The Challenge of Creating a Patient Experience Report Card for Individual Physicians

Safran DG, Karp M, Coltin K, et al. Measuring patients' experience with individual primary care physicians: results of a statewide demonstration project. J Gen Intern Med 2006;21:13–21.

Study Overview

Objective. To determine the feasibility and merit of rating individual physicians using patient-reported experiences with health care.

Design. Cross-sectional survey.

Setting and participants. 9625 adult patients sampled from panels of 215 primary care physicians across 67 practice sites within Massachusetts in 2002 and surveyed using the Ambulatory Care Experiences Survey (ACES). Patients were enrolled in 1 of 5 commercial health plans or Medicaid. The ACES assesses the quality of physician-patient interactions (communication quality, interpersonal treatment, whole-person orientation, health promotion, patient trust, relationship duration) and organizational features of care (organizational access, visit-based continuity, integration of care, clinical team, and office staff).

Main outcome measures. Physician-level reliability of measures of patient care experience, influence of each level of the health system on each measure, and risk of misclassifying individual physicians.

Main results. A sample size of 45 patients per physician produced a physician-level reliability of at least 0.70 (range, 0–1) for the majority of measures. A physician-level performance report involving 3 levels of performance produced less than 2.5% risk of misclassification of physicians into the adjacent category. Patient characteristics accounted for 2.4% to 6.5% of the overall variance in patient experience measures, while features of the health care delivery system accounted for 2.4% to 16.9% of the overall variance. Practice sites accounted for the majority of variance in organizational features of care (range, 45%–81%), and physicians accounted for the majority of variance in the quality of physician-patient interactions (range, 62%–84%); physicians also accounted for 18% to 39% of variance in organizational features of care. Physician network organizations and health plans were negligible contributors to variance.

Conclusion. Individual physician-level reporting of patient experiences appears feasible based on this statewide survey. Physicians and practice sites play a much more significant role than health plans in patient experiences with the health care delivery system.

Commentary

The Institute of Medicine identified patient-centered care as a critical component of delivering high-quality health care [1]. Tools to evaluate patient experiences with health care have become increasingly available and are being used to evaluate health plans and physician groups. Unfortunately, there has been a decrease in the quality of patient-reported experiences with the U.S. health care system in recent years [2]. While patients are probably most interested in evaluations of their own personal physician, individual physician-level quality reporting, either of clinical quality or patient experiences, has been limited because of concerns related to feasibility of data collection and statistical reliability [3].

In this study, Safran and colleagues describe the results of the ACES Project, a collaboration of health plans and physician practice groups designed to test the feasibility and merit of measuring patient care experiences at the individual physician level. Not only did this study determine that it was, in fact, feasible to collect such data but also that it was possible to create a statistically reliable physician-level "report card" and that the most informational and reliable framework for such reports involved 3 levels of performance (below average, average, above average). In addition, the study revealed that physicians and their individual clinics play an important role in determining patient experience, as opposed to health plans. While it is not surprising that physicians were important contributors to the quality of patient-physician interactions, they also played a substantial role in ratings of organizational features of care, suggesting that individual physicians may be a primary target of interventions to improve patient experiences with the overall health care system.

This study represents a major stride in demonstrating the ability of a large-scale initiative to accomplish quality reporting at the physician level; however, it is subject to important

limitations. Most notably, while patient experience measures allow sampling of an entire physician panel, many clinical quality measures (eg, diabetes care) may still be imprecise at the individual physician level due to patient eligibility criteria. In addition, although the findings have identified physicians as important drivers of patient experiences within the health care system, only 11% of the variance could be explained using data the authors collected. Therefore, efforts to target individual physicians for quality improvement may have less significant effects on patient experiences overall when factoring in variation that could not be measured (89%).

Applications for Clinical Practice

Patient experiences with care are an increasingly recognized facet of quality, and this study provides a model by which physician-level reporting of patient experiences might be accomplished on a large scale. Such reporting is particularly relevant, as physicians appear to be important drivers of patient experiences within the health care delivery system. However, these initiatives may be cost-prohibitive (50¢ per adult resident according to the authors) and will require commitment of resources to evaluate only 1 aspect of quality of care.

–Review by Thomas D. Sequist, MD, MPH

References

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