Patients’ Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care

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**Background:** Patient global ratings of care are commonly used to assess health care. However, the extent to which these assessments of care are related to the technical quality of care received is not well understood.

**Objective:** To investigate the relationship between patient-reported global ratings of health care and the quality of providers’ communication and technical quality of care.

**Design:** Observational cohort study.

**Setting:** 2 managed care organizations.

**Patients:** Vulnerable older patients identified by brief interviews of a random sample of community-dwelling adults 65 years of age or older who received care in 2 managed care organizations during a 13-month period.

**Measurements:** Survey questions from the second stage of the Consumer Assessment of Healthcare Providers and Systems program were used to determine patients’ global rating of health care and provider communication. A set of 236 quality indicators, defined by the Assessing Care of Vulnerable Elders project, were used to measure technical quality of care given for 22 clinical conditions; 207 quality indicators were evaluated by using data from chart abstraction or patient interview.

**Results:** Data on the global rating item, communication scale, and technical quality of care score were available for 236 vulnerable older patients. In a multivariate logistic regression model that included patient and clinical factors, better communication was associated with higher global ratings of health care. Technical quality of care was not significantly associated with the global rating of care.

**Limitations:** Findings were limited to vulnerable elders who were enrolled in managed care organizations and may not be generalizable to other age groups or types of insurance coverage.

**Conclusions:** Vulnerable elders’ global ratings of care should not be used as a marker of technical quality of care. Assessments of quality of care should include both patient evaluations and independent assessments of technical quality.

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Patient ratings of care are commonly used by health plans, payers, providers, and consumers to assess the quality of health care received. Measuring satisfaction is common in other service industries for various purposes, including marketing and improving service delivery. Patient evaluations of care, although variable across providers, are generally high (1, 2). On the contrary, there is increasing concern about the technical quality of patient care (3) and a growing emphasis on improving patient safety (4). Although reports and ratings of care are important indicators of patients’ subjective experiences with the health care system, the relationship of these perceptions with technical quality of care is not well understood.

In his conceptual model of quality of care, Donabedian (5) defined 3 components of quality: technical quality of care, interpersonal quality, and amenities. Technical quality of care describes the extent to which the use of health care services meets predefined standards of acceptable or adequate care relative to need (5). Interpersonal quality describes the characteristics of interaction between provider and patient. Whether global ratings of care simply reflect interpersonal quality or encompass both technical and interpersonal quality (as well as amenities) is unknown. Only a few studies have investigated these relationships; most have focused on condition-specific evaluations, some demonstrating positive relationships and others showing equivocal findings (6–12). To date, no study has examined the relationship between a comprehensive measure of technical quality of care measured by quality indicators and patients’ global ratings of care.

We developed and applied a conceptual model (Figure 1) based on Donabedian’s work that examines the relationship of quality of care, both technical and interpersonal, with patients’ global evaluations of health care. Earlier literature has demonstrated that many patient characteristics are important determinants of health care preferences, and

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Appendix Table
Conversion of figures and tables into slides
improving patient care

Global Ratings of Health Care Are Not Associated with Quality of Care

Context

Patients’ overall ratings of their care could reflect its technical content, their interaction with the clinician, or both.

Contribution

The authors asked 236 vulnerable elderly patients to rate their care in the past 12 months and the interpersonal communication that they experienced. They also reviewed medical records for adherence to standards of care for common conditions. Overall ratings of care were high and directly correlated with ratings of interpersonal communication. Neither correlated with the ratings of technical quality of care, which were much lower. Patients’ overall ratings of their care are not a reliable indicator of adherence to practice norms.

Cautions

The respondents were frail and elderly.

Implications

Patients’ overall ratings of their care are not a reliable indicator of adherence to practice norms.

—The Editors

understanding these preferences provides insight into particular care needs (13). Eliciting patient preferences and placing priority on the personal relationship between physician and patient have been shown to be key strategies of a patient-centered approach that can enhance both aspects of quality of care: medical treatment and patient satisfaction (13–17). On the basis of these findings, we hypothesized that patient (age, sex, educational level, ethnicity, and income) and clinical (physical and mental health status, vulnerability, and comorbid conditions) factors, as well as technical and interpersonal quality of care received, relate to patients’ global evaluations of their quality of care.

One study showed that patient global ratings of overall care had a small but statistically significant correlation with mammography rates, but these ratings did not significantly correlate with performance on 5 other Medicare Health Plan Employer Data and Information Set measures (18).

The ACOVE project developed and applied a quality assessment system for vulnerable older persons. The measurement system consisted of process measures and covered the spectrum of care for 22 conditions that are important in the care of vulnerable elders. Methods for selecting conditions, developing the quality indicators (20, 21), and identifying vulnerable elders (22) have been described elsewhere. The 236-item ACOVE quality indicator set (Appendix, available at www.annals.org) was assembled by formal group judgment process and is grounded in the medical literature. Better quality of care as measured by this set of quality indicators (a higher score for technical quality of care) was associated with lower 3-year mortality rates (23).

Patients and Data Collection

By using the ACOVE quality indicator set, we assessed care for vulnerable elders who were enrolled in 2 large managed care organizations, one in the northeastern United States and the other in the southwestern United States. Each managed care plan had more than 20,000 elderly members and contracted with a network of providers for delivery of care. We conducted telephone interviews to identify vulnerable older adults by using the Vulnerable Elders Survey (22) to collect data regarding age, self-reported health quality, and functional status. This 13-item questionnaire produces a vulnerability score and identifies older people at increased risk for functional decline or death over the next 2 years. Among a random sample of 3,207 community-dwelling older adults drawn from eligible persons in both managed care organizations, 475 vulnerable elders were identified and 420 consented to participate in the study. Of these 420 participants, 372 had medical records available for quality-of-care assessment during the 13-month study period. Adequate medical records were not available for 20 patients, 24 patients received no care during the study period, and 4 patients received only an influenza vaccine. After the study period, we conducted computer-assisted telephone interviews of patients (or, if participants were incapable of responding, their proxies) about their medical care. Among the 372 patients with available medical records, 341 were alive during the interview period and 245 (72%) completed the quality-of-care interview, which was conducted from August 2000 to October 2000. Most incomplete interviews were attributable to respondent unwillingness (n = 66); 30 patients could not be contacted. The ACOVE data collection has been described in detail elsewhere (19).
RAND Institutional Review Board approved the study protocol.

**Measures**

**Patient Global Ratings**

The Consumer Assessment of Healthcare Providers and Systems survey (24), formerly the Consumer Assessment of Health Plans Study, was used to measure patients’ global ratings of all their health care. Our quality-of-care interview included a single item from the second stage of the survey: “We want to know your rating of all your health care in the last 12 months from all doctors and other health providers. Use any number from 0 to 10 where 0 is the worst health care possible and 10 is the best health care possible. How would you rate all your health care?”

**Providers’ Communication**

The quality-of-care interview also included the 4 communication report items from the Consumer Assessment of Healthcare Providers and Systems survey (24). Participants were asked, “In the last 12 months, how often did doctors or other health providers listen carefully to you? . . . explain things in a way you could understand? . . . show respect for what you had to say? . . . spend enough time with you?” Possible responses consisted of never, sometimes, usually, and always. A possible score ranging from 0 to 1 was computed as the mean of the responses to the 4 items (Cronbach reliability coefficient \( \alpha \) was 0.83). Five participants missed 1 of the 4 communication items; in each case, the score for the missing item was imputed by the chained equation method of multiple multivariate imputation (25) to compute a composite communication score. This score was used in these analyses as a measure of the quality of providers’ communication.

**Technical Quality**

Data regarding technical quality of care were collected from medical records and patient interviews. The complete medical records (inpatient, outpatient, mental health, home care, and nursing home) were abstracted for enrolled participants from 1 July 1998 to 31 July 1999; we obtained 95% of records requested. We evaluated reliability of the abstraction method by reabstracting a random 10% sample of medical records. For 95% of quality indicators, the identical quality indicator eligibility and score were identified in abstracted and reabstracted records (19). A quality-of-care interview was conducted to ask study respondents about aspects of technical care that might not be captured in the medical record.

We computed an overall quality-of-care score for each patient by using both chart abstraction and interview data. Of the 236 quality indicators, 207 indicators could be evaluated by using data from the medical record abstraction or interview. A quality indicator was scored for a patient if he or she was eligible to receive the specified care process. A score of 1 was awarded if the care process was completed.

### Table 1. Patient Characteristics*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>ACOVE Patients Included in Analysis (n = 236)</th>
<th>ACOVE Patients Excluded from Analysis (n = 184)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean technical quality of care (SD)</td>
<td>0.55 (0.11)</td>
<td>0.53 (0.11)†</td>
</tr>
<tr>
<td><strong>Demographic characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age (SD), y</td>
<td>80.2 (6.7)</td>
<td>81.5 (7.0)†</td>
</tr>
<tr>
<td>Men, %</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>High school graduate, %‡</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>White ethnicity, %‡</td>
<td>97</td>
<td>98</td>
</tr>
<tr>
<td>Annual household income &gt;$15 000, %‡</td>
<td>10</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Clinical characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean SF-12 score, physical health component (SD)‡</td>
<td>39 (10)</td>
<td>41 (11)</td>
</tr>
<tr>
<td>Mean SF-12 score, mental health component (SD)‡</td>
<td>57 (9)</td>
<td>58 (7)</td>
</tr>
<tr>
<td>Mean vulnerability score (SD)</td>
<td>5.1 (2.2)</td>
<td>5.5 (2.4)</td>
</tr>
<tr>
<td>Mean number of comorbid conditions (SD)§</td>
<td>2.8 (1.7)</td>
<td>2.2 (1.7)</td>
</tr>
<tr>
<td>Diabetes mellitus, %</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td>Heart failure, %¶</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, %</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Dementia, %</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Falls, %¶</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Urinary incontinence, %¶</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Smoker, %</td>
<td>11</td>
<td>8</td>
</tr>
</tbody>
</table>

* ACOVE = Accessing Care of Vulnerable Elders; SF-12 = 12-item Short-Form Health Survey.
† 48 patients were excluded because medical records were unavailable.
‡ 144 patients in the ACOVE excluded sample were excluded because characteristics were collected from the quality-of-care interview.
§ \( P < 0.05 \).
¶ 1 patient in the analytic sample and 22 in the ACOVE excluded sample were excluded.
\( \) Patients reported “unintentionally coming to rest on the ground, floor, or other lower level”; from reference 28.
and a score of 0 was awarded if it was not. For quality indicators that included several triggering events, a score between 0 and 1 was possible. If it was documented that a patient declined a recommended care process, the quality indicator was considered to be passed (credited in both the numerator and denominator). Patients with a contraindication to a care process or documented preferences that conflicted with a care process were considered ineligible for the quality indicator (excluded from both the numerator and denominator). The overall quality-of-care score for a patient was the percentage of care processes received for all quality indicators for which the patient was eligible. This overall quality-of-care score was used in these analyses as a measure of technical quality of care.

**Other Variables**

The quality-of-care interview also collected information about health status and vulnerability by using the 12-item Short-Form Health Survey (SF-12) (26) and the Vulnerable Elders Survey (22). Demographic information, including age, sex, ethnicity, income, and educational level, was also gathered.

**Statistical Analysis**

We examined the relationship of patients’ global ratings of health care with technical quality of care and the quality of providers’ communication by using graphical representation with scatter plots. We used jittering to display overlapping data points. Because patients’ global ratings of health care and ratings of the providers’ communication had non-normal distributions, we considered using ordinal logistic regression to study the relationship of patients’ global ratings. However, in conducting these analyses, we could not find categories for the patient global rating that satisfied the proportional odds assumption. Therefore, we created dichotomous categorical variables for patients’ global ratings of health care and ratings of the providers’ communication, using the median to create the 2 categories for each. The measure for technical quality of care had a normal distribution. We performed bivariate tabular and logistic regression analyses to identify significant correlates of the global rating item. We built a multivariate logistic regression model of the global rating by using managed care organization as a stratification factor. First, we included patient and clinical factors as independent variables in the model. Second, technical quality of care was added to the model. Third, providers’ communication was added to the model. Fourth, we examined interactions between any of the significant predictors. A previous systematic review found that the minimally important difference for a variety of health-related quality-of-life instruments was approximately one half of an SD (27). To report clinically meaningful and comparable changes in the global ratings that were estimated by the model, we rescaled our continuous independent variables by approximately halving an SD; we divided the score for technical quality of care by 0.05, communication score by 0.1, age by 5 years, and the SF-12 physical and mental component summaries by 5 points.

All data analyses were performed with Stata statistical software, version 9.0 (Stata Corp., College Station, Texas).

**Sensitivity Analyses**

Because proxies completed the quality-of-care interview if participants were incapable of responding, we performed subgroup analyses for those patients with a quality-of-care interview completed by a proxy. Many patients included in the analyses had a communication score of 1; therefore, we conducted a sensitivity analysis by repeating the main analysis while excluding those with a communication score of 1. Our examination of the impact of omitting this group of satisfied participants helped to identify whether a different set of predictors was associated with the global rating in the subgroup of participants who were less satisfied.

We conducted 2 additional analyses to evaluate alternative constructions of the score for technical quality of care instead of using a simple percentage of the recommended care received. One sensitivity analysis repeated the main analysis by using weights proportionate to the number of quality indicators for which patients were eligible. These weights reflected the stability of quality scores by placing greater emphasis on scores calculated from more care processes and less emphasis on unstable quality scores that were calculated from a few care processes. The second analysis adjusted for differences in the level of difficulty satisfying individual quality indicators by creating an alternative quality score. We calculated this alternative score by subtracting from each person’s score the population mean score for the set of quality indicators for which the patient was eligible. This alternative score represented how much
the individual’s score deviated from the mean score of the population eligible for the same set of quality indicators.

**Role of the Funding Source**
This study was supported by a contract with Pfizer Inc. The funding source had no role in the design, analysis, or interpretation of the study or in the decision to submit the manuscript for publication.

**RESULTS**

**Sample Characteristics**
A total of 245 patients had medical records available and had completed the quality-of-care interview; the global rating and scores for communication scores and technical quality of care were available for 236 patients, who constituted the analytic sample (Table 1). The mean age of the analytic sample was 80.2 years; one third were men, and nearly all were white. Proxies completed the interviews for 57 (24%) participants. The mean SF-12 score was 39 for the physical component and 57 for the mental component. These results are similar to those from a national sample of persons 70 years of age and older in which the mean scores were 40 for the physical component and 52 for the mental component (29). For our sample, the mean vulnerability score was 5.1 (range, 0 to 10; a score ≥3 was required for a patient to be identified as vulnerable). Other patient characteristics are shown in Table 1. There were no statistically significant differences in mean scores for overall technical quality of care between our analytic sample and the remainder of the ACOVE cohort. Except for a higher mean number of comorbid conditions in the analytic sample (2.8 versus 2.2; $P < 0.001$), demographic and clinical characteristics were similar.

Patients’ median rating of all their health care in the past year was 10 on a 10-point scale (mean, 8.9 [SD, 1.3]; range, 5 to 10). The median communication score was 0.92 on a scale of 0 to 1 (mean, 0.85 [SD, 0.20]; range, 0.17 to 1.00), and the mean score for overall technical quality of care was 0.55 (SD, 0.11) on a scale of 0 to 1 (range, 0.27 to 0.79). A summary of mean quality-of-care scores by rating is shown in Table 2. Patients’ global ratings of health care were more widely distributed than scores for technical quality of care (Figure 2) and ratings for communication (Figure 3).

**Logistic Regression Analyses**
The bivariate analyses revealed 4 significant associations with patients’ global rating of health care: communication rating, educational attainment, and physical and mental health status (as quantified by the physical and mental components of the SF-12). These factors were positively associated with patients reporting the highest global rating.

The logistic regression model that included only demographic and clinical factors revealed 3 predictors that were associated with patients who selected the highest global rating versus a lower rating. Physical health status and mental health status were positively associated and educational attainment was negatively associated with global rating. When technical quality of care was added to the logistic regression model, educational attainment and physical health status remained significant. The addition of communication rating to the model displaced educational attainment, yielding only the communication rating and physical health status as significant positive predictors of

![Figure 2. Relationship of patient global rating of care to technical quality of care.](image-url)
the highest global rating of health care (Table 3). Techni-
cal quality of care was not significantly related to the global
rating of care in any model.

Sensitivity Analyses

The sensitivity analyses produced results similar to the
main analyses. Compared with patient respondents, the 57
patients whose quality-of-care interview was completed by
a proxy reported similar global ratings of all health care in
the past year (median, 9.0; mean, 9.0 [SD, 1.3]; range, 5 to
10), overall technical quality of care (mean, 0.55 [SD,
0.09]), and score on the SF-12 physical (mean, 38; [SD,
11]) and mental (mean, 56 [SD, 10]) components. Proxies
reported a slightly higher communication score (median,
1.00; mean, 0.91 [SD, 0.17]; range, 0.17 to 1.00) than
patient respondents. Logistic regression models performed
on subgroups of patient and proxy respondents were not
meaningfully different from the overall model. The statis-
tical significance for technical quality and communication
remained the same.

In the model that excluded patients with a communi-
cation score of 1, technical quality of care was not related
to having the highest global rating. The patients remaining
with a higher (but not perfect) communication rating had
increased odds (1.9) of having the highest global rating,
but this did not reach statistical significance.

The analysis that used weights to reduce the effect of
unstable quality scores yielded a coefficient for commu-
ication rating of 1.73 (95% CI, 1.07 to 2.38). When qual-
ity scores were adjusted for the difficulty of passing each
patient’s set of quality indicators, the coefficient for com-
munication rating was 1.73 (CI, 1.11 to 2.36). These
models were nearly identical to the overall model. The statis-
tical significance of all the model terms remained the same,
and, with the exception of the alternately con-
structed technical quality-of-care scores, the parameter es-
imates were similar.

### Table 3. Logistic Regression Estimates for Predictors of
Highest Patient Global Ratings of Health Care (Full Model)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rating</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical quality of care per 0.05-point increment</td>
<td>0.03 (–0.12 to 0.18)</td>
<td>0.68</td>
</tr>
<tr>
<td>Communication rating  ≥0.9</td>
<td>1.73 (1.10 to 2.35)</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Patient characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age per 5-y increment</td>
<td>–0.01 (–0.27 to 0.25)</td>
<td>0.94</td>
</tr>
<tr>
<td>Male sex</td>
<td>–0.65 (–1.32 to 0.01)</td>
<td>0.05</td>
</tr>
<tr>
<td>High school graduate</td>
<td>–0.61 (–1.26 to 0.05)</td>
<td>0.07</td>
</tr>
<tr>
<td>White ethnicity</td>
<td>0.35 (–1.33 to 2.04)</td>
<td>0.68</td>
</tr>
<tr>
<td>Annual household income &gt;$15,000</td>
<td>0.26 (–0.76 to 1.29)</td>
<td>0.62</td>
</tr>
<tr>
<td>Interview completed by proxy</td>
<td>–0.46 (–1.28 to 0.37)</td>
<td>0.28</td>
</tr>
<tr>
<td><strong>Clinical characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical health status per 5-point increment†</td>
<td>0.18 (0.02 to 0.35)</td>
<td>0.03</td>
</tr>
<tr>
<td>Mental health status per 5-point increment‡</td>
<td>0.10 (–0.08 to 0.28)</td>
<td>0.29</td>
</tr>
<tr>
<td>Vulnerability score§</td>
<td>0.03 (–0.14 to 0.20)</td>
<td>0.76</td>
</tr>
<tr>
<td>Number of comorbid conditions</td>
<td>0.03 (–0.17 to 0.22)</td>
<td>0.79</td>
</tr>
</tbody>
</table>

* Global rating of health care, the dependent variable, was dichotomous—those with a rating of 10 compared with those with a rating of less than 10. Technical quality of care ratings ranged from 0 to 1. Communication ratings also ranged from 0 to 1 but were made dichotomous in these analyses—those with a rating of 0.9 and above compared with those less than 0.9. The vulnerability score ranged from 0 to 10 with a score of ≥3 required to identify the patient as vulnerable.
† Quantified by physical health component of the 12-item Short-Form Health Survey.
‡ Quantified by mental health component of the 12-item Short-Form Health Survey.
§ Quantified by Vulnerable Elders Survey.
Global Ratings of Health Care Are Not Associated with Quality of Care

Improving Patient Care

**DISCUSSION**

In this comprehensive evaluation of quality of care, we found that patient reports about interpersonal quality were distinct from technical quality of care as measured by medical records and patient interviews. Higher patient global ratings of health care were not associated with technical quality of care in this sample of older adults, but they were strongly associated with ratings of communication. This finding suggests that patient global ratings of health care do not reflect technical quality of care.

The positive association between global ratings of care and reports about communication is consistent with previous research (14, 30–35). In particular, a study of the psychometric properties of the Consumer Assessment of Healthcare Providers and Systems survey found a strong positive association between the global rating of health care and rating of communication (35). However, our findings contrast with a study that found a significant correlation at the health plan level between the global rating of health care and 1 of 6 high-prevalence measures, the Health Plan Employer Data and Information Set’s mammography measure (18). Our study, however, presents a more comprehensive measure of technical quality of care.

These findings guide how we should measure quality of care at the health plan level. In our sample of older patients in 2 health plans, higher global ratings of health care provided insight into patients’ assessment of their providers’ interpersonal quality, not technical quality. Technical quality of care is related to survival, at least among vulnerable elders (23), and therefore represents a construct of quality that is probably of importance to many patients and their families; however, patients’ global ratings do not reflect this aspect of care. This finding has implications for the interpretation of overall ratings of health care and how these data should be presented to health plan consumers. Although patient ratings of health care are easier to obtain and report, our results suggest that such ratings should not be presented alone to consumers. However, these ratings remain important because of their positive association with provider–patient communication (17) and the potential effect of provider–patient interactions and relationships on patients’ health (16).

The relationship between physical function and health status also has implications for measuring patient ratings of health care. Previous studies have suggested a relationship between functional status and satisfaction with care. Patients with better functional status are more likely to be “fully satisfied” (14, 36–38), and persons with a major disability are more likely to be dissatisfied with physicians’ communication (36). We found that current physical health status is positively associated with the odds of higher patient global ratings of all health care in the past year. This relationship is complex, as denoted by a potential interaction between communication and physical health.

Patient satisfaction surveys and efforts to improve patient satisfaction should include measures of physical health status. Higher interpersonal quality, along with higher health status, may contribute to higher patient satisfaction with care.

To our knowledge, our study is the first to examine the relationship between patient global ratings of health care and a comprehensive measure of technical quality of care within the same data set, but it has several limitations. First, there was nonresponse or missing data at several levels of the study; we could not evaluate response bias at some of these levels. However, except for the mean number of comorbid conditions, demographic and clinical characteristics of excluded individuals were not significantly different from the analytic sample (Appendix Table, available at www.annals.org). Second, patients tended to have high global ratings of health care and communication. The non-normal distribution of patients’ global ratings and communication ratings limited our ability to use multiple regression analyses to model the relationship between patient ratings and technical quality and communication ratings. Instead, we analyzed our response data by using a dichotomous variable that limited our statistical interpretation to the odds of having a higher patient rating. Third, the measurement of patients’ global ratings of care and interpersonal quality of care, which occurred during the same patient interview, was subsequent to the measure of technical quality of care. It is possible that intervening events affected the global rating. It is also possible that we have found a strengthened relationship between measures collected at the same time. Fourth, we studied only vulnerable elders. However, quality of care is related to outcomes in this population, making it a prime target for assessment of quality. Fifth, we studied patients from 2 managed care organizations and therefore findings may not be generalizable to all older adults. Our results bear repeating in fee-for-service settings.

In conclusion, global ratings of health care in this sample of older adults were not related to technical quality of care. Technical quality of care and reports about interpersonal quality of care seem to be separate domains, and patients’ global ratings of health relate only to the former. These results suggest that global ratings of care should not be used as a marker of technical quality of care. Comprehensive assessment of quality of care requires measurement of both patient evaluations of care and technical quality.

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