



# Public Presentation of Health System or Facility Data about Quality and Safety: A Systematic Review

**EXECUTIVE SUMMARY**

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## **PREFACE**

Health Services Research & Development Service's (HSR&D's) Evidence-based Synthesis Program (ESP) was established to provide timely and accurate syntheses of targeted healthcare topics of particular importance to Veterans Affairs (VA) managers and policymakers, as they work to improve the health and healthcare of Veterans. The ESP disseminates these reports throughout VA.

HSR&D provides funding for four ESP Centers and each Center has an active VA affiliation. The ESP Centers generate evidence syntheses on important clinical practice topics, and these reports help:

- develop clinical policies informed by evidence,
- guide the implementation of effective services to improve patient outcomes and to support VA clinical practice guidelines and performance measures, and
- set the direction for future research to address gaps in clinical knowledge.

In 2009, the ESP Coordinating Center was created to expand the capacity of HSR&D Central Office and the four ESP sites by developing and maintaining program processes. In addition, the Center established a Steering Committee comprised of HSR&D field-based investigators, VA Patient Care Services, Office of Quality and Performance, and Veterans Integrated Service Networks (VISN) Clinical Management Officers. The Steering Committee provides program oversight, guides strategic planning, coordinates dissemination activities, and develops collaborations with VA leadership to identify new ESP topics of importance to Veterans and the VA healthcare system.

Comments on this evidence report are welcome and can be sent to Nicole Floyd, ESP Coordinating Center Program Manager, at [nicole.floyd@va.gov](mailto:nicole.floyd@va.gov).

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### **BACKGROUND**

The public presentation of quality and safety data is essential to the Department of Veterans Affairs (VA) commitment to transparency. By making data available VA hopes to engage veterans and families in care, promote informed choice, and stimulate performance improvement activities.

The objectives of this project are: 1) to update a recent systematic review of the evidence that making performance data publically available leads to improvements in quality of care and safety; and 2) to summarize current research about patients' and families' use of performance data and how the presentation and distribution of these data could be designed to maximize their use by veterans and family members.

The Key Questions were:

1. What is the most effective way of displaying quality and service information so that it is understandable?
2. How do patients prefer to receive or access this information?
3. What is the evidence that patients or their families use publicly reported quality and safety information to make informed health care decisions?
4. What is the evidence that public reporting of quality and safety information leads to improved quality of safety?

### **METHODS**

We searched Web of Science through 2010 using standard search terms. We limited the search to peer-reviewed articles published in the English language. Additional citations were identified from reference mining and content experts. Titles, abstracts, and articles were reviewed in duplicate by reviewers trained in the critical analysis of literature. All data were narratively summarized.

Study characteristics and key findings were extracted by trained research associates under the supervision of the Principal Investigator. We assessed study quality according to criteria developed by Fung and colleagues, and used AMSTAR grading criteria for systematic reviews.

### **DATA SYNTHESIS**

We constructed evidence tables showing study objective, subject of public reporting, whether the article discusses public reporting of hospital or health plan data, location, sample, study design, key findings and ratings, organized by key question. We analyzed studies to compare their characteristics, methods, and findings. We compiled a summary of findings for each question based on qualitative synthesis of the findings.

### **PEER REVIEW**

A draft version of this report was reviewed by seven technical experts, as well as by clinical leadership. Reviewer comments were addressed and our responses were incorporated in the final report.

## **RESULTS**

We screened 370 titles and rejected 261, and performed a more detailed review on 117 articles. From these, we identified 55 articles that addressed one of the key questions.

### **Key Questions #1 and #2**

We identified reports commissioned by AHRQ and the Robert Wood Johnson Foundation regarding how to best produce and disseminate public reports. Their conclusions about solutions for the design of public reports are three-fold. To make the information more relevant to what consumers already understand and care about, public reports should give an overall definition of quality, define the elements of quality and use them as the reporting categories, and include information about the sponsor and methods. To make it easy for consumers to understand and use the comparative information summarize, interpret, highlight meaning, narrow options and help bring the information together in a choice by using summary measures and meaningful symbols. Finally, testing reports with consumers during development will help identify areas of misunderstanding and assess users' perceptions of the report's value.

### **Key Question #3**

Conclusions from the studies of public reporting are mixed, but most studies found the use of publicly available data to be modest at best. Although consumers may show interest in public reports, in most cases interest does not seem to translate into actual use. The studies that do show use suggest that consumers may avoid low performers, but higher performers may not reap comparable positive benefits of public reporting.

### **Key Question #4**

We identified relatively few new studies within our scope in the peer reviewed literature during the five years since the search was conducted for Fung et al. Two of the newly identified studies addressed the impact of reporting on quality improvement activities. Some empirical evidence and the conclusion of the prior review support the theory that public reporting stimulates quality improvement activities. Five new studies identified address a variety of outcomes (patient or consumer experience, obtaining performance targets, rates of caesarean and mortality) and four of the five are national studies. All five conclude that public reporting has a positive impact on quality or safety outcomes; however, the effect was small and two studies were time series studies in a single country, where all providers were subject to public reporting and the change, each could have been due to other changes that impacted all providers.

This small and varied amount of additional evidence is not sufficient to change the conclusion of the Fung et al. review that "the effect of public reporting on effectiveness, safety, and patient-centeredness remains uncertain." However, the CHOP assessment from 2005 provides some encouragement that this may be changing.