

Patient Experience Surveys Are Not Harming Patients or Physicians

Ron D. Hays, Marc N. Elliott, Paul D. Cleary

Richman and Schulman (2022) raise questions about patient experience measures. Unfortunately, their commentary has shortcomings with respect to both context and its primary example. For example, the authors note that measures need to “be updated to be useful” (p. E1) and claim that “most instruments were developed more than 20 years ago” and “developed in a world of paper-based, mailed surveys.” The original Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey was indeed developed that long ago, but it has been updated regularly using stakeholder input, analyses of data from large CAHPS survey administrations, and ongoing focus groups and cognitive interviews. The current CAHPS health plan survey is version 5: <https://www.ahrq.gov/cahps/surveys-guidance/hp/about/survey-measures.html> This and other CAHPS surveys have been modified to reflect changes in care and patient concerns and extensive research assessing different electronic administration strategies (Anhang Price, Quigley, Hargraves et al., 2022; Brown et al., 2016; Parast et al., 2019).

The authors acknowledge studies demonstrating positive associations of multiple process and outcome measures with patient experience measures. They are critical of the fact that these studies evaluate information across large groups of patients and do not focus on individual physicians. We do not see how this could be considered a limitation of the literature. The literature is more extensive than the few examples they reference (Anhang-Price et al., 2014) but it is not feasible, for example, to study the relationship between experience scores and mortality after heart attack treatment (Meterko et al., 2010) because no physician would have enough heart attack patients in a short period to conduct such a study. The observed effects may be in part due to the characteristics of clinics and systems within which physicians practice, but that does not mean that the experience of patients should not be central to the efforts to support both physicians and systems.

The authors reference one study of joint arthroplasty patients showing no correlation between patient experiences and outcomes but do not explain why they think that study is important. As we indicate above, there have been many studies of the associations between patient experience measures and other measures of process and outcomes (Anhang-Price et al., 2014; Elliott, Adams et al., 2021). Some show a positive association, some show a negative association, and some show no association, but those associations reflect the characteristics of process or systems related to care quality rather than the validity of different measures. This is also true for more “objective” process measures (Wilson et al., 2007). The second article they cite is a 2012 study that claims that information from patient surveys result in negative consequences for patients, including higher mortality. They refer to the article as “famous” but neglect to cite a subsequent article that identified serious methodological flaws in the 2012 work that resulted in incorrect conclusions (Xu et al., 2014).

After failing to describe accurately the ways in which the surveys have evolved over time and impugning the value of surveys based on correlation studies and one flawed analysis of patient experiences and mortality, they assert, with no support, that “they are not responsive to the

performance of individual physicians or care teams.” There are several studies documenting that they are responsive to change in provider behavior (e.g., Orr et al., 2022; Quigley, Elliott et al., 2021; Quigley, Qureshi et al., 2022).

The authors’ primary argument for how it would be possible to misuse data is a hypothetical analysis that is inconsistent with widely used guidance about how to calculate and report reliable differences in patient experience scores

(<https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/guidance-cg-cahps.pdf>): "Imagine a clinician who treats 120 patients each month and enjoys a mean patient rating of 9.5, well above the national mean. With a survey response rate of 20%, it takes only 1 disgruntled patient giving a score of zero to cause the clinician’s mean score to plummet below 9.1" (p. E1). This is based on an extreme case with a small sample of 24 surveys ($23 \times 9.5 + 0 \times 1 = 218.5/24 = 9.1$). The same thing could be said about surgeon mortality rates. If a surgeon enjoyed a 95% survival rate on average but one more person died in a small sample of 24, the rate would plummet to 91%. CAHPS surveys are administered with number of completion thresholds that exceed the sample used in the hypothetical example to ensure sufficient reliability for the unit of assessment. Indeed, one could construct such an example showing problems with any quality measure; examples such as this reflect an inappropriate use of data, not the validity of the underlying measures.

The authors also fail to recognize the distinction between measures of patient satisfaction and patient experiences (<https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html>). The CAHPS surveys ask for reports of specific experiences with health care, in addition to asking respondents to give general evaluations (or “ratings”) of their care, CAHPS provides survey users with actionable information for improving care based on patient experiences. Reports about whether a respondent had a particular experience are less subjective than are satisfaction ratings or evaluations. Such reports of experience are easier to interpret and use for quality improvement efforts than are satisfaction ratings.

Without providing any support, the authors blame physician burnout and bad medical care on measures such as the CG-CAHPS survey. Making physicians and systems aware of the needs and experiences of patients has been widely credited for leading to significant improvements in patient-centered care (Elliott et al., 2015). The relationships of patient experience with physician satisfaction and burnout have not been extensively studied (Quigley, Reynolds et al., 2021). Although it is possible that focusing on physicians rather than system flaws to foster quality could create frustration (Shojania & Dixon-Woods, 2013), it is also plausible that systems that promote high quality care and better patient experiences are the kinds of systems that physicians feel most supported by (Haas et al., 1998; Quigley, Slaughter et al., 2022).

We suggest that those who are frustrated with quality improvement initiatives encourage systems to support positive changes in care, rather than “shoot the messenger.” The messenger in this case is a rigorously developed and evaluated set of measures that give voice to patient concerns (Cleary, 2022).

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