Hospital Foodservice and Patient Experience: What's New?

In 2003, hospital food quality ranked lowest of 10 items measured on a scale of satisfaction, according to a Press Ganey survey of 1.8 million patients (1). Since then, hospital foodservice has dramatically remade itself, employing chefs, using more fresh and seasonal ingredients, offering cook-to-order room service, and increasing the number of choices for each meal (2). At California-based Kaiser Permanente, for example, the menu includes citrus-marinated pork loin and barley pilaf, grass-fed beef, and fresh produce straight from farmers' markets (2). Grilled salmon, tilapia, quesadillas, stir-fry, pot roast, and roasted vegetable lasagna are some of the menu items offered at hospitals in Baystate Health in Springfield, MA; Hendricks Regional Health in Danville, IN; and Saint Francis Health System in Tulsa, OK. "There has definitely been a big change from your two-entrée selections to more of a restaurant-style menu," says Lisette Coston, MBA, RD, LD, director of nutrition and foodservices at Saint Francis Health System in Tulsa, OK, for the last 13 years, and a member of the board of directors for the Association for Healthcare Foodservice. "It follows what we see in our society, with the trend toward much more eating at restaurants. At hospitals patients expect to see the same choices and quality."

Conventional wisdom holds that this direction is no longer just a trend for hospitals, but rather a new baseline expectation by consumers that they must meet to compete. For many hospitals, that has meant moving to a room-service, cook-to-order menu. "We would never go back to the traditional tray line," says Martha Rardin, MSM, RD, CD, director of nutrition and dietetics for Hendricks Regional Health in Danville, IN, which serves about 300 patient meals per day and implemented room service in 2006. "Customer expectations have risen over the years. At first room service, that option and that quality, was a 'nice to have.' Now I believe it's the industry standard—patients are expecting that to be the norm, rather than being surprised by it." In 2008, a survey of 270 health care food and nutrition practitioners, suppliers, and manufacturers found that more than half planned an overhaul of their facilities by 2010. Thirty-seven percent offered room service, and 81% who had implemented room service saw their patient satisfaction scores increase by more than 10% (3).

Hospitals use retooled foodservice options as marketing tools (4). And in January, the Culinary Institute of America announced a new foodservice management course designed "to raise the quality of food served at hospitals and other health care facilities nationwide" (5). Will hospitals continue to see increasing innovation in foodservice? "I don't think you'll see a scaling back," Coston says. "At least not for markets like ours where food becomes a marketing tool. We are constantly told we've got to increase quality."

Along with more restaurant-style tray service, hospitals also have dramatically expanded their retail offerings in recent years to include on-site cafes, cafeterias, restaurants, coffee shops, and catering services to help offset per-patient meal costs. At Saint Francis Health System, for example, the largest hospital in Tulsa, Coston oversees a food court at the main 603-bed campus; Café Francisco, a coffee kiosk that had $133,000 in sales last year; another coffee kiosk at The Heart Hospital, with more than $131,000 in sales last year; PJ's Snax, a grab-and-go outlet for coffee, smoothies, and sandwiches; Redbud Café, a full retail operation at a professional building housing financial and human resources departments; and Zone Appetit, a grab-and-go location connected to the system's fitness facility. (That's on top of separate menus for the 162-bed children's hospital, the 912-bed main campus, the 91-bed Laureate Psychiatric Clinic and Hospital, and a couple of physician lounges [6].) It's critical to keep the retail options fresh and trendy, Coston says, or lose sales. She says since the main campus transitioned from a cook-chill system to room service in 2008, they also are earning more money from selling room-service trays to guests, charging $5 for breakfast and $8 for lunch and dinner. "It's very reasonable considering that you can get a salmon or tenderloin dinner, a drink of your choice, and dessert," Coston says. "Last year we generated $80,000 in guest tray revenue, and that's just additional income coming into the hospital."

The move to increase the sophistication of patient meals and hospital retail offerings would seem to auger for an increasing number of dietetic career offerings in hospital catering or room service menu planning. But rising food costs, increasing technological efficiencies, impending reductions in Medicare and Medicaid reimbursement, and uncertainty over what changes health care reform might bring to reimbursement for private insurance will challenge administrators to consistently deliver more with less (7). In this article, we'll explore the evolution of hospital foodservice quality, its current and future challenges, and the outlook for dietetics practitioners as part of this profession.

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SURVEY SAYS? PATIENT COMMENTS REVEAL TRUE QUALITY

Despite the push toward higher quality, food takes a low profile on standard hospital patient satisfaction questionnaires. It's not featured at all on the Centers for Medicare and Medicaid Services (CMS) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which was rolled out nationwide in 2006 as an apples-to-apples consumer comparison tool. (In focus groups used to design the HCAHPS, different patient groups consistently came up with these measures of quality as most important [8].) In his book on patient satisfaction, Irwin Press, cofounder of Press Ganey, proposes a rank order of patient satisfaction that neatly sums up where foodservice fits within its reimbursement category of "room and board":

a. Good food counts more than lousy food.
b. Friendliness counts more than good food.
c. Communication counts more than friendliness.
d. Empathy enhances communication (9).

"Food is more of a comfort and basic need issue, and often doesn't have a tremendous impact" when compared with the need for clear and empathic communication, good clinical quality, and a clean, safe environment, says Deirdre Mylod, PhD, vice president of hospital services for Press Ganey Associates, a health care consulting company based in South Bend, IN. "It doesn't have as direct an impact as communication with nurses about medication, for example, but it can influence a patient's global perception of the hospital experience as negative or positive."

Regardless of where they fit on the amenity-quality continuum, foodservice administrators must continuously address quality as measured by patient satisfaction scores, or risk losing customers. They know it's up to them to find the quality "sweet spot" that generates the most bang for their hospital buck—from one-size-fits-all tray service to Wolfgang Puck–quality cuisine (10).

It's somewhat surprising, then, that the survey used by Professional Research Consultants (PRC) in Omaha, NE, includes just one foodservice question: "Overall, how would you rate the food that was delivered to (your/your family member's) room?" Both Coston and Mary Jane Rogalski, MBA, RD, LDN, manager of clinical nutrition at Baystate Health, who use a PRC patient satisfaction scoring tool, would like more responsiveness from the survey format. "We would like to see questions about food temperature and options, and be able to compare responses versus whether they had room service or not," Rogalski says. "The method we currently use does not really drill down in a useful way for us—it's one question only about food, plus we are benchmarked based only on our excellence scores." The Press Ganey survey, which is used by more than 2,000 hospitals—47% nationwide—features three standard questions about food quality, temperature, and courtesy of the server, plus space to provide comments about "good or bad experiences with meals." (Foodservice departments may also add customized questions.)

People Skills Matter Most

- Improved tray delivery matters even more than food quality (9,11,13,18).
- Addressing concerns promptly increases patient satisfaction (13).
- Patients care most about clear, empathetic communication (8,9).

Studies have found that "food quality" translates to patients as freshness, taste, temperature, variety, and aroma (11). When Coston finished rolling out room service at Saint Francis Health System, carefully piloting it in each unit first, comments like "We think the food is wonderful" started pouring in. A long-time administrator was amazed, telling Coston that in all his years in foodservice, he had never once gotten a letter with good comments about the food. Even more important, improving food quality also improves patient intake (12).

A 2009 study published in the *Journal,* "Can Patient-Written Comments Help Explain Patient Satisfaction with Food Quality?" suggests that many important questions aren't being asked (11). Not surprisingly, the study found that "respondents who provide written comments tend to give lower ratings for food quality." The authors also found that patient-written comments tended to differ from the domains commonly included about food in patient questionnaires—specifically regarding choices/variety and receiving what was ordered. These two items "were shown to be prevalent in patient comments but were not captured in the standard items in the Press Ganey satisfaction survey," the authors concluded. "Patient-written comments provide foodservice managers detailed and specific information to identify concerns that cannot be determined from simple satisfaction rating questions."

Indeed, Mylod says, that's exactly the point—to be useful as comparison tools, surveys need to be standardized and broad; foodservice preferences would tend to vary significantly by region, as well as patient age and demographics. "Many times a low score on food quality can indicate that you're not serving a particular patient population well. We counsel administrators to filter that information—it can act almost like a focus group on the fly."

Speaking of focus groups, foodservice administrators interviewed for this story use different units this way for small-scale pilot testing before rolling out any changes in foodservice. At Baystate Health, Rogalski is piloting an "ambassador" program that would have hospitality employees take individual orders from patients too ill to order room service themselves. Coston piloted room service starting in the cardiac care unit before gradually rolling it out to the entire system. Currently, Saint Francis Health System is testing whether giving away a homemade chicken noodle soup at discharge improves patient satisfaction scores.

UNCOVERING TRUE COSTS AND VALUE OF QUALITY AMENITIES

There is no question that the consumer experience side of medicine matters, and was a primary impetus for CMS to produce the HCAHPS. Studies have found that focusing on the inpatient hospital experience and patient satisfaction can result in higher quality of care for patients, less employee turnover, and improved financial and competitive perfor-

mance (13). Recently, a study of Los Angeles–area hospitals quantified this effect for hospital bottom lines, finding that a one-standard-deviation increase in quality of amenities increased a hospital's demand by 38.5%, whereas the same increase in clinical quality increased demand by only 12.7% on average (14). "As the Centers for Medicare and Medicaid Services increasingly pursue 'value-based purchasing' [US Department of Health and Human Services (2007)], the social benefits and costs of amenities and clinical quality, and the provision of each in market equilibrium, become all the more important" (14).

In their studies of hospital amenities to date, Dana Goldman, PhD, and John Romley, PhD, health policy economists at the University of Southern California and the nonprofit RAND Corporation, have found that delivering amenities drives patient volume, but also is costly for hospitals. Delivery of higher-qualityamenities is also correlated with productivity—therefore, the more productive a hospital, the higher its amenities (15). Together, Romley says, these studies suggest that to date the value that amenities are delivering for hospitals is poorly understood and ripe for dissection. "Hospitals spend $700 billion a year, not including doctors," Romley says. "If 14% of those total costs are due to inefficiency, we wanted to know, is that true, or is it possible that studies to date haven't adequately measured what they are providing? It's early days yet for this area of research."

Could a CMS emphasis on "value-based purchasing" separate clinical outcomes from those of amenities? It seems unlikely, Romley says. "In our view amenities were an important phenomenon that hospitals knew about, but it's not out there being discussed," he says. In a *New England Journal of Medicine* editorial Romley and Goldman wrote summarizing their studies, they pointed out that physicians placed considerable weight on the patient experience when referring patients; that one third would honor a patient's request to be treated at a hospital that provided a superior nonclinical experience but care that was clinically inferior to that of other nearby hospitals; and that patients themselves said that nonclinical experience is twice as important as the clinical reputation in making hospital choices (16). Given that his research has correlated high productivity with a high level of amenities, Romley says more research may uncover a higher value for amenities as well. "There is some evidence that these things are related to clinical quality of care," Romley says, citing a study in the journal *Nature* from the early 1980s that found that patients whose rooms had a pleasant view healed faster, with fewer complications and lower costs (17).

THE POWER OF COMMUNICATION

No hospital service operates in a vacuum, and that includes foodservice. Studies have shown that patients are more likely to rate their meals satisfactorily when other aspects of care are also pleasing (13). Many studies of hospital foodservice also have documented the powerful effect of personable service on overall patient satisfaction (11). Recently, California's largest county hospital, Los Angeles County University of Southern California Medical Center (LAC+USC), saw this effect first-hand. LAC+USC offers a cook-chill meal system, meaning food is plated in frozen form and then re-heated on individual patient units immediately before serving. "We currently do not have a select menu here," says Lisa Trombley, MA, RD, CNSD, senior director of food and nutrition services. "Patients don't really get a choice on what they receive for a meal. We offer substitutions within a physician-specified diet order, or for allergy, or if they don't like something, but it's very simplistic and limited. It's very easy to maintain costs."

Charged with increasing patient satisfaction scores without increasing the foodservice budget, Rachel Pascual, RD, CNSD, director of patient services at LAC+USC, got creative. In observing the servers who delivered patient meal trays, Pascual noticed they weren't making a strong patient connection. If she were the patient, Pascual reasoned, she would want the server to knock before entering the room, introduce himself or herself, be able to talk knowledgeably about the food and the patient's diet, and position the tray in such a way that the patient could easily reach it. Accordingly, she introduced a training program that uses shadowing and role-playing, and that provides server incentives such as earning nominal gift cards and being listed on the "wall of fame" for outstanding service. In pre- and post-training tests, Press Ganey overall meal scores improved from the 62nd percentile rank to the 84th percentile rank. Food temperature improved from the 66th to the 84th percentile, and food quality improved from the 63rd to the 81st percentile rank (18). "It's definitely interesting that we didn't change anything about the food," Pascual says. "But it made a huge difference."

Trombley also was surprised to find that a choice program she piloted in the pediatrics and oncology wards (offering a cold or "lighter" option to the entrée, such as a fruit and cottage cheese plate or soup and sandwich) did not lead to significant patient satisfaction gains. She estimates she would have hired four more full-time employees to implement the choice program. "Room service has been the big buzzword for the last decade or so, but in the hospitals I've worked at I've seen that it's that person interacting with the patient that makes all the difference. Whether or not you're taking orders or offering very upscale menus, I think you can get the same result."

In patient focus groups to develop HCAHPS, communication, respect, empathy, and "hearing" the patient were consistently the number one aspects of quality patients wanted in a hospital-ranking system. Could it be, however, that this kind of quality is a wholly different kind than that captured in the survey's two catch-all questions, and one that ultimately most interests foodservice professionals? These final two HCAHPS questions ask the patient to rank a hospital on a 10-point scale from best to worst, and whether he or she would recommend the hospital. If the medical communication you received during your hospital stay was great, but the food was bland, you had to wait for a tray, and your room was noisy or cold, would you rate that hospital a 10? Or recommend it to friends? Perhaps not. On the other hand, if that hospital delivers a higher quality experience than you were expecting, you just might.

This effect is a *disconfirmation* of your expectations, Mylod says, and it has a disproportionately powerful effect on your overall perception of an experience. "A small amount of nega-

tive experience can bring an evaluation down further than a small amount of positive experience can bring it up," Mylod says. On the other hand, "if you go into a hospital expecting the food to be terrible and it's fantastic, that enhances your opinion of the hospital." It's this elusive distinction that Romley hopes future studies will be better able to quantify. "At the end of day, when you ask the question, 'Would you recommend this hospital,' I suspect you're going to pick some of that up," he says. "They're going to be rewarding you for performing well on creature comforts."

For registered dietitians (RDs), contributing to a positive "global" perception means understanding their patient makeup and their hospital's position in their market, and adapting food quality and training to respond at the appropriate level. Trombley, for example, knows LAC+USC is not competing at the level of the area's upscale private hospitals, some of which offer steak, lobster, and champagne because there is a different patient base.

DO MORE WITH LESS

Health care foodservice is projected to grow at a rate of 3.1% through 2011, with the caveat that most of the growth opportunities will be in expanding retail options. "Food's role in improving patient satisfaction remains a competitive advantage, but will get support only when other financials are in balance. More hospitals are trying to keep catering in-house, but want rock-bottom costs for providing services, often a zero-sum game" (7). Another report takes a gloomy outlook for onsite catering, calling it "depressed" and not quickly rebounding (19). "It's an expendable area that is the first thing to go," during budget crunches, says Susan Laramee, MS, RD, LDN, CDR, clinical dietitian recruitment manager for Sodexo. In an interview with FoodManagement, health care consultant Georgie Shockey, principal with Ruck-Shockey Associates, said she expects administrators to scrutinize amenities for cuts, such as room service hours or menu selections, concierge services, or meals for new fathers. At the same time, Shockey and others say that high quality is still a must, and that food trends in health care will continue to be driven by more fresh prepared food, an increase in association with sustainable practices, and "menuing of foods tied to healthcare outcomes by research" (20).

After the Gourmet Hype: Realistic Trends

- Increased food quality can be tied to better patient intake (12).
- Comfort has perceived value (9).
- Reduced anxiety is tied indirectly with food experience (13).

What will the push to cut costs and maintain quality mean for hospital dietetics positions? Currently, say hospital foodservice administrators, they see clinical dietetics positions mostly staying flat or declining—with the caveat that demand will vary according to region. In California, Trombley says, RD positions are growing in hospitals because everything related to patient nutritional care must be performed or overseen by an RD. "Clinical RD positions are stable, neither increasing nor decreasing," she says. "We are recruiting more for management positions, and they are taking on roles previously done by nurses or other allied health professionals such as case management, clinical research coordination, and performance improvement management." Overall, trends point away from a big increase in these positions, although many RDs will be retiring during the next 20 years, Laramee says. Practitioners responding to the Compensation and Benefits Survey of Dietetics Profession 2009 indicated that job losses had occurred due to economic conditions. (One in eight dietetics practitioners, 12%, reported experiencing a dietetics-related job loss due to economic conditions [21].) Laramee says she sees many hospitals not filling vacant positions, making them part-time jobs, or turning to registered dietetic technicians (DTRs). DTR positions will provide growth, she says, in part because there is a shortage. "Hospitals will be constantly reevaluating who is the appropriate person to perform that level of service, and DTRs can contribute a great deal and their salaries cost less," Laramee says. Hospital foodservice administrators agree. "Dietetic departments, like other departments, are undergoing processes of strict self and administrative evaluation," wrote Ruby Puckett, MA, RD, director of the Dietary Manager Training Program at the University of Florida, in a letter to *FoodManagement*. "This often results in department restructurings with reductions in staff (often from the ranks of clinical RDs, since their salaries are the highest), as well as the implementation of new practices designed to cut food costs, increase productivity, etc." (22).

Unless they work in small community hospitals or have culinary or foodservice operation backgrounds, RDs can look to areas beyond menu development, Laramee says. Many hospitals rely on outside vendors or equip their chefs with nutrition analysis software. Laramee and others see the biggest opportunities for RDs in leadership and management roles. "Positions related to patient services, that oversee quality improvement and patient satisfaction will be good opportunities," Laramee says. "There is a demand for dietitians to work in those jobs because they understand medical nutrition needs, they maintain a good dialog with nurses, and they understand how to manage systems in a way that is collaborative."

There may be opportunities in outpatient services, wellness initiatives, and community service programs, but these will vary widely depending on the hospital and region and how they can be funded. "If providing nutrition services doesn't generate enough money to pay for a person's salary, there will be a move by hospitals to get out of that business," Laramee says. Health reform will influence the direction of future dietetics jobs in ways we currently can't predict. "Maybe nutrition will get factored into a patient's overall outcome," she says. "As long as we are relying on individual reimbursement for individual services, we'll continue to see challenges."

QUALITY: REFOCUS ON HEALING

How will quality of hospital amenities, including food, ultimately drive the discussion around health care costs and reimbursement? According to Goldman and Romley's editorial in

the *New England Journal of Medicine*, a "value-based payment system" may tap HCAHPS, capturing amenities as part of that value (16). Or it may rely on process of care measures of quality, such as for patients with common conditions, including acute myocardial infarction, heart failure, and pneumonia (23). It seems more likely that the former route will be embraced. In March, the US Department of Health and Human Services announced that "building patients' perspectives into all performance assessments" will be part of its three-pronged National Quality Strategy. "The Affordable Care Act uses HCAHPS as one of the measures to calculate value-based incentive payments to hospitals beginning in 2012," the report announces. "And also calls on CMS to expand the use of patient experience information to assess physicians and other facilities" (24). In a blog post, Cheryl Clark, senior editor at health care consulting firm HealthLeaders Media/HCPro wrote: "If it's true that improving amenities really does translate to more satisfied and happy patients, hospitals might increase their federal payments" (25).

But don't bank on that. Regardless of what system is finally implemented, RDs say "quality" will mean a continued trend toward more sophisticated menus and fresher, higher-quality food, delivered for less. That means RDs have to become ever more savvy about purchasing efficiency, delivering equipment, pushing retail development, and training staff. "Everybody's looking to pay hospitals less," says Rardin. "So your people skills are going to be absolutely critical, not only in managing your staff efficiently but also making sure they're saying the right things in front of that customer, and not over-blowing their expectations."

Perhaps going forward, the marketing of hospital food will shift from that of a gourmet-focused "amenity" toward a key part of a patient's comfort and recovery. "I think you're going to see a much stronger emphasis on nutrition in foodservice," Rogalski says. "It plays a vital role in goals to decrease readmissions, such as for congestive heart failure, or in preventing and speeding healing of pressure ulcers and other pressure wounds."

Mylod says it's easy for foodservice administrators to get carried away in viewing food as a consumer aspect. Granted, it is much more than it used to be, especially in large, competitive markets. But fundamentally, she says, food is an issue of comfort and basic need. "Hospitals need to understand that food is one important aspect in mitigating the anxiety, stress, and suffering of a patient," she says. "If the food is not up to the quality or cultural standards they expect, or if they're left waiting and hungry, or their restrictions are not well explained, then we've just added to that patient's suffering." But is it far-fetched to try to link food with healing as a measure of quality? "I don't think it's far fetched," Mylod says. "And those hospitals that perform best (on quality surveys) view food as part of clinical healing."

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