FINAL REPORT:
2004 CMS LISTENING SESSIONS

DEVELOPMENT OF ROBUST PRIORITIZED STRATEGIC MEASURE SET FOR HOSPITAL PUBLIC REPORTING

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EXECUTIVE SUMMARY

CMS and its collaborators in the Hospital Quality Alliance (HQA) share the goal that, in the near future, all private and public purchasers, oversight and accrediting bodies, payers, and providers of hospital care will voluntarily use the same measures in their public reporting activities. To achieve this goal, we have agreed to expand and standardize the set of measures that hospitals will use to voluntarily report on their care.

The challenge facing this national voluntary initiative is how to build on the foundation established by the HQA's initial efforts and those of others, in order to identify common measures and to continue to expand the set of publicly reported measures in a manner that reflects the interests and needs of all stakeholders. To address this challenge, CMS worked with its collaborators in the HQA to engage stakeholders in a public discussion of what should be included in an expanded set of measures for hospital public reporting.

From April 27 through June 28, 2004, CMS sponsored five "Listening Sessions" in Boston, Orlando, Dallas, San Francisco and Chicago. Each site was selected because of its unique activities, reflecting the efforts of coalitions of local public and private purchasers, providers and consumers. The Listening Sessions provided a forum for a national public discussion on public reporting of performance measures of hospital care beyond the conditions and types of measures currently included in the HQA. Health care consumers, payers, plans, providers, purchasers and other interested parties presented their individual views at these meetings, and through submitted comments. The discussions at the Listening Sessions drew upon, but were not limited to, the priority areas for clinical quality performance measurement and criteria for selection of measures identified by the National Quality Forum and the Institute of Medicine. The sessions were structured but also wide-ranging, permitting exploration of complementary and competing priorities and the concerns of various stakeholders interested in public reporting.

These five CMS-sponsored Listening Sessions provided suggestions and observations on the overall endeavor of assessing hospital quality and CMS's role in those reporting activities, as well as particular areas or topics for expansions of the current set of measures used for hospital performance measurement.

Six overarching themes emerged from the review of the comments received during Listening Sessions:

1. **Leadership and Partnership are Essential to the Long-Term Success of Public Reporting.**
    - CMS heard repeatedly that strong, consistent leadership is required to provide focus and assure the commitment of stakeholders to measurement development and reporting. Participants felt that the federal government is the logical locus for such leadership, particularly in light of the significance and diversity of the roles it plays in health care.
    - At the same time, in describing their local activities and needs, participants indicated their desire for partnership and participation in national efforts, to assure that local needs are addressed as consolidation of the many quality-reporting initiatives facing hospitals takes place.

2. **Measures and Reporting Activities Should be Standardized and Aligned.**
    - Providers, purchasers and consumers all see CMS's leadership as essential to the creation of a set of national standards, and many see mandatory reporting as necessary for a level playing field.
    - Rationalization of, what meeting participants characterized as, the current welter of reporting programs was assumed by several stakeholders to be the greatest contribution CMS could make to hospital quality reporting.
    - Providers stated a wish to reduce their reporting burden as much as possible and would ideally like to be able to submit one report, in a single format, whose data would be used for as many distinct processes (QI, auditing, clinical management, public disclosure) as possible without requiring additional information.

3. **A Robust Measurement Strategy Will Require Adoption of New Measures and Commitment to the Maintenance of Existing Measures.**
    - CMS heard comments from providers, consumers, payers and health plans championing different types of quality measures (process, outcomes, condition- or procedure-specific, cross-cutting, *etc*.).
    - CMS heard about the necessity of committing resources to maintain the measures used for reporting, to ensure that measures always reflect the most current standards of practice.
    - There was little discussion about the mechanism for adopting new measures, although implicit in much of the discussion (and explicitly mentioned by at least one participant) was that the established voluntary consensus process of the National Quality Forum is the anticipated vehicle for measurement standardization and other issues involved in the adoption and maintenance of measures.

4. **Reported Measures Should be Valuable and Easy to Use.**
    - Participants were insistent that information on hospitals must reflect those institutions' complexities and the diverse services they offer, as well as the diversity of interests and needs of the audiences who will use the information.
    - Consumers and purchasers were insistent that the value of measures be readily apparent and that the onus be placed on those who develop and require measures to explain how results can and should be used to make purchasing and treatment decisions.
    - Participants had many concerns about the ability of audiences to actually use quality reports, citing the failure of consumer-oriented reports to attract large numbers of users.
    - Different audiences require different kinds of quality information, and although many reports might be produced from a single database, participants observed that no one report will meet the needs of providers, consumers and purchasers. In general, providers want more detailed information about specific care processes reported by condition or procedure, while consumers and purchasers look for more global information to characterize the hospital as a whole.

5. **Measurement and Reporting Require a Commitment to Information Technology and Reporting Infrastructure.**
    - Hospitals are hoping that CMS leadership will result in consensus around standards and technology so that collecting and reporting clinical information for quality measurement can eventually be more cost effective.
    - Hospitals and others called for CMS to provide not only encouragement but also funding for the development of electronic medical records,
    - Hospitals expressed concern that it is important that CMS create an efficient and cost-effective means of receiving, validating, editing and processing electronic data submissions from hospitals.
    - Hospitals expressed an interest in greater direct involvement in the data quality assurance and audit processes when they send public reporting data to CMS or to the Joint Commission.

6. **While Different Measures Interest Different Groups, Additional Measures Interest All.**
    - Different audiences (consumers, purchasers, hospitals, physicians) have different information needs and supported different types of hospital quality measures.
    - Providers expressed interest in process measures for feedback and quality improvement. Providers have more confidence in process measures than in outcome measures; in condition- and procedure-specific measures than in cross-cutting and composite measures; and in measures derived from clinical data than in measures derived from administrative data.
    - Hospitals want measures for consumers and purchasers to fairly portray their hospitals. This is a particularly important issue for small and rural hospitals.
    - Consumers and purchasers favor outcome measures, cross-cutting measures that provide an institution-wide look at performance in a certain category (such as hospital-acquired infection), and composite measures which "roll up" several measures within a clinical category. Consumers and purchasers are interested in choosing hospitals, often long before they know which service(s) they might require.
    - Purchasers proposed that CMS should combine quality with cost data because purchasers and patients usually weigh both those factors, except in the case of very complicated procedures. Purchasers felt that a full, robust measure set would include the current starter set of core measures in the HQA initiative, and proceed from there to reporting of all National Quality Forum measures - including safe practices and nursing-sensitive measurement sets - and the HCAHPS survey of patient perception.
    - A recurring concern of consumers and providers about the current national measurement sets was that they do not include anything for children, psychiatric patients, or specialty hospitals.
    - A frequently voiced concern of hospitals and providers was the need to identify measures that address the "system-ness" of the hospital, the extent to which the hospital is organized to provide appropriate care, rather than just look at discrete processes. In this vein, outcome measures were identified as important but complex to interpret.

Interest was expressed in measures addressing a wide variety of areas and topics, but most of the proposals were in support of measures that would require moderate to substantial developmental work (see table 1).

TABLE 1
MEASURES AND TOPICS MENTIONED BY PARTICIPANTS IN CMS LISTENING SESSIONS

Measures Recommended	Related NQF-Endorsed Measures
• Overall hospital-acquired infection rate • Service-specific infection rates • Surgical infection rate • Surgery-specific infection rates • Ventilator-acquired pneumonia rates	• Central line catheter-associated blood stream infection for ICU patients [H] • Urinary catheter-associated urinary tract infection for ICU patients [H] • Ventilator-associated pneumonia for ICU and high-risk nursery patients [H] • Deep sternal wound infection rate [C]
• Overall complication rate • Rate of surgical complications • Procedure-specific complication rate (e.g., hip and knee replacement, CABG) • Deep vein thrombosis rate	• Deep sternal wound infection rate [C] • Death among surgical inpatients with treatable serious complications (failure to rescue) [N] • Post-op renal insufficiency in cardiac surgery patients [C] • Prolonged intubation in cardiac surgery patients [C] • Pressure ulcer prevalence [N] • Stroke/Cerebrovascular Accident (CVA) [C] • Surgical Re-exploration [C] • Third- or fourth-degree laceration [C]
• Procedure specific volume • Condition-specific volume	• CABG volume [C] • PCI volume [H] • Heart valve surgery volume [C] • Valve + CABG surgery volume [C]
• Medication management • Drug error rate • Medication errors	
• Condition-specific readmission rates • Procedure-specific readmission rates • Procedure-specific 10-day and 90-day readmission rates	
• Pain control (“not only in cancer, but for all conditions”) • Pain control assessment for all patients	
• All NQF nursing-sensitive measures • Nursing care hours per patient day • “Staffing ratios”	• Pressure ulcer prevalence [N] • Falls prevalence [H] [N] • Falls with injury [N] • Restraint prevalence (vest and limb only) [N] • Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients [H][N]

Measures Recommended	Related NQF-Endorsed Measures
	• Central line catheter-associated blood stream infection rate for ICU and high-risk nursery (HRN) patients* [N] • Ventilator-associated pneumonia for ICU and HRN patients [H][N] • Smoking cessation counseling for acute myocardial infarction [H][N] • Smoking cessation counseling for heart failure [H][N] • Smoking cessation counseling for pneumonia [H][N] • Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract) [N] • Nursing care hours per patient day (RN, LPN, and UAP) [N] • Practice Environment Scale—Nursing Work Index (composite and five subscales) [N] • Voluntary turnover [N]
• Fall prevalence • Fall incidence • Unit-specific falls rate	• Falls with injury [N] • Patient falls [H][N]
• Time to treatment (pneumonia, angioplasty, TPA) • Street time to angioplasty	• Thrombolytic agent within 30 minutes of arrival for AMI [H]
• Condition-specific mortality rates • Procedure-specific mortality rates	• AMI inpatient mortality [H] • Failure to rescue (major surgical patients) [N] • Neonatal mortality [H] • PCI mortality [H] • Risk-adjusted inpatient operative mortality for CABG [C] • Risk-adjusted operative mortality - mitral valve replacement/repair + CABG surgery [C] • Risk-adjusted operative mortality - aortic valve replacement + CABG surgery [C] • Risk-adjusted operative mortality for CABG [C] • Risk-adjusted operative mortality - aortic valve replacement [C] • Risk-adjusted operative mortality - mitral valve replacement/repair [C]
• Rate of turnover in nursing staff • Rate of turnover of radiological staff	• Voluntary turnover [N]
• Overall smoking cessation measure	
	[H] = Hospital Care Measures [N] = Nursing-Sensitive Care Measures [C] = Cardiac Surgery Measures

Measure Concepts Recommended	Related NQF-Endorsed Measures
• Care coordination • Integration of patient care ("the transition points from one physician to another physician or one nurse to another nurse, as well as the support system for that"). • Continuity of care • Degree to which multidisciplinary teams are effective	
• Stabilization and transfer of patients (esp., small and rural hospitals)	
• Composite, aggregate, "roll-up" measures	
• "Metrics that reflect 'system-ness', which indicate that the hospital organized care well"	
• Rural hospitals' top ten chief complaints: "Patients present to the emergency room with these ten symptoms-- shortness of breath, chest pain, etc. Find out what those ten chief complaints are and then build measures around them, rather than around diagnoses"	
• Cross cutting measures for children's healthcare	
• Cost/efficiency measures	
• Inpatient psychiatric care measures	
• "Index of quality of doctors at the hospital"	
• Education provided to the patient (particularly around discharge instructions)	• Detailed discharge instructions for CHF patients [H]
• Use of clinical pathways	

INTRODUCTION

Over the period of April-June 2004, CMS sponsored five public meetings to solicit input from health care consumers, payers, plans, providers and purchasers regarding its ongoing initiative to provide hospital-specific information on clinical quality.

The objective of these five public meetings was for CMS to receive feedback and comments from interested parties "outside the beltway." The meetings provided a unique opportunity to assess the face validity of and demand for measures proposed for the next round of public reporting on the clinical quality of hospital care, as well as to obtain more general opinions from audiences of end-users. CMS expects to use the insights and suggestions provided by the stakeholders to inform both its own measure development activity as well as its efforts as a collaborator in the public-private voluntary reporting initiative of the Hospital Quality Alliance (HQA): Improving Care Through Information.

DESCRIPTION OF MEETINGS

The five "Listening Sessions" were designed to allow leaders representing local health care consumers, payers, plans and providers (both hospitals and physicians) to discuss hospital quality reporting issues in their own markets while giving CMS the benefit of lessons learned, their experience to date with CMS initiatives, and suggestions for future direction. The sites for these five meetings (Boston, Orlando, Dallas, San Francisco, Chicago) were chosen because they are dynamic health care markets where we could involve CMS Regional Administrators and their staff, active employer and consumer coalitions and sophisticated provider organizations.

The schedule and locations for the meetings were as follows:

- April 27, Hilton Boston Logan Airport, 85 Terminal Road, Boston MA
- May 17, Holiday Inn Universal Orlando, 5905 Kirkman Road, Orlando FL
- June 8, Cooper Guest Lodge, 12230 Preston Road, Dallas TX
- June 14, San Francisco Airport Marriott, 1800 Old Bayshore Highway, Burlingame CA
- June 28, Oak Brook Marriott, 1401 West 22nd Street, Oak Brook IL

The Boston listening session was held in conjunction with a meeting of the National Quality Forum. Local employer health care purchasing coalitions were involved in planning sessions at the other four sites (Orlando, Dallas, San Francisco and Chicago). Attendance varied from approximately 60 in San Francisco to over 150 in Boston and Chicago; the majority of attendees were from the hospital industry. Although the public was invited to submit written comments in conjunction with these meetings there was minimal write-in activity.

Meeting co-hosts included the American Hospital Association, Federation of American Hospitals, Association of American Medical Colleges, AFL-CIO, AARP, National Association of Children's Hospitals and Related Institutions, Consumer-Purchaser

Disclosure Project, National Partnership for Women & Families, Consumers Union and the AMA, as well as local consumer, provider and purchaser organizations at each site.

The format of each meeting consisted of a panel discussion involving local consumer, provider and purchaser organizations, followed by an open discussion involving all attendees. For the meetings in Orlando, Dallas, San Francisco and Chicago, attendees were also invited to participate in concurrent break-out sessions, intended to encourage small-group discussion of specific topics in hospital quality measurement. The small group discussion topics included issues that CMS hoped to discuss at each meeting (such as small and rural hospitals) and those specific to the meeting site (such as current state reporting initiatives). Meetings were announced in the *Federal Register* and promoted at each site by both local and national co-hosts. Each meeting was taped (except for the break-out sessions). The audiotapes are available on both the CMS website www.cms.hhs.gov and the contractor's website www.ipro.org.

OVERVIEW OF COMMENTS AND OBSERVATIONS

While the expressed purpose of the Listening Sessions was to gather input about topics of concern and potential measures for expansion of the hospital performance measures, most meeting participants simply wanted to describe the situation in their local market and comment on CMS's public reporting initiative in very broad ways. We received more general comments on measurement and reporting than specific suggestions for particular measures.

Overall, there was a consistent message from all participants, across all sites that quality measurement and reporting was important, and that hospital quality measures need to make sense and be actionable, based on standardized evidence and a common national set of measures. While many raised concerns about the burden of data collection, meeting participants were inconclusive about the value of administrative data as source of quality information, as compared to chart review – in general, providers were uncomfortable with the use of administrative data, but purchasers and consumers were not. In addition, all parties made it clear that no one presentation of information would be useful to all interested audiences. Purchasers asked for information to be put into a broader context, by combining quality and cost information, for example. At several sites, participants reminded CMS of the important role of media in reaching consumers.

As discussed below, certain themes did emerge from the comments we received. For the most part, the themes emerged without prompting (for example, providers in Chicago discussed the importance of outcome measures such as condition- or procedure – specific mortality). The discussion of particular measures and topics, on the other hand, largely reflects repeated efforts to focus on specific measurement topics in the break-out sessions, which were designed to obtain input from the participants on issues related to such topics as small and rural hospital measures, pediatric measures, nosocomial infection rates, and patient safety measures.

It should be noted that all Listening Session attendees (with the exception of certain panelists) participated as individuals, not as designated representatives of a group or organization. In developing this report, however, we have attributed individual's comments to the stakeholder group with which they associate in order to make sense of the input we received: certain strands of the discussion were consistent by type of stakeholder. In addition, while it is possible to categorize comments by theme, we reiterate that participants took the opportunity to express a variety of concerns, not just about specific measures but about the different reasons for measurement and reporting and the importance of commitment over the long-term to this endeavor. Finally, we found it noteworthy that, while not an explicit topic in the initial scope of the Listening Sessions, many speakers focused on issues related to how to maintain that commitment, including mandatory *vs*. voluntary reporting, and pay for performance options.

THEMES

Theme #1: Leadership and Partnership are Essential to the Long-Term Success of Public Reporting.

Listening Session participants across constituencies were positive about the leadership role CMS has assumed. CMS heard from them that, in its dual capacity as a federal agency and the nation's largest purchaser of health care services, it is uniquely able to bring together purchasers, payers and providers to reach agreement on issues such as consistent national standards for hospital quality reporting. Participants also stated their assumption that CMS involvement will eventually result in both mandatory reporting and Medicare "pay for performance" programs, and many stated that they see mandatory reporting as necessary for a level playing field.

Providers, purchasers and consumers in general showed little hesitation with CMS acting as *primus inter pares* among, for example, its collaborators in the Hospital Quality Alliance. It was observed by several participants that CMS has legitimacy that other stakeholders don't have, and as a federal agency it has a responsibility for public accountability.

Participants felt that CMS should continue and should amplify its national leadership role on quality disclosure and that the Agency should use its "bully pulpit" to make sure that national attention stays focused on quality measurement and reporting.

Theme #2: Measures and Reporting Activities Should Be Standardized and Aligned.

A principal focus of CMS's program in hospital quality reporting, and the rationale behind the Hospital Quality Alliance, is the establishment of a single unified set of national standards for reporting on hospital quality. Rationalization of the current welter of reporting programs was stated by several stakeholders to be the greatest contribution CMS could make to hospital quality reporting. Consumers, physicians and purchasers at various meetings stated their belief that mandatory reporting would be necessary for

"apples to apples" comparisons of hospitals. Voluntary reporting was felt to be inherently biased: hospitals choosing to report are more likely to be better performers than those that don't. Hospital participants and physicians repeatedly noted that, in addition, mandatory data are what get the attention of providers, especially hospital administrators responsible for resource allocation.

Providers expressed their wish to reduce their reporting burden as much as possible; they would like to submit one report, in a single format, whose data would be used for as many distinct processes (QI, auditing, clinical management, public disclosure) as possible without requiring additional information. Hospitals raised the issue of reimbursement for reporting costs, but more realistically they expect relief in the form of a single set of consistent, predictable reporting requirements, continued progress in automated collection and electronic reporting of clinical data (which would reduce their costs), and CMS leadership in establishment of standards (for data reporting and transmission, for example) to make reporting more cost-effective.

Regarding quality measures themselves, comments from several meeting participants indicated that the established voluntary consensus process of the National Quality Forum (NQF) had general acceptance as the arbiter for measure development and public vetting. There was sentiment that CMS should expand the initial set of measures to include the complete set of currently-approved NQF measures, in order to make use of an existing and accepted vehicle for identifying acceptable measures rather than create a new one.

Hospitals and physicians felt it is critical to find a common data set that everyone can agree on, a tool that would be automated and could be used to produce different reports in a variety of formats for all audiences. As one hospital executive put it, CMS should collect all the necessary data once, then report different measures to different audiences, not mount a separate data collection effort for each type of report.

Hospital participants mentioned several times that current data collection and external reporting requirements have become burdensome for hospitals: the number of different entities to whom hospitals report, the number of quality measures they report, different definitions required for similar measures, *etc*. Hospitals are looking for consolidation and rationalization of quality reporting requirements. Hospital participants expressed their concern, however, that the need for additional resources to expand reporting beyond current requirements dictates that the pace of expansion be measured, if outside funding to support additional reporting costs is not forthcoming. Additional measures that require medical record abstraction will result in further diversion of clinical resources to meet reporting requirements.

Several meeting participants mentioned that to drive internal performance improvement as well as to hold hospitals accountable through public reporting, quality data have to be accurate, valid, timely, credible, and severity-adjusted (where necessary) by a methodology that is recognized as valid by the relevant professional societies.

In addition, CMS was advised that it should choose measures consistent with what other national organizations currently require and are planning to ask for. Measures need to be in the public domain and have one definition and reporting specification nationally. Participants felt that CMS is in a position, as the largest payer and a public agency representing the consumer, to demand a single definition for each measure.

Theme #3: A Robust Measurement Strategy Will Require Adoption of New Measures and a Commitment to the Maintenance of Existing Measures.

CMS heard comments from providers, consumers, payers and health plans that the current set of common measures is not sufficient and needs to be expanded. Participants championed several different types of quality measures (process, outcome, condition- or procedure-specific, cross-cutting, *etc*.). Please see Theme 6 for additional discussion.

Providers and physicians were adamant about the necessity of "maintaining" measures after adoption to ensure that measures always reflect the most current standards of practice. Participants expressed concern that process measures necessarily lag, and they might codify old practices when, in fact newer "best practices" are evolving over time. Purchasers urged CMS to use process measures that reinforce the most evidence-based medicine. It was felt that clinical specialty societies might be helpful in this regard. Physicians noted that they look to their specialty societies for guidance on practice, and if a quality measure is promoted by CMS or NQF but has not yet been accepted by their specialty societies, it's difficult to leverage change among physicians.

Theme #4: Reported Measures Should Be Valuable and Easy to Use.

Purchasers asked that CMS make hospital quality measures more "actionable" by those who it hopes will use them. Purchasers asked that expansion of measurement and reporting efforts address the following questions: "What do we want employers to do, what do we want their employees to do, what do we want patients to do with this information, and what actions will it lead them to?"

A point mentioned several times was that CMS should support the use of quality measures which can drive changes in hospital organization and practice (the activities encompassed by the "leaps" of the Leapfrog Group were an often cited example). Health plans noted that detailed clinical information is of less interest to consumers than to doctors and hospitals (for example: the NYS CABG report was hardly used by consumers, but attention from providers led to changes in practice and a reduction in mortality) and proposed that CMS report measures that will induce those providers being reported on to change. In general, it was felt that CMS should produce measures that, with several reporting formats, can be used by multiple audiences (consumers, purchasers, plans, providers). It was felt that such a multi-layered approach to leveraging information, even if it were primarily directed at consumers would be more effective than a single presentation, because the biggest gains in quality come from letting providers compare and improve their own performance.

There were differences of opinion on how best to make measures more valuable and useful. Across the different sites, the discussion of the relative merits of process and outcome measures was often spirited. Purchasers, consumers and some providers spoke in favor of outcomes measures, with the *caveat* that they require risk adjustment and are therefore more difficult to produce. Physicians and hospitals, on the other hand, want process measures that are relevant to their particular type of practice or institution, and enough of them (or measures which are sufficiently broad) to fairly characterize an entire institution's performance. In the end, hospitals and physicians agreed that outcome measures are the most meaningful for consumers, but they are difficult to get

right and can be more costly to produce. Most process measures don't require risk adjustment, so volumes don't matter as much. Process measures were felt to be important for providers to see how they're doing relative to their peers, but outcome measures should be reported as well, because hospitals can demonstrate excellent process compliance that doesn't necessarily result in good outcomes.

While not addressed in great detail at any meeting, several participants commented n issues related to the sources of the data needed for quality measurement, specifically concerns about the value of administrative data compared to data abstracted from medical records. Providers, expressed reservations about the limitations of administrative data for assessing quality at the hospital level, saying that administrative databases were designed to address issues related to the administration and financial management of hospitals and payers; they were not primarily designed to measure quality, and they are not readily accepted by physicians for that purpose. Purchasers and consumers, on the other hand were more accepting of the use of administrative data for quality reporting.

Participants suggested that CMS can ensure that measures would be better utilized by providing different measures for different audience segment - process measures for providers, outcome measures for purchasers and consumers, *etc*. Participants underscored that users need to know that the information that is presented to them is uniform, trustworthy and timely enough that users can be confident that measures reflect recent performance. Specifically regarding consumers, it was suggested that they want hospital-wide (such as measures of patient safety) and summary measures to allow them to compare hospitals along important dimensions that don't require that they predict exactly which hospital services they will need in the future. Consumers suggested that they would prefer reports with fewer "laundry lists" of individual measures, and instead more cross-cutting measures, measures upon which consumers could base a decision. Purchasers also said they felt that cumulative hospital scores would be more helpful to consumers than separate pieces of information. Consumers especially need easily understood reports that contain a smaller number of metrics.

Theme #5: Measurement and Reporting Require a Commitment to Information Technology and Reporting Infrastructure.

Listening Session participants frequently mentioned the need for national standard setting as well as for technical development around the mechanics of collecting and reporting clinical data for quality measurement.

Hospitals expressed their hope that CMS leadership will result in consensus around standards and technology so collecting and reporting clinical information for quality measurement can eventually be more cost-effective. There were some calls from hospitals for CMS to provide not only encouragement but also funding for the development of electronic medical records, but short of that they feel it is important that CMS create an efficient and cost-effective means of receiving, validating, editing and processing electronic data submissions from hospitals. Participants felt that CMS leadership should include several issues where federal involvement and standard-setting would be beneficial – not only choice of quality measures and measure definitions, but also provider reporting specifications and the development of electronic health records.

Theme #6: While Different Measures Interest Different Groups, Additional Measures Interest All.

Different audiences (consumers, purchasers, hospitals, physicians) expressed different information needs and supported different types of hospital quality measures, but all supported the notion that expansion of the set of common measures would be worthwhile. Table 1 portrays the measures and topic areas suggested by Listening Session participants. The list is arranged into specific suggestions and general recommendations; the list also notes all corresponding measures that have already been endorsed by the National Quality Forum.

Several participants from each of the stakeholder groups stated strongly that measurement and reporting should ideally embody "system-ness", that is, the measures should reflect the level of organization and capacity of a hospital to provide high-quality care. It was felt that this approach would meet the information needs of consumers and purchasers for choice, while encouraging hospitals to improve their care without the perverse incentives that unintentionally arise from less integrated measures.

Providers, in general, expressed more confidence in process measures than in outcome measures; in condition- and procedure-specific measures than in cross-cutting and composite measures; and in measures derived from clinical data than in measures derived from administrative data. Providers stated that they would use process measures for feedback and QI. One commenter noted that most hospitals are community hospitals which do "bread and butter" medicine and are therefore interested in "bread and butter" indicators—high-volume, high-cost and perhaps, risk-prone diagnoses and procedures – which would mean much more to them than esoteric indicators for esoteric conditions.

Hospitals want measures that are intended for use by consumers and purchasers to fairly portray their hospitals. This was a particularly important issue for small and rural hospitals. During the break-out sessions on issues related to small and rural hospitals, a number of suggestions were offered to attempt to address their concerns. Hospitals suggested that small or rural hospitals should be specifically identified for consumers on sites such as the CMS website. Since small and rural facilities often stabilize and transfer certain patients, rather than provide full treatment, it was suggested that CMS develop measures that reflect this different pattern of practice. It was also noted that improved measurement of the treatment of emergency room patients would also benefit small and rural hospitals. It was suggested that CMS consider a symptom or complaint-oriented approach to assessing care in these emergency settings, rather than the current diagnosis related measurement set. Measures could be developed to assess how well hospitals treat the primary complaints or presenting conditions for emergency room visits (such as, shortness of breath, chest pain).

Consumers and purchasers, on the other hand, favor outcome measures, cross-cutting measures that provide an institution-wide look at performance in a certain category (such as hospital-acquired infection), and composite measures that "roll up" several specific measures within a clinical category. Consumers and purchasers stated that they are interested in measures that assess a facility rather than the treatment of a particular diagnosis, since hospital choice, when it occurs, happens often long before consumers know which service(s) they might require.

Purchasers feel that single-condition outcome measures, while of great value to patients with that condition, are not much help to those requiring hospitalization for other reasons. Purchaser participants stated that they want a full, robust measure set of standardized measures that would build upon the current "starter set" of measures in the HQA, and include reporting of all National Quality Forum measures - including safe practices, nursing sensitive measurement sets - and the HCAHPS patient survey. Employers, health benefit managers and others from the purchaser community were interested in assuring that they are not paying for poor care and, as such, were interested in measures (and interventions) to prevent adverse events and medical errors. Cross-cutting measures addressing patient safety and adverse events were of particular interest. Consumers at all sites were also very interested in patient safety measures. Several commenters suggested that nosocomial infection rates be reported and provided input from state and national consumer campaigns to require such reporting. Consumer participants frequently said infection rates are an important cross-cutting measure to add to CMS's reporting. (It was noted that this would require risk adjustment for tertiary care facilities, to account for specialized populations, such as transplant patients.)

Although outside the scope of the Listening Sessions, the need for measures of patient satisfaction or experience of care was discussed by several participants. While consumers expressed their interest in such measures, physicians were concerned about how they would be presented and interpreted. They felt that patient experience measures should be kept separate from and not combined with clinical measures, because they are not clinical outcomes.