VIEWPOINT

Time for Transparent Standards in Quality Reporting by Health Care Organizations

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Transparency is becoming the norm in US health care. With this evolution, the volume of publicly available data on health care quality has increased rapidly. Federal agencies, private organizations, health plans, state governments, and others report publicly on the performance of hospitals and physicians.[1-3] However, there are no agreed upon standards for what information should be reported, its accuracy, and the underlying data that support it. All these are needed to allow the public to determine whether the measure and data are truthful, timely, and transparent.[4] In this Viewpoint, we propose that hospitals and physicians adopt standards for their own public reporting of quality measures and that an external entity make transparent the extent to which reporting by each organization adheres to these standards.

Current State of Reporting

Hospitals and physicians are helping inform patients about their quality by posting performance data on their own organization's website. However, the lack of reporting standards is especially concerning when hospitals and physicians report their own data, or emphasize those data that suggest high-quality care. Although hospitals and physicians are perceived as trusted entities, these organizations have an incentive to present themselves in a positive light. This conflict of interest should be less pronounced when outside entities, such as the Centers for Medicare & Medicaid Services (CMS) or the Leapfrog Group, report to the public about health care quality.

Evidence suggests that some organizations may be providing potentially misleading information to the public. For instance, one hospital stated on its website, "Come to us, we have no infections," without stating which types of infections were included, how this performance outcome was measured, or how long the hospital had gone without an infection.[5] Even though there has not been a systematic study of the accuracy of the quality data reported by hospitals and physicians on their own websites, concerns are likely to increase with the number and types of measures now being reported (eg, patient experience, costs), some of which may be more meaningful to patients.

The potential for misinformation is understandable given the absence of standards to guide the reporting efforts of hospitals and physicians. Many of these efforts appear to be led by marketing departments that are not aware of appropriate scientific standards. This has the consequence of diminishing the scientific rigor of claims and enhancing the risk of inaccurate inferences. Although the reporting of quality measures by health care organizations is important, reporting on each organization's website is inefficient. The reporting by individual health care organizations is likely to supplement rather than supplant other sources of information for consumers.

Proposed Standards for Reporting

As a component of reporting quality measures on their own organization's website, hospitals and physicians might self-attest as to whether they meet a set of standards and whether they conduct an independent audit of their quality measures, in the same way they do for reporting financial data. Auditing could help ensure the accuracy of the data reported and a single auditing standard could help reduce variation in auditing practices. For example, an internal audit at Johns Hopkins Hospital revealed that some of the quality measures that were reported were inaccurate because some of the data elements comprising the measure were inaccurate. Specifically, the *US News and World Report* 30-day mortality measures exclude patients who are transferred in from another hospital. The internal audit identified that some coders at this hospital were recording the patient's admission source incorrectly and including patients who were transferred in from another hospital, resulting in reported mortality rates that were twice the mortality rate when these patients were not included. It is quite possible that other audits might have discovered errors that were less favorable to the hospital.

The idea of standards is not unique to measures of health care quality. Analogous standards in clinical research and in financial reporting are used to support data quality control. Standards for measures of health care quality could include information about how the patient population, the measure, and hospital or physician performance are defined. For measures that health care organizations report from an external source (for example, CMS's Hospital Compare), linking to that external source could be sufficient to meet these standards. Suggested potential standards for hospitals and physicians publicly reporting their own quality data are shown in the **Table**.

Once these standards are established, organizations could use them to guide the reporting of their own quality data on their websites. An external entity could report which organizations comply with these standards, making transparent those that do not comply, and advising caution when interpreting quality measures for those organizations. These standards could provide an important foundation for improving quality measures, and ultimately the quality of care that patients receive.

Challenges

There are several challenges to enacting this proposed approach. First, although a number of groups—including hospitals, hospital associations, health care purchaser organizations, health plans, and consumer advocacy

Table. Suggested Potential Standards for Hospitals and Physicians Publicly Reporting Their Own Quality Data

Standard	Details of the Standard
Information About the Patient Population	
Describe how the patient population for the measure is constructed	Describe which patients are included in the measure Could include describing the corresponding codes or specific diagnoses
Describe how patients from this population were selected for measurement	Describe if the quality measure is based on the entire population or a sample If a sample is used, describe how that sample was selected
Describe the period from which the patients were drawn	Reflect the period during which care was provided
Information About the Measure	
Describe the measure specifications	Describe in detail if the measure has been newly developed by the health care organization Describe who is in the numerator (events), who is in the denominator, and any exclusions If the measure is used or endorsed by other entities, the provider organization could note this and link to the measure specifications
Describe evidence for the validity and reliability of the measure	If the measure is new, the provider organization should describe how they evaluated its validity and reliability If the measure is used or endorsed by another entity, the provider organization can link to the external entity's evaluation of the validity and reliability for that measure
Information About Performance on the Measure	
Provide information about the point estimate of performance	Provide a summary statistic for performance Provide the raw data for the numerator and denominator, if the sample size is sufficiently large to avoid identifying patients
Provide information about uncertainty	Provide a measure of uncertainty around the point estimate, if relevant
Provide information over time	Display data over time for as many periods as possible, recognizing that measure definitions can change Unit of time should be defined explicitly Avoid displaying before and after results, especially when the postperiod is not defined a priori
Provide information about potential biases	Provide information about known potential biases in the measure; especially important if the organization is publicizing inferences that care has improved

organizations—have provided feedback about the idea of establishing reporting standards, additional input will be needed to refine the standards and ensure they gain broader acceptance. Second, the burden on health care organizations of applying these proposed standards needs to be evaluated. Although the burden of applying standards is unlikely to be significant, the burden from auditing could be greater. There have been numerous calls for less measurement in medicine rather than more, and this proposed approach could help to complement this effort by seeking to improve the accuracy of reported measures.[6] Third, the best ways to encourage health care organizations to adopt and adhere to reporting standards in an environment of competing priorities for quality reporting remains to be determined. It would be helpful if the proposed standards were evaluated and endorsed by national organizations, such as CMS, the National Quality Forum, or the American Hospital Association. Fourth, once standards for reporting were established, additional work will be required to make consumers aware of the degree to which an organization adheres to them, including solicitation of feedback from patient and consumer groups. Fifth, there is no evidence that this proposal will result in improved reporting, will be of value to patients or to the public, or most important will serve to improve patient outcomes. Data should be collected as the process moves forward to prospectively assess its potential advantages and limitations.

Other groups that report measures, such as the federal and state governments, health plans, purchaser organizations, and consumer groups could benefit from applying a similar set of reporting standards. Having hospitals and physicians lead the way by adopting standards may stimulate others to do the same. Patients deserve truthful, timely, and transparent measures of quality. Without standards in place to ensure that the data presented by health care organizations meet these goals, the recommendation to patients remains: "Let the buyer beware."

ARTICLE INFORMATION

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