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
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

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
The Patient Advocacy Reporting System (PARS)® Project

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
**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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**The PARS® Team**

- Lisa Barksdale
- David Campbell
- Anna Caruso Hayden
- Bernadette Cornett
- Amanda Harasty
- John Hickman
- Gerald Hickson
- Beverly Huff
- Mackenzi Johnson
- Christina Leo
- Ann Loffi
- Ilene Moore
- Ana Orrett
- Kristie Parnell
- Jim Pichert
- Mark Powell
- Keith Rawlings
- Mallory Ross
- Marbie Sebes
- Mercedes Smith
- Renee Stein
- Deb Toundas
- Spencer Zachary

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

Jodi Fawcett, Director

Sue McKenzie  
Mary Sturgis  
Marbie Sebes  
Cathy Anderson  
Jan Livingston, VCH  
Nathalie Jones, VCH  
Mike Stringer  

Plus Guest Services  
Reps (ad hoc)  
Johnny Woodard, PHV

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?
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

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...”
Let’s get specific:

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

What if the complaints are about a physician?
### 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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Resources:
Patient Complaint Process at VUMC

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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)

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
# 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 |

---

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

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### Spectrum of Patient Dissatisfaction

<table>
<thead>
<tr>
<th>Lawsuits</th>
<th>(tip of the iceberg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voiced Complaints</td>
<td></td>
</tr>
<tr>
<td>Drop out</td>
<td></td>
</tr>
<tr>
<td>Non adherence</td>
<td></td>
</tr>
<tr>
<td>Bad-mouthing the practice to others</td>
<td></td>
</tr>
</tbody>
</table>

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### Spectrum of HCP/Staff Dissatisfaction

<table>
<thead>
<tr>
<th>Harassment suits</th>
<th>(tip of the iceberg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of retention</td>
<td>Errors</td>
</tr>
<tr>
<td>Burnout</td>
<td></td>
</tr>
<tr>
<td>Jousting</td>
<td></td>
</tr>
</tbody>
</table>

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What's Right in Health Care™ | Evidence to Outcomes

www.studergroup.com

© 2008 Studer Group
### Common Issues

"Why do we need to do anything anyway?"

"Dr. ___ is technically outstanding (just a bit challenging)…"

"Is there any ROI?"

---

### The Malpractice Environment

- Our background
- Our research in risk mgmt

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What’s Right in Health Care™ | Evidence to Outcomes
Can high risk physicians be identified by means other than counting lawsuits?

Do unsolicited complaints link to malpractice risk?

Receiving Patient Complaints

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

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

Note: 35-50% get NO complaints

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


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Med Mal Research
Background Summary

• Unsolicited complaints predict claims


CONFIDENTIAL: This material is confidential and privileged under the provisions set forth in T.C.A. §47-2-219 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?

When Patterns Emerge: Lessons from our malpractice research background
**Disruptive Behavior Pyramid**

- Vast majority of professionals-no issues
- Single "unprofessional" incidents (merit?)
- Apparent pattern
- Pattern persists
- No

- Level 1 "Awareness" Intervention
- Level 2 "Authority" Intervention
- Level 3 "Disciplinary" Intervention


---

**“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)


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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


---

**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)
Frequency Distribution of Complaint Indexes: "You are Here"
Audit Period: mm/dd/yy - mm/dd/yy

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.

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

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

Dr. _____________

<table>
<thead>
<tr>
<th>Complaint Type Categories</th>
<th>Number of Complaints</th>
<th>Distribution of Complaints*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year Complaints</td>
<td>Average for Surgery</td>
</tr>
<tr>
<td>Care &amp; Treatment</td>
<td>13</td>
<td>4.5</td>
</tr>
<tr>
<td>Communication</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>Concern for Patient &amp; Family</td>
<td>9</td>
<td>1.3</td>
</tr>
<tr>
<td>Accessibility &amp; Availability</td>
<td>6</td>
<td>1.0</td>
</tr>
<tr>
<td>Safety of Environment</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Money or Payment Issues</td>
<td>4</td>
<td>0.7</td>
</tr>
<tr>
<td>Total Number of Complaints</td>
<td>42</td>
<td>11.3</td>
</tr>
</tbody>
</table>

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

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

---

Frequency Distribution of Complaint Indexes
Audit Period: mm/dd/yy - mm/dd/yy

- Dr.____
- Mean for Medical Center
- Mean for Surgery

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.

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

Composite Physician Intervention Results on Complaints:

18 Institutions
34 Hospitals/Med Groups
### PARS® Progress Report

**1998 through Today**

<table>
<thead>
<tr>
<th>Year</th>
<th>MD Interventions</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998-2000</td>
<td>First Time Interventions</td>
<td>27</td>
</tr>
<tr>
<td>2001-2002</td>
<td>First Time Interventions</td>
<td>68</td>
</tr>
<tr>
<td>2003-2004</td>
<td>First Time Interventions</td>
<td>64</td>
</tr>
<tr>
<td>2005-2006</td>
<td>First Time Interventions</td>
<td>160</td>
</tr>
<tr>
<td>2007-2008</td>
<td>First Time Interventions</td>
<td>86</td>
</tr>
</tbody>
</table>

**Total MD Interventions**

405

---

**Follow up Results:**

<table>
<thead>
<tr>
<th>Category</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good – Interv. visits suspended</td>
<td>128</td>
<td>(38%)</td>
</tr>
<tr>
<td>Good – Anticipate susp. in ’08-’09</td>
<td>37</td>
<td>(11%)</td>
</tr>
<tr>
<td>Better – Still need tracking</td>
<td>30</td>
<td>(9%)</td>
</tr>
</tbody>
</table>

Subtotal 195 (58%)

<table>
<thead>
<tr>
<th>Category</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unimproved/worse</td>
<td>70</td>
<td>(21%)</td>
</tr>
<tr>
<td>Departed</td>
<td>71</td>
<td>(21%)</td>
</tr>
</tbody>
</table>

**Total follow-up results**

336

First follow-up later in ’08-’09 69

**Total Interventions**

405
### 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

*VUMC Policy, Pt Complaint Monitoring Committee

---

**Pt complaints not only offer information about individual physicians, but can also be used for units or practice groups**
Complaint Rates per 1,000 Bed Days

Institution X
Mean Rate: October 2004 – September 2007

Complaint Rates per 1,000 Patient Visits

Institution X
Mean Rate: October 2004 – September 2007

Copies of complaint reports are available at the Center for Patient and Professional Advocacy. Call x3-4500 to schedule an appointment to review your complaints.

This information is peer review material designed to improve the quality of patient care and is privileged and confidential pursuant to TCA 63-6-219.
What’s the payoff (ROI)?

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

“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.”


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

So what about our claims experience?

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)
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

But not everyone responds

- Ortho surgeon with 6 $ claims pre...7 $ claims post
- (refused intervention)
You Are Important:
You may be aware of many more patient complaints than are now being recorded.
Benchmarking Data Against Other Medical Centers (MC)
Percentage of Physician-Associated Complaints with Clearly Identified Physicians

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
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

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
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?

Next: Service Recovery

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

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

Service Recovery:

Utilizing Patient Complaints

3 M’s
- Moral
- Mktg
- Money

1. Make it right
2. Do the right thing
3. Rebuild confidence in the practice
4. Retain loyalty
5. Reduce risk
6. Improve your bottom line
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?”

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

1) Hear the patient
2) Empathize
3) Acknowledge, Appreciate, thank patient/family member for sharing their concerns, (apologize)*
4) Respond to the problem
5) Document appropriately

* Really “acknowledge, appreciate, and sometimes apologize”
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 ...


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Spectrum of Patient Dissatisfaction

Lawsuits  (tip of the iceberg)

Voiced Complaints

Drop out

Non adherence

Bad-mouthing the practice to others

Assets

Potential liabilities

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Capturing complaints also allows us to influence the bottom line

(The “Money” Dimension)

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

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Self Assessment (another handout)


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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?
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

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???
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.

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)
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

Ways to Increase Cmplnt 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?
### 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?

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

http://www.mc.vanderbilt.edu/CPPA
Thank You!

www.mc.vanderbilt.edu/cppa

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