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# **Public reporting of safety and quality in public and private hospitals**

**Report on consumer and clinician focus groups and expert interviews**

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## Key findings

The findings of the consumer and clinician focus groups and expert interviews regarding public reporting of safety and quality in health care across public and private hospitals included:

- One of the key purposes of public reporting is to support patients to make informed choices about their care. This includes the role of general practitioners (GPs) in providing advice to consumers through the use of publicly reported safety and quality information.
- Another key purpose of public reporting is the contribution to quality improvement and quality assurance, providing a national and international benchmark for clinicians. Examples of the impact of data reporting on process improvement included prevention of hospital-acquired complications (HACs) and medication errors.
- The important factors of reporting included objectivity, transparency and accountability.
- Safety concerns within hospitals and strategies to address them were viewed as a matter of relevant public interest by consumers. It was suggested that information be released to the hospital first to allow for action and response.
- One of the dependencies of quality indicator information in driving organisational improvement was noted as ensuring that clinical staff can relate to the data.
- A list of indicators was likely to be the most useful way to achieve the aims of public reporting. Suggestions of indicators included: performance against the Commission's National Safety and Quality Health Service (NSQHS) Standards; Core Hospital-Based Outcome Indicators (CHBOI); Standardised Mortality Ratios (SMR); hand hygiene; escalation of care; hospital-associated infections; surgical mishaps; post-intervention and procedure outcomes; medication errors; readmission rates; length of stay; and waiting times.
- There was general agreement that public reporting should occur online and be common across both private and public hospital sectors. Hospital-level information was seen as appropriate for public reporting, from existing sources where possible.
- Consumers indicated a lack of objective and transparent information available to support healthcare choices. The MyHospitals website and state-wide information portals were not well known.
- Ease of access and use of public information is essential, noting varying health literacy levels among audiences. This includes being clear on the purpose and ways to use the information in decision-making. Public reporting initiatives would benefit from advice from health literacy experts and investing in strategies to communicate and adapt public information appropriately.

# Summary

This report provides a summary of findings from consumer and clinician focus groups and expert interviews undertaken to inform options for national public reporting standards of safety and quality in health care across public and private hospitals in Australia.

The consumer and clinician focus groups and expert interviews are part of a project that was undertaken by the Australian Commission on Safety and Quality in Health Care (the Commission) in response to the request from the COAG Health Council (CHC). In August 2017, the Commission was asked to identify options to align public reporting standards for the safety and quality of health care across public and private hospitals nationally, with a view to this work being incorporated in the national work being progressed on the Australian Health Performance Framework (AHPF).

Findings from the focus groups and expert interviews are provided in this report and summarised thematically. Along with this report, a literature review and environment scan were undertaken and reported, and these findings helped to prompt discussion in the focus groups.

## Methods

### Focus group and interview questions and themes

Focus group questions considered key themes about the purpose for public reporting for the lay audience. Focus group questions included:

- What are the reasons that safety and quality information should be reported publicly?
- What safety and quality information should be reported publicly?
- How should safety and quality information be reported publicly? Should it be the same across the public and private health sectors?
- Who should be responsible for making safety and quality information available publicly?
- What are the other considerations (including barriers and challenges) that are important to consumers/clinicians in the public reporting of safety and quality information?

The expert interviews covered the above thematic areas to the extent possible.

### Focus groups

Seven face-to-face focus group forums were held in four cities in Australia, with four focus group forums composed of health consumers and three groups of clinicians.

Consumer and clinician focus groups discussed key themes emerging from the environment scan and literature review to understand what is relevant and useful to consumer and clinical stakeholders. Discussion also included the identification of gaps, challenges, barriers, risks and limitations for implementation, and how these matters may be best addressed.

### Expert interviews

Five industry experts from Australia, the United States of America (USA) and Norway with recognised experience in the area of public reporting participated in expert interviews. Experience of the interviewees included state government health administration, private health care, university and non-profit settings (Table 1).

The interviews aimed to bring a 'real world experience' overlay on the information gathered through the focus group sessions, the environment scan and literature review.

**Table 1: Summary of interviewees**

Interviewee	Role
Interviewee A	Director, private health insurer, Australia
Interviewee B	Professorial Fellow, university, Australia
Interviewee C	Administrator, state government, Australia
Interviewee D	Administrator, health trust, Norway
Interviewee E	Administrator, non-profit organisation, USA

## Summary of findings

### What are the reasons that safety and quality information should be reported publicly?

The consumer and clinician focus groups and expert interviews determined that transparency and accountability of public reporting contributes to quality improvement, quality assurance and support for patients to make informed choices about their care.

#### Support for consumer decision-making

Focus groups identified that public reporting would help support patients to make informed decisions, with the consumer groups indicating that there is often little, if any, objective and transparent information to support an individual to make choices, for example to determine whether or not they need a certain intervention. The MyHospitals website and state-wide information portals were not well known across the consumer focus groups.

Information to support choices was particularly cited as a concern for groups such as those from lower socio-economic groups or Culturally and Linguistically Diverse backgrounds (CALD). Some consumers expressed that some people from CALD backgrounds may not currently understand what their rights are and may feel 'pushed' into healthcare decisions.

The forums flagged that public reporting enables GPs to be able to more effectively provide advice to their patients. Further, one interviewee's view was that GPs should become the primary source of advice for consumers through the use of publicly reported safety and quality information.

Focus groups identified the importance of objective reporting and it was noted at several clinician focus group forums that, in the absence of good public reporting, the information gap is replaced by media coverage with stories that are overwhelmingly negative.

#### Informing clinical improvement and quality assurance

Focus groups identified that public safety and quality information can help support clinical quality improvement activities and provide a national and international benchmark for clinicians. It was noted at one group of clinicians that public reporting was vital to moving away from an existing defensive mindset in hospitals that can hinder quality improvement.

One interviewee identified that data provided for hospital-acquired complications (HACs) have led to changes in processes within private hospitals, although it was difficult to determine causation. Another interviewee noted that publicly reported information has led to

enhancements to hospital systems in Norway, citing examples addressing medication errors and stroke treatment outcomes.

Transparency of potential or actual areas of safety concerns within hospitals and strategies to address them was viewed by the consumer focus groups as a matter of relevant public interest. While reflecting on the critical components for public reporting (particularly for private hospital groups), one interviewee felt that the information should be released to the hospital/group first, so that they have an opportunity to respond and comment on actions currently underway to resolve any issues.

## **What safety and quality information should be reported publicly?**

The clinician focus group forums expressed a general view that no information should be considered out of bounds for transparency but there was concern that an overload of information without appropriate context would not be helpful. It was suggested that a list of indicators was likely to be most useful to achieve the aims of public reporting.

### **Indicators of healthcare safety and quality**

It was agreed among focus groups that information about hospital performance against the Commission's National Safety and Quality Health Service (NSQHS) Standards and the linked indicators would be relevant to public reporting. Other types of information identified by clinician focus groups that could be reported included Core Hospital-Based Outcome Indicators (CHBOI), Standardised Mortality Ratios (SMR), hand hygiene and escalation of care. A number of indicators were commonly identified by consumer groups as relevant for public reporting, including healthcare-associated infection rates, surgical mishaps, post-intervention and procedure outcomes, medication errors, readmission rates, length of stay and waiting times, as well as reporting of information outside of the hospital environment.

Information about relative benefits and risks of procedures was seen as important by clinician focus groups to inform choices, with caesarean section used as an example.

### **Hospital-level reporting**

Consumer groups felt that hospital-level information was a practical first step, with a view to moving toward clinician-level reporting. The clinician group forums agreed that reporting at a hospital level (with appropriate risk adjustment) is most useful to achieve the aims of transparent reporting. However, to support ongoing clinical improvement, clinician group forums supported providing information at a ward level (rather than clinician-level).

Clinician groups suggested the reporting of data that represent new thinking on safety and quality, moving from focusing on what went wrong to considering and learning from all outcomes within an organisation as a means of building organisational resilience. One interviewee indicated that in their experience there had been little benefit seen in pursuing individual clinician reporting, noting that by focusing on clinician-level reporting, this elevates the importance of one person above the clinical team. Such a focus would therefore result in a lack of understanding on why an issue may have occurred.

## **How should safety and quality information be reported publicly? Should it be the same across the public and private health sectors?**

Clinician and consumer focus groups and interviewees agreed that ease of access and use of the information is essential, including the consideration of varying health literacy levels. It was expressed that safety and quality information made publicly available should be common across both the private and public hospital sectors.

## **Meaningful and accessible information**

There was a common view across all clinician focus group forums that any indicator reported publicly should be accompanied by a clear explanation of its purpose and what it measured, and how results could then be used to inform decision-making.

One interviewee suggested that public reporting initiatives require a communication strategy that needs staff talent, time and resources to ensure the information is contextual and useful. Another interviewee emphasised that their organisation's public reporting had been extensively tailored to make it accessible to consumers. The language has been simplified to focus on errors, infections, injuries and accidents, and symbols are used that the consumer can relate to. The organisation worked closely with health literacy experts to present the data in a way that is understandable.

One interviewee felt that the most important aspect of their organisation's public reporting strategy was to name a patient safety 'dream team' expert panel, comprising some of the most well-known experts in the sphere (for example, Lucien Leape) to advise on the development of the tool. This has added a significant degree of credibility to the initiative.

Another interviewee observed that in their experience, use of quality indicator information to drive organisational improvement is dependent upon ensuring that clinical staff can relate to the data. It was noted that clinical staff often respond better to research information than performance information, which are the type of data that are typically reported and acted upon by governments.

## **Online reporting of data at varying levels and formats for diverse audiences**

There was general agreement across all focus groups that public reporting should occur online. Consumer groups generally reported that a combination of numerical and narrative information is beneficial. Suggestions included simple infographics and short videos. Consumer groups recommended the consideration of other ways to publicise information for those who do not regularly access the internet. Clinician groups suggested sharing information through additional means such as hospital waiting rooms.

Clinician groups suggested that information made public should also be able to provide the level of detail needed to drive improvement for the clinician audience. One clinician noted for example that in the USA, clinicians could access the data to perform analyses. One of the interviewees noted that in Norway there is a national quality dataset that every hospital reports continuously, which is used by the leadership of these hospital organisations.

The clinician focus groups agreed that the information should be released regularly but there was no consensus across groups on the ideal interval. Clinician groups noted the importance of presenting trends or comparisons over time for some data to be meaningful.

It was apparent from the various consumer focus group forums that currently available information on safety and quality outcomes was not very well known or understood. The groups reported that consumers who sought out such information were relying on search engines such as Google and Facebook groups dedicated to discussing medical conditions and experiences with healthcare organisations, as this social media platform was seen as helpful and user-friendly.

One interviewee argued that the patient driven ratings models that were gaining popularity in Australia and overseas were not very effective in the healthcare setting. It was noted that consumers' feedback on its own lacks the required risk adjustment and integrity.

## **Same reporting for public and private hospitals**

There was broad agreement that the same types of publicly reported information should be made available by both the private and public hospital sectors. A number of consumers felt that for those who did not have private health insurance, private sector information was of no



relevance. However, it was noted at one focus group forum that having private and public information available would likely provide an evidence base for consumers to judge perceived notions of quality across sectors.

One interviewee remarked that there can be tension in letting consumers know about the quality of care between the private and public hospitals. Where perceptions of care being better in one sector are disproven this can lead to a major shift in demand for services to the other sector, creating a resourcing imbalance.

## **Who should be responsible for making safety and quality information available publicly?**

### **National reporting generally agreed with no consensus on responsibility**

While the focus groups did not specifically identify who should be responsible for making safety and quality information publicly available, consumer groups suggested a national reporting system rather than states and territories undertaking individual reporting that was not coordinated.

There was no consensus among clinician groups about where responsibility should lie for public reporting, with suggested organisations including the Australian Institute of Health and Welfare (AIHW) and the Commission. There was a common view that, ideally, it should be a single, national body empowered to release information.

One interviewee felt that the tendency to push for a single organisation to have responsibility for reporting was a challenge and ideally, the measurement data that are mandated through government requirements should be made available as open source for interested organisations (both public and private) to report in ways that caters to various audiences.

One interviewee noted that, to promote greater reporting and transparency by the private sector, it was suggested that the Australian Government could potentially tie premium increases to improved transparency of outcomes.

It was noted in focus groups and interviews that existing mechanisms should be used for reporting where possible. Some consumers expressed that the pace at which governments release information was perceived to be slow and may not always present information in the way consumers want.

## **What are the other considerations (including barriers and challenges) that are important to consumers/clinicians in the public reporting of safety and quality information?**

A recurring theme across all consumer focus group forums was trust. The sharing of information, and all the potential benefits and advantages that come with it, was viewed through the broader lens of building trust between patients and healthcare providers. In particular, transparency of hospital performance would enable GPs to provide more objective advice to patients on suitable options for treatment.

### **Using existing data for reporting**

All clinician focus group forums noted that there is considered to be substantial amounts of useful data that already exist and which could be utilised for public reporting purposes. Focusing on better use of existing administrative data, including coding data, was seen as an important first step towards more useful public reporting.

A number of clinician focus group forums identified that there are already successful examples of public reporting in Australia, which have led to ongoing quality improvement. Antimicrobial stewardship and hand hygiene rates were cited as examples from which to adopt learnings.

One interviewee noted (specifically in the context of private hospital reporting) that one issue that is often discussed is that of appropriate risk adjustment. It was noted that this is likely an issue that can be overcome, as the relevant techniques and skills are available.

### **Culture and meaning of information and public reporting**

Several clinicians across all focus group forums commented the potential for negative consequences from poor performance was viewed as impacting the decision-making process and hindering more transparent sharing of information.

One interviewee noted the current system has developed a defensive approach of arguing that health does not need to be shared in the same way as it is across other sectors, which leads to confusion for consumers. Another interviewee noted (specifically in the context of private hospitals) that a cultural shift is required in terms of accepting the benefits of sharing this information.

One interviewee noted that privacy concerns, particularly at the individual clinician level, remained a barrier to reporting.

# Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) is a government agency that leads and coordinates national improvements in safety and quality in health care across Australia. The Commission is an Australian Government agency, funded jointly by all state and territory governments and the Commonwealth government. It is established under the *National Health and Hospitals Network Act 2011* and its role codified in the *National Health Reform Act 2011* to lead and coordinate national improvements in safety and quality in health care.

The Commission works in partnership with the Australian, state and territory governments and the private sector to achieve a safe, high-quality and sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The Commission works in four priority areas:

1. Patient safety
2. Partnering with patients, consumers and communities
3. Quality, cost and value
4. Supporting health professionals to provide care that is informed, supported and organised to deliver safe and high-quality health care.

## Project background and context

In August 2017, the CHC asked the Commission to identify options to align public reporting standards of safety and quality in health care across public and private hospitals nationally. The CHC requested that on finalisation, this work be incorporated in the national work being progressed on Australia's health system performance and information reporting frameworks. The Commission was requested to report back to AHMAC and the CHC in early 2019.

A number of reports have signalled a commitment by the Australian Government for increased transparency in reporting about public services, particularly to promote informed decision-making by the consumers of those services. Firstly, in December 2016 the Australian Government Productivity Commission released the report *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform*. This report sets out the Productivity Commission's view on priority areas for reform that will improve individual and community wellbeing. One area of focus was for improving consumer choice through increased transparency and public reporting, and a final report making recommendations to the Australian Government was submitted in October 2017.<sup>1</sup>

Secondly, in November 2017, the CHC endorsed the Australian Health Performance Framework. The Framework arose following the AHMAC *Review of Australia's health system performance information and reporting frameworks: final report*. This report recommended a single national performance reporting framework for primary and hospital care across both public and private sectors, identifying in particular the current lack of public reporting about private hospitals' performance. The Heads of Agreement<sup>2</sup> on public hospital funding and health reform February 2018, which sets out the agreement between the Commonwealth and the states and territories (Clause 7.d.ii) on public hospital funding and health reform, endorsed the implementation of the Framework. Governance of the Framework is undertaken by the Health Services Principal Committee, under AHMAC.<sup>3</sup>

In late 2017, the Queensland Government undertook a public consultation process to gauge community views about the collection, reporting and use of healthcare quality and patient safety information in Queensland through the release of a discussion paper. The Queensland Government received overwhelmingly supportive responses to public reporting on safety and quality across public and private hospitals within the state. The Queensland Government found through this consultation that public reporting was seen to support a safety and quality culture, increase transparency and drive improvements in performance.<sup>4</sup>

The Commission convened the Patient Safety Reporting Steering Committee to advise on the deliverables of a four-phase project to develop the options for public reporting on safety and quality in health care. The phases involved:

- **Phase 1. Evidence collection and analysis**
  - Step 1. Environment scan
  - Step 2. Literature review
  - Step 3. Focus groups and interviews
- **Phase 2. Options development**
- **Phase 3. Validation of draft options**
  - Step 1. Public consultation survey
  - Step 2. Key stakeholder workshops
  - Step 3. Consensus through the Commission's governance processes
- **Phase 4. Finalise and report on options**

As part of Phase 1, an environment scan and literature review were undertaken (Steps 1 and 2), together with a number of focus groups with consumers and clinicians across Australia. In addition, specific interviews with local and international experts in the area of public reporting were undertaken. This report outlines the findings from the focus groups and expert interviews (Step 3 of Phase 1).

Phase 1 of the project, including the focus groups with clinicians and consumers, expert interviews, environment scan and literature review set out to answer the following overarching research question:

*What does evidence from research, policy and practice, and consumers tell us about the best ways to ensure every person has timely access to relevant, valid, and trustworthy information to enable well-informed decision-making?*

## Rationale

Consumer and clinician focus groups discussed key themes emerging from the environment scan and literature review (Appendix A) to understand what is relevant and useful to consumer and clinical stakeholders. Discussion also included the identification of gaps, challenges, barriers, risks and limitations for implementation, and how these matters may be best addressed. The interviews aimed to bring a 'real world experience' overlay on the information gathered through the focus group sessions, the environment scan and literature review.

# Method

## Discussion questions and themes

The themes arising from the environment scan and literature review were used as a guide for the development of consumer and clinician focus group forum questions. The thematic areas were discussed in the focus groups using the following questions:

- What are the reasons that safety and quality information should be reported publicly?
- What safety and quality information should be reported publicly?
- How should safety and quality information be reported publicly? Should it be the same across the public and private health sectors?
- Who should be responsible for making safety and quality information available publicly?
- What are the other considerations (including barriers and challenges) that are important to consumers/clinicians in the public reporting of safety and quality information?

The expert interviews covered the above thematic areas to the extent possible. Information sought through the interviews aimed to bring a 'real world experience' overlay on the views gathered through the focus group sessions, the environment scan and literature review.

## Consumer and clinical focus group forums

Seven face-to-face focus group forums were held in four cities during May 2018. Of these, four focus group forums were with health consumers and three were with clinicians. A fourth focus group forum for clinicians was cancelled due to insufficient participants registering for the discussion. Focus group forums were held in Perth, Brisbane, Sydney and Melbourne. All of these cities had both a health consumer and clinician focus group session (except Brisbane which had a consumer focus group session).

Consumers who participated in the focus group forums were from a mix of metropolitan and regional areas and had experience as consumers and carers in both public and private hospitals. While focus group forums were not held in Darwin, Canberra, Adelaide or Tasmania, the Melbourne consumer group forum had two participants from Adelaide and one participant from Tasmania. There was no representation from the Australian Capital Territory or Northern Territory. There was consumer representation contributing with views and experiences of culturally and linguistically diverse (CALD) groups.

Health consumers were recruited using existing Commission relationships with consumers and consumer groups. Clinician recruitment was carried out using requests issued to various professional colleges and via representatives of the Commission's Inter-Jurisdictional Committee (IJC). Knowledge and experience of safety and quality initiatives and public reporting of these data were not specified as a requirement for participation, to obtain a broader, more representative view of clinician and consumer opinions on the benefits and challenges of public reporting. In total, 28 health consumers and 14 clinicians contributed to the focus group forums.

Moderator scripts were prepared for the two forum facilitators (Appendix A). The scripts included a list of overall thematic areas and specific questions to guide the discussion. Facilitators were required to ask particular questions of attendees in the exact same manner, and were provided with additional prompts to use if the group discussions stalled or deviated from the topic of concern. Facilitators were able to exercise their discretion and judgement

on the order of the scripts, while also ensuring that the overall thematic areas were covered in each discussion.

Following the first forum in Perth, there were minor revisions made to the questions and the order of the questions in the moderator scripts prior to the Brisbane, Sydney and Melbourne focus group forums.

## Expert interviews

Five industry experts from Australia, the USA and Norway with recognised experience in the area of public reporting participated in the expert interviews. These individuals were viewed as having recognised interest and expertise in the area of public reporting, either through direct implementation experience, policy advisory roles or both.

The interviews took place via teleconference with the following experts:

- Director at a private health insurer in Australia
- Professorial Fellow at a university in Australia
- Administrator at a state health government agency in Australia
- Administrator at a health trust in Norway
- Administrator at a non-profit organisation in the USA.

Interviewees have not been identified as permission was not sought from the experts interviewed to release the outcomes of their interviews publically.

With the overseas interviewees, more time was given to understanding specific learnings from the experiences in their respective jurisdictions (both in terms of benefits and costs).

## Focus group forum findings

This section outlines the findings from the focus group forums, with the findings from the health consumer forums presented first, followed by the clinician forums findings presented separately. Findings for the consumer and clinical forums have each been structured by discussion themes. Common findings arising from the focus group forums are provided against each theme first, followed by a description of any other pertinent information that may have been raised in one or two sessions but not others (where applicable).

### Findings from consumer focus group forums

#### What are the reasons that safety and quality information should be reported publicly?

##### Informed choices

Across most consumer focus group forums, knowledge of hospital and clinician performance was linked to the issue of informed consent and choice. Currently, in the absence of information, consumers indicated that they generally trust what they are told by the healthcare system and healthcare providers, and rely upon the opinions of friends and family who have had experiences in the healthcare system. However, consumers indicated there is often little, if any, objective and transparent information that can support an individual with all the information they would require, for example to determine whether or not they need a certain intervention.

This was particularly cited as a concern for those from CALD backgrounds, who may not understand what their rights are and may feel 'pushed' into healthcare decisions.

Consumers stated that they wanted the ability to know what their power is and what their options were, and felt they could make decisions on these options with sufficient information.

### **To improve care coordination, processes and communication**

Consumers indicated they felt there was lack of consistency in coordination of care, administrative processes and communication across both the public and private healthcare sectors. Through the publication of safety and quality performance information, consumers felt hospitals and healthcare providers may be compelled to take further measures to improve overall care coordination efforts, which was considered to be a potential positive step.

### **Transparency and accountability**

Public reporting of safety and quality information was considered to be important to inform the public about any potential or actual areas of safety concerns within hospitals. This was viewed as a matter of relevant public interest. At several focus group forums, consumers felt that discussing outcomes in the open and keeping the public informed regarding what organisations may be doing to rectify any concerns was a potential positive step.

### **What safety and quality information should be reported publicly?**

A number of indicators were commonly identified as relevant to being publicly reported by consumer groups. These included:

- Healthcare-associated infection rates
- Surgical mishaps, post-intervention and procedure outcomes
- Any medication errors
- Readmission rates
- Length of stay.

Consumers also voiced their support for waiting time information being publicly available. Other items suggested included post-discharge (in-home care) outcomes and the continuum of care information outside of the hospital environment.

### **Accreditation status and performance against standards**

A small number of consumers were aware of the Commission's National Safety and Quality Health Service (NSQHS) Standards.<sup>5</sup> When these were discussed, consumer representatives agreed that information about performance against the NSQHS Standards would be useful to have in the public domain. This would be more than a simple statement of accreditation status, rather, actual performance against the indicators included in the Standards.

### **Organisational culture**

Several consumer focus group forums discussed the value of understanding the culture of a healthcare organisation, as they felt it was a good indicator of how the organisation would perform in terms of patient outcomes. Some consumers suggested this may be captured through patient experience information which is currently reported (variably) by healthcare organisations, while others felt organisational culture would include aspects such as staff wellbeing. A few consumers felt that all they needed to know was that the clinician was 'on the ball' and skilled for the work they needed to do, and that aspects such as culture were not as relevant.



## **From hospital-level to clinician-level reporting**

Hospital-level information was generally seen as a practical first step, with a view to moving toward clinician-level reporting. Overall, the consumer groups were of the view that public reporting should occur at the hospital level, as this was considered to likely be most practical in the short term.

Several consumers mentioned that they had tried to seek such information for particular interventions and had not found this information readily available. The consumer groups were generally well aware of some of the difficulties in comparing hospital information, with several making mention of issues that may arise from the different risk profiles of patients seen by different hospitals. Another challenge to reporting discussed at the consumer focus group forums was the inconsistency in collecting data by hospitals.

Over time, there was a desire to see information reported at a clinician level expressed across a number of groups, with consumers noting this would provide an added level of transparency. However, a number of consumers flagged the potential complexities in reporting data at a clinician level, including the relative risk issues and that clinicians may not be agreeable to publishing individual-level information. Another issue identified was the perceived pace for which governments provide structured information.

## **How should safety and quality information be reported publicly? Should it be the same across the public and private health sectors?**

### **Currently available information is not well known/understood**

It was apparent from the various consumer focus group forums that currently available information on safety and quality outcomes (for example, through online portals such as MyHospitals) was not very well known or understood. Across the four consumer focus group forums, MyHospitals was discussed in only one session and consumers indicated that state-wide information portals were equally not well known. Currently, those consumers who sought out such information were relying on search engines such as Google to find the relevant data, and many raised the concern that not everything returned through these searches could be trusted to the same degree.

### **Ease of access and use of the information is essential**

A common requirement outlined through the consumer focus group forums was that any information that is made publicly available should be easy to find, navigate and understand. There was a clear view that information on performance that was presented without suitable context to support interpretation by consumers was not helpful. Providing context about how results can be used to inform or influence decision-making was determined as essential, for example, the use of accreditation information including where services had not met standards.

It was suggested that information should be available in multiple forms and should take into account a base level of health literacy that was 'low'. Representatives at the consumer group forums felt that information should ideally be published on websites using simple infographics and short videos, with consideration of other means of publicising this information for those who do not regularly access the internet.

Consumer groups suggested that information should be basic and simple to understand, and there should be effort not to overload consumers with too much information. A suggestion raised in some groups related to having high level information with the opportunity to drill down further if more detail was required. Many consumers suggested that the information should ideally be personalised in a manner that is meaningful to the individual accessing the information, recognising there are differing levels of health literacy within the community.



Attendees at consumer group forums also felt that carers and patients may have different information needs. While the information might be the same, patients and carers have different needs and perspectives when viewing the information, therefore differing presentation may be relevant.

### **A combination of numerical and narrative information is beneficial**

While not raised specifically at all groups, several consumers indicated that numerical presentation of data is, overall, better and easier to read than long, narrative text. However, it was noted that narrative information (for example, patient experience) provides useful information for consumers when making decisions, with several participants noting the importance of hearing information in the patient voice. The combination of numerical data with narrative experience was considered particularly helpful.

A few consumers mentioned the increase of Facebook groups that were dedicated to discussing medical conditions and shared experiences with various healthcare organisations. This kind of information was often relied upon by consumers and the presentation was seen as user-friendly and helpful.

### **Same reporting from both private and public hospital sectors**

Consumers were in broad agreement across the focus group forums that the same types of publicly reported information should be made available by both the private and public hospital sectors. Some consumers suggested that from a private hospital perspective, this was particularly important for their reputation and marketing purposes.

A number of consumers felt that for those who did not have private health insurance, private sector information was of no relevance. This was noted as a growing issue due to people ceasing their insurance.

### **Who should be responsible for making safety and quality information available publicly?**

The consumer focus group forums did not specifically identify who exactly should be responsible for making safety and quality information publicly available. However, the groups generally tended to suggest there needed to be a national reporting system and that states and territories should not be undertaking individual reporting that was not coordinated.

Some consumers expressed that the pace at which governments release information was perceived to be slow and that may not always present information in the way consumers want it to be presented. One comment was made that there were existing and proven mechanisms to connect with consumers (for example, through the private sector using tools such as apps), and that these existing mechanisms should be used where possible.

### **What are the other considerations (including barriers and challenges) that are important to consumers in the public reporting of safety and quality information?**

#### **Trust**

A recurring theme across all consumer focus group forums was trust. The sharing of information, and all the potential benefits and advantages that come with it, was viewed through the broader lens of building trust between patients and healthcare providers. A number of people commented that, often, information on hospital performance is limited to negative coverage in the media, which impacts trust in the system. Openness in sharing information directly with health consumers was considered a means which could potentially help to provide more balanced viewpoints on hospital performance and strengthen trust in

the system. In particular, transparency of hospital performance would enable general practitioners (GPs) to provide more objective advice to patients on suitable options for treatment.

## **Findings from clinician focus group forums**

### **What are the reasons that safety and quality information should be reported publicly?**

#### **Quality improvement and consumer empowerment**

All clinical focus group forums identified that two key benefits of public reporting are to support ongoing clinical quality improvement activities and also to promote transparency in support of decision-making by consumers.

It was noted at one group that public reporting was vital to moving away from an existing defensive mindset in hospitals that can hinder quality improvement. It was suggested, for example, that the tendency to claim medicine is complex and will always involve errors, and can take away from efforts to reduce these errors.

One clinician commented that it was important for clinicians to know where they sat in terms of performance nationally and internationally, as a means of driving self-improvement.

#### **To provide a balanced and objective view of performance**

At several focus group forums, it was noted that, in the absence of good public reporting, too often the information gap is filled through media coverage with stories which are overwhelmingly negative. This causes a significant loss of trust in the organisation which can have a flow-on effect on staff morale. Having objective public reporting of information was considered a means by which informed discussion and debate about performance could be driven.

#### **To support general practitioner referral and provision of advice to patients**

At one focus group forum, it was flagged that public reporting also enables GPs to be able to more effectively provide advice to their patients. It was noted that GPs were the service providers from whom consumers would typically seek advice or be referred to specialists / hospitals, and that GPs often did not have the information to make an objective assessment of performance between providers. It was further noted that the most common determinant in this regard related to personal experience or relationships.

It was discussed that such a reliance on GP support and advice was particularly the case with disadvantaged groups (for example, health consumers from relatively lower socio-economic backgrounds and CALD groups) and that they would often be the ones that would benefit most from their GP having access to this type of information.

### **What safety and quality information should be reported publicly?**

The clinician focus group forums expressed a general view that no information should be considered out of bounds for public reporting, as this was important for transparency. However, there was discussion at each session around the benefits of having a specified list of indicators that were likely to be most useful in achieving the aims of public reporting. There was concern that an overload of information without appropriate context would not be helpful.

## **Performance against the National Safety and Quality Health Service Standards**

There was a common view that information about hospital performance against the NSQHS Standards and the linked indicators would be relevant to public reporting. It was noted that this information is pertinent to both clinicians (to know how their organisation is performing) and for consumers (to support choice). At one focus group forum, the example of information on blood transfusion (linked to NSQHS Standard 7, Blood Management)<sup>6</sup> was provided, where the requirements under the Standard and the resulting activities has led to significant changes in practice.

Other types of information that could be reported that were discussed at various focus group forums included Core Hospital-Based Outcome Indicators (CHBOI), Standardised Mortality Ratios (SMR), hand hygiene and escalation of care (for example, REACH – Recognise, Engage, Act, Call, Help – in NSW<sup>7</sup> and Ryan’s Rule in Queensland<sup>8</sup>).

One group suggested amending the indicators to report in a different way (for example, days since last pressure injury or days since last fall), which was considered to resonate more with the public.

## **Standardised, hospital-level information is most useful**

Similar to the consumer group forums, the clinician group forums tended to agree that reporting at a hospital level (with appropriate risk adjustment) is most useful to achieve the aims of public reporting in terms of public transparency. To support ongoing clinical improvement, the attendees at clinical group forums expressed a view that information at a ward level would be useful in driving best practice across an organisation and reducing existing heterogeneity between departments.

Across a number of the focus group forums, concerns were raised regarding the merits of individual-level reporting. A number of clinicians commented that individual performance measures distract from true quality improvement, as health care is a team game and successful outcomes are highly dependent on the performance of the team and system as a whole. There was some discussion on alternative approaches, for example, grouping of clinicians by speciality within a hospital, but there was no consensus reached on whether this was a feasible option.

## **Data that represent new thinking on safety and quality**

One focus group forum discussed the impact caused by the shift from traditional to patient safety to more novel approaches, i.e. moving from focusing on what went wrong to considering and learning from all outcomes within an organisation as a means of building organisational resilience. This shift requires the information that is presented for public reporting to reflect this new way of thinking. It was expressed that, to support more proactive management of safety, a good grasp of normal performance and everyday outcomes is needed.

## **Information about relative benefits and risks of procedures**

The issue of higher than recommended caesarean section rates arose during two of the clinician focus group forums. There was a suggestion that a higher proportion of these procedures are conducted in the private sector and are demand driven, and that consumers should have access to details on benefits and risks of these procedures to make better-informed decisions. Clinicians in one focus group forum recognised this (and broader consideration of similar elective procedures) as an issue where consumers are not provided with the necessary information to undertake truly informed decision-making.

## **How should safety and quality information be reported publicly? Should it be the same across the public and private health sectors?**

### **Data presentation should consider audience health literacy levels**

The issue of data presentation was discussed across all of the clinician focus group forums. It was recognised that presenting safety and quality information in a way that makes sense to the intended audience was critical. The issue of generally poor health literacy was seen as a concern that needs to be addressed.

It was suggested, however, that information made public should also be able to provide the level of detail needed to drive improvement for the clinician audience. A clinician suggested that the example of what occurs in the USA was a good approach, where clinicians could access all the data including the necessary statistical packages needed to perform detailed analyses.

There was a common view across all clinician focus group forums that any indicator reported publicly should be accompanied by a clear explanation of its purpose and what it measured.

### **Common reporting across both the private and public hospital sectors**

There was broad agreement across the clinician focus group forums that the same level of reporting should apply across public and private health sectors. It was noted that there was no reason why the same types of information could not be reported and that the private hospital sector already collected a significant amount of information related to safety and quality.

It was noted at one focus group forum that having this information available would likely provide an evidence base for consumers to judge whether perceived notions of higher quality in the private sector were accurate.

### **Ease of access and use of the information is essential**

There was a general agreement across all groups that public reporting should occur through online channels. It was also noted that other means of sharing this information (for example, in hospital waiting rooms) would also be beneficial.

In line with previous comments on ensuring the information was contextual and useful, several clinicians noted that it would not be sufficient to load a PDF version of a dense report online and consider that as public reporting. Rather, the prevailing view expressed was that information needed to be made accessible and easy to comprehend.

### **Information should be released regularly**

The clinician focus group forums agreed that the information should be released regularly. There was no consensus across groups on the ideal interval, and one clinician group suggested that it should be real-time. Among two clinician group forums, quarterly release of information was suggested by several clinicians as being appropriate.

It was also noted that often for the data to be meaningful, an aggregate of some period of time was important to provide trends or comparisons of related representations. Accordingly, it was considered that this context needed to be factored into how information was presented.

## **Who should be responsible for making safety and quality information available publicly?**

There was no consensus amongst the clinician group forums on who should be responsible for making the information public. A number of organisations including the AIHW and the Commission were mentioned as potential candidates. While a specific organisation was not identified, there was a common view that, ideally, it should be a single, national body empowered to release information.

## **What are the other considerations (including barriers and challenges) that are important to clinicians in the public reporting of safety and quality information?**

### **Perceptions of consequences to publishing data on performance**

Several clinicians across all clinician focus group forums commented that a significant potential barrier to public reporting was the lack of political will to publish information. The potential for negative consequences from poor performance was viewed as impacting the decision-making process and hindering more transparent sharing of information.

### **Learning from successful initiatives**

A number of clinician focus group forums identified that there are already successful examples of public reporting in Australia, which have led to ongoing quality improvement. They cited the examples of antimicrobial stewardship and hand hygiene rates from which to adopt learnings.

### **Better use of the existing administrative data**

All clinician focus group forums noted that there is considered to be substantial amounts of useful data that already exist and which could be utilised for public reporting purposes. It was therefore broadly considered that there was little need for major new data collections. It was recognised that while clinical registries were often the gold standard, these were expensive to establish and maintain. Better use of existing administrative data, including coding data, was seen as an important first step to developing more useful public reporting.

## Expert interview summaries

Telephone interviews were conducted with five Australian and international experts, to supplement the learnings from the environment scan, literature review and focus group forums. These interviews were with individuals who had a recognised interest and expertise in the area of public reporting, either through direct implementation experience, policy advisory roles or both. The information sought through these interviews was obtained in order to bring a 'real world experience' overlay to the material gathered through the environment scan, literature review and focus group forums.

A summary of interviewees, including roles and locations, is at Table 1. A summary of each interview is provided below. Interviewees have not been identified as permission was not sought from the experts interviewed to release the outcomes of their interviews publically.

**Table 1: Summary of interviewees**

Interviewee	Role
Interviewee A	Director, private health insurer, Australia
Interviewee B	Professorial Fellow, university, Australia
Interviewee C	Administrator, state government, Australia
Interviewee D	Administrator, health trust, Norway
Interviewee E	Administrator, non-profit organisation, USA

### Interviewee A: Director, private health insurer, Australia

#### Reporting undertaken by the private health insurer

Interviewee A described the current reporting undertaken by the private health insurer, which has been underway for several years. The private health insurer currently shares performance information, including safety and quality information, with 13 hospital groups across the country. It was noted that overall this has been a challenging process, with varying degrees of acceptance of the data amongst the groups. Currently, the full breadth of information is not reported publicly.

The private health insurer is currently working with hospital groups to agree on the public release of patient experience data on a hospital-by-hospital basis. Interviewee A noted that members are extensively surveyed, and therefore the organisation has a rich source of patient-provided information. The same patient experience survey used in the USA by the Centres for Medicare and Medicaid Services (CMS) is used.

#### Benefits of public reporting to the private hospital sector

Interviewee A noted that transparency of performance reporting is beneficial and that available information should be released publicly. It was noted that insurers have mixed incentives to release this information but such transparency can be a competitive advantage and should be accepted.

It was Interviewee A's view that the primary benefit of releasing this information (from a private hospital perspective) is to drive quality improvement activities to be competitive within the sector. Interviewee A was not as confident that consumer behaviours could be

influenced by public reporting, particularly because much of the clinical indicator information that may be reported is hard to interpret. However, it was noted that members appeared keen to access any information available on hospital performance.

While it was noted that the private health insurer has yet to see significant change brought about through the information currently reported by the private hospital groups, one area that has seen improvements is hospital-acquired complications (HACs). Data provided on HACs have led to changes in processes within private hospitals. It was noted that causation was difficult to determine in this instance, as it is possible that this is due to adverse financial impacts.

## **Challenges of public reporting in the private hospital sector**

Interviewee A recognised that there are a number of issues and concerns in the private hospital sector around public reporting. One that is often discussed is around the need for appropriate risk adjustment. It was noted that this is likely an issue that can be overcome, as the techniques and skills are available to accurately undertake the required risk adjustment.

Another potential challenge identified was that some indicators collected by private hospital groups were likely to be more accurate than others. It was noted that, in general, indicators that were linked to payment tended to be more accurate and these were a good starting point for any public reporting of data.

Interviewee A also felt that indicators on safety and quality could not be looked at in isolation and, therefore, developing a methodology to combine and present this information was important. It was noted that this would likely present further technical challenges, for example for weightings. Other significant challenges include how the information is actually presented to allow for the data to be easily interpreted and used.

While some private hospital groups publish information on hospital safety and quality on their websites, it was noted that this was selective and not particularly conducive to helping consumers make meaningful comparisons between hospitals.

Overall, in Interviewee A's view, the technical challenges around the data could be overcome but public reporting of data from the private sector would not occur until there was a corresponding cultural shift in terms of accepting the benefits of sharing this information. It was noted that while releasing patient experience information is a good step, this does not substitute sharing information on clinical outcomes. A recent analysis undertaken by this private health insurer was cited, looking at potential correlation between patient experience and clinical outcome indicators, and it was noted that no direct links were found.

## **Other considerations for public reporting**

Interviewee A identified a number of critical components for any successful public reporting regime, particularly for private hospital groups:

- The information needs to be easy to collect and report
- The indicators need to be robustly defined
- The information should be released to the hospital/group first, so that they have an opportunity to respond and comment on actions currently underway to fix any issues, prior to the information being reported.



## **Interviewee B: Professorial Fellow, university, Australia**

### **Benefits of public reporting**

Interviewee B was of the opinion that making information available to the public introduces competition and consumer choice, which is a better form of accountability of the health system than what governments alone can drive through their requirements on health sector providers. It was indicated that there is no reason for performance information not to be made public as data are there and available from two sources: private health insurance providers and governments. Interviewee B noted that private health insurance providers have information about every specialist provider and every private hospital, including readmission rates and similar performance information. It was noted that the public system has the equivalent information for public hospitals.

Interviewee B noted that, currently, it is possible to use a search engine such as Google to find information about a disease or a procedure and there will be step-by-step information about what treatment to expect. However, it was further noted there is no information about the surgeon or specialist performing the procedure and the quality and outcomes of care of that surgeon, which are the critical components of information a consumer needs to make an informed choice about a procedure.

Interviewee B's view was that GPs should become the primary source of advice for consumers through the utilisation of publicly reported safety and quality information. This view was based on the issues associated with health literacy that exist in the community. Accordingly, it was noted that publicly reported information should be provided in a manner that is meaningful to GPs. It was suggested that GPs should assist consumers interpret this information and should be remunerated for providing this advice. Interviewee B believes that private health insurers may have a conflict of interest when providing such information, so it may be preferable that a GP should be the source of advice in relation to quality of care. When referring consumers to specialists, Interviewee B felt that consumers should be given a choice based on data (i.e. which is the best hospital, who are the best surgeons) so that they can make an informed choice about their care.

### **Challenges of public reporting**

Interviewee B noted the current system has developed a defensive approach of arguing that health is different and therefore information does not need to be shared in the same way as it is across other sectors, which leads to confusion for consumers. It was noted that there is a tendency amongst governments and professional groups to not release information for fear of a public backlash. Interviewee B also remarked that there can be tension in letting consumers know about the quality of care between the private and public hospitals. Such an approach can make deficiencies in care transparent between public and private sectors and, where perceptions of care being better in one sector are disproven, can lead to a major shift in demand for services to the other sector, creating a resourcing imbalance.

Interviewee B argued that the patient driven ratings models that were gaining popularity in Australia and overseas were not very effective in the healthcare setting. It was indicated that they should not be a primary source of advice; rather, they should be an adjunct to objective safety and quality measures. This was due to the fact that consumers' feedback on its own lacks the required risk adjustment and integrity.

Interviewee B cautioned against composite ratings noting that, while they can be helpful (and are used in a variety of other sectors to inform choice), they can also tend to over-simplify information. It was noted that consumers may weight different aspects of care in a personalised manner based on what is important to them.



Privacy concerns, particularly at the individual clinician level, also remained a barrier to reporting. The example of Surgical Variance Reports was used, which are developed in conjunction with the Royal College of Surgeons. These reports have identifiable information and show high levels of variance in the quality of care by specialists. It was noted private health insurers have these details, but they cannot disclose them because doing so would create a privacy issue in respect of the surgeon.

## **Examples of good public reporting**

Interviewee B expressed the view that the United Kingdom (UK) and the Netherlands are the best jurisdictions in terms of public healthcare reporting. It was noted that in the Netherlands, consumers are informed about the safety and quality information on the healthcare system through their GPs.

## **Changes required to drive better public reporting**

Interviewee B believes that courage and leadership from governments and public empowerment will lead to change. It was argued that once one jurisdiction reported more broadly, it would be a lever for all other states and territories to also report. It was also argued that if the state governments were willing, they could publish information about the quality and outcomes of surgeons so that this could inform choice. It was noted that consumers should be able to go to their GPs, who should be able to make an informed recommendation on the surgeon to whom the consumer is referred. Interviewee B also felt that funding should be linked with quality of care performance and used as leverage to improve performance of hospitals.

To promote greater reporting and transparency by the private sector, it was suggested that there is a way forward through the Australian Government, which controls premium increases and could potentially tie these increases to improved transparency of outcomes.

## **Interviewee C: Administrator, state government, Australia**

### **Benefits of public reporting**

Interviewee C noted the benefits of public reporting are not purely about choice. Transparency of information has multiple benefits: choice; quality assurance; and stimulation for quality improvement. It was noted that there are health service administrators who believe they are providing high quality health care but do not appreciate that the health service performs poorly in comparison with others, and that public reporting can help to change that illusion. It was stated that there was significant evidence internationally and in Australia that hospitals are highly motivated to do something about their performance once the information is publicly reported.

Interviewee C also noted that public reporting allows consumers to see who is not providing quality care and then make choices between private or public hospital sectors (when they have private health insurance).

Interviewee C noted that many Organisation for Economic Co-operation and Development (OECD) countries have been reporting for over 20 years, but Australia has been a late adopter. It was indicated that the USA, UK and Canada started reporting 20 years ago and today they report a wealth of knowledge on safety and quality information, whereas Australian has only in recent times started to report nationally and locally on hospital safety and quality. It was noted, however, that Australia, has since moved forward at a rapid pace in this area.

## Challenges of public reporting

While recognising that Australia has made significant progress in a short space of time, Interviewee C indicated the view that there was tremendous room for improvement. In particular, Interviewee C noted the importance of appreciating that merely putting a report in the public arena is not public reporting. It requires a communication strategy around performance that needs staff talent, time and resources to ensure the information is contextual and useful.

## Examples of good public reporting

Interviewee C spoke about use of advertisements overseas to drive awareness of publicly reported information. It was suggested that there are many examples of how other countries use advertisements and media for engagement and providing information in the way clinicians or consumers can understand the information.

Interviewee C believes that, in most cases, information should be presented in the same way for clinicians and consumers. For example, information about variation should be transparent for all audiences. It was also indicated that such information should be presented in a way so that the least data literate clinician can understand the graphics and that those consumers with low levels of health literacy can also understand it.

## Interviewee D: Administrator, health trust, Norway

### Background on public reporting in Norway

Interviewee D stated that data are published on 256 indicators nationally in Norway. Some are published annually and others quarterly. Data are at hospital level on different procedures, but not at a clinician level. Everyone has access to the same publicly reported information through the same mechanisms and the information is published using simple language. From Interviewee D's experience, consumers have not been afraid of the information and are reassured to know that organisations are acting on this information.

Interviewee D noted that publicly reported information has led to enhancements to hospital systems in Norway, including the rollout of closed-loop medication systems to overcome medication errors that were identified. Similarly, reported data on outcomes of stroke treatment led to analysis of the issue to identify potential reasons for differing results across two sites in the same hospital group. The analysis led to a reorganisation of stroke care to one site with sufficient after-hours support, which led to improved outcomes.

Interviewee D further noted that the prevailing culture in Norway has broadly accepted that it is not appropriate to blame individual clinicians for errors in hospitals. As evidence of this view, Interviewee D cited the example of the highest ranking prosecutor in Norway commenting that, when there is a serious issue in the hospital, the systemic issues, instead of individual clinicians, should be reviewed.

### Benefits of public reporting

Interviewee D stated that it is imperative for the community to appreciate that hospitals and healthcare organisations are open and transparent on what is happening and that they use the information they report for improvement in hospitals. In his view, information kept within the hospital only has a minimal learning impact. By raising awareness of issues with patient groups and others, there is a much greater chance of creating positive change.

In Norway, there is a national quality dataset that every hospital reports continuously, which is used by the leadership of these hospital organisations. There is also a strong culture of patient involvement through patient organisations. Interviewee D's experience has indicated

that when data are provided to patient organisations, good discussions are generated amongst all stakeholders around the data to promote quality improvement.

In Interviewee D's experience, consistent, systematic use of quality indicator information can drive organisational improvement. However, this was dependent upon ensuring that clinical staff can relate to the data. It was noted that clinical staff often respond better to research information than performance information, which are the type of data that are typically reported and acted upon by governments. Creating a shift in thinking so that clinicians also respond and act on performance information is key to success in driving organisational improvement.

It was also noted that public reporting on performance can put pressure on governments for funding and resources or drive the case for implementing further training and leadership capability within organisations. The other benefit of reporting publicly is the ability to see a pattern across hospitals or departments, and this could be related to a piece of equipment or other external factors that require broader action.

## **Challenges of public reporting**

Interviewee D indicated that, in Norway, there was little benefit seen in pursuing individual clinician reporting. It was noted that by focusing on clinician-level reporting, this elevates the importance of one person above the clinical team and that health care is very much a team game. Such a focus would therefore result in a lack of understanding on why an issue may have occurred or why an organisation is underperforming in a certain area.

It was also stated that while understanding patient experience and organisational culture were important, they were probably not as helpful in leading to safety and quality improvement as the public reporting of safety and quality indicators.

## **Interviewee E: Administrator, non-profit organisation, USA**

### **Background to public reporting in the USA**

Interviewee E stated that public reporting by hospitals started with President Bush around inpatient program reporting and has expanded significantly since that time. Hospitals are required to report on quality data or they forfeit a percentage of their Medicare payment. During the Obama presidency, there were additional programs added that tied further funding to performance including safety and quality outcomes.

The nucleus of information that is publicly reported on in the USA is based on data collected through the Medicare Inpatient Quality Reporting Program (IQRP). There are some other data sources; however, these sources are very limited. Interviewee E remarked that the indicators are sometimes endorsed by the Centers for Medicare & Medicaid Services (CMS) before they are put in place. Some measures that are endorsed are not implemented after testing because they are deemed not fit for purpose.

The non-profit organisation reports publically on healthcare performance. Interviewee E said the reporting system has been running for several years and uses national performance measures from the IQRP, a voluntary hospital survey and other sources including, the Agency for Healthcare Research and Quality (AHRQ), the Centres for Disease Control and Prevention (CDC), and the American Hospital Association's Annual Survey and Health Information Technology Supplement. There are currently 2,000 hospitals reporting to the organisation for inclusion in the system.

Measures included in the system are vetted regularly (usually every six months) for currency and impact. The overall risk weighting methodology is based on best practice research and that too is assessed regularly and can be changed, depending on developing evidence.

## Reaction to the public reporting system

Interviewee E stated that there was contention initially, with hospitals arguing about the validity of the grade they had been given. In Interviewee E's opinion, the most important aspect of the strategy was to name a patient safety 'dream team' expert panel, comprising some of the most well-known experts in the sphere (for example, Lucien Leape) to advise on the development of the tool. They volunteer their time to be on the panel and add a significant degree of credibility to the tool itself amongst healthcare organisations. The panel has stood firmly behind the program and this has meant that healthcare organisations now rarely question the validity of the approach.

## Benefits of public reporting

Interviewee E stated that the organisation had not undertaken any analysis on changes in consumer behaviour but knows that whenever results are released they receive significant media coverage. Interviewee E commented that it is very apparent (anecdotally) of how powerful the reporting has been in driving changes within hospitals. It was noted that hospitals have become extremely focused with their results and every hospital is competing to get high results. Hospitals with high results have billboards and advertisements showcasing this. The reporting system has also resulted in hospital boards questioning the performance of their hospitals, which is changing the whole dynamic in quality.

Interviewee E emphasised that the reporting has been extensively tailored to make it accessible to consumers. The language has been simplified to focus on errors, infections, injuries and accidents and they use a symbol that the consumer can relate to and compare with other hospitals with ease. The organisation worked closely with health literacy experts to present the data in a way that is understandable, as the data can be very confusing (for example, explaining to people that a small number is good for certain indicators, such as infection rates, but higher overall results are better). Based on market research conducted, the organisation knows that consumers will drill down for more information only if they are interested in the headline information.

## Challenges of public reporting

A challenge faced by the organisation is that the survey used as part of the reporting system is voluntary. Being voluntary makes it more difficult to achieve consistent reporting and therefore ensure a level playing field. If the hospitals do not respond to the survey, they are identified as declined to respond and their assessment is based on a subset of indicators. Over time, the public have started to question why an organisation is not responding and Interviewee E indicated that this has sometimes had a positive effect in driving those organisations to respond to the survey.

When discussing challenges to public reporting beyond the specific issues faced by the organisation, Interviewee E identified a number of potential issues. One particular challenge is the tendency to push for a single organisation to have responsibility for reporting. It was suggested that if this organisation is a government entity, this may be more susceptible to political pressure, which would therefore impact on the efficacy of its reporting. Ideally, the measurement data that are mandated through government requirements should be made available as open source data for interested organisations (both public and private) to report in ways that caters to various audiences. Lobbying and political pressure in general are a challenge to public reporting, with Interviewee E citing the example of recent efforts to try and get hospital accreditation details published publicly in the USA, which did not succeed.

Making reporting of information as easy as possible is also essential to get organisational buy-in to the reporting process. The reporting system works well because the bulk of the data is already being collected for CMS purposes.

## Future of public reporting

Interviewee E advised that the organisation does not have plans to move towards individual physician reporting; rather, the organisation will be focusing on outpatient and ambulatory systems. Interviewee E felt there was value in individual reporting for certain types of procedures, but that the focus on teams and organisations was more important. In Interviewee E's experience, the same surgeon could have different outcomes depending on the location where the procedure was conducted. Interviewee E also described research that showed certain patient experience measures correlate closely with safety outcomes and noted that capturing patient experience was certainly important, although should only be a complement to the overall picture of an organisation's performance.

# Appendix A: Moderator scripts for forums

## Moderator scripts for consumer forums

### Warm up and introductions (~10 minutes)

Once everyone is sitting down, give a brief introduction of the forum leaders and representatives, the purpose of the focus group discussion and the rules for group conduct.

#### **Suggested Script**

*[Introduce moderator's names] I am conducting this focus group on behalf of the Australian Commission on Safety and Quality in Health Care. The Commission's role is to lead and coordinate national improvements in the safety and quality of health care.*

*The Commission works in partnership with the Australian Government, state and territory governments and the private sector to achieve a safe, high-quality and sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.*

*The Commission is especially interested in helping consumer and patient voices to contribute to improvements in the quality of health care that is provided to people. One way of doing this is to report to the public about how safe our hospitals and healthcare providers are, and the quality of care given to people when they are in hospital.*

*In Australia, all public and private hospitals must comply with a range of National Safety and Quality Health Service Standards. These standards ensure that hospitals and health care providers deliver safe and high-quality care.*

*All public and private hospitals collect, monitor and report on a wide range of information about how hospitals work, and the services they deliver. For example, information on how many people go to hospital for which reasons, whether or not they receive surgery, whether they get a complication (like an infection, or bed sore) while they are in hospital, and whether they are satisfied with their hospital stay. Some of the information collected is publicly reported at a hospital, district and state level. However, the process and requirements for public reporting of this information varies across Australia and between public and private hospitals. Also, not all of it is reported.*

*This focus group is your opportunity to give your perspective about what safety and quality information you would like to see made public, whether safety and quality information should be made public, the type of safety and quality information you would find helpful, how you would use this information and how you would like to access this information. We are also interested in whether you know what is reported now, and whether it is useful. Similar focus groups are taking place in Brisbane, Melbourne Sydney and Perth.*

*So that we allow all of your voices to be heard in this discussion group, we will have a few basic rules. The group will go for a maximum of two hours. I will ask you some basic questions to start you off, and will help the discussion to keep on track along the way, but the idea of the group is for a conversation to develop between all of the participants. We are*



*interested in your reactions to what other participants say, but these discussions must always be respectful of everyone in the group.*

*We want everyone to feel comfortable in sharing all of their experiences, and so we will also use the Chatham House Rule, which means that everyone commits not to repeat information they hear in this group in a way which could identify the person who revealed it. As you have already heard, the recordings of these discussions, and the transcriptions of them, will be securely stored. Any names and identifying details will be removed upon transcription, so that none of this information is used in the subsequent analysis. Participants' personal information will be protected under the Privacy Act 1988.*

*Do you have any questions?*

### **Introductory question (5 minutes):**

*Can you introduce yourself and tell us a bit about yourselves?*

**Note for moderator (NFM):** Keep this brief, to ensure that everyone can introduce themselves before any discussion related to public reporting starts.

### **Suggested Script**

*Now we know a bit about each other, we are hoping to run through a series of questions. These are intended to start the discussion on your perspectives on some of the questions we have about reporting to the public on information about the overall safety and quality of hospital care. There are no right or wrong ways to do this; we are interested in anything you might have to say about your experiences in getting information about our hospitals and what you think about how this information gets reported to the public, even if it seems small.*

**NFM:** At this point, give a quick explanation about what we mean by safety and quality information to provide clarity to participants on what we are referring to in the discussion (see below).

### **Suggested Script**

*This forum is about finding out your views about making information on safety and quality of patient care available to everyone. We want to make sure that you are clear about those concepts.*

*When we talk about patient safety information, we're really talking about any details on how hospitals perform in protecting their patients from errors, injuries, accidents, and infections during their treatment, or how often these errors happen and how the health service provider is preventing these things from happening.*

*While Information about individual treatment plans or illnesses is very important to patients and carers, we would like to focus on the type of safety and quality information that is important and meaningful for you to know about your healthcare providers.*

**Emphasis:** When we refer to information about the quality of care, this is a broader concept, covering overall actions taken by an organisation to increase the chances of a positive outcome for patients and the results of these actions.

**NFM:** Notice if any participants appear to be shy or reserved or confused when introducing themselves, and make a mental note to specifically ask for their view if they are not participating equally in the later discussion.

### **Transition Question - Question 1 (10 mins)**

**What does safety and quality in a health context mean to you?**

***NFM:** Remind participants there are no right or wrong answers. The purpose of this question is to measure the level of knowledge on the concept of safety and quality among the participants, which will then set the tone for the rest of the discussion. If the level of general understanding is reasonable, you can potentially offer a bit more detail on the other questions.*

**NFM:** Think of a time when you may have been a patient or carer?

### **Question 2 (~30 minutes)**

**What information would you want to know about health care, hospitals and the people who provide health care in a hospital? Does this include information on safety and quality as we discussed earlier?**

Optional prompt – if no one brings it up, moderator should ask the following:

- (i) *Thinking about what you have said on what safety and quality mean to you, would information on this also be useful?*
- (ii) *Does it make a difference whether you are a patient, or are going to be a patient, or know someone who is going to be a patient? Or you might just want information generally?*

**NFM:** What information matters to you / is important?

**NFM:** Is this information different if you are a patient/consumer or caring for someone?

### **Question 3 (15 minutes)**

**In the past, have you ever tried to search for this kind of information on a hospital or healthcare provider? If yes,**

- **Where did you look?**
- **Did you find what you were looking for?**

**If no, why not?**

**NFM:** Did you try to find information about a health service or a specialist?

**10 minute break**



**Question 4 (~10 minutes):**

**Reflecting back on what kind of information you have said would be useful, what is the best way for this to be shared with you?**

**NFM:** This is trying to understand what the best medium of sharing this information is, i.e. website, social media, or published report – please prompt the audience if unclear.

**Question 5 (~10 minutes)**

**How would you like this information presented? We want you to think widely about this, as we are looking for modern ideas.**

**NFM:** The literature suggests that the public reporting we do now, particularly in Australia, is not designed to be user friendly. It is important to gauge how consumers want this information presented (not just the medium by which it is presented).

**Question 6 (~10 minutes)**

**Would you find it useful to be able to compare information between hospitals on how safe they are and the overall quality of the care they provide? Or between providers?**

**What types of comparisons would be useful?**

**NFM:** If unclear, it should be explained that comparison types could include how hospital providers perform in terms of outcomes for certain illnesses or procedures (such as surgery), for example, how many people may have got an infection while in hospital.

**Question 7 (~5 minutes):**

**If you could have or see this information in the ways we have just discussed, would it make a difference to how you choose a hospital or healthcare provider in the future?**

**NFM:** The literature suggests that even where safety and quality information is made available, it does not typically sway consumer choices, which are often driven by other factors. This question is trying to confirm whether, if the information is presented in the way consumers want and is easily accessible, it would change selection behaviour.

**Question 8 (~5 minutes):**

**Is there anything else that you feel is relevant that we have not covered so far?**

**NFM:** Is there anything else that you would like to add to the discussions today? Do you feel like there is something that we missed or was not covered during the session?

## Moderator scripts for clinician forums

### Warm up and introductions (~10 minutes)

Once everyone is sitting down, give a brief introduction of the forum leaders and representatives, the purpose of the focus group discussion and the rules for group conduct.

#### **Suggested Script:**

*[Introduce moderator's name] I am conducting this focus group on behalf of the Australian Commission on Safety and Quality in Health Care. The Commission's role is to lead and coordinate national improvements in the safety and quality of health care. The Commission works in partnership with the Australian Government, state and territory governments and the private sector to achieve a safe, high-quality and sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and hospitals.*

*The Commission is especially interested in helping clinicians, consumers and patients to contribute to quality improvement in healthcare. One way of doing this is by supporting public reporting of safety and quality information by public and private hospitals.*

*In Australia, all public and private hospitals must comply with the National Safety and Quality Health Service Standards. These standards ensure that hospitals and health care providers deliver safe and high-quality health care.*

*All public and private hospitals collect and monitor a wide range of information about how hospitals work, and the services they deliver. For example, admissions, casemix, cost information, clinical incidents, complication rates, patient satisfaction, information on outcomes of procedures and so on. Some of this information is publicly reported at a facility, local hospital district, hospital group and/or state-wide level. However, the process and requirements for public reporting of safety and quality outcomes vary across states and territories and between the public and private health sectors. Not all the information collected is reported, and most is not reported in a comparative way.*

*This focus group is your opportunity to give your perspective and insights about the type of safety and quality information you would find helpful to be routinely reported to you, how you would use this information and how you would like to access this information. Another question is whether, and how, safety and quality information should be made public. Similar group forums are taking place in Brisbane, Melbourne, Sydney and Perth.*

*The information you give us will be used to support the Commission to develop options for the future of public reporting on safety and quality information in healthcare across Australia.*

*So that we allow all of your voices to be heard in this discussion group, we will have a few basic rules. The group will go for a maximum of two hours. I will ask you some basic questions to start you off, and will help the discussion to keep on track along the way, but the idea of the group is for a conversation to develop between all of the participants. We are interested in your reactions to what other participants say, but these discussions must always be respectful of everyone in the group.*

*We want everyone to feel comfortable in sharing all of their experiences, and so we will also use the Chatham House Rule, which means that everyone commits not to repeat information they hear in this group in a way which could identify the person who revealed it. As you have already heard, the recordings of these discussions, and the transcriptions of them will be securely stored. Any names and identifying details will be removed upon transcription, so that none of this information is used in the subsequent analysis.*

*Do you have any questions about the purpose of these groups or how the group session will run?*

**About the session** – there are four key themes on how the questions have been structured today. These are:

1. *What safety and quality information should be reported?*
2. *Why should this information be reported?*
3. *How should this information be reported?*
4. *And who should be responsible for reporting?*

### **Introductory question (10 minutes):**

Can you tell us a bit about yourselves and what you do?

**Note for moderator (NFM):** Keep this brief, to ensure that everyone can introduce themselves before any discussion related to public reporting starts.

### **Suggested Script**

*Now we know a bit about each other, let's start to talk about the public reporting of safety and quality information across our healthcare sector. There are no right or wrong ways to do this, we are interested in anything you might have to say about your thoughts or perspective, even if it seems small. We would like to know what safety and quality information you think is important to the public and how this information can be used.*

**NFM:** At this point, give a quick explanation about what we mean by safety and quality information to provide clarity to participants on what we are referring to in the discussion (see below).

Quality in health care means the best possible health outcomes given the available circumstances and resources, consistent with patient centred care. Safety in health care relates to reducing the risk of unnecessary harm from clinical care to an acceptable minimum level.

## Theme 1: WHAT should be reported

### Question 1 (~15 minutes)

**What indicators / information do you think need to be publicly reported on?**

**What would be useful for you to know as a clinician?**

**Why is this information important?**

**NFM:** Are they important to clinicians or consumers or both? Is some information important because it allows a clinical conversation between the clinician and the patient (for example, patient reported outcome measures)?

**NFM:** If you have to report on five key indicators, what might they be and how would you rank them by importance? What could be reported on (i.e. pressure injuries, falls, etc)?

**Are there any indicators or measures that you think should not be reported on publicly? What are they?**

**Why shouldn't they be reported?**

**NFM:** Keep this section brief.

### Question 2 (10 ~minutes):

**Who is the primary audience for information about healthcare quality and patient safety? Why?**

**If there is more than one audience, should the information be presented differently to cater for them?**

**NFM:** The literature suggests one of the issues with current public reporting relates to confusion on the primary audience and also whether forms of public reporting should cater to specific groups; for example, one portal that is consumer friendly and intended for their use, another specific to clinicians/administrators. This question aims to test that view.

## Theme 2: WHY should we report

### Question 3 (~10 minutes)

**Thinking about your own experiences, do you believe current public reporting of safety and quality data drives ongoing quality improvement activities in the health sector?**

**Using examples from your own experience, explain why or why not?**

**NFM:** Are there any examples of where you have seen public reporting (even between facilities) work to drive improvement or conversely where it may have been problematic?

**NFM:** This is a key point in the literature (i.e. that public reporting can drive healthcare organisations' ongoing quality improvement efforts) so it is important to validate this with the audience.

## Theme 3: WHO should report

### Question 4 (~5 minutes)

**Which hospitals should publicly report healthcare quality and patient safety indicators / information in the acute care sector?**

**NFM:** Does size of a hospital matter?

**NFM:** Suggest options and prompt if necessary.

## Theme 4: HOW should information be reported

### Question 5 (~5 minutes)

**How should quality and safety information be presented? Does this depend on the audience?**

**NFM:** We are interested in understanding whether views on how information is presented includes not only traditional methods or reporting but novel and contemporary ways of reporting.

### Question 6 (~15 minutes)

**How important is it that there is national consistency in healthcare quality and patient safety indicators / information? What are the challenges with this?**

**NFM:** We are seeking to understand consistency not only across jurisdictions but also between the public and private health sectors. It is likely that potential issues with trying to gain consistency due to risk adjustment issues etc. will come up here.

### Question 7 (~10 minutes)

**When/if healthcare quality and patient safety information is reported, should the information relate this to the performance of hospitals and healthcare providers?**

**Should the information draw comparisons between groups or facilities for example?**

**Are there comparisons that you would find useful? Why?**

### Question 8 (~5 minutes)

**If the primary reason for public reporting of safety and quality information is to drive safety and quality improvement, how often do you think reporting should be published to achieve the greatest effect?**

**Would this be different for clinical and consumers / public audiences?**

**NFM:** If options are not offered, suggest potential frequencies, for example, monthly, quarterly

**Question 9 (~5 minutes)**

**Who do you think should be responsible for publishing healthcare quality and patient safety indicators / information and why?**

**NFM:** Jurisdictions, national bodies, individual health services etc.

**Question 10 (~15 minutes)**

**What are some of the challenges and barriers you see for reporting safety and quality information for private and public hospitals that we have not covered in the questions so far?**

**Question 11 (10 mins)**

**How might these barriers be overcome, so that information is accessible to clinicians and the public?**

**Are there other solutions to providing this information to everyone?**

**Question 12 (5 mins)**

**Is there anything else you think we haven't covered and is important?**

# References

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