring, more must be done for patients, providers, and payers to truly derive the intended benefits of these efforts.

So, the question remains: Just how can this be accomplished? The answer may be found by addressing the major weakness of this QI tool—its framework (or lack thereof). By implementing a standardized and ethically sound framework to guide the practice of reporting on performance and quality measures, many of the current ethical issues would be resolved. As such, the framework should include the following principles to guide the practice of public reporting on the Internet: legitimacy, data integrity and quality, transparency, informed understanding, equity, privacy and confidentiality, collaboration, accountability, and evaluation and continuous improvement.

While this article reviews several of the leading ethical issues surrounding performance reporting on the Internet, its overall intent is to present a possible solution that will (1) drive the improvement of healthcare quality and (2) reduce the competing ethical concerns

that surround performance reporting. It offers suggestions to guide the current and future development and implementation of performance reports. It attempts to frame the issue by providing background information on the practice of performance reporting. It describes popular Internet databases and websites that currently influence American healthcare consumers and references several pertinent scientific studies that have addressed the utility and impact of publicly disclosed performance reports. In doing so, this article purposely makes reference to existing ethical standards and codes of conduct applicable to the Internet, to the healthcare industry, and to some of the legislative initiatives that have been taken thus far. The article concludes with recommendations for the future of quality reporting and further suggests how the continued absence of a sound ethical framework will affect its development.

CONTEXT

Identified quality gaps in the U.S. healthcare system have led to the introduction of QI initiatives. Though progress has been made, the nation is still struggling to determine the soundest and most reliable metrics to gauge the effectiveness and efficiency of processes and outcomes (Finlayson et al. 2002; Clarke and Oakley 2007). Additionally, finding a way to properly measure quality and cost of healthcare continues to be a problem. Such challenges have been especially prominent in performance reporting and appraisals of quality. Nevertheless, performance reports are still widely disseminated, especially with the American public's

ever-increasing use of the Internet (Leonardi, McGory, and Ko 2007).

Though public disclosure is generally viewed in a positive light, the validity and quality of the information generated by reports available on the Internet is subject to competing arguments. Critics heavily scrutinize the data and purport that it is often flawed. Yet, the public has access to little information that reinforces or negates these arguments (Krumholz et al. 2002; Walther, Wang, and Loh 2004), especially because websites that report on quality and performance measures have been subject to little regulation (Fung et al. 2008). Similarly, no agreed-upon framework exists to guide the development and implementation of these reporting systems (Richard, Rawal, and Martin 2005). Even so, this does not counteract the demand of consumers, who show no signs of slowing their search for quality information on the Internet (Leonardi, McGory, and Ko 2007).

THE NATURE OF PERFORMANCE AND QUALITY REPORTS

In response to the Institute of Medicine's (IOM) 1999 report on medical errors and the public's demands for increased transparency, the nation has witnessed a proliferation of web-based public report cards and ratings systems (Komaroff and Gharib 2004). Public report cards¹, also referred to as league tables, rate and compare distinct quality measures of care and outcomes of hospitals, physicians, and managed care plans (Krumholz et al. 2002). While websites that rate healthcare quality and

performance abound (Scalise, 2001), so, too, do variations in how quality measures are used, methods employed to generate them, and platforms used to communicate them to the public.

As Figure 1 shows, measures of quality are derived from three major categories as they relate to patient care: structure, which denotes the characteristics of a healthcare setting; process, which refers to the activities surrounding the provision and reception of care; and outcomes, the clinical and financial results of providing distinctive treatments and the patient's satisfaction level with his or her overall experience (Ireson et al. 2002). Typically, report cards reflect the measurement of outcomes, while hospital performance and quality measures for specific indicators reflect the measurement of processes.

The data on which quality ratings and reports are based come from various sources. Administrative and clinical data, data measured by the Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Health Plans Survey (Epstein 2000), physician surveys, customer satisfaction scores, mortality and outcome data from Medicare (Komaroff and Gharib 2004), self-reported adverse events, and MEDPAR data are all used in varying modes and amounts. Figure 1 clearly reveals a lack of consistency in the data used to generate ratings reports, even among systems that are rating the same items.

Over the years, the range of organizations known to produce such evaluations has broadened to include federal and state agencies, accreditation organizations, consulting companies, for-profit

FIGURE 1
Selected Healthcare Quality and Performance Reporting Programs Accessible Via the Internet

Organization	Type	Website (www.)	What's Rated	Indicators Used to Base Ratings	Public Access Charge
The Joint Commission	Federal	jcaho.com	Multiple care settings	Mortality data Patient safety practices	Free
Centers for Medicare & Medicaid Services (CMS)	Federal	cms.gov	Hospitals and nursing homes	Mortality data Morbidity data	Free
National Committee for Quality Assurance (NCQA)	Federal	ncqa.org	Health plans	Health plan employer data and information data set (HEDIS)	Free
Consumer Checkbook	Non-Profit	checkbook.org	Hospitals, top physicians, health plans	Physician surveys Mortality data Adverse outcome rates HEDIS data	Fee-Based
Consumer Reports Health	Private	consumerwebwatch.org/health-resources.cfm	Hospitals	Consumer satisfaction	Fee-Based
U.S. News and World Report	Private	usnews.com	Top hospitals and health plans	Mortality data NCQA data	Free
Health Grades, Inc.	Private	healthgrades.com	Hospitals, physicians, nursing homes, and others	Patient discharge info (i.e., MEDPAR data)	Fee-Based
Leapfrog Group	Private	leapfroggroup.org	Hospitals	Surveys of safe practices	Free
Select Quality Care	Private	selectqualitycare.com	Hospitals	MEDPAR data State-payer data	Member only

SOURCES: Data from Carlisle (2007), Komaroff and Gharib (2004), and Scalise (2001).

healthcare information companies (Krumholz et al. 2002), employer groups, health insurers, and even newspapers (Komaroff and Gharib 2004). Additionally, several private companies have capitalized on the public availability of quality information and have made a nice little business out of collecting and assembling that information (Komaroff and Gharib 2004). As such, the public can usually access this information for a fee, while information reported by federal and state agencies is typically free.

Quality and performance reports can be organized and presented in different ways, especially when the Internet is used as a platform. Some quality measurement programs express their ratings using category-specific performance dimensions based on five-point ordinal scales (Labig 2009) or five-point star ratings. Others simply rank hospitals or health plans from best to worst or allow consumers to compare several hospitals and their measures against one another.

A PRESSING ISSUE

According to the Society for Healthcare Strategy and Market Development (2009), the increasing demand for publicly available data on quality and outcomes, patient satisfaction, and costs will generate unprecedented competition within the healthcare industry. Similarly, healthcare organizations will increasingly use the Internet for promotional purposes and to claim superiority over their competition by referencing report cards, quality ratings and rankings, and additional statistics and measures. The trend of public disclosure will significantly affect the expectations and behaviors of health services consumers

and shift social and professional expectations about accessing and sharing health information and performance data (Maddox 2003).

MAJOR ETHICAL ISSUES REVIEWED

Informed Consent

The healthcare market continues to follow its consumer-driven trend, which relies heavily on transparency. Performance and quality reports are expected to drive accountability of healthcare service providers, accelerate quality improvements, and stimulate consumers and purchasers to seek high-quality healthcare (Marshall, Hiscock, and Sibbald 2002). Public disclosure of quality information helps consumers make responsible and informed healthcare decisions.

Information on healthcare quality has already substantially affected both providers' and consumers' behavior (Bates and Gawande 2000). This seems to be true for consumers even though they cite varying levels of confidence in their ability to choose the "best" hospital, physician, or private practice (Runy 2000). Such reasons lead critics to argue that the report cards do not effectively guide healthcare decision-making. Instead, many would argue that due to the lack of a standard definition of quality, these quality measurement programs do more to confuse the issue than to clarify it (Scalise 2001).

Quality and Utility

Though many websites purport to rate healthcare quality, much criticism is aimed in their direction. Some critics assert that the website comparisons in

question “are based on faulty methodology, misplaced assumptions, and just plain bad data” (Scalise 2003). Report cards and the process by which their results are generated is not currently an exact science, and the results are criticized for not being sufficiently comprehensive (Sisson 2003). Different report cards use different measurements, which results in not only vastly dissimilar rankings for the same facility (Sisson 2003), but altogether inaccurate and incredible data that cannot be compared with a different report that claims to measure the same quality indicators. Though noteworthy progress has been made in the field of quality improvement, there is still no easy way to summarize quality or to present quality information in a way that is useful to all healthcare consumers².

Legitimacy

Mortality data is just one type of information that is difficult for most consumers with an average medical knowledge base to interpret (Scalise 2003; Sisson 2003). Consumers tend to be intimidated by quality information because they cannot understand it, while regulators and purchasers prefer that the data be presented this way (Scalise 2001). Those who generate and present performance and quality data must ensure that all stakeholders perceive their reports to be legitimate (Richard, Rawal, and Martin 2005).

Consistency and Timeliness

Websites use various measurements to assess performance and generate reports. Curiously, even among the most potentially credible quality ratings

databases³, no standardization exists in *what* data is reported or *how* the data is reported. The data on which reports are based varies (as presented in Figure 1), and some of the information used is years out of date due to a lag in its release by government agencies (Komaroff and Gharib 2004).

Practical problems also exist. For example, participation in reporting quality information is often voluntary⁴. Furthermore, use of data from different years attracts scrutiny and judgment, and questions arise regarding the standard of care at the time the data was recorded (Mitka 2009). These factors relating to timeliness and inconsistency alone exacerbate skepticism about the accuracy and consistency of performance reports.

Motivation

Another issue of quality ratings involves the ethics of individual raters. The increased demand by consumers for public reports has given certain companies incentive to disseminate them, which has further increased the sale of magazines and advertising space (Mitka 2009), for example. Opportunistic, private companies have created a profitable business collecting and assembling performance data. Specifically, Health-Grades.com has been criticized for charging a large but undisclosed licensing fee to hospitals that wish to publicize the website’s ratings (Scalise 2003). Instances such as these raise questions about a rater’s motives; some seem to be rooted in self-interest rather than the sole desire to inform the public.

However, those who oppose this criticism have rationalized that the

efforts of Healthgrades.com, for example, are well intentioned and that their practices are consistent with those of other agencies and corporations that generate and disperse report cards (Naylor 2002). They contend that their efforts are grounded in providing an education source for consumers and promoting patient safety.

REVIEW OF RELEVANT POLICY INITIATIVES

In 2002, the Internet Healthcare Coalition (IHC), a nonprofit organization dedicated to ensuring quality healthcare resources on the Internet, made strides in addressing the credibility of quality reports and ratings available on the Web. Through their collaboration with a number of other interested parties, the IHC has written and implemented an International e-Health Code of Ethics, which sets forth eight principles to guide behavior: candor, honesty, quality, informed consent, privacy, professionalism in online healthcare, responsible partnering, and accountability (Marwick 2000; Maddox 2003). Even with the code in place, enforcement remained difficult, as simply not every website could be monitored (Marwick 2000). Several institutions began to independently define the content of their online medical information, and guidelines were crafted using the input from a wide variety of sources (Marwick 2000).

Currently, major sources that have published public reporting guidelines, recommendations, or principles include the American Medical Association (AMA; 2005), Massachusetts Medical Society (Auerbach et al. 1999), RAND

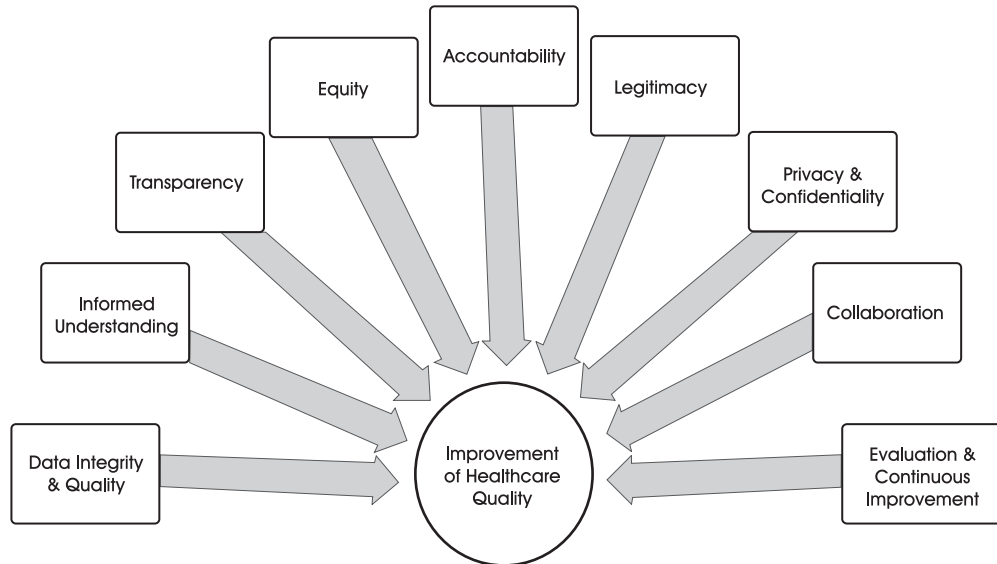
Corporation (Leatherman, Marshall, and Shekelle 2000), and the AQA Alliance (2006). The AMA has also developed guidelines specific to content, advertising and sponsorship, privacy and confidentiality, and e-commerce (Marwick 2000). Gormley and Weimer (1999) developed a normative framework from which to develop organizational report cards. Marshall, Romano, and Davies (2004) created similar strategies to enhance the impact of healthcare report cards. However, though most of the themes found in these guidelines sought to address the ethical issues surrounding performance and quality reporting, they were not derived from accepted ethical theory (Richard, Rawal, and Martin 2005).

PROPOSED ETHICAL FRAMEWORK

Existing quality reports and ratings lack standardization. They also lack a uniform ethical framework. For quality information to positively impact industry performance and consumer awareness, the practice of generating quality information should be standardized and homogeneous. This is especially important for third-party sources and Internet databases that report quality information to the public. Standardization would help ensure that valid quality information is being disseminated to consumers in an ethical way.

Little work has been done thus far to construct an ethical framework that would specifically guide the development and implementation of healthcare performance and quality reports, especially as this behavior relates to the Internet. Therefore, I have drawn from

FIGURE 2
Proposed Ethical Framework and Ten Guiding Principles to Public Quality Reporting



SOURCE: Adapted from American College of Cardiology Foundation (2008); Carlisle (2007); Labig (2009); Richard, Rawal, and Martin (2005); and Ruger (2008) ⁵

the results of existing research to support the inclusion of each element of the proposed framework.

The proposed ethical framework illustrated in Figure 2 includes nine guiding principles, all of which are directed toward attainment of the tenth and central principle—the improvement of healthcare quality. Each principle is interrelated and overlapping, which is why all must be present in order to maximize the efforts to improve healthcare quality reporting. Each of the principles is outlined as follows:

1. **Legitimacy:** Quality and performance measures should meet the needs of stakeholders and therefore should include clinical indicators of quality and indicators deemed important by the consumer (i.e., patient survey results, customer satisfaction).
2. **Data Integrity and Quality:** The data included in report cards and similar quality reports should be held to the highest standards of accuracy. They should be free of bias and disseminated by an objective third party. All data should be risk adjusted according to a standardized method that is publicized and easy to replicate. Reports should be valid and easy for the average consumer to understand. The data should provide utility to all stakeholders and should be compatible with other quality reports and ratings of comparable institutions.
3. **Transparency:** Quality and performance information, along with

notable strengths and weaknesses of distinctive processes and outcomes, should enhance transparency. It should lend itself useful to holding rated organizations accountable for the quality of care delivered.

4. **Informed Understanding:** The reports should educate consumers on multiple levels of healthcare quality. Information should be comprehensive, reliable, relevant, and useful to the consumer. Additionally, consumers should have access to information that will validate the integrity of websites that rate quality and performance.
5. **Equity:** The dissemination of information should be equitable and equally accessible to all public consumers. It is strongly suggested that the information be made available free of charge.
6. **Privacy and Confidentiality:** Medical data is commonly used in the generation of quality reports, and the move toward electronic records of such information deepens concerns about protecting the privacy and confidentiality of individual patients' healthcare information. Therefore, the practice of quality reporting should be highly secure, with established protocols and procedures in place in case of a breach, and continually monitored for unauthorized access.
7. **Collaboration:** Collaboration should exist among multiple stakeholders, including physicians, patients, and reporting agencies. Data should have the ability to be

shared and merged among raters, so as to maximize all QI efforts, including transparency and the quality of data.

8. **Accountability:** Public disclosure efforts should encourage accountability from healthcare professionals, consumers, raters, and the regulators of the system. For example, performance-rating and quality-ranking websites should provide accurate and truthful information and a public oversight mechanism should hold these parties accountable for unethical behaviors.
9. **Evaluation and Continuous Improvement:** The system should be continuously monitored for utility, efficiency, and effectiveness as these factors relate to healthcare quality improvement. Organizational ethics committees and relevant government agencies should monitor the system for possible misconduct.

FUTURE IMPLICATIONS

The United States should not expect the dissemination of public reporting to subside anytime soon. If it is not corrected, the lack of standardization in performance metrics may well have deleterious consequences in the future, which will only hinder the original intention of QI and its tools. Report cards and QI-related tools have been cited as increasingly necessary to compete in the healthcare marketplace (Ireson et al. 2002). The proliferation of quality-rating sites paired with the increasing frequency with which employers and consumers consult

them to gauge who provides the “best” care allows raters—and not those on the front lines of care—to define what constitutes healthcare quality (Scalise 2003). As such, the nation must realize the urgency of this matter and institute a standardized framework to improve the practice of public reporting.

NOTES

1. Public report cards are also known as and have been commonly been referred to as “hospital comparisons,” “outcome report cards,” “organizational performance report cards,” hospital and physician “profiles,” “quality and performance measures” of individual physicians and nonprofit and freestanding organizations, individual “physician ratings,” and other terms.
2. To name one example, most outcome data—and specifically mortality data—is of debatable quality due to the need for proper risk adjustment (Sisson 2003). Though patient volume is a common measuring tool in judging quality, this relationship does not pass perfect correlation eligibility standards by any means (Komaroff and Gharib 2004).
3. For example, those federally run practices and databases such as Hospital Compare by CMS, Health Ratings Center by Consumer Reports, Quality Check by the Joint Commission, and Leapfrog Hospital Ratings by Leapfrog, just to name a few.
4. In 2006, only thirty-seven states and the District of Columbia had mandatory reporting systems in place for inpatient data, while ten states had made reporting voluntary (Steinbrook 2006).
5. Perhaps most notably influential in the proposed ethical framework is the work of Richard, Rawal, and Martin (2005), who developed a framework specifically guiding the development and dissemination of cardiac report cards. However, these researchers also noted

the congruence of the items included in their framework to the work of others related to the subject of report cards. Therefore, Richard, Rawal, and Martin wisely suggested that their framework might also be applicable in other contexts and to other types of healthcare reports. The author of this report agrees with this view and recognizes the functionality of a framework as the one proposed.

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