


WHAT'S *Right* IN HEALTH CARE





WHAT'S *Right* IN HEALTH CARE™

Service Recovery: Making it Right, Rebuilding Confidence, Learning from our Patients, and Reducing Malpractice Risk

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 Center for Patient and Professional Advocacy at Vanderbilt



Presentation Goals and Objectives

- Participants will recognize that patient complaints can:
 - Provide information on high malpractice risk physicians/practice sites/med ctrs/orgs
 - Provide information regarding systems issues in practice sites/med ctrs/orgs
 - Provide quality improvement information to healthcare professionals/practice sites/med ctrs/orgs
- Participants will identify the elements of a well-documented complaint

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VUMC Service Renewal

- Multi-year organizational development approach
- Focuses All Faculty and Staff on:
 - Financial Performance
 - Staff Satisfaction
 - Service and Patient Satisfaction
 - Clinical Quality
 - Growth



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VUMC's Pursuit of Excellence: Physician Involvement

- Promoted service excellence
- But, we've also taken a complementary approach...the vast majority of our physicians (and others) are exemplary, some need feedback, a few need a little help, and a very small number need to begin discipline processes

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The Patient Advocacy Reporting System (PARS)[®] Project

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Center for Patient and Professional Advocacy

- Founded in 1994
- Provides intervention services, patient relations consultation, research and education
- As of February 2008, works with many hospitals/ clinics/physician groups to provide intervention services

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Center for Patient and Professional Advocacy

CPPA's Mission Statement:

To promote patient and professional satisfaction with healthcare experiences, restrain escalating costs associated with patient dissatisfaction, and to make healthcare "safer and kinder." We pursue our mission through the inter-related functions of research and education.



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Professional Advocacy
at Vanderbilt

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The PARS® Team

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- Mercedes Smith
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Data Come From The VUMC Office of Patient Affairs

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Sue McKenzie

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Cathy Anderson

Jan Livingston, VCH

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Mike Stringer

Plus Guest Services

Reps (ad hoc)

Johnny Woodard, PHV

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Recurring Complaints (handout)

- How do you know what they are? (are you sure?)
- Why do they recur?
- What barriers keep you from dealing with recurring complaints?
- In an ideal world, what could be done to reduce or eliminate these concerns?
- What % come from "heartsink" pts/families? (and why is it important to deal with these concerns?)
- What makes it easy for your pts/families to express complaints?
- What makes it hard?

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Overview

- Today: Case-based discussion, Q&A
- Importance of patient/family/guest complaints
 - What is service recovery?
 - HEAT/HEART/HEARD
 - Documenting concerns
 - Improving complaint capture

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System/Staff Complaints

- "I called the office twice and got XXX on the phone. Both times she was abrupt and rushed. Last time she hung up on me."
- "The waiting room has broken furniture and the floor was dirty. I don't think a waiting area is supposed to be like that."
- "The Dr said that I would be called about my test results. They never called, and finally I called and got the results. They had my results the whole time..."

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Let's get specific:

**What would another person on
your staff most likely do in the
following situations?**

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**What if the complaints
are about a physician?**

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Physician Complaints

- “Dr. ___ seemed distracted, she ignored my records, and so her diagnosis makes no sense. I don’t think I should have to pay for this visit.”
- “Dr. ___ ignored my pain and refused to give me the medicine that makes me feel better.”
- “My appointment was supposed to be at 10:00, but Dr. ___ didn’t even come in the building until 10:45, and he never apologized for being late.”

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Infrastructure for Service Recovery

- Leadership commitment
- Model to guide levels of service recovery
- Supportive policies
- Signage and surveillance systems
- Multi-level professional/leader training
- Resources that can help

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Hickson, Pichert, Webb, Gabbe. Acad Med, Nov, 2007

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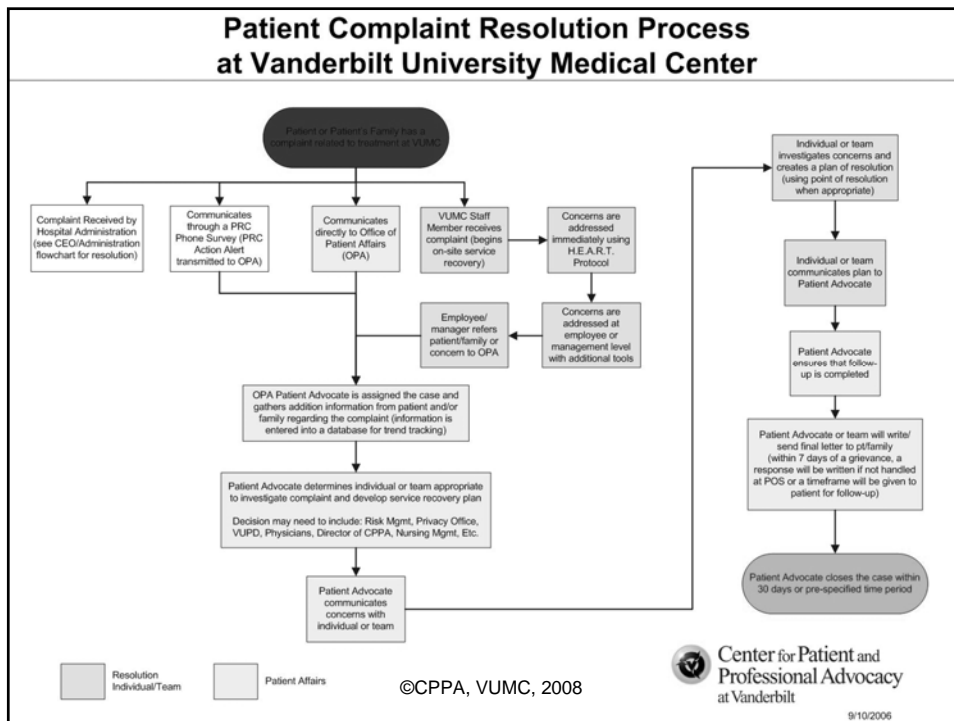
Resources: Patient Complaint Process at VUMC

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Patient Complaint Resolution Process at Vanderbilt University Medical Center



To Patient Relations When:

- Concerns involve several departments
- Complaints involve physicians
- Patient asks to terminate an MD/pt relationship
- Complaint is unresolved (or repeat complaint)

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To Pt Relations When:

- Allegations of Malpractice, threats to call the media (Involve Pt Relations and Risk Management)
- Concerns relate to a bad outcomes (Involve Pt Relations and Risk Management)

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To Pt Relations When:

- Allegations of abuse/boundary issues (Involve Pt Relations, Police, and Risk Management)
- Complaints regarding Confidentiality Issues (Involve Privacy Office and Pt Relations)
- Concerns are about patient /injury sustained while on Vanderbilt property (Involve Risk Management – Veritas-II)

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What Office of Pt Relations Does NOT Handle

- Parking complaints, meals, food issues
- Routine billing inquiries
- Routine equipment, housekeeping issues
- Routine requests for information:
 - These are capably and efficiently handled by staff and mgrs on site and documented by staff/mgrs for tracking and trending

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Recommended Service Recovery Model

- Level 1:** Concerns are addressed immediately by employee on site
- Level 2:** Concerns are addressed at employee level with local management help
- Level 3:** Employee/manager refers Patient/Family or concern to Patient Relations for assistance with resolution

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Patient Complaints offer a rich resource of information for your practice/med group/med center

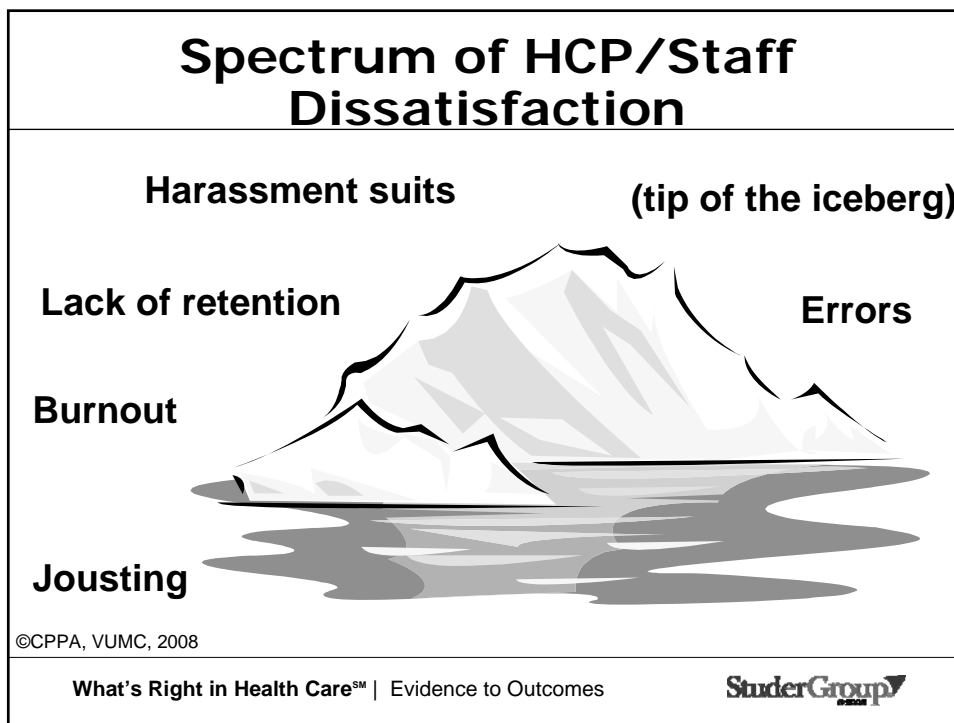
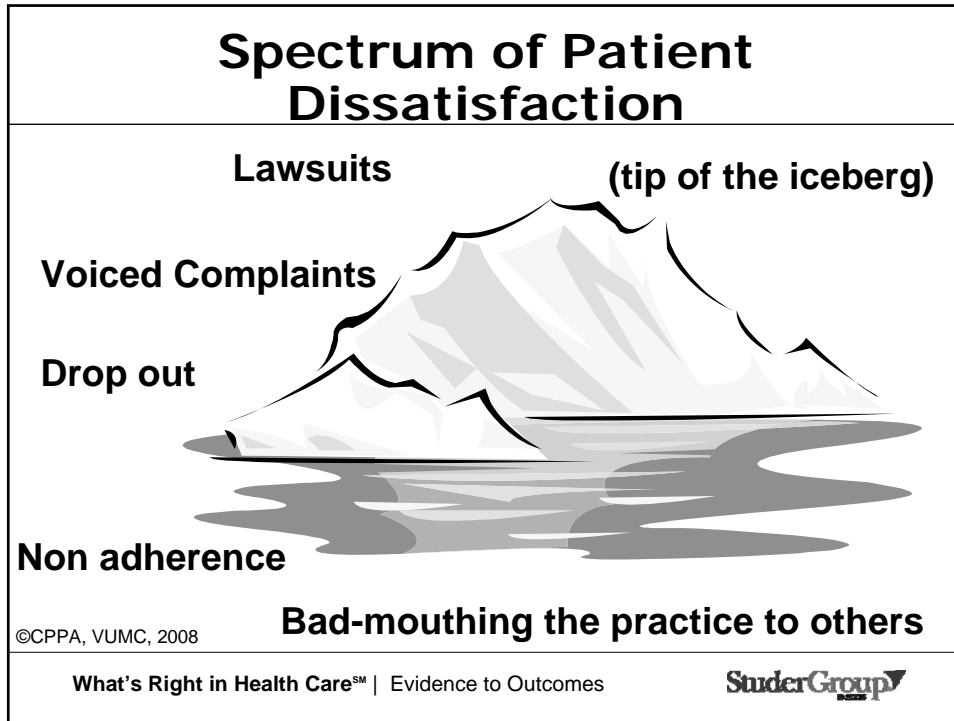
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Why and How?

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Common Issues

“Why do we need to do anything anyway?”

“Dr. ___ is technically outstanding (just a bit *challenging*)...”

“Is there any ROI?”

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The Malpractice Environment

- Our background
- Our research in risk mgmt

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Can high risk physicians be identified by means other than counting lawsuits?

Do unsolicited complaints link to malpractice risk?

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Receiving Patient Complaints

- Patient complains
- Someone at office responds
- Complaint documented
- MD, staff, admin, RM contacted

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Research Questions

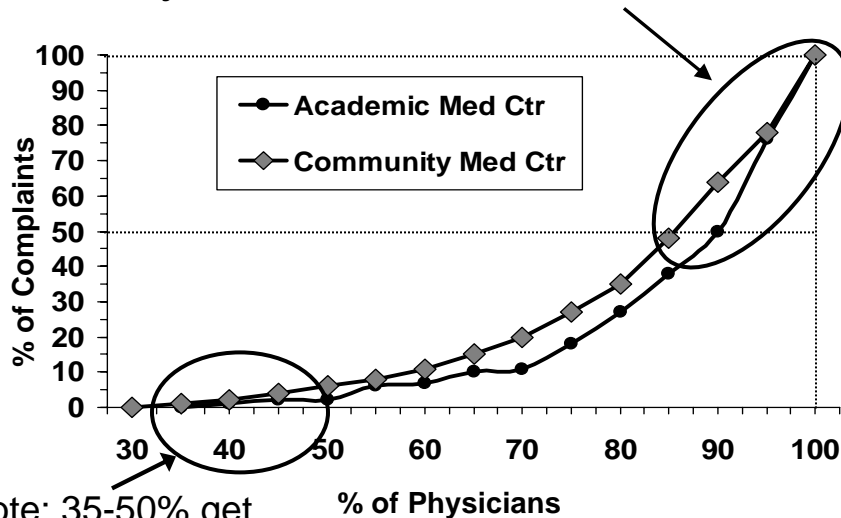
- What is the distribution of unsolicited complaints recorded by Patient Relations among members of a medical group?
- Is there an association between complaint generation and risk management activities?

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Academic vs Community Medical Center
50% of Complaints are Associated with 9%-14% of Physicians



Note: 35-50% get NO complaints

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Hickson GB, et al. Patient complaints and malpractice risk in a regional healthcare center, *So Med J.* 2007;100(8):791-796

How does the PARS® team at Vanderbilt process these pt/family concerns?

And how are the data used?

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PARS® Coding Patient Complaints

- 6 major complaint categories:
Tx, communication, access, etc.
- 34 specific subcategories:
Rudeness, jousting, diagnosis, etc.
- Code locations and persons
associated with complaints
- Good inter-rater and test-retest r's

Hickson, et al, *Law and Contemporary Problem*,
1998

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Med Mal Research Background Summary

- Unsolicited complaints predict claims

Hickson GB, et al. JAMA 2002;287:1583-1587.

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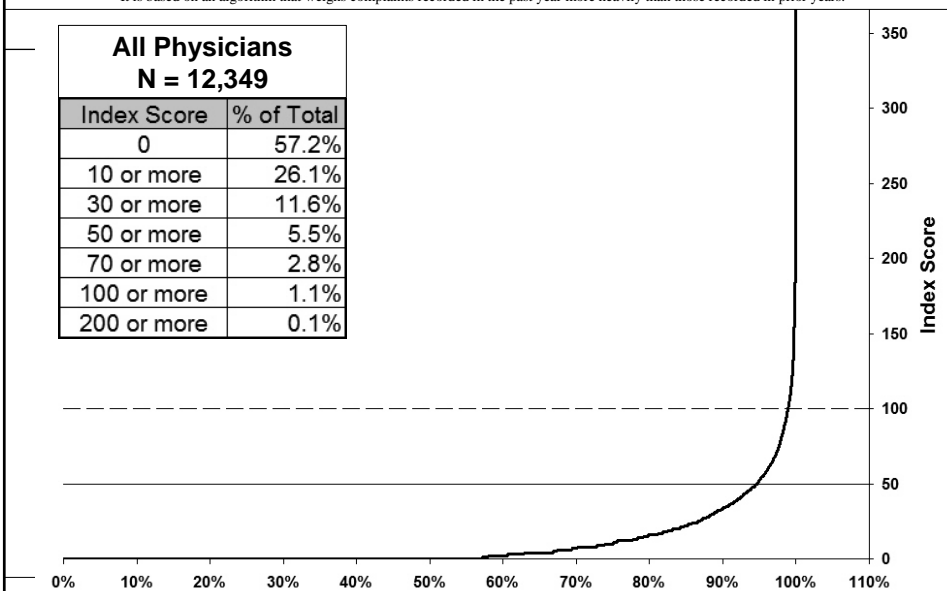
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Index Score vs. Percent of PARS[®] Physicians at all Institutions

The Index reflects the complaints with which each physician was associated.
It is based on an algorithm that weighs complaints recorded in the past year more heavily than those recorded in prior years.

All Physicians N = 12,349	
Index Score	% of Total
0	57.2%
10 or more	26.1%
30 or more	11.6%
50 or more	5.5%
70 or more	2.8%
100 or more	1.1%
200 or more	0.1%



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CONFIDENTIAL: This material is confidential and privileged under the provisions set forth in T.C.A. §63-6-219 and shall not be disclosed to unauthorized persons.

If complaints predict risk, how are they used to reduce risk?

1. Excellent service recovery one complaint at a time by staff and, when necessary, Patient Relations Specialists
2. Aggregating data to identify physicians/units/clinics at high risk, then peers feed back the data

How does #2 work?

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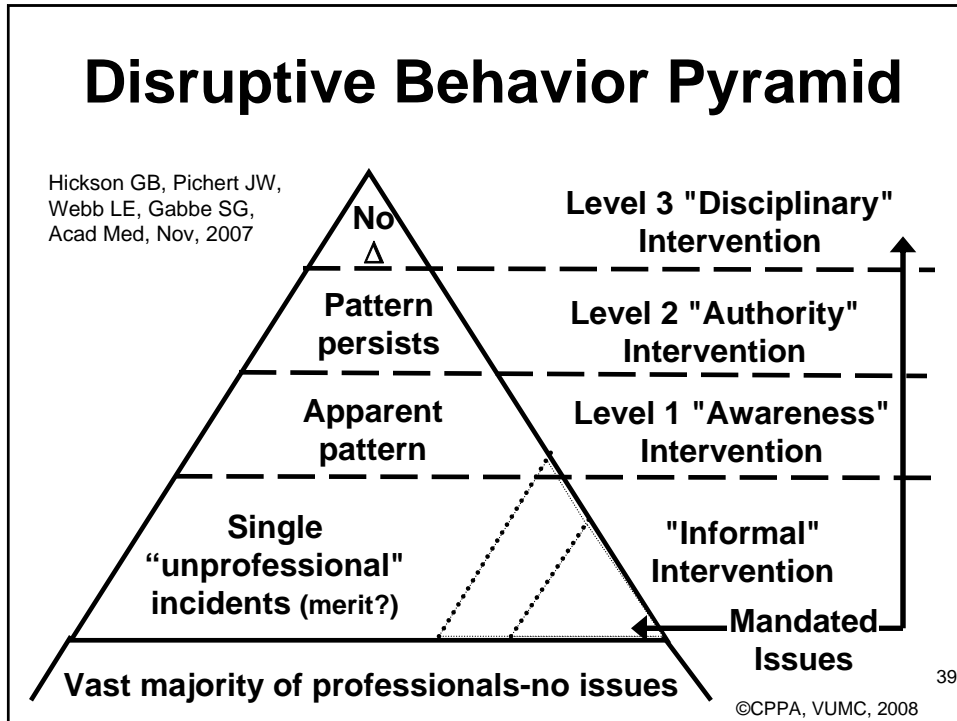


When Patterns Emerge: Lessons from our malpractice research background

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"Messenger" Peers

Nominated based on:

- Distribution among practice types
- Active practices now or not-distant past
- Respected by colleagues
- Willingness to serve
- Complaint scores mostly okay (but a few MDs intervened upon are messengers at other sites)

Moore, Pichert, Hickson, Federspiel, Blackford. Vanderbilt Law Review, 2006
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PARS® Level 1 “Awareness” Intervention

- Peers (mostly) agree to share the info
- Make high complaint doctors aware of data via letter and personal visit
- Use graphic displays, peer-based data comparisons (“educational outreach”) and all individual complaint reports
- No diagnoses or prescriptions, just encourage creative thinking
- Continue ongoing assessments to promote accountability
- Note: “Level 1” may last 2-3 rounds

Moore, Pichert, Hickson, Federspiel, Blackford. Vanderbilt Law Review, 2006
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Intervention Process: [Two folders: for colleague, for messenger records]

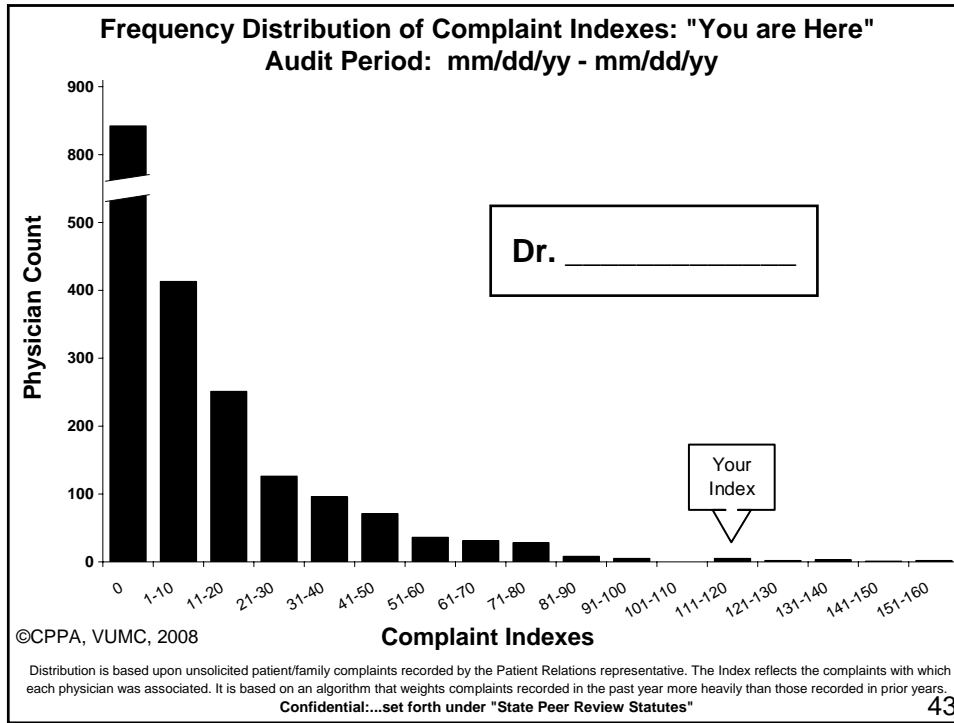
1. Signed letter is sent from messenger
2. A meeting is set
3. At the meeting, the following materials are delivered:
 - Report Card (illustrates standing in group or change over time and ranking)
 - Complaint Type Summary
 - Complaint narratives (full stories)
 - (Institutional policy)

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Complaint Type Summary

Audit Period for Data in this Table
 December 1, 2003 - November 30, 2007

Dr. _____

Complaint Type Categories	Number of Complaints		Distribution of Complaints*	
	Your Complaints	Average for Surgery	Your Complaints	Average for Surgery
Care & Treatment	13	4.5	31.0%	39.8%
Communication	10	2.9	23.8%	25.7%
Concern for Patient & Family	9	1.3	21.4%	11.5%
Accessibility & Availability	6	1.9	14.3%	16.8%
Safety of Environment	0	0.0	0.0%	0.0%
Money or Payment Issues	4	0.7	9.5%	6.2%
Total Number of Complaints	42	11.3		

Total Number of Reports†		
In the past 48 months:	21	5.9
In the past 12 months:	5	1.7

*Complaint distribution figures are rounded to the nearest percent; therefore, the totals may not equal precisely 100.
 †Each report may contain multiple complaints.

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Representative Concerns by General Category

Concern for Patient/Family

- I never felt like he cared whether [my spouse] lived or died. He does NOT live up to your motto
- He may be famous worldwide for his research, but I have to tell you that he's also famous among the patients in his waiting room—and they come from all over—for being the rudest, crudest, most arrogant jerk doctor in this state

Communication

- He did not keep us informed about my daughter's condition...and didn't answer our questions
- Pt upset with lack of info from Dr. ____...no one is able to tell him what his x-rays show

Care and Treatment

- Dr. ____ delay in care made my mother's medical status worse

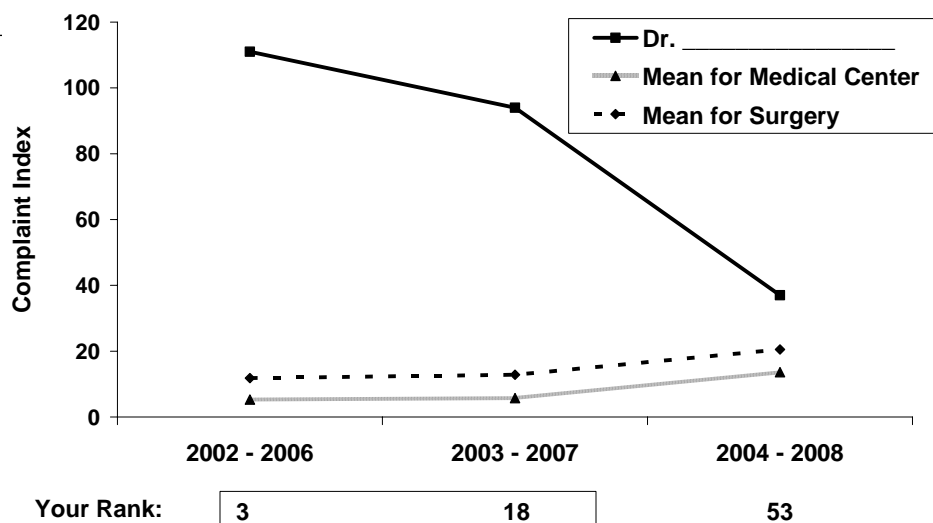
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Frequency Distribution of Complaint Indexes

Audit Period: mm/dd/yy - mm/dd/yy



Your Rank: 3 18 53

Distribution is based upon unsolicited patient/family complaints recorded by the Patient Relations representative. The Index reflects the complaints with which each physician was associated. It is based on an algorithm that weights complaints recorded in the past year more heavily than those recorded in prior years.

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Confidential:....set forth under "State Peer Review Statutes"

Interim Observations

- More than 1,000 interventions completed
- All messengers emerged intact (so far)
- <2% responded with hostility
- Most responded professionally:
 - ✓ Asked Patient Relations to shadow, give ideas
 - ✓ Went to Chief: Asked for resources
 - ✓ Reorganized the unit
- ~15% go to Level II Interventions (Persistent pattern needing an improvement plan)
- Follow-ups ongoing

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Composite Physician Intervention Results on Complaints:

18 Institutions
34 Hospitals/Med Groups

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PARS® Progress Report

1998 through Today

1998-2008	MD Interventions	No.
1998-2000	First Time Interventions	27
2001-2002	First Time Interventions	68
2003-2004	First Time Interventions	64
2005-2006	First Time Interventions	160
2007-2008	First Time Interventions	86
Total MD Interventions		405

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PARS® Progress Report

Follow up Results:

Good – Interv. visits suspended	128 (38%)
Good – Anticipate susp. in '08-'09	37 (11%)
Better – Still need tracking	30 (9%)
	Subtotal 195 (58%)
Unimproved/worse	70 (21%)
Departed	71 (21%)
Total follow-up results	336
First follow-up later in '08-'09	69
Total Interventions	405

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Level 2 "Authority" Interventions*

- Involve authority figure
- Review of data
- Develop a plan, tailored to extent and severity of issues, e.g.:
 - Review practice systems, mgmt
 - Refer for health evaluation
 - Relevant CME, RM training

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*VUMC Policy, Pt Complaint Monitoring Committee

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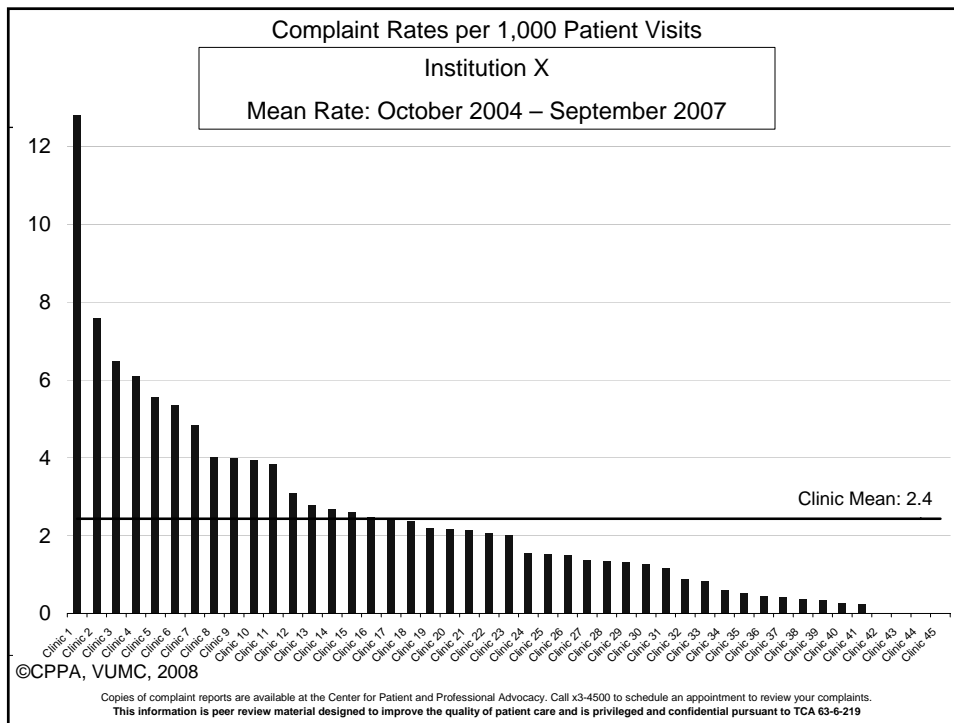
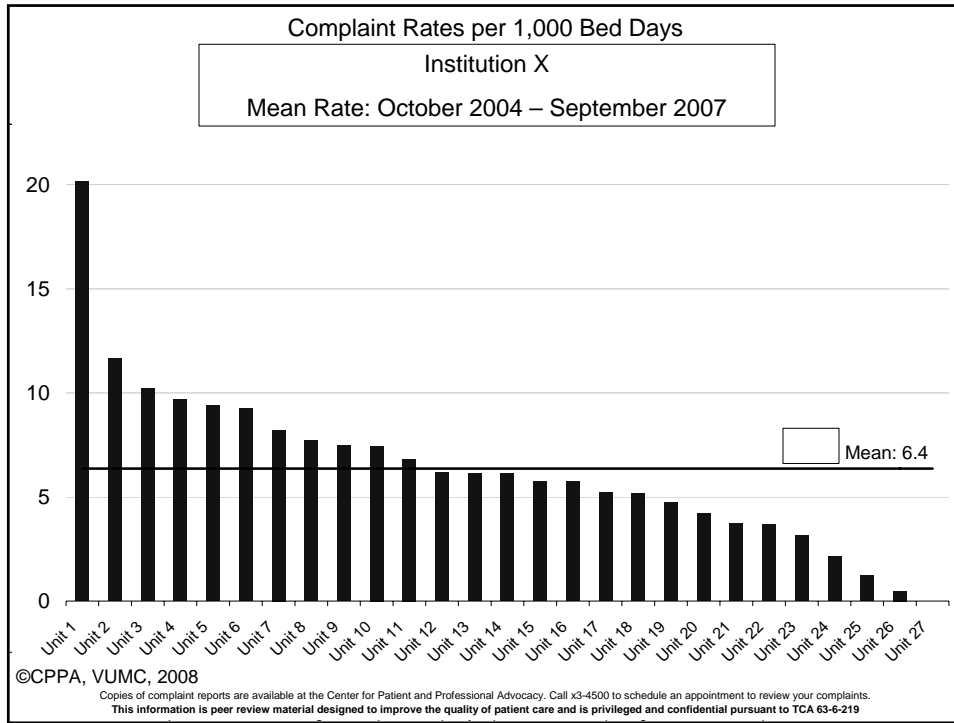


Pt complaints not only offer information about individual physicians, but can also be used for units or practice groups

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What's the payoff (ROI)?

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Disruptive conduct impairs communication...

Communication problems lead to adverse events.¹

- Communication breakdown factored in OR errors 50% of the time²
- Communication mishaps were associated with 30% of adverse events in OBGYN³
- Communication failures contributed to 91% of adverse events involving residents⁴

1. Dayton et al, J Qual & Patient Saf 2007; 33:34-44. 3. White et al, Obstet Gynecol 2005; 105(5 Pt1):1031-1038.

2. Gewande et al, Surgery 2003; 133: 614-621.

4. Lingard et al, Qual Saf Health Care 2004; 13: 330-334.

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- **“RN did not call MD about change in patient condition because he had a history of being abusive when called. Patient suffered because of this.”**

Rosenstein, A., O'Daniel, M. Impact and Implications of Disruptive Behavior in the Perioperative Arena. J Am Coll Surg. 2006;203:96-105.
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Failure to Address Disruptive Conduct Leads To

- High turnover
 - Pearson et al, 2000 found that 50% of people who were targets of disruptive behavior thought about leaving their jobs
 - Found that 12% of people actually quit
- These results indicate a negative effect on return on investment

Felps, W et al. 2006. How, when, and why bad apples spoil the barrel: negative group members and dysfunctional groups. Research and Organizational Behavior, Volume 27, 175-222.

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So what about our claims experience?

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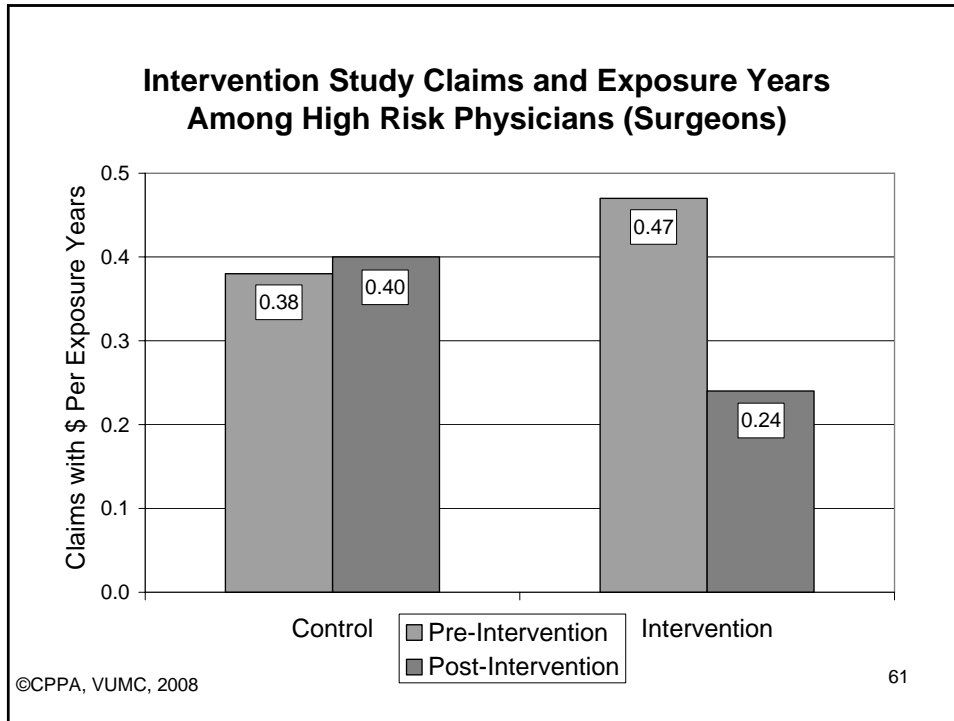
Can a peer based intervention program reduce claims?

- 54 high complaint physicians identified
- Randomized based on discipline and RVU production into control and intervention groups
- Peer messengers trained and intervention folders created
- First interventions completed 4/98 with yearly follow up visits through 4/04
- 4/07 – all claims files reviewed for study inclusion 4/92-4/04 (statute of limitations)

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**But what does this
mean for the
individual physician?**

But what does this mean...

- Ortho surgeon with 7 \$ claims pre...1 \$ claim post
- Neuro surgeon with 6 \$ claims pre...0 \$ claims post
- Urologist with 3 \$ claims pre...0 \$ claims post

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But not everyone responds

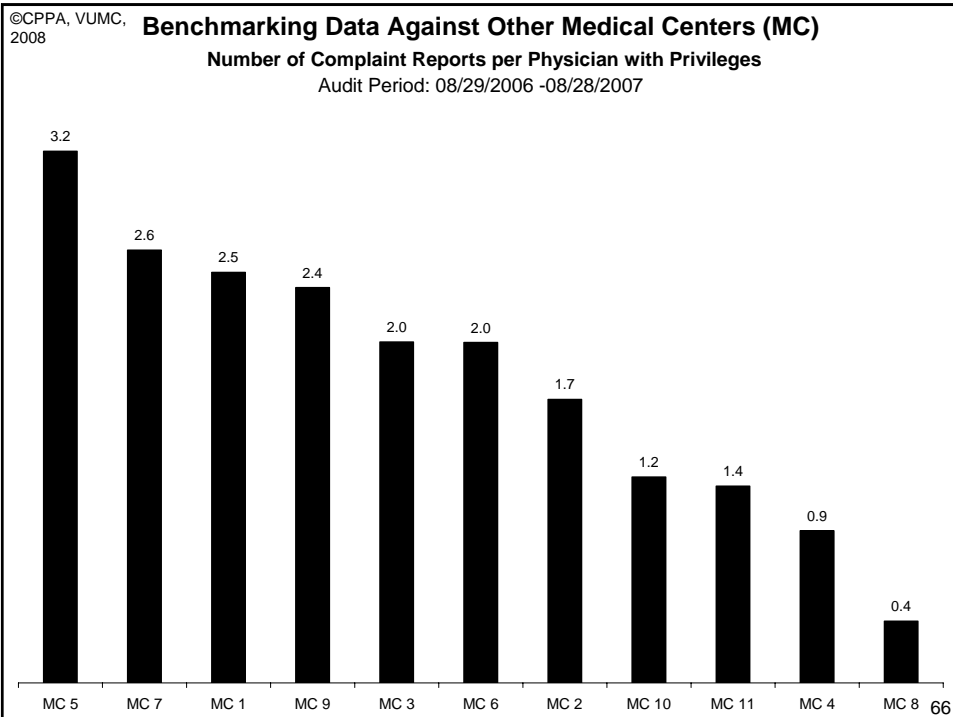
- Ortho surgeon with 6 \$ claims pre...7 \$ claims post
- (refused intervention)

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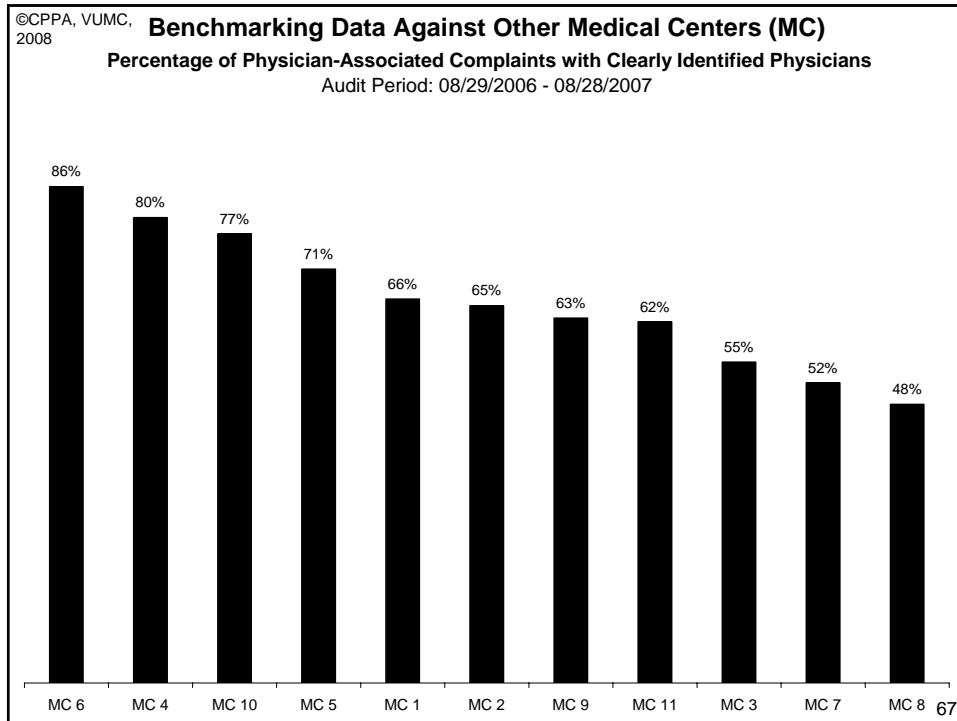
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**You Are Important:
You may be aware of many
more patient complaints than
are now being recorded**



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How can you help with complaint capture?

- Centralize complaint capture so that all complaint reports are recorded in one database
- Expand opportunities for all partners, employees and patients to learn about the patient complaint services you provide and why they are important
- Advise patients, families, and staff on how to file a complaint or compliment

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A Division of

How can you get the most out of the complaints you record?

- Include quotes from the person making the complaint
- Include the first and last name of the person complained about (if the complaint is about a person) and the location of the complaint. If there are multiple persons involved, clearly ID all parties
- Help one another provide accurate and detailed reports

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So What? Why Care? What's In It For You?

- Complaints can ID areas of increased risk
- Complaints can ID areas of patient dissatisfaction
- Complaints can ID systems issues
- Complaints can ID disruptive professionals (reduce staff dissatisfaction)
- Complaints can be instrumental in helping improve your practice group culture and your bottom line

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An Opportunity

- We've identified a few "pros" for identifying and recording patient/family complaints. Can you think of others?
- What, if any, are the potential barriers to identifying and recording patient/family complaints?
- What questions, concerns, observations do you have?

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Next: Service Recovery

- What it is
- Tools for implementing service recovery
- Discuss cases: ours and yours

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Service Recovery

...To promote exemplary patient care... when dissatisfaction occurs... "making right what went wrong"

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Service Recovery:

Utilizing Patient Complaints

3 M's

- | | |
|-------|---------------------------------------|
| Moral | 1. Make it right |
| | 2. Do the right thing |
| Mktg | 3. Rebuild confidence in the practice |
| | 4. Retain loyalty |
| Money | 5. Reduce risk |
| | 6. Improve your bottom line |

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Patient Observations

- “Asked me on a scale of 1-10, about the pain in my ankle. I replied 10...P.A. with an attitude said: ‘Oh, you mean liked it was yanked off by a shark?’”

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Tool: H-E-A-R-D Protocol (see handout)

- 1) Hear the patient
- 2) Empathize
- 3) **A**cknowledge, **A**ppreciate, thank patient/family member for sharing their concerns, (apologize)*
- 4) **R**espond to the problem
- 5) **D**ocument appropriately

* Really “acknowledge, appreciate, and sometimes apologize”
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Tip of the Iceberg

... Consumer and medical literature indicate voiced complaints represent only a small fraction ... for every pt/fm that complains there are many more ...

Annandale. Accounts of disagreements with doctors. Soc Sci Med 1998.

Carroll. Characteristics of Families that Complain Following Pediatric Emergency Visits. Ambulatory Pediatrics. 2005.

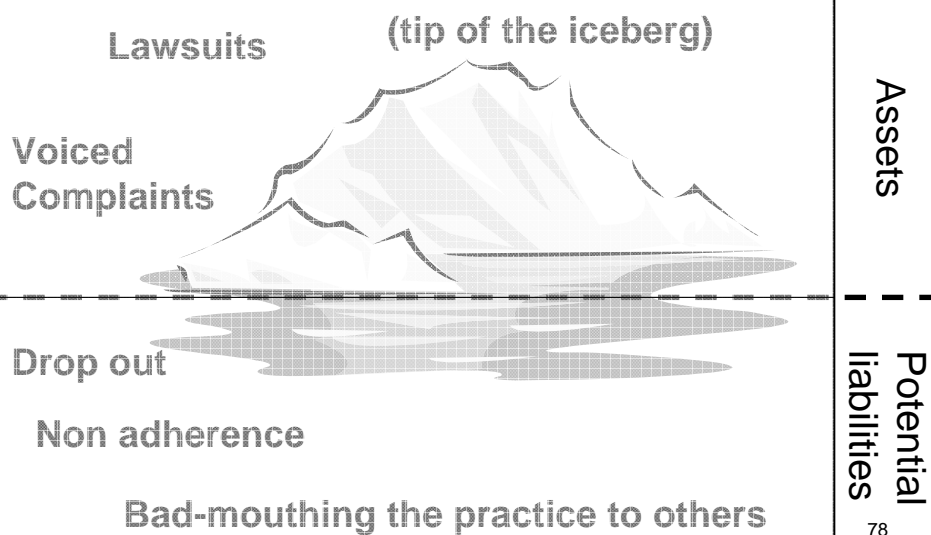
"Consumer Complaint Handling in America: An Updated Study for the U.S. Office of Consumer Affairs," 1986.

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Spectrum of Patient Dissatisfaction



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Capturing complaints also allows us to influence the bottom line

(The “Money” Dimension)

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Cost of Dissatisfied Patients

- Patients' perceptions of bad experiences shape their desire to stay with your practice or go elsewhere
 - “Hard” costs are the loss of future revenue from the pt visit and/or hospitalization
 - “Soft” costs take into consideration the impact the pt's negative advertising
 - See the handout

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Self Assessment (another handout)

Leebov, W. Resolving complaints: for professionals in health care. Mosby-Great Performance, 1995, pg 5.

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Common Obv/Problem:

Substantial variation among managers,
assistants and staff

1. Some virtually never refer to Pt Relations
2. Some refer virtually everyone
3. Some do routine SR on site, refer selected challenges to Pt Relations

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Problems With Varied Use of Patient Relations Personnel

- Substantial variation in SR practices, outcomes, reporting and follow-up
- Inconsistent system-related problem-solving and improvement efforts: "nothing changes"
- Frustration, discouragement, resignation confusion and burnout

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What Might be Recorded?

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What to Record

- Unique ID code for complaint
- Date of first contact with patient relations
- Method of contact (visit, call, etc.)
- Person contacting patient relations
- Relationship to patient (helps avoid HIPAA issues later on)
- Patient name
- Additional info on patient
- Location where incident(s) occurred

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Recording..., continued

- Summary of concern being raised (quotes help)
- Resolution/result
- Names and types of professionals associated with the concern(s)
 - Embed associated name within details of the complaint to remove ambiguity regarding to whom the patient/family is referring
- Attachment(s) of original documentation
- Other items???

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More Complaints...

- ... the daughter said that the nurse could not attend to her mother because a patient had died in another room and that patient needed her attention now...
- ...patient feels unit needs to be blessed due to inexplicable voices...
- ...she said she had asked several nurses for the number to Pat. Relations and no one seemed to know it. Further, she said staff had laughed at her for asking.

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What About CMS Grievance Process?

- § 482.13, Patients' Rights. "The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance."
 - But what's a grievance?"
 - A "**patient grievance**" is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489.
- Source: CMS Interpretive Guideline Interpretive guidelines §482.13(a)(2)

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Doesn't documentation make it a grievance?

- Writing it down does NOT automatically create a grievance
 - Staff can note that the concern was resolved and your documentation is for quality improvement
 - Have a check box for grievances
 - Have an established policy regarding resolution of grievances & "definitions" for what constitutes a grievance

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Ways to Increase Cmplt Collection

- Concerns are sent to the Office of Patient Relations without pre-screening or filtering
- Concerns forwarded from other receivers: billing, patient surveys, compliance line, clinic managers, administrators on call, administration, other?

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Best Practices

- Respond with HEART/HEAT/HEARD
- Document
 - Good: Do it yourself
 - Best: Ask *pt/family* to document (comment cards, letter, email, etc.)
- Analyze trends

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How staff can refer to Pt Relations

- Ask Pt/Family to call/email/mail/fax [provide numbers/links] to contact a pt advocate, provide card, literature
- Let Patient/Family member know that you will call on their behalf and that a patient advocate may follow up
- Ask Patient/Family to stop by the Pt Relations office for face to face discussion, see website

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Increasing Collection, cont.

- Advertise!!
 - Signs
 - Videos
 - Publicizing phone # (tent cards, bills, etc.)
 - Meet w/nursing and clinic managers, staff orientation
- What else?

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Upcoming CPPA Conferences at Vanderbilt

The Why and How of Dealing with "Special" Colleagues: Discouraging Disruptive Behavior
June 26-27, 2008; November 12-13, 2008

The How and When of Communicating Adverse Outcomes and Errors
August 7-8, 2008; March 5-6, 2009


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Thank You!

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