There are a multitude of hospital rankings—Thomson Reuters “100 Top Hospitals,” U.S. News & World Report “Best Hospitals,” HealthGrades, Consumer Reports’, Hospital Compare, and so on. Certainly, promoting achievements within these rankings internally to employees and physicians can generate significant employee morale and loyalty. Using rankings in physician recruitment is a powerful tactic. But as marketers, many of us struggle with the true effect these rankings have on consumers. In this article we will discuss one of the main ranking sources in the country—U.S. News & World Report “Best Hospitals.” We will demystify the general methodology, discuss the meaning of these rankings to consumers, as well as the benefit of rankings improvement and marketing initiatives for hospitals.

Many of these ranking systems are criticized on the basis of one bad case having a disproportionate impact on a hospital’s or system’s rank. For some ranking systems, this is a legitimate criticism. Some scoring methodologies attempt to adjust for the true impact on overall outcomes of that case. Either way, the patient perspective is that one bad case should be enough to change my view since nothing else matters if the next bad case is me. This should not surprise us as marketers given the research which confirms the disproportionate impact of negative recommendations in customer selection versus positive ones. So, we are left with little choice but to mitigate this risk through a focus on quality care and excellent outcomes, which is actually what these ranking systems should seek to encourage.

These rankings are also criticized as favoring large systems over community and local hospitals. Whereas U.S. News & World Report has a minimum bed size in order for a hospital to qualify for rankings, some rankings do not take this into account.

Therefore, one bad outcome from a hospital with a lower number of total cases will skew the rankings. Whereas larger hospitals with larger cases volumes—one poor outcome will have a lesser affect. That one bad case appears to be more significant when your total volume is six cases instead of 60.

Here again, the rankings have a mixed track record. Some rankings attempt to ensure that a large enough sample size exists to make comparisons, which often causes smaller providers to be dropped from consideration. Some simply apply their scoring systems regardless of the sample size producing assessments which can be misleading. Unfortunately, once published these assessments do influence patient and physician perception as these subtleties are lost in the big-picture messaging. So, either way we must understand and manage the impact or seek to avoid an impact in the first place.

The Mystery
Many hospital professionals believe that Top Hospital ratings are an unfair popularity contest. I disagree. Through partnership with RTI International, an independent, nonprofit research institute, U.S. News & World Report evaluates nearly 5,000 hospitals in 16 adult specialties and 10 pediatric specialties. In 12 of the adult specialties, data such as procedure volume, mortality rates, and the patient safety index (PSI) are evaluated, as well as reputation, nurse/patient ratios, technology, quality of care, and so on. In the four remaining specialties—psychiatry, rehabilitation, rheumatology, and ophthalmology—hospitals were ranked on reputation alone. For Best Hospital adult specialties all criteria are ranked based on the rolling three-year data summation.

U.S. News & World Report evaluates Best Children’s Hospitals in 10 pediatric specialties which are ranked using a rigorous survey, as well as reputation. For the Best Children’s Hospitals, all ranking criteria outside of reputation are on a year to year basis (versus a three-year data summation).

U.S. New & World Report “Best Hospitals” bases approximately 32.5 percent of its scoring on Process—their reputation survey. Many professionals believe this makes the rankings essentially “a popularity contest.” However, another 32.5 percent is based on Outcomes (three-years worth of mortality indicators from MEDPAR (Medicare Provider Analysis and Review) data), with another 30 percent on Structure or a detailed survey outlining technology, depth and breadth of services offered, etc. The last 5 percent of scoring is based on PSI—Patient Safety Indexes. I believe the patient safety component, which is relatively new, will increase in percentage of weighting in the years to come.

Without going into the full methodology of the rankings and the statistical weighting to ensure fair and accurate measurement, generally the U.S. News & World Report and other...
Top Hospital rankings take far more into account than merely physician “voting.” As we can see from the U.S. News & World Report survey methodology, there are steps taken to “smooth” the reputation data which essentially lowers this score for the highest ranking hospitals. There is also a statistical adjustment for physician voting to account for the likelihood of doctors voting for their own hospital or others in their immediate geographic area. There is greater weight to those votes from physicians furthest away geographically.

(See Figure One, above.)

The Metro Market
In the 12 adult specialties that include data analysis versus reputation only, the starting point for the metro market rankings is the 5,000 U.S. hospitals they use for national rankings categorized into specialties to group hospitals which meet stringent benchmarks for patient volume and other indicators. Once all qualifying hospitals are scored within the specialties, the top 25 percent, including the nationally ranked hospitals, are identified. Hospitals in the top 25 percent but not ranked nationally are identified first by the number of specialties in which they were nationally ranked, then by the number of specialties in which they were high-performing.

The online reporting identifies hospitals with national rankings, number of specialties ranked nationally, the number of specialties considered high-performing, and the specialties in which each hospital is ranked. Few metro areas have more than one or two, making decisions about where to take a sick child more straightforward and ranking unnecessary.

(See Figure 2, below.)

The Meaning
According to a Thomson Reuters 2010 survey, 25 percent of consumers will switch providers based on “Top Hospitals” rankings. That is up from 20 percent previously reported in the 2007 “Quest for the Quality Driven Consumer”, according to Linda MacCracken, VP Product Management. The Quality Driven Consumer findings show that if consumers learn about low ratings at their selected hospital, then 60 percent of them are more likely to switch providers. Who are these quality-driven consumers? According to the study, these potential patients have higher income, higher education, and are more likely to have comprehensive health insurance.

The Thomson Healthcare research brief entitled “The Target Market for Top Hospital Ratings: Who Is Really Interested?” reveals that adults who say a top hospital rating has a major impact share these characteristics:
• Advanced educations: Post-graduate degree
• Higher incomes: Adults earning more than $50,000 annually
• Older than younger: Baby boomers 55-64 years of age

Research indicates that top hospital ratings have a major impact (Continued on page 17)
on many adults, although they have the most impact on post-graduate-degree earners.

(See Figure 3, to the right.)

Consumers with incomes above $50,000 are also more likely to cite top hospital ratings as having a major impact on them. And Baby Boomer adults (55-64 years) are most likely to say that top hospital ratings have a major impact as compared to younger adults.

Thomson healthcare researchers compared these same demographics to 2007 research using both the HouseholdView segmentation system and the PRIZM® NE segmentation system. They identified the following PRIZM NE segments, representing the high-income, Baby Boomer and older-age segments, most impacted by top hospital ratings.

We know that with many diagnoses consumers research doctors as well as hospitals. Who are researching physician rankings? The same quality-driven consumers are researching this. According to data compiled in a May 2009 Experian Hitwise report, “Diagnosing Online Health,” nearly a third of visits to doctor-referral web sites come from people age 55 or older. Slightly more than 50 percent of users reported earning $60,000 or more. These individuals are starting to view physician rankings as an important consideration in their healthcare decision making.

The Benefit

If a hospital is fortunate enough to be ranked among the top hospitals, marketing that ranking is always a hot topic in the C-suite. Clearly, the use of top hospital (and top physician) rankings impacts some consumer segments more than others. It’s beneficial to target this messaging on rankings for maximum effectiveness and resource efficiency.

There are several stages to the purchasing cycle. For ranking purposes, focus on the new patient acquisition “recruiting” and the consumer “research” phases. In the new patient acquisition “recruiting” phase, quality driven consumers need to have your hospital on their radar and know your hospital is focused on quality excellence. That does not necessarily mean marketers need to promote the rankings. It is obvious by the research that the target audience will be researching rankings on their own. Hospital marketing which trumpets their institution’s rankings has become less effective. The market is oversaturated and the public tunes out these messages based on the lack of believability. All hospitals seem to have an accolade or two to promote. Our quality driven consumers however, trust the third-party endorsements or rankings including press coverage, professional medical organizations, and

Marketing Recommendations:

For those hospitals whose market research reveals that they are known for high quality—in your mass media advertising, use messaging on the patient benefits of your hospital’s quality excellence versus highlighting the rankings themselves. It isn’t worth the cost of the licensing because the quality driven consumers will find your hospital rankings on their own. It will be third-party endorsed and more believable to the consumer.

For those hospitals whose market research reveals that they are NOT known for high quality—it may be beneficial to target media to the quality driven demographic and promote the rankings (with the ranking logos) in an attempt to change consumer perception of your hospital’s quality. This may put your hospital on the audience’s radar during the patient acquisition “recruitment” phase and encourage consumer researchers to review your hospital’s quality scores. However unpopular this may be to the C-suite, it is not worth the money to promote these rankings outside of that demographic.

Focus public relations efforts to have credible third-party sources publish articles on your hospital’s rankings.

Try to have them list the ranking site pages noting your hospital (and physician) quality reports.

For online publications, encourage the publisher to provide a hotlink to the top hospitals site, as well as your hospital.

Links are even more important for those hospitals with competitors that have poor ratings.

Create rich-media online ads placed in close proximity to the hospital listings on the rankings sites which link to your hospital service line landing page.

Drive additional traffic through Search Engine Marketing to hospital landing pages which promote the rankings and link back to the ranking site pages outlining your hospital’s quality (and possible the low quality reports of your competitors.)
the ranking web sites themselves.

If marketers choose to use rankings in their marketing (if for nothing more than for political purposes) keep in mind that it can be expensive. The licensing fee for a hospital to use the U.S. News & World Report logo or “badge”, which is available by specialty, is approximately $10,000 for a one-year licensing for the web, over $20,000 for web and print, and $40,000 for web, print, TV, and radio. That expense is before adding on creative development and paid media.

Recommendation

Top Hospital rankings are not going away and they are building in usage for a coveted target audience. In order to use marketing and public relations to promote high rankings, hospitals first have to attain high rankings. Hospitals can advance their quality outcomes, patient safety, physician reputation, and ultimately their rankings. The most important steps are:

- **Crucial Step 1**: Benchmark mortality, patient safety, HCAPS, and physician reputation
- **Crucial Step 2**: Outline strategies, critical success factors, and tactical steps for improvements
- **Crucial Step 3**: Prioritize service lines to maximize ranking opportunities
- **Crucial Step 4**: Create dashboards to track progress and results
- **Crucial Step 5**: Develop a marketing plan for reputation improvement

Is a national “Top Hospitals” ranking guaranteed through this process? No. But essential benchmarks, improved outcomes, increased leverage for physician recruitment, and a more powerful brand are—and they’re just as important for attracting and keeping patients. Many of the top hospital judging criteria overlap across entities from HealthGrades to U.S. News & World Report. Benchmarking and improving one set of ranking criteria may translate into improving others.

Perhaps more importantly, everything a hospital or health system would do to improve their rank should have the effect of improving patient care and outcomes. This should be a continuous improvement goal for everyone regardless of your opinion of the rankings.

Further, the Patient Protection and Affordable Care Act which was approved by Congress in 2010 will begin connecting reimbursements to quality of care and outcomes. The provisions of the law will begin to affect hospitals through the Value-Based Purchasing Program in 2012, with a similar system affecting physicians scheduled for 2015. Also in 2012, incentives for forming Accountable Care Organizations will take effect.

While the current ranking systems are not exactly the measures HHS will use, the quality care portions of them can provide an indication of where your hospital or system is relative to peers and whether your reimbursement might be affected. It is also reasonable to believe the rankings groups will need to adjust their methodology to account for the HHS quality measures to avoid the loss of credibility should they provide high rankings to groups which get poor rankings from the government. So, the existing rankings systems provide a useful benchmark against which to build internal systems for improvement and tracking. Adjusting to the new measures for Medicare or Medicaid reimbursement will be far simpler than building those systems after your reimbursements have been negatively impacted.

Summary

Hospital leadership does not have to conduct quality improvements with the exclusive intent to achieve rankings status. When hospitals make quality excellence their mission, rankings and patients may follow. Whether we like it or not, these rankings are building in influence. Through a greater understanding of their affect on consumers, hospitals can manage their influence more effectively. Moreover, all healthcare facilities—from large academic medical centers to small community hospitals—can use top hospitals rankings to benchmark themselves and find clues about creating processes to improve quality and patient-safety outcomes. And isn’t that what it’s all about?