



**California Hospital Association
Guiding Principles:
Publicly Released Hospital Quality Scorecards**

November 2012

The California Hospital Association and its member hospitals support the appropriate collection, validation and dissemination of publicly reported hospital quality and patient safety information. Transparency of hospital quality data can improve patient outcomes by promoting collaboration among health care providers and enabling consumers and payers to make better informed health care choices.

Public disclosure of hospital quality metrics, often referred to as “scorecards,” has become a means of assessing, ranking and disseminating publicly reported information about health care providers. The California Hospital Association believes that the following set of core guiding principles should be considered:

1. GENERAL CONSIDERATIONS:

- a. Scorecards reflect only one source of available information to facilitate an understanding of the quality of health care delivery. They often serve as a good starting point for patients to ask more specific questions of their health care providers.
- b. Quality improvement is an iterative and continuous process. An assessment of the quality of hospital care represents a single snapshot in time, and should always use the most current available data. Even if the scorecard uses the most current available data, it will rarely represent present performance.

2. MEANINGFUL DATA:

- a. Scorecards typically include a combination of measure types - structure, process and outcomes. Outcome metrics, if appropriately determined, can be the most meaningful reflection of patient care.
- b. Publicly reported quality data included in the scorecard should be derived from an assessment of evidenced based quality measures that have been demonstrated to reliably assess meaningful aspects of patient care. The measures should be clinically and statistically confirmed, and relevant to the needs of health care consumers and providers. The National Quality Forum is a prominent organization that examines the reliability and validity of hospital quality measures.
- c. Reported measures should include clear descriptions of sample size and methodology, the time period reflected, and numerator/denominator definitions.

- d. Inclusion of condition specific measures is preferable. Aggregation of multiple measures into a single score for public release is not recommended because they typically represent a combination of disparate metrics that are not actionable for consumer selection or provider performance improvement.
 - e. While it is important that quality measures are feasible to collect, the construction of comparative quality measures using exclusively administrative (coded medical record) data remains challenging and results may be more indicative of documentation practices than actual delivery of care. When utilized, administrative data should incorporate all payer categories, rather than a single payer.
3. APPROPRIATE USE of RISK ADJUSTMENT :
- a. All scorecard data should be risk adjusted, using standardized, transparent statistical techniques that can be replicated. The scorecard needs to provide sufficient detail of both the measure construction and the risk adjustment methodology to be able to compare performance of specific procedures or clinical functions.
4. USE OF STANDARDIZED RATING FORMAT:
- a. The scorecard uses a basic standardized format, with explanations of symbols for presenting ratings, that facilitates comparison between hospitals' data without compromising accuracy.
 - b. Ratings of hospitals based on cost or patient payment obligations should be separate and distinct from ratings based on clinical quality indicators.
 - c. Ratings of hospitals based on patient assessment of the experience of care should be separate and distinct from ratings based on clinical quality indicators. In addition, for those hospitals that serve a disproportionate number of economically diverse patients, data should be further stratified to reflect socio-economic and cultural patient differences.
5. PROVIDER RECONCILIATION PERIOD:
- a. The organization developing the scorecard should, prior to public release of data, notify all hospitals included in the report and allow for a designated time period for hospitals to preview reports (a minimum of 30 days), and provide for necessary data corrections and comments. Those data corrections should be incorporated before the scorecard is release and include appropriate comments.
6. DISCLOSURE OF INFORMATION:
- a. The organization should disclose any challenges or deficiencies with the methods and/or data that were used to create the scorecard.
 - b. The organization creating and releasing the scorecard and individuals providing expert opinion on behalf of the organization must disclose potential financial or non-financial conflicts of interest for the organization or the individuals with the release of the scorecard.