Dear Dr. Jeff:

One of the facilities where I am the medical director seems to have gone crazy over satisfaction surveys. They are surveying residents, former residents, families of residents, and the staff. Surveys are repeated every 2 months and tracked by the quality improvement committee, even though response rates are often less than 10%. According to rumors, salaries and bonuses will be based on the results. Do you think anything in all this actually improves patient care?

Dr. Jeff responds: The Hawthorne effect is a concept in industrial psychology. It suggests that simply making workers aware that the effects of a change in work processes are being measured leads temporarily to improved performance, regardless of the nature of the change. Indeed, changing back to the initial system can produce the same improvement all over again.

In the case of your facility, it is likely that satisfaction scores improved from the first measurement to the second, reinforcing management’s belief that the facility was making progress. However, the likelihood is that the numbers will gradually return to baseline if the act of measurement isn’t followed by meaningful changes in care processes.

Simply tracking data over time leads to pizza parties when the numbers are good and awkward explanations when the numbers are bad but does not change outcomes over the long run. Only changing care systems can do that.

Measuring quality of care is a difficult business. Outcome measurements are often considered the gold standard, since in the end what matters is whether the care provided had positive results. But most easily measured and seemingly concrete outcomes, such as whether pressure ulcers developed or were healed, are highly dependent on the underlying health of the patient.

Healthy residents are likely to do well, while patients who are overwhelmingly ill are likely to have bad outcomes. Although the Centers for Medicare & Medicaid Services has initiated some attempts at risk adjustment in their published quality measures (the binary “high-risk” and “low-risk” categories are a poor substitute for genuine risk adjustment), most facilities concentrate on the state and federal survey process as a quality measure. It is much more useful to know that a problem exists on a specific shift or on weekends than to just know that it exists.

CMS has already mandated routine satisfaction studies for home care agencies. Certified home health agencies must contract with outside agencies that will send out these questionnaires. The results, along with state and national benchmarks, will ultimately be available for public scrutiny on the Medicare Compare website along with standard outcome measures already available from mandatory data collection. The cost, of course, is borne by the agencies.

Although many of the questions are too vague to be useful, many agencies have found that responses about communication have encouraged changes in patient education, such as the development of standardized information sheets about many common medications and their potential side effects.

Several states have already developed their own satisfaction studies of the families of nursing home residents. It seems likely that this trend will increase whether or not the federal government officially extends the mandate for customer-satisfaction surveys from home care to nursing homes.

The majority of long-stay nursing home residents suffer from significant cognitive impairment. The quality of their day-to-day lives within the facility is only minimally affected by medical or skilled nursing services. Instead, their interactions with the direct-care staff, primarily the certified nursing assistants, determine the quality of their experiences in the facility.

If experienced CNAs see “their” residents as special individuals with unique histories and personalities, respond to their needs (including the vital need for human contact), reaffirm their worth as individuals, and break up the boredom that is the greatest curse of long-term care, then residents and families will be pleased. Without this, the prettiest building, the most charming views, the best wound care, or the most powerful antidepressant will not satisfy. The QIS exempts dementia patients from interviews, but observation of their lives in nursing homes can often show whether these residents are happy with their care.

This leads back to the question of staff-satisfaction surveys. Medicare included a less staff turnover as a major target of the 2009 pay-for-performance initiative. The presumption was that decreasing turnover is a key step toward improving quality. Unfortunately, the payment rewards were poorly targeted and far too small to demonstrate whether such an initiative might be effective.

Few facilities are prepared to survey employees regarding the sufficiency of salary and benefits, but it’s clear that facilities that offer CNAs little more than minimum wage and do not provide health insurance will not retain good staff, even with a charm campaign. Nevertheless, these surveys may at least affirm that the facility recognizes the vital role of its employees in the care process. It doesn’t hurt to ask — unless the facility is totally unwilling to pay attention to the responses.

Again, survey questions seeking to measure satisfaction need to be carefully written and thought out. For example, a facility where I worked received highly favorable responses to most questions in an employee survey but a rather low score on “I would recommend that a friend work here.” When a focus group of employees was asked to explain this result, one dietary worker said, “This is a nice place, but my friends are a bunch of bums. I wouldn’t want them to come here and embarrass me.” The question was rewritten to ask, “If you had a friend who you thought would be a good employee, would you recommend that they work here?”

The notion of linking salaries and bonuses to satisfaction surveys is particularly offensive. It runs directly contrary to the notion that all good geriatric care is team care. All the team members need to support and respect each other. Competition for bonuses undermines this process. Residents thrive in an environment where they are respected as individuals and surrounded by an interdisciplinary team working in tandem.

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. He invites your questions for possible discussion in this column, to caring@elsevier.com. You can also comment on this and other columns at www.caringfortheages.com, under “Views.”