Guiding Principles for Public Reporting of Provider Performance

The number of organizations issuing reports on hospital and physician quality performance has increased remarkably over the past decade. Differences in the measures, data sources, and scoring methodologies produce contradictory results that lead to confusion for the public, providers, and governing boards, and impair the public's ability to make well-informed choices about health care providers. A paper published in *Health Affairs* (2008), showed markedly divergent rankings of the same institutions by Hospital Compare, Healthgrades, Leapfrog Group, and *U.S. News & World Report*.[1] This variability continues today and points to concerns about validity and reliability among the measures used by these groups.

The hospital community supports the principle of accountability through public reporting of health care performance data. However, performance data that are not collected, analyzed, or displayed appropriately may add more confusion than clarity to the health care quality question. For data to be understood and for results to be comparable, publicly reported data should adhere to a set of guiding principles. With that goal in mind, the AAMC (Association of American Medical Colleges) convened a panel of experts on quality reporting to develop a set of guiding principles that can be used to evaluate quality reports. The principles are organized into three broad categories:

- Purpose
- Transparency
- Validity

Purpose: Public reporting and performance measurement occur for a variety of reasons, including consumer education, provider quality improvement, and purchaser decision making. Each website that reports performance data should explicitly state its target audience and the intended purpose of the report. The data, measures, and data display should fit the report's stated purpose. Stakeholders may have differing opinions on how well the measures and methodology meet the intended purpose; however, a discussion on divergent viewpoints cannot occur if the purpose is not well defined.

Transparency: Methodological details can impact both providers' performance data and the appropriate interpretation of the data. Transparency requires that all information necessary to understand the data be available to a reader; this information includes measure specifications, data collection methods, data sources, risk adjustment methodologies and their component parts, composite score methodologies, and reporting methods used to translate results into graphical displays. Details should be sufficient for independent replication of the results. Limitations in the data collection and methodology and relevant financial interests also should be disclosed.

Validity: Validity ensures that the methodology, data collection, scoring, and benchmarks produce an accurate reflection of the characteristic being measured. Ideally, measures, as well as composite and scoring methodologies, should be supported by clinical evidence, field-tested and, where appropriate, have National Quality Forum (NQF) endorsement. Validity is necessary to ensure that results are accurate and that providers are appropriately characterized.

Public reporting that adheres to these guiding principles will ensure appropriate interpretation of performance results.

[1] Rothberg MB, et al. Choosing the best hospital: the limitations of public quality reporting. *Health Affairs*. 2008;27(6):1680-1687.

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Purpose: What Is the Goal of the Report?	**Transparency:** How Are the Measures Calculated? How Should the Results Be Interpreted?	**Validity:** Is the Measurement Appropriate?
• Dashboards should have a clear, concise purpose statement, including the intended audience(s). • Dashboard displays should be tailored to the specified audience. • Measures should contribute to the stated purpose. • Ratings, scores, and grades should be useful for the stated purpose. • Data timeliness should be relevant to the stated purpose.	• Methodology must be transparent addressing but not limited to: o Clearly identified data sources o Identified date ranges o Detailed specifications for individual measures and composites, with sufficient detail to facilitate replication of results o Detailed scoring methodology o Risk adjustment methodology with open architecture that includes documentation of reliability/validity and details of the variables and weights used o Disclosure of any proprietary methodology • Limitations or exclusions in the data reporting should be disclosed, including but not limited to: o Data timeliness o Small sample sizes o Validated vs. nonvalidated data o Use of proprietary measures/ methodologies o Disclosure of financial interests or other business related interests (consulting services, reports, etc.) o Limitations to accurately address differences in patient populations (such as socio-economic status) o Other limitations in data collection	• Measures should be tested, validated, and ideally endorsed by the National Quality Forum (NQF). • Measures need to be supported by the latest clinical evidence. • Data collection and data sources need to be rigorously defined, validated, and verified to ensure usefulness, relevance, and comparability. • Outcome measures should be risk adjusted and risk adjustment methodology validated to conform to industry standards. • Categories of performance (grades or ratings) should be developed using only robust statistical methods. • Methods should distinguish between missing data and poor performance. • Creating composites from disparate measures for ease of display should be avoided. Composite measures that receive NQF endorsement should be used.

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Orgranizations listed above are for identification purposes only.

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The following organizations have endorsed these guiding principles:

American Hospital Association®
www.aha.org

AMERICA'S ESSENTIAL HOSPITALS
www.essentialhospitals.org

Federation of American Hospitals®
www.fah.org

CHA Catholic Health Association of the United States
www.chausa.org

CHILDREN'S HOSPITAL ASSOCIATION
www.childrenshospitals.org