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What is This?
Consumers’ Understanding of and Interest in Provider- Versus Practice-Level Quality Characteristics: Findings From a Focus Group Study

Brad Smith, PhD1, Wendy D. Lynch, PhD2, Cathie Markow, MBA, RN3, Sarah Lifsey, MPP4, and Michael Slover, MS4

Abstract
Quality measures are currently reported almost exclusively at the facility level. Forthcoming physician quality data are expected to be reported primarily at the level of the group practice. Little is known about consumers’ understanding of and interest in practice-level measures. The research team conducted 4 focus groups, half with individuals who had a chronic illness and half with individuals who did not. Most consumers correctly understand the concept of a physician practice. However, consumers exhibit little interest in practice-level characteristics, preferring information about their personal doctor. Understanding of and interest in practice-level quality does not differ by chronic disease status. Additional work must be done to design, develop, and test promotional and educational materials to accompany the planned reports to highlight the relevance of practice-level characteristics for consumer decision making.

Keywords
quality, public reporting, consumerism, providers

In response to the call to transform the quality of care in the United States,1 the health care system has produced a broad array of measures of health care quality and patient satisfaction. The US Department of Health and Human Services Measure Inventory, one of several public and private repositories, contains more than 2100 quality indicators alone. A much smaller subset of these quality measures has made its way into public reports sponsored by the Centers for Medicare & Medicaid Services (CMS) for consumers of inpatient, nursing home, dialysis, and home health care.

Although basic information on the relative performance of facilities is available, comparative data on the performance of individual providers is less centralized and harder to find. A wealth of informal, crowd-sourced data that can be associated with clinical quality2 are available from social media sites such as Yelp and Angie’s List and through health-focused sources such as HealthGrades.3

Quality measures for individual providers are available in some states and communities, such as through New York’s Cardiac Surgery Reporting System4 and through special initiatives in several Aligning Forces for Quality Communities.5 Although CMS’s Physician Compare data are slated to appear in early 2014, “if technically feasible,”6,7 they will present quality data on only 5 measures for just 66 group practices that reported data satisfactorily in 2012. Given the age of the data and the limited scope, they are unlikely to be useful to consumers when selecting a provider. At this juncture, there is currently no national source of systematic, reliable, valid provider-level quality data for consumers.

When quality measures do eventually appear for providers at the national level, they will largely be presented at the level of the physician group or clinics rather than at the individual provider level. Analysis and reporting at the group level is necessary because of data collection methods, sample size constraints, the growth of group practices,8 and resistance by physicians.9 Both the process-focused and patient experience measures of quality proposed for national reporting are poised to come from practice-level data aggregated from encounters between

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individual patients and providers within the practice. Patient experience of care measures will be drawn from the Clinician Group Consumer Assessment of Healthcare Providers and Systems and are planned for public reporting, perhaps as early as 2015. There has been substantial research on the impact of ways in which consumers interact with public reports and on the impact of public reporting. Despite our depth of knowledge about best practices in public reporting, the bulk of what we know about consumers’ use of data is based on reporting of quality at the institutional level. The eventual reporting of quality data through Physician Compare will be novel on at least 2 levels: (1) It will be the first national report on provider quality data, and (2) it will present quality data in such a way that consumers will be required to weigh the importance of information at the level of the group practice or clinic. Given evidence that quality varies significantly across and within provider groups, the presentation of group-level results has potentially significant implications for consumer decision making.

Although researchers have documented a variety of best practices for presenting quality information, little is known about consumers’ understanding of and interest in practice-level quality and patient experience data. This article explores (1) how well consumers understand the concept of a physician “practice,” (2) the level of interest among consumers in practice-level versus provider-level information for health care quality and patient experience measures, and (3) whether opinions and attitudes on these topics differ between patients with and without a chronic illness.

Methods

The research team conducted a total of 4 focus groups in late 2012 in 4 metropolitan areas. The areas were selected to provide geographic diversity and to ensure access to significant populations of racial and ethnic minorities. All participants were recruited through the panels of commercial marketing research facilities, consented to participate in the project, and were compensated at market rates for focus group participation. The study protocol was reviewed and approved by the Chesapeake Institutional Review Board.

Potential participants were screened to ensure that they made most of the health care decisions in their household; were between the ages of 30 and 50, to ensure some level of contact with the health care system; and had attended, either for themselves or as a caregiver, 2 or more office visits to a primary care or specialist provider in the past year. The research team sought heterogeneity in the groups’ composition to achieve a mix of sex, race, ethnicity, and education levels in each group consistent with the makeup of the local population. The team drew from a limited age range because they expected health care consumption patterns to differ significantly between middle-aged and older consumers and wanted to focus primarily on differences between consumers with and without a chronic disease within the same age group.

Two of the groups consisted of individuals who self-identified during the screening process as having a chronic condition or a close loved one with a chronic condition for whom they coordinated medical care. The research team asked respondents to identify whether they or a loved one had a “chronic medical condition that requires ongoing treatment” and then listed a number of exemplar conditions, including diabetes, high blood pressure, stroke, heart disease, chronic fatigue syndrome, arthritis, chronic obstructive pulmonary disease, asthma, and fibromyalgia. The remaining 2 groups consisted of individuals who reported negative answers to the same screening question.

The research team developed a discussion guide that focused on consumers’ understanding of the concept of a practice and explored participants’ interest in health care quality and orientations to health care decision making under various hypothetical circumstances. Participants also participated in a card sort activity consisting of 14 cards representing various measures of health care quality, patient experience, or other provider characteristics that either are currently publicly reported or might be publicly reportable. Each participant was asked to sort the cards in priority order and then to discuss the rationale behind their top 3 and bottom 3 choices.

All focus groups were recorded and professionally transcribed. Transcripts were imported into NVivo version 8 (QSR International Pty Ltd, Doncaster, Victoria, Australia) and subjected to formal qualitative analysis. The lead analyst on the research team (SL), who has extensive experience conducting qualitative analysis, developed an initial set of codes based on a review of the transcripts for the first 2 focus groups. The research team then reviewed and refined the list of codes and transcripts as a group before the lead analyst completed coding the remaining transcripts. The node summary from NVivo along with supporting quotes from participants formed the basis for the analysis reported herein. Data from the card sort activity were tabulated and formatted in Microsoft Excel (Microsoft Corporation, Redmond, WA). The order in which the 14 cards were sorted was recorded for each participant and then converted (by subtracting the priority order from 15) into an “importance rating,” where higher scores indicated increased importance.

Results

As shown in Table 1, there was a reasonable degree of racial and ethnic variation across the 4 groups. Age and sex composition were roughly on par at each site.
Consumers’ Understanding of a “Practice”

Across all groups conducted, respondents agreed in general on the concept of a practice. Several participants reported that they understood a practice to represent doctors who share resources, including supporting staff, and make joint business decisions, or a group of doctors working together in partnership. One respondent felt that a practice was when doctors “make joint decisions about how the practice is run.” Another noted that a practice is when “[t]hey are familiar with all your records; they have access to everything; and because they work as a team, if anything had to be [an] emergency or whatever, it still should go smooth.” Other respondents identified the concept of a practice from the benefits that they may receive by being able to see another doctor within the practice if their regular doctor is unavailable.

A minority of participants exhibited confusion about what a practice represents. For some respondents, the idea of practice had to do with the types of insurance plans accepted or with the hospitals with which physicians are affiliated. One respondent said, “I think some doctors do belong to different groups . . . that they practice within, but also different groups that allow different insurances.” Others thought a practice involved physicians who share the same care philosophy or level of skill, so only “good” doctors would work together. Another participant reported that they thought the term “practice” pertained to ownership and that it represented a business that was private and for profit, the opposite of a publicly funded clinic such as a community health center.

Although participants were largely familiar with the concept of a practice, it was not a term that they routinely used when talking to friends and family about health care. The individuals with whom we spoke whose primary doctors were part of a group practice said that they were more likely to talk about the practice with terms such as doctor’s office, Dr Smith’s office, or Riverwalk Dermatology. No differences in understanding of the concept of practice or the way in which the term is used were noted between participants with and without chronic conditions.

Consumers’ Relative Levels of Interest in Provider and Practice Characteristics

After providing a formal definition of a practice as “a group of two or more medical professionals who see patients at the same location and share resources,” the research team then asked participants to imagine that they had an online tool that had an infinite variety of data in it about providers and practices and to tell the team some of the kinds of things that they might want to know about a physician and separately about that physician’s practice.

Participants were more likely to express a desire to know something about the characteristics of individual providers than a group practice. They said that they would want to know whether their doctor provided quality treatment, and some felt that knowing information about a doctor would help them feel a personal connection with the doctor and develop a relationship. One respondent said that knowing about their physician’s biography (medical school, undergraduate training, personal interests, or hobbies) helped make “a personal connection. . . . It was, for me, just being able to read where he went to school, a little . . . of his life; you could see that there was a connection, and for me, he was doing cancer. . . . Just that little bit of something in common made it easier to meet him and it set a nice tone.” Other participants echoed the importance of knowing background information such as medical school because knowing about the doctor’s background or experiences helps ensure the doctor has the required knowledge to give good treatment: “You just want to make sure that that particular person that is seeing you has the knowledge [required]. . . . You want to make sure somebody just doesn’t have something up on the wall.” Another respondent would use information about the doctor’s medical background to assess the medical knowledge: “I feel like, in this area, we have some of the best colleges for medical professionals, so knowing that they went to some of those schools . . . it’s a lot easier on me seeing them.”

Where interest in practice-level characteristics was shown, it was typically secondary to a potential need to see other doctors in a group practice if their personal doctor was not available. They wanted to ensure that they would receive the same level of care that they expected from their doctor and have a similar experience if they were sent to other doctors within the practice. One participant said that when her child is sick, “we call and we need an appointment. Our doctor might have appointments already, and the doctor who doesn’t have appointments is the one we see.”

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Table 1. Participant Characteristics by Site.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group 1 Phoenix</th>
<th>Group 2 Boston</th>
<th>Group 3 Detroit</th>
<th>Group 4 San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (years)</td>
<td>42.1</td>
<td>39.4</td>
<td>42.0</td>
<td>41.3</td>
</tr>
<tr>
<td>Male (%)</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Race (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>75</td>
<td>75</td>
<td>83</td>
<td>70</td>
</tr>
<tr>
<td>Other/African American</td>
<td>25</td>
<td>25</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>Hispanic</td>
<td>16</td>
<td>8</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>n</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>
However, many other participants expressed a near-total disinterest in practice-level characteristics. This group cited a number of reasons for their disinterest. One respondent said that they “don’t have time to research other doctors” because they see another doctor within the practice only if their regular doctor is unavailable. Another set of participants seemed willing to trust their doctor’s choice of colleagues. A typical respondent in this group suggested that because their regular doctor is “very well qualified . . . it’s his business; you don’t want to bring in a doctor that doesn’t know what they’re doing.” A third set of participants who were disinterested in practice-level statistics cited the overwhelming importance of the quality of their interpersonal relationship with the doctor and the ease of switching if the alternative choice was unsuitable. One of these participants said, “If you’re referred to somebody and you like them, then you stay. If you don’t like them, I think you just kind of look into maybe switching to a different doctor.” The last subset of participants could not articulate a specific reason spurring their disinterest in practice-level characteristics. Analysis of the transcripts could not discern a difference in level of interest in practice-level characteristics between those with and without a chronic condition.

Consumers’ Interest in Practice-Level Quality, Patient Experience Measures, and Provider Characteristics

In addition to the open discussion about provider and practice characteristics that might be of potential interest, the research team also asked participants to review and reflect on a series of formal patient experience and quality measures that either are currently or might soon be available for public reporting. The team began by defining clinical quality as “measurements related to how effectively doctors treat their patients according to guidelines for the good practice of medicine.” Then, the team introduced and briefly discussed 14 hypothetical measures (the full list is provided in online appendix A, available at www.ajmq.sagepub.com/supplemental) and asked respondents to sort them in priority order given the need to choose a new individual provider for themselves.

A complete ranking of measures is displayed in Figure 1 separately for the groups with and without a chronic condition. The measures are ordered by the average rank across both types of groups, with highly ranked items near the bottom and less highly ranked items toward the top.

Subsequent to the card-sorting exercise, participants were asked to tell a little bit about the logic for why they ordered the measures in the way they did. Communication skills were considered important by respondents across all 4 groups conducted, as further evidenced by the rankings in Figure 1. A physician who can communicate well was viewed as an important prerequisite to the patient’s ability to understand the doctor’s instructions and to receive a high quality of care. Communication also was viewed as essential to building a trusting relationship between patient and provider. As one participant put it, “If I am supposed to have a test, are they going to follow up with me if they don’t get the results? Are they maintaining my care and keeping in communication with me about what’s going on?” Other participants prioritized good communication in response to past negative experiences with doctors whose native languages were not English. Also widely cited as important to participants was timeliness in care experiences. Timeliness was often viewed as fundamental because of access. One participant told us, “If I can’t get in timely, then it really doesn’t matter.”

Least important to group participants were 2 clinically focused concepts, one focused on a physician’s success in caring for patients with asthma and the other focused on the provision of mammography for female patients. As one male patient noted, “I don’t have asthma; I’m never going to get a mammogram. If I have a kid who has asthma, obviously that gets more important; if I’m trying to get a good idea for my wife, that’s more important; but for me, not important.”

Two other clinically focused concepts fared better in the importance ratings, specifically the items for success in taking care of asthma and diabetes. Participants’ interest in specific measures of health care quality appeared to be tied closely to their own biographies. One participant from a chronic condition group who was probed for why he/she had prioritized the diabetes measure higher responded, “Selfish reasons: I have diabetes, [so] success in taking care of patients with diabetes—that’s the most important thing to me.” Self-interest, however, did not seem to bolster the importance of the mammography rate measure, which was ranked lowest despite the groups being approximately 50% female, perhaps because of a preponderance of younger women.

Few differences in prioritization between the groups with and without a chronic condition were clear from the data. The analysis of the card-sort data revealed a few modest differences in priorities across the groups. A doctor’s communication skills, malpractice history, and overall rating were valued slightly more by those with a chronic condition than those with no chronic condition. Participants without a chronic condition valued electronic medical record use, location of medical training, and board certification a little more highly than those with a chronic condition. Although the 2 clinically focused concepts were ranked the lowest overall, these were modestly more important to participants in the chronic disease groups.
At the conclusion of the ranking discussion and exercise, respondents were asked how they would alter their ratings if they were evaluating a practice rather than a single provider. In general, respondents reported that they would not change their rankings and that they would want to know the same basic information at the practice level as at the provider level: “I’d say the same. I want to make sure they went to a school I’ve heard of and not some Joe’s Bar and Grill.” There was little consensus as to what respondents would like to know at the practice level that was different from the individual doctor level. Where there was interest expressed, the specific desires for information were quite different from the provider-specific topics in which they were interested with regard to their individual provider. Specific practice-level suggestions from the groups included an overall patient satisfaction rating across all physicians in the practice, the availability of other doctors in the practice for appointments, whether referrals to outside care were timely, whether the practice was in debt (to ensure that decisions were made with no financial interests in mind), and whether the doctors shared a common approach to or philosophy of care. Stability, specifically defined as how long the practice had been together and how long the physicians had been part of the practice, also was identified as important. One participant suggested about stability, “You can kind of infer something about how they feel about the quality of care, how they feel about their personalities and as business partners.”

**Discussion**

In summary, these focus groups revealed a fairly high degree of understanding of the concept of a physician practice that did not vary based on the consumer’s chronic condition status. Although most consumers have a good understanding of the concept, they rarely exhibit interest in knowing about practice-level characteristics. One
group of consumers thought that it would be nice to know something about the practice, mostly in case they had to seek care urgently when their doctor was not available. Another group of consumers expressed a near-total disinterest in practice-level information, saying that they either trust their doctor in his or her choice of colleagues, would trust the facility employing these doctors, or would be in too much of a hurry to do background research at the practice level. When specific hypothetical measures of quality, provider qualifications, and patient experience were reviewed with participants, participants across both types of groups tended to value interpersonal and logistical measures (eg, communication, ability to get appointments) over measures based on clinical process. However, first and foremost, consumers reported that their primary interest was in their own personal doctor, not the practice.

Although novel, these findings also are limited in important ways. First, they are limited in generalizability because of the research design. Although a great deal is known about the opinions and thoughts of the individuals who participated in these 4 groups, the research team has little idea whether these opinions are typical of what consumers believe generally. The study is further limited by the hypothetical nature of some of the discussions. Many of the questions asked required participants to draw on past experience seeking care. Other questions, however, focused on what they might find useful if a tool were made available. In light of that structure, the research team is not able to speak to consumers’ behavior in the presence of actual health care decisions. The discussion of what a group practice constitutes, focusing on multiple providers sharing resources in a single location, served well to unite the focus groups quickly around a very simple idea of what a group practice represents. Reality is, of course, more nuanced, and providers within group practices are likely to share an electronic medical record and also to have shared practice patterns or philosophies. Because these shared characteristics may affect clinical practice, the nonclinical definition of group practice that the research team adopted may have influenced the course of discussion in unknown ways. Finally, because the sample was limited to middle-aged participants, additional work detailing knowledge and interests of both older and younger patients is needed.

Despite these limitations, these findings have a number of important implications for pending plans to report physician quality at the group level through CMS’s Physician Compare. Although extensive educational materials related to the concept of a practice do not appear to be warranted, the very low level of interest in practice-level characteristics found among those with and without chronic conditions stands as a potentially significant barrier to consumer interest in and use of these data. Much additional work remains to be done to better understand consumers’ interest in public reports on provider quality, particularly how interest may vary by experience with the health care system, as well as a more formal, large-scale assessment of differences across and within sociodemographic groups. Additional work to evaluate the role of context in the way quality data are perceived by consumers as well as to design, develop, and test promotional and educational materials for the planned reports also will be necessary to enhance the relevance of practice-level characteristics for consumer decision making.

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