VIEWPOINT

Criterion-Based Measurements of Patient Experience in Health Care

Eliminating Winners and Losers to Create a New Moral Ethos

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Prevailing measurements of patient experience in health care are norm based and focused on percentile scores and rankings, a system of assessment that inherently produces winners and losers. There is a better way: a criterion-based system with transparent reporting of results, driven by intrinsic motivation toward benchmark practices that make health care team members' work easier and patients' lives better. Simply stated, norm-based measurements are based on an individual's or organization's standings relative to that of others, or "grading on the curve," producing rankings. Criterion-based measurements rely on standards that produce ratings instead of rankings, of which board certification examinations are perhaps the most common example in health care. Percentile scores and rankings rely on extrinsic motivation and are often linked to perverse payment and incentive systems in which teamwork, mentoring, mutual accountability, and sharing best practices are far too rare.[1,2] Health care is thus not unlike many educational systems, in which rankings have devolved into a zero-sum game, chilling learning and treating "grades" as more important than the individuals whose performance is being assessed.

> [I]f the purpose is, as it should be, to develop mastery in improving patient experience while making health care work less stressful, then a change to criterion-referenced ratings is essential.

Despite these well-known and fundamentally inexorable consequences of grading on a curve, surveys from the Centers for Medicare & Medicaid Services' current Care Compare and Consumer Assessment of Healthcare Providers and Systems (CAHPS) continue to score individual measures and calculate Hospital CAHPS (HCAHPS) Star Ratings using a cascade of percentile scores and comparative assessments despite no apparent congressional statutory requirement to do so.[3] Undeniably, the underlying concepts and aims of HCAHPS focusing on patient-centric principles are fundamentally sound and valid, but the implementation of scoring has degraded that central purpose into a zero-sum game.

But as Kohn[4] noted, "Excellence is not a zero sum game." In fact, pursuing excellence ought not to be a game at all; but it has become one. In addition, the "game" has become so extreme that financial incentives have spurred an entire industry of consultants,[2] whose purpose appears to be to focus on patient experience "losers" to help them attain "winner" status. Hospitals and health care systems have invested in strategies to improve their scores and rankings, with little if any evidence that such strategies have improved performance or outcomes.[1,2] As Berwick[2] previously noted, "The aim should be to measure only what matters and mainly for learning….an enormous amount of time [is] wasted on generating and responding to reports that help no one at all."

The Problem: 2 Truths

There are 2 truths regarding using measurements to improve patient experience: it is essential, and done poorly, it does far more harm than good. (Although these also apply to other measures of quality, the focus in this Viewpoint is on patient experience.) Measurement of patient experience and a commitment to patient-centered care are welcome additions to the way in which quality is judged in health care, as is a deep commitment to continuous improvement for all clinicians. In a cross-sectional study of 5445 physicians, 44% met criteria for burnout (defined as emotional exhaustion and depersonalization on the Maslach Burnout Inventory), and although overall higher resilience scores were associated with lower odds of burnout, among the 1359 physicians with the highest resilience scores, 29% met criteria for burnout.[5] Two of the most common causes of burnout among physicians are dealing with the electronic health record and an unreasonable focus on rankings, particularly in norm-based percentile systems,[6] which are examples of what Muller[7] has referred to as "metrics fixation" or "metrics madness."

The dynamic tensions between job stressors and adaptive capacity or resiliency could be resolved by moving not *away* from measurement and improvement but *toward* a more humane and healthier system of transparent criterion-referenced reporting of what works best for everyone to improve patient experience.

Clinical leaders should take a lesson from medical education in realizing these benefits. Already, 90% of 153 medical schools that responded to the Association of American Medical Colleges 2020 survey indicated they have abandoned letter or numeric grades in the preclinical curriculum, and 80% continue that approach into the required clinical clerkships,[8] with no evidence of diminution in the quality of their graduates. Thus, medical education has adopted criterion-referenced evaluation, but health care writ large has not.

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The Purpose of Measurement? Improving Patient-Centric Care

All of this speaks to the purpose of any measurement. If the purpose is to create competitive rankings, the current norm-based system is perfectly designed to do so. But if the purpose is, as it should be, to develop mastery in improving patient experience while making health care work less stressful, then a change to criterion-referenced ratings is essential.

What does not work? Few would disagree that the current approach is not working, in that current methodologies promulgate an endless cycle of measuring and reporting statistical percentile results derived from frustratingly narrow raw scores, in which differences in quality derived from small sample sizes have little to no clinical meaningfulness, let alone provide a path to excellence. Measurement systems fixated on these scoring systems may also discourage the sharing and, in turn, scaling of best practices because of the inherently competitive nature of comparative rankings, which implicitly provides a competitive disincentive to share improvement strategies with other hospitals or clinicians.[2,3] Although many who designed, built, and implemented these systems have cautioned against using individual rankings as a threshold to reward or penalize, in fact health care leaders have routinely done so in an attempt to create vertical alignment or trickle-down organizational incentives to individual clinicians. Absent a wholesale change to transparent ratings instead of rankings, they will likely continue to do so.

A Proposed Solution

Improvements could occur more quickly and could become more pervasive if measurement and reporting of health care patient experience abandoned the current percentile ranking system and instead adopted a simple criterion-referenced rating system, in which it is possible that everyone can "get an A."[4] It is no more difficult than that. Metrics based on a ranking system should give way to those based on a threshold system identifying criterion-based scores attained through best practices. The criteria need not be static; what constitutes excellence can continue to be elevated over time as new ways to improve patient experience evolve and are shared. The goal remains continuous improvement in patient experience for everyone in health care while avoiding "the toxicity of pay for performance."[9] Patients deserve a system in which excellence can be attained by anyone who is willing to do the challenging work of continual improvement and for whom collaboration trumps competitiveness because doing so better supports learning and growth.

Here are some potential ways to begin the process:

- Use a rating and reporting system with raw scores, not percentiles, on all questions, with a threshold established above which scores are considered an A or excellent.
- As do other industries with much larger economic scales than health care (such as financial services or aviation), use the net promoter score concept as a noncomparative assessment of customer experience.[10] (This approach involves a 10-point scale for the question "How likely would you be to recommend?" with scores of 9 and 10 rated as "promoters"; and the current "overall assessment" and "likelihood to recommend" scores could easily serve this purpose.)
- Use the other component CAHPS questions to help individual clinicians and health care systems to guide improvement efforts, just as they were initially designed by Agency for Healthcare Research and Quality.
- Use narrative responses from the patient to further refine how to guide improvement efforts to capture "What matters to you?"[2]

Critics will maintain that a criterion-based system would create a psychology of mediocrity. That criticism misses the crucial point that the key question about the quality of care from the viewpoint of society is not whether an individual is moving to the right on the bell-shaped curve, but rather whether the entire bell-shaped curve is moving continuously to the right. A criterion-based measurement and reporting system is a necessary first step to achieve that goal. Professionalism ought to mean not only that everyone should aspire to get an A but also, and crucially, that everyone should be able to get an A in patient experience even as all seek continuously to improve. As Kohn[4] noted, "Everyone may not succeed, but at least in theory all of us could." This will be an important step toward creating a new moral ethos in health care in which the goal is excellence for all, not defeating one another.[2] It is time to move from Care Compare to "Care Collaborate."

ARTICLE INFORMATION

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