CHAPTER 1

PATIENTS AND THEIR FAMILIES

INTRODUCTION

Patients and residents are at the core of the healthcare "business." As managers, the challenge is providing care that is accessible, of high quality, cost effective, and efficient. Ironically, this challenge is particularly difficult in this period where the patients' choices may be either limited by the health insurer or, in some cases, unlimited by the nature of their insurance.

Today's patients have the benefit of a vast amount of public information about their providers of care as well as their diseases. The manager's job is to be a provider of useful information to the consumer. Such information can range from assisting patients in selecting practitioners to helping them understand their health conditions. The following pages on consumers leveling the playing field by cruising the information superhighway are excerpted from the chapter "Management and the Educated Consumer" in my textbook *Principles of Health Care Management, Second Edition.*

Cruising the Highway for Doctors

To begin, we might ask the following question: How much can a patient find out about a potential doctor? At one level, people seem to know more about institutions than individual physicians, and thus the institution can play a role in connecting the patient with a doctor.

How does a healthcare organization assist the consumer in finding a doctor? Consider the following three websites servicing the same general community. On the Plantation, Florida, Westside Regional Medical Center site, there is a Resource tab that brings the user to a Find a Physician page where one can list as much or as little information as possible. For my "experiment," I acted the part of a consumer looking for a cardiologist. I clicked on Cardiology under the Specialty tab and was presented with a long list of physicians. The only information available on any of these physicians was their name, their medical degree (some were MDs and others DOs), their office addresses, and the language(s) they speak. My next web stop was Holy Cross Hospital in Fort Lauderdale. Their website was similar to that of Westside and equally uninformative. If I were handing out stars, they would each get one star. In contrast, the Cleveland Clinic in Weston, Florida, would get five stars for its website. Once again, I was able to find a cardiologist. But this time when I clicked on his name I found pages of information on the physician, including the following: a four-paragraph biographical sketch; his picture; the languages he speaks; professional highlights of his career; his education and fellowships; and his certifications, specialty interest, awards, honors, and memberships. In other words, I had all the information I needed to decide whether I was interested in potentially using him.

In Florida (and many other states), the interested consumer has another important resource: the government. Through a state website, www.floridashealth.com, considerable information about any practitioner can be obtained. For example, there is information about the doctor's education and training, academic appointments, specialty certification, financial responsibility, and any proceedings or actions taken against him or her. This website is continually updated and provides the public with enough information to make the basic decision: Do I see this particular physician or find another one?

There are also two private companies that pop up when searching the web. One of these, HealthGrades (www.healthgrades.com),

provides useful general information in sidebars on its site. For example, if the consumer arrives at this website when doing an online search for "hand surgeon Florida," the core of the webpage has a list of cities where there are hand surgeons. Selecting a particular area, such as Fort Lauderdale, will bring up a page with the names and addresses of the local hand surgeons. Selecting a particular surgeon brings up another screen with a map of his or her location and additional information (self-reported) about the group or practice he or she is a member of, the specialties within the practice, insurance plans accepted, conditions treated, and languages supported. At no charge, HealthGrades provides information about the physician's education and training, any disciplinary action, specialty certifications, hospital affiliations, and a patient rating profile based on consumer surveys.

An alternative site is UCompareHealthCare (www.ucompare-healthcare.com), which offers consumers similar information to that presented by HealthGrades. However, neither of these sites tells the consumer much about the doctor's experience, personality, or bedside manner. The smart consumer always simply Googles the doctor of interest and often comes up with surprising (and sometimes disturbing information). For example, I ran a Google search on a doctor and found a website full of criticism as well as an official sanction from another state. None of this was available from the other sites! Caveat emptor!

Cruising the Highway for Hospitals

Thanks to the U.S. Department of Health and Human Services (HHS), there is a relatively user-friendly website for comparing hospitals: www.hospitalcompare.hhs.gov/. The site is a good educational tool for consumers; it explains subjects such as the hospital process-of-care measures and hospital outcome measures. Users of this site can compare up to three hospitals at a time and examine how the hospitals did with a range of medical conditions and surgical procedures. Overall, the data available covers six medical conditions: heart attack, heart failure, chronic lung disease, pneumonia, diabetes in adults, and chest pain. The data can also be used to compare how well hospitals handle 22 surgical procedures such as those involving the heart and blood vessels (angioplasty, pacemaker implants, and heart valve operations); abdominal procedures for removal of the gallbladder or hernia repairs; procedures involving the neck, back, and extremities

(neck or back fusions or other bone-related surgeries); bladder and prostate surgery; and finally, surgery related to the female reproductive organs. Depending on the condition or surgery selected, the report will compare processes and outcomes across the hospitals. The following are illustrative questions on various conditions and procedures: (1) percentage of surgery patients who were given an antibiotic at the right time (within 1 hour before surgery) to help prevent infection; (2) percentage of surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery); (3) percentage of surgery patients whose blood sugar (blood glucose) is kept under control in the days right after surgery; (4) percentage of heart attack patients given aspirin at arrival; (5) percentage of heart attack patients given a beta blocker at discharge; (6) percentage of pneumonia patients given oxygenation assessment; and (7) percentage of pneumonia patients assessed and given pneumococcal vaccination. These reports also contain a fascinating section on a survey of patients' experiences with the hospitals in question. Here the consumer states how well the hospital doctors and nurses responded to his or her needs, rates the cleanliness of the facility, and finally, gives a recommendation.

Of considerable importance to all managers are three questions: First, do consumers really look at these sites? Second, is the site providing accurate information about your institution? Third, what do you do about it? The answer to the first question is simple: we don't know, but we should assume that some percentage of consumers and perhaps healthcare insurers and other providers are looking at the site for information and competitive comparisons. The data is likely reasonably accurate because it comes from a variety of sources including the Online Survey, Certification, and Reporting data system (OSCAR), managed by the Centers for Medicare and Medicaid Services. A problem is that this data, which is from recent survey results, is merely a snapshot in time and, although likely reasonably correct, does not account for changes since the time of the snapshot. Other data comes from The Joint Commission (TJC), formerly known as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) as well as from ongoing surveys and other regular submissions. Hospitals have the responsibility of updating basic characteristic information, and the website for this project acknowledges the issue of time lag.

For the healthcare manager, the bottom line is what to do about this public information. In a joint effort, the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges publish a quality

advisory that makes suggestions to health providers on how to deal with the Hospital Compare release. The August 15, 2008, advisory offered providers a set of likely questions and answers that could be expected from the media and the public subsequent to the government's data release. Some of the answers were merely technical such as explaining the meaning of the statistic confidence level. Other answers might be considered mild spin, with statements pointing out the problem with the data (primarily Medicare data) or data on mortality not allowing for the decisions made by patients or their families. So while the message put forth is always, "We love quality and want to always improve quality," the second message is that what the government says doesn't really hold much water—so trust your doctor, and certainly trust us!

Cruising the Highway for Nursing Homes

Once again, the government is providing consumers with a wealth of data—this time to help them select a nursing home (information on this subject can be found in my book *Choosing a Nursing Home*.) The website www.medicare.gov/NHcompare/ is similar to the HHS hospital site but specific to nursing homes, for which the government has developed a five-star quality rating system. The homepage of this site discusses the various elements within the rating scale and allows the consumer to find a home based on state, zip code, and star ratings. Once several homes are selected, they can be compared. Initially, these comparisons are shown by star ratings, but the user of the website can get behind the star ratings and can find more detailed data on fire inspections, health inspections, quality care deficiencies, resident assessment deficiencies, nutrition and dietary deficiencies, pharmacy deficiencies, staffing, 14 quality measures for long-stay residents, and 5 quality measures for short-stay residents. For all these measures, the tables present the date of the inspection, the date of correction, the level of harm associated with the deficiency (least to most), the number of residents affected by the problem (useful to see if widespread or isolated), contact phone numbers for the state long-term care ombudsman, the state survey agency, and the state quality improvement agency.

Some states, such as New York, make life for the consumer particularly easy. For example, in New York if a consumer merely searches the name of the nursing home, he or she will retrieve

a New York State Health Department website that provides an overview of the nursing home, report on its quality, inspection reports, complaints, and any enforcement activities.

As with the hospital compare site, administrators are typically not happy with consumers having such easy access to this information, particularly when their institution has fewer than four stars. The explanations one hears for these low ratings are usually that the data is old, that the snapshot was taken last year, that the government is measuring the wrong thing, and finally that the surveyors "had it in" for the nursing home. Regardless of the validity of any of these claims, these reports are potentially helpful or harmful, or perhaps a useful signal for self-improvement!

Cruising the Highway for Self-Doctoring and Self-Medication

Interested in practicing medicine on the side? Or perhaps in simply avoiding a doctor's visit? Or, better yet, securing a prescription drug without visiting a doctor? All of this is now possible thanks to the Internet. Name practically any disease or even symptoms—Google it and the consumer will find a treasure trove of information. Try searching something as simple as "backache." You will find millions of websites. In addition, a consumer will find scores of web advertisements. In a sample search, on one webpage for backaches, there are eight sidebar advertisements and one sponsored ad that leads the webpage and sells all manner of merchandise for improving the back—chairs to cushions and everything in between. Another site provides ads plus a range of home remedies. A third site, medicinenet.com, although having some advertisements, does provide a significant amount of substantive physician-authored information on low-back pain. Other sites include, among others, self-help, dictionary definitions, and holistic health.

For the most traditional and clinically substantive information, the consumer can learn a great deal at medical center sites such as www.mayoclinic.com (the site of the Mayo Clinic in Rochester, Minnesota), www.hss.edu (the site of the Hospital for Special Surgery in New York City), or www.ninds.nih.gov (the site of the National Institute of Neurological Disorders and Stroke, a division of the National Institutes of Health).

Securing a prescription on the Internet is fairly easy. For example, www.controlleddrugs.com is a site from which a range

of drugs can be ordered, including the anti-anxiety medications Ativan, Valium, and Xanax; the antidepressants Prozac and Zoloft; and the erectile dysfunction medications Cialis and Viagra. To order, you need a credit card and must agree to a disclaimer that states that you have had a recent physical and understand the terms of the transaction and the costs and benefits of the medications. The website then requires you to fill out some basic medical information. In fact, the site's customer service representative said that in many cases it was unnecessary to even fill out that information. Drugs are shipped from outside the United States to the customer. Essentially, a consumer who wants to bypass the medical system can enter a gray market of drugs purchasing and, assuming the legitimacy of the quality of the drugs, self-medicate. If a person has a legal prescription, it can also be transmitted to online pharmacies for fulfillment; but, in those instances, the transaction is really about cost and convenience.

Although patients and their care are discussed in numerous cases throughout this book, this chapter presents five unique perspectives. The first case, set in a nursing home, demonstrates the various players involved in decision making, including the federal government. The second case is particularly interesting because it is primarily written by a former nursing home resident whose unique perspective should prove to be of value to all managers. The third case again visits the dynamic triangle of patient, staff, and family. The fourth case focuses on hospitals, doctors, and effective communication with patients. The last case explores the ethical obligation of the medical community with regard to impaired driving by senior patients. Changes are clearly afoot. The challenge is dealing effectively with these changes.

CASE 1-1 The Unwanted Resident

Mr. and Mrs. Jack Ross investigated nursing homes for their elderly and impoverished aunt, Ms. Janet Horner, who was living with them. On their visit to California's College Valley Home, they met with its administrator, Mr. Albert Press, who explained to them that even though Ms. Horner would be on MediCal, prior to and as a condition of admission, Mr. Ross (who was known as a wealthy man in the community) would have to make a donation of $10,000 to the home.

Mr. Ross made the donation, and Ms. Horner was admitted. A few weeks after her admission, Mr. Ross called the home to tell Mr. Press that he was quite dissatisfied with the care at the home, particularly the quality of nursing care, which he found disrespectful and unresponsive to Ms. Horner's needs. Mr. Press then wrote Mr. Ross the following letter.

November 1, 20__
College Valley Home
Prentice Hill Southern, California

Dear Mr. Ross:

I am sorry to hear that you are unhappy with the care that we are providing to your aunt, who actually seems perfectly happy, particularly with our food. However, in light of your dissatisfaction, we have decided to discharge her on November 10, 20__. Please make the appropriate arrangements to pick her up on that date.
Finally, because of your negative attitude toward the home, I hereby bar you from visiting Ms. Horner at any time prior to her discharge.

Sincerely,

Albert Press, Administrator

* * *

QUESTIONS

1. What options does Mr. Ross have?
2. Who has the power to make a decision about staying or leaving? Ms. Horner? Mr. Ross? Mr. Press?
3. What Omnibus Budget Reconciliation Act (OBRA) compliance issues are raised by this case?

CASE 1-2 The Residents Speak Out

By *Seth B. Goldsmith* and *Roberta Bergman*

Note: Roberta Bergman (of blessed memory), my sister, was a teacher, mother, and devoted friend who suffered from multiple sclerosis and spent the last 11 years of her life in a nursing home. During this period, she was an inspiration to everyone she met and remains a special spirit in our lives.

An increasing number of complaints from the families of residents as well as an informal meeting with the ombudsman from the state department of elder affairs led the administrator of the Green Meadow Home to hire Gary Newman as an outside consultant to clarify the problems residents and their families were having with the home. Newman met with a number of residents and their families and felt the following four situations exemplified the state of affairs at the home.

1. Miss Fish, a 74-year-old woman who was never married, was admitted to the home 6 months before the meeting with Newman. Prior to her admission, which was precipitated by two massive strokes, she had lived independently and for 35 years had been an active volunteer at the Green Meadow Home. Her two sisters attended the meeting with Newman and told him that their formerly vivacious sister was now very withdrawn. After some probing by Newman, it came out that the sisters were quite frustrated because none of the staff seemed to have the time to deal with Miss Fish. In their opinion, this appeared to be because Miss Fish had lost her ability to communicate verbally. One sister said she was particularly disappointed because it seemed that everyone in the home was just interested in forcing Miss Fish to "become part of the system, you know what I mean: getting up when the nurses or aides want you up, eating when they want you to eat, going to the bathroom when it is convenient for the aides, sitting around the nurses' station 10 hours a day, and going to sleep like a baby at 6:30 PM even in the summer when the sun is still shining!" The sister added that Miss Fish "deserves much better treatment, particularly in light of her years of contributions to the home."

2. Mr. Lester Mead is an 88-year-old man who has been a resident of the home for 2 years. In his meeting with Newman, he stated, "Forty years ago I was a pretty well-off businessman in this town, and in fact I was one of the guys who raised the money to build this home. I frankly never thought I would ever live here. And when my wife and I moved to Sun City in Arizona, I never thought I would ever move back here to Metropolis. But here I am—my wife is dead, and my only son lives 100 miles away. I look around and see many people who I used to associate with and see what they have become, and it is a scary sight! The thing I hate about this place is that there are many staff who don't respect old people. This is our home and we should be treated accordingly, and we are not. And particularly me—I'm private pay, not one of those Medicaid patients."

3. Mrs. Meg Douglas also had some things that she wanted to share with Gary Newman: "I have been a resident of the home for 4 years. As you can see, I have had one leg amputated because of my diabetes. A few weeks ago I cut my index finger and told the aide that it looked like it was getting infected and asked her to tell the nurse. The nurse told her to tell me not to worry—so I didn't, until a few days later when my son came to visit and saw it and made a whole big stink on the floor about my care. He also called the administrator, and finally I was taken care of, but what could have been a small problem now took weeks to clear up, and because of my diabetes it might have had to be cut off. When the nurse was asked about it, she said she was never informed, so she sided with the aide. I wish I could get out of this place!"

4. Mr. Max Stein is an 81-year-old man who has been a resident of the home for 5 years. He is one of ten Jewish residents in the home. Still ambulatory, Mr. Stein is one of the most physically active residents in the home. He met with Gary Newman to express his anger and outrage at the anti-Semitism displayed by some of the other residents, who he said have called him a range of offensive names. Mr. Stein said he handles these slurs by occasionally "smacking the bastard," but he added that he only does this if no one is looking. He also stated that he does not like to take the law into his own hands, "but nobody is doing anything about this problem

here because we are such a small minority." Mr. Stein would not provide Newman with the names of the residents who had insulted him. In checking with the director of nursing and the administrator, Newman found no recollection of any resident complaining of being hit by another resident.

* * *

QUESTIONS

1. What problems are likely to be identified by Newman at the nursing home?
2. To what extent do the problems reported by the consultant relate to the issues discussed in this chapter?
3. What steps can administration take to correct or minimize the problems presented in these situations?

CASE 1-3 Mother and Son Case

Mrs. Gigi Noir is a 72-year-old widow who has been a resident of the Greenway Nursing Home in Miami, Florida, for the past 2 years. Unfortunately Mrs. Noir has multiple sclerosis, which is an autoimmune disease affecting the brain and spinal cord. Until moving into the nursing home, she was able to function in her Florida condominium with some outside help. Now in addition to her having very slurred speech, she has occasional muscle spasms and needs help eating, bathing, transferring, toileting, and taking her medications.

When she moved into Greenway, she brought with her two personal items, a 32-inch flat-screen TV and a 25-year-old La-Z-Boy-type recliner. Every morning after the staff cleans, feeds, and dresses Mrs. Noir, they help her into her chair and turn the TV to her favorite channel. The staff typically checks in with her every 2 hours and provides whatever care is needed.

Over the past several months, the recliner chair mechanism has broken several times and in each instance, except the last, the nursing home's maintenance staff has been able to fix it. The last breakdown determined that the chair was beyond

repair. At the behest of the nursing staff (who are quite fond of Mrs. Noir), the maintenance staff searched the nursing home's warehouse and found another recliner that was in decent shape and could, with some work, become functional. This recliner differed from the first by having an electrical system for positioning and also having a lift assistance capability whereby the chair tilted forward. The chair was given to Mrs. Noir, who greatly appreciated the concern of the staff.

Once again, Mrs. Noir was positioned each morning to watch her TV shows. One day, she had a spasm and accidentally hit the armrest button that tilted the chair forward, resulting in her being ejected from the chair. She was discovered 30 minutes later on the floor, taken to the hospital where they found two broken legs, casted her, and returned her to the nursing home. The nursing home Executive Director, Malcolm Contento, immediately called her son, who lives in Charlotte, North Carolina, informed him of the situation, and told him that she would have around-the-clock aides sitting with her for the next several weeks to ensure that everything was okay. The son, Guy Noir, seemed appeased by the conversation. Six weeks later, the casts were removed, everything seemed to have healed satisfactorily, and the orthopedist stated that there was no need for the around-the-clock aides. Mr. Contento decided to keep aides on for the 7 AM to 7 PM shift for another month, as a precaution.

The day after the evening aides were dismissed, Mr. Contento received a call from Guy Noir demanding that the aides watch his mother 24/7, stating that otherwise he would see a lawyer. Contento then called his social services department to see if they knew anything about Mr. Noir. The response from the head social worker was, "I'm no private eye but I know that this Noir guy is no loving son. Since his mother has been in the home, he hasn't visited her once in 2 years, despite the fact that there are plenty of flights between here and Charlotte. Also, I know that even after the accident he didn't visit despite the fact that he was 30 minutes away in Fort Lauderdale going out on a Caribbean cruise on the *Allure of the Sea*."

* * *

QUESTIONS

1. How relevant to this case is the relationship between Mrs. Noir and her son?
2. Is it the home's business that Mr. Noir went on a cruise and did not visit his mother?
3. What options does Mr. Contento have? What are the costs and benefits of these options?
4. Should anyone else be involved in the decision process?
5. What type of documentation should be kept? Why?
6. Is there a policy issue about the role of maintenance and nursing staff in providing for resident amenities?

CASE 1-4 Community General Hospital

MEMO

From: Kip Kipling, MD, Medical Director
To: Medical Staff
Subject: Patient Interaction

In the 4 years since I joined the staff of this institution, I have become increasingly convinced that, in general, we provide an excellent quality of care here. Our hospitalists are well trained and our attendings are both well trained and experienced. Unfortunately, as you all well know, our patient census has declined as an increasing number of patients are migrating to some of our newer neighboring facilities. Additionally, malpractice claims and awards against us, both personally and organizationally, have skyrocketed.

Although I cannot pinpoint the exact causes of either the loss of patients or the malpractice activity, I have heard enough complaints from patients and their families to know that we need to improve our patient interaction and communication skills. As has been pointed out numerous times, patients don't sue when they feel connected to their MD and when they feel they are being listened to.

Let me give you an example of a communication issue we recently encountered. A patient with esophageal cancer who was being seen by one of our staff came in and mentioned a therapy that is being used in NYC but is not available here. She was rudely dismissed with the comment, "Why bother? You probably don't have more than a year to live, so what you really need is palliative care." Although the MD might have been technically correct, he was emotionally wrong in both dismissing her and stealing her hope. In another case brought to my attention, one of our specialists dismissed a patient who he felt was ready for hospice. The patient went across town and was treated by another specialist, and now, 3 years later, she is still ill but ambulatory, functional, living at home, and certainly more hopeful. Frankly, we don't have the Bucksbaum Institute that they do at the University of Chicago (where many of you have trained), but even without that money, we need to find ways to better interact with our patients. I welcome your suggestions about improving patient interactions as well as what penalties might be applied to staff who do not assist in this critical effort.

* * *

QUESTIONS

1. What is the Bucksbaum Institute, and what are they trying to accomplish?
2. Is there evidence that better communication between practitioners and patients results in better outcomes?
3. Is Dr. Kipling being too aggressive in this memo? Is the threat of penalties appropriate?
4. Is there a better way to encourage good patient interaction?

CASE 1-5 Elderly Drivers

The Luxtown Medical Center (LMC) is a 73-physician multispecialty group practice located in southern New England. The following is a memo from its CEO to staff:

MEMO

From: Bob Rudyard, CEO, Luxtown Medical Center
To: All physicians, nurses, and professional staff
Subject: Impaired drivers

Last week this community experienced the tragedy of a 91-year-old man who lost control of his car and hit a group of children at a school crossing. As you might have heard, the man was visiting from out of state and was visually impaired and had been diagnosed with early Alzheimer's disease. Despite these medical issues, he was able to rent a car at the airport—with an unrestricted license!

You might be aware that our neighboring state of New Hampshire now has some of the strictest laws for senior driving, requiring, among other things, a pre-license-renewal road test after age 75. Here the legislature has failed to act, so our seniors generally have no problems renewing their licenses. The data from New Hampshire now shows a dramatic decline in accidents involving seniors.

In my own family we had a major-league hassle when we tried to get my 88-year-old father to stop driving. He finally agreed, after two fender-benders—followed by a big hike in his insurance premiums!

As physicians and other healthcare professionals, we have an ethical responsibility to be aware of when our patients' health is so compromised that they should not be driving. Although at this moment we do not have a legal responsibility to report people we suspect of being impaired to the Department of Motor Vehicles or to the police, we do have an ethical obligation to protect them and the public.

All of this brings me to an issue that I would like your thoughts about. Specifically, almost 30% of our patients are over 65 years of age, and we have a large number of people we care for who are over 75 and 80. What can we do to both help them be safer drivers and, when the time comes, make the transition to nondriver status smoother? I look forward to hearing from you!

* * *

QUESTIONS

1. Is the CEO of Luxtown exaggerating the problem?
2. What ideas exist to make seniors better drivers?
3. What strategies can be used to prevent someone with a license from driving?
4. What specifically can or should the medical center be doing? Is it a good idea for the medical center to be involved in this or is this a public health issue?