What Makes Consumers Satisfied?

Dear Dr. Jeff: Our facility administrator has asked all the “providers” to participate in a chain-wide program to boost “consumer satisfaction.” Our medical team would be happy to participate in quality improvement projects. But most of us object to the paradigm where our patients become consumers of medical care and we become short order cooks in a medical fast food chain, selling drugs on demand while wearing smiley buttons. Good care often requires saying “no” to antipsychotics used as sleeping pills, excessive opioids, siderails, antibiotics for fictitious smelly urine, Vitamin prescriptions for 90-year-olds, and a long list of other substandard practices which are, unfortunately, common in the community. Is there a legitimate way for medical professionals to participate in the project and not compromise patient care?

Dr. Jeff responds:
When Mick Jagger and the Rolling Stones complained, “I can’t get no satisfaction,” it wasn’t because the sales clerk at the local fish-and-chips shop didn’t smile and wish them a happy day. They were complaining about a phony society that confused surface and slogans and advertising for substance. Our patients and residents come to us for quality, person-centered care. If they receive it, they will be satisfied. If they don’t, no volume of repeated wishes to “have a nice day” will compensate. A bud vase on the bedside stand does not make up for two hours lying in a soggy diaper. However, there is a long list of ways that facilities and practitioners can anticipate needs that may appear minor, address genuine patient and family concerns, relieve anxiety, and thus improve the quality of care and the “patient experience.”

The vast majority of nursing home admissions now come to us directly from hospitals, and they only intend to be in the facility for a recuperative stay before returning home. Even the terminally ill or those with minimal prognosis need to begin at the time of admission. Most hospital transfers to nursing homes occur in the late afternoon or evening, often after the admissions staff have left. Someone needs to be available in the lobby armed with a “Welcome to Sunnydale” message and a list of expected admissions and room assignments, who can direct the ambulance personnel to the correct unit and room.

The message of welcome needs to be continued when new patients reach their rooms, and it should include repeating the name of the facility — many transfers have never been informed or may have forgotten their destination. Floor staff frequently give new patients the spoken or unspoken message that their late arrival is a problem and is possibly even their own fault. The hospital practices that create this pattern are certainly deplorable: Hospital clinicians frequently delay discharges until morning laboratory or radiology results are available, and transportation to nursing homes is a low priority for ambulance companies. None of this has been the patient’s choice.

Our staff needs to sympathize with these late admissions for their terrible day; depending on the hour, we should even state that we were worried about them. Rather than informing new arrivals that the kitchen is closed, dietary services should have a dinner set aside, potentially to be reheated, under the presumption that the patient has missed a meal.

It never hurts to repeat that we know the patient is a short-term admission and that we will be working with them to get back home. If no physician or nurse practitioner is in the building, the new admission (and family) should be told that the doctor was expecting them — which needs to be true — and that the initial orders based on the hospital’s recommendations would be confirmed by telephone and computer until the practitioner is in to see them. Without this routine information, patients and families understandably worry that needed medications and treatment will be missed.

Newly admitted patients should also be informed of when the rehabilitation staff is likely to see them. Again, patients have no way to know typical nursing home practices, and they may be expecting no medication or treatment until their initial visit from the physician.

Clinicians need to reassure these new patients that we have received their transfer information from the hospital and will be proceeding with their plan of care — but not necessarily that we will be ordering exactly what was recommended by the hospital. Medication reconciliation means checking that we are ordering everything that the patient needs, which may not be exactly what is on the transfer documents. “Fortunately, no longer needed” is a better explanation than “Never needed to begin with” in this setting. Practitioners should, of course, inform patients and families about the results of examinations and tests and changes in the medical plan of care.

Our frustration with hospital practices — including intensive care unit transfers to SNF late on Friday nights, inadequate transfer information, use of medications inappropriate for the elderly, inappropriate use of antipsychotics for dementia patients, unsafe and unscientific anticoagulation practices, overtreatment of asymptomatic bacteriuria, and expensive polypharmacy, to name a few — should not be shared with the patient and family. Instead, the message should continue to be one of communication with the patient’s previous care providers. Blaming others, particularly when the resident has no reason to trust them rather than prior providers, is always a losing strategy.

Customer satisfaction means knowing what to expect, not simply that the practitioners are there when needed. Practitioners should inform patients about their anticipated schedule of follow-up visits. Many residents are shocked that the doctor does not come to see them every day, which had been the pattern in the hospital. However, patients are satisfied with not being seen daily if they understand that their primary reason for admission is rehabilitation (or even intravenous antibiotics or wound care), and that the plan has been set but that revisits will occur as needed to check on progress. Also reassure them that the nursing and rehabilitation staff always know how to reach you should unexpected problems occur. Again, this is information which may seem obvious to us because this has been our routine practice for years, but is unknown to most patients.

We should not confuse customer satisfaction with bromides about the customer always being right. Customers prefer stores and products where knowledgeable staff help guide them to the best products rather than stores that simply sell them whatever they want.

Quality patient-centered care requires listening to the patient. There may be no better single question to ask a patient than “What worked for you at home?” The art of medicine is recognition that all patients are different and that a medication that might in theory be riskier or less effective than alternatives may be the best choice if the patient has already used it with good effect and without experiencing the potential side effects. This is shared decision-making, a key component of many satisfaction studies, and it is also smart care.

Your concerns regarding saying “no” to patient demands are justified if the answer is simply “no.” As a medical director, I often have to deal with families who are infuriated because they were told by staff that something they want is either not allowed or against federal and state regulations (sometimes just simplified as “the Code”). Responses such as these are obviously frustrating for those who don’t understand our policies or the reasons behind them.

Inadvertently conveying the idea that our facility would happily tie down or give unnecessary, risky medication to their relative if only the administration or state regulators would let us is totally wrongheaded. Instead, responding that we do not use side rails for restraint because they have been shown to increase resident injuries or even directly cause injuries and death is a sensible response a consumer can accept.

Similarly, our policies on hypnotics, antipsychotics, and antibiotics are based on a nuanced view of the risks (sometimes substantial) and benefits (often negligible or nonexistent). Even though most patients and families are

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involvement with hospitals and the community as a result of the shift to value-based care.”

Clinical priorities are changing as well, and Caring will address this, too. “Years ago, we weren’t dealing with morbid obesity or HIV. These are now issues, along with mental health, the opioid crisis, and the growing younger population we’re seeing in our facilities. We need to deal with more social determinants of health. We need to address new issues. We need to talk about outcomes of care,” said Dr. Stefanacci.

Caring Continued
Both new editors appreciate the history of Caring and its role in the world of PALTC publications. “Caring has pioneered a down-to-earth, practical approach; it’s accessible to practitioners, caregivers, family members, and others. It addresses challenges and controversies, but it also talks about successes. It’s a very positive publication,” said Dr. Galik. “We plan on building on that tradition, and we look forward to expanding the readership and exposing more people to geriatrics.” Dr. Stefanacci added, “Caring’s format lends itself to a wide, diverse audience. There is no ‘average’ AMDA member; everyone is incredibly unique, and we have an opportunity to reach out to all of them.” He noted that flexibility will be key as Caring moves forward. “Our world is rapidly changing. We need to be agile and stay on top of change and innovation. In response we will move the publication in that direction.”

Dr. Galik noted, “It’s exciting to take on a new challenge in a comfortable area. While I am a researcher and educator, I think of myself as a clinician at heart, and Caring is a great fit for my experience, as well as my goals to serve as an ambassador and advocate for our profession.”

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