Categorizing and Rating Patient Complaints: An Innovative Approach to Improve Patient Experience

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Abstract
The Ombudsman Office at a large academic medical center created a standardized approach to manage and measure unsolicited patient complaints, including methods to identify longitudinal improvements, accounting for volume variances, as well as incident severity to prioritize response needs. Data on patient complaints and grievances are collected and categorized by type of issue, unit location, severity, and individual employee involved. In addition to granular data, results are collated into meaningful monthly leadership reports to identify opportunities for improvement. An overall benchmark for improvement is also applied based on the number of complaints and grievances received for every 1000 patient encounters. Results are utilized in conjunction with satisfaction survey results to drive patient experience strategies. By applying benchmarks to patient grievances, targets can be created based on historical performance. The utilization of grievance and complaint benchmarking helps prioritize resources to improve patient experiences.

Keywords
patient experience, patient complaints, prioritization, benchmarking

Measuring Patient Experience
Patient experience has garnered significant attention among hospitals across the country, sparked by the Institute of Medicine’s (IOM) report entitled “Crossing the Quality Chasm: The IOM Health Care Quality Initiative” (1). Patient experience has also been driven by reimbursement policies from the Centers for Medicare and Medicaid Services (CMS) for performance on validated patient satisfaction surveys. These surveys, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) have raised awareness of patient experience, and have driven many system improvements (2). However, HCAHPS surveys have many challenges, do not capture the full range of patients’ experiences (3), and are hampered by weeks of delay in result reporting, selection bias, and attribution to a single discharging physician. Furthermore, these surveys are not sufficient in capturing the longitudinal experiences of our patients, given that they focus on one encounter at a time. Thus, additional data sources are needed to more fully assess patients’ experiences in health care.

In contrast to HCAHPS data, complaint and grievance rates can give hospitals a more agile, real-time approach to resourcing and performance improvement opportunities (4). These data represent a supplemental source of detailed feedback about experiences which can drive improvements for safe, high quality, and better care. Furthermore, effective management of complaints and grievances contributes to our medical center’s overall patient experience approach, which focuses on teamwork, empathy, safety, and ease (5). Complaints and grievances are routinely collected by health care systems and are utilized to reduce patient concerns, improve experience, and may also save organizations money from a

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reduction in lawsuits, legal fees, and insurance costs (6). Studies show that an increase in patient complaints increases malpractice risk (6).

Despite the importance of complaint and grievance data, there are no public sources of these data and an absence of national benchmarks. The purpose of this report is to share rates of complaints and grievances, and describe their frequency, type, and level of severity at a large academic medical center. Unlike other similar systems, we also manage employee-generated requests to assist with patient issues and share these data in this report. Our goal is to highlight the value of these data to establish internal and external benchmarks to inform improvements in health care nationwide.

Management of Complaints and Grievances

The Ombudsman Office in the Office of Patient Experience at our medical center records all unsolicited patient complaints and grievances in a software program RLDatix Patient Experience Platform (RLDatix, n.d., https://rldatix.com/en-nam). Complaints are defined as concerns about care that can be addressed at the point of service within 12 hours. Grievances are defined as “a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient’s representative, regarding the patient’s care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital’s compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.” As the grievances process is defined in CoPs regulations, they must be responded to in writing to patients, in most cases resolved within 7 days, and are reviewed during unannounced surveys to ensure a thorough investigation occurred (7). These data are categorized by type of issue(s) that occurred in the patient encounter, such as lack of communication, long wait times, rude behavior, or any other issue the patient experienced. This process allows for the specificity of a targeted survey, while also bringing in the details of the patient’s story for more complete and accurate feedback. In our health care system, ombudsman reports are distributed monthly to hospital leadership and include categories of issues, institute and department-level data, provider type, most frequent grievances and compliments by provider, trending performance, and detailed narratives. Ombudsman report categories are as follows:

**Frequency/Rate of Complaints and Grievances**

The frequency of complaints and grievances are recorded and classified to characterize the nature of the problem, involved party/ies (i.e., nursing issue, provider concern, process problem), and assigned a severity rating based upon the suffering caused to the patient following the investigation, determined on a 1-5 Severity Scale, presented in more detail below. Rates are also assigned to complaints and grievances based on the number of cases per every 1,000 patient encounters. This attribution permits smaller hospitals in a system to be compared to larger 1,000 bed hospitals. This is established on a month by month basis. The rate is measured over time to see if improvement occurs, without impact from number of patients served.

**Classification**

The classification is the category(ies) or type of concerns that a patient or representative’s grievance relates. The classification is documented by the Ombudsman based upon the specific issues raised during their investigation. The patient or their representative’s complaint could revolve around multiple classifications.

**Communication**

Grievances where the patient/representative’s complaint was based upon any issue relating to communication such as lack of explanation, follow-up, or courtesy.

**Perception of Care/Safety**

Grievances wherein the patient/representative’s complaint was based upon any issue related to their perception of the care received and/or any issues about patient safety such as allegation of misdiagnosis, inappropriate treatment, or other quality concerns.

**Appointments and Access**

Grievances where the patient/representative’s complaint was based upon issues with appointments and/or access to care such as ease of appointment, scheduling processes, or cancellations.

**Response/Delay**

Grievances where the patient/representative’s complaint was based upon issues surrounding a response to the medical care and any issues with a delay in their medical care such as delay to receive test results or excessive wait times.

**Medication Communication/Pain Management**

Grievances wherein the patient/representative’s complaint was based around communication issues with medication and issues with pain management, such as concerns about lack of attention to pain needs or prescription disagreements.

**Involved Party/ies**

The “Involved Party” is defined as the patient/representative that contacts the Ombudsman Office to discuss their complaint or grievance.
Severity Scale

Complaints and grievances are assigned a severity rating by the Ombudsman who investigates them. Categorization by topic is useful, albeit not fully standardized in national practice despite existing frameworks. But a topic approach misses an opportunity to focus attention on the harm caused as a result of the concern, to elevate patient complaints on par with safety events, and to allow for allocation of resources and process. The Severity Scale was created in 2017 by our team to rate the harm of patient grievances. While focusing on reducing patient dissatisfiers can generally improve practices, an urgent response to some patient concerns can actually cause harm, especially in an era of opioid crisis (8). The Severity Scale numerically classifies case issues from no actionable events to permanent serious harm or death, using a 5-point scale, and is internally applied to all of our safety events in risk management. The scale also aligns with the well-known National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) index for categorizing medication errors (9) and crosswalks with World Health Organization (10,11) and Healthcare Performance Improvement (12) classifications. Table 1 presents the description, definition, and an example of each of the five levels of the Severity Scale. Monthly reports of all cases with a classification of 4 and 5 are generated and distributed to clinical risk management and safety leaders. The important connection between patient complaints and safety improvement is well-respected through this process (13).

Casework Audits

Ombudsman Office casework is audited using an internal Excel tool developed in 2015. This tool is utilized by management to ensure consistency in individual ombudsman casework and to bring standardization and reliance to data reports. The audit tool is grounded in governmental oversight body grievance criteria and patient experience service excellence standards, such as courtesy, appropriate expectation setting, apology, and timeliness (7). A case is reviewed utilizing a comparison to this tool, which serves as a checklist to standardize and verify case compliance—an effective approach in health care (14). The checklist is then provided to an ombudsman for review during audits to drive discussion of casework. Random audits are conducted by management each month.

Complaints and Grievances Data

The total number of complaints and grievances from September 1, 2017, to August 31, 2018, was 9233, divided by the total number of individual patient encounters, established a 1 year rate average of 1.27 complaints for every 1000 patient encounters. Most of the complaints and grievances related to challenges with communication with hospital employees (n = 2348, 25%), followed by patient perceptions that medical care and patient safety were compromised (n = 1267, 14%). Details on types and frequency of complaints and grievances are presented in Figure 1. With regard to severity, 15% of complaints and grievances were rated 1 on the Severity Scale—not actionable and no identifiable opportunity for improvement, and none were rated

Table 1. Grievance Severity Scale Applied to Complaints and Grievances Reported to Ombudsman Department at a Large Academic Medical Center.

| Level | Description | Definition | Examples |
|-------|-------------|------------|----------|
| Level 1 | Almost inconvenience/processes/not actionable | The patient care was not impacted or the issue is not preventable. Processes appropriate, patient disagreed. | A pain management contract process with which the patient disagrees. The need for a driver required following a colonoscopy/sedation procedure |
| Level 2 | No harm/inconvenience | The event effected the patient but did not cause physical harm | An employee displayed rudeness to a patient. Patient experience long hold time on the phone. |
| Level 3 | Temporary harm (mild or moderate) | Temporary harm to the patient required Ombudsman intervention. Temporary harm/required additional treatment. | A delay to a patient in getting prescription medications. A lack of follow-up requested following a procedure. |
| Level 4 | Significant harm | Significant, not temporary, harm to a patient. | A patient received a misdiagnosis. A patient experienced an unanticipated complication or infection. |
| Level 5 | Death | Death to a patient while under the care of the facility. | Disclosures made with clinical risk and law department (proactive or reactive) involving a patient death. |

Figure 1. Top categories of 9233 complaints and grievances reported to Ombudsman Office from September 2017 to August 2018.
which leaders can apply lessons. When complaint and grievance details are utilized as a driver to improve patient experience, it is based on unsolicited feedback without the full breadth of the patient’s true experience in health care are needed. By categorizing and interpreting may be viewed as a limitation, it accurately reflects how complaints are collected and utilized in a real-world hospital system, perhaps increasing the applicability of teamwork, empathy, safety, and ease? These questions drive our medical center’s patient experience framework, which aligns CAHPS survey items with our patient-centered promises and organizational values (5). The system our hospital implemented to manage complaints and grievances has been effective. However, since this innovation was employed within one hospital system, its generalizability may be limited. In addition, the data we report were collected and coded by multiple members of the Ombudsman team. While this inherent variability in data interpretation may be viewed as a limitation, it accurately reflects how complaints are collected and utilized in a real-world hospital system, perhaps increasing the applicability in other organizations.

In conclusion, innovations in how to measure patient experience in health care are needed. By categorizing and rating complaints and grievances, hospital systems nationwide will have a richer source of information to make informed improvements that reduce expenses, drive better

5-patient death as a result of reported complaint. Two-thirds were rated 2 on the Severity Scale-communication issues or minor inconveniences. See Figure 2 for more details about the Severity Scale scores of grievances reported to the Ombudsman Office.

In addition, the Ombudsman Office received 11267 requests for assistance during the same 1-year period. These requests were often initiated by employees seeking assistance to resolve patient issues before they became patient-directed complaints and grievances. In addition, employees sought assistance with patient and/or family boundary setting and behavior modification needs.

Impact

We demonstrate that patient experience data extracted from a large medical center’s complaint and grievance database can be reported in easily quantifiable ways. We also provide a benchmark for these data, which may help other hospital systems interpret their own rates. Importantly, the innovation of the Severity Scale advances the field by enabling hospitals to further prioritize and benchmark their data in order to systematically improve experience, safety, and quality of care.

While these data provide valuable metrics, they are paired with real patient stories in their own words. This is vital, given that pairing metrics with stories is particularly impactful and often motivates change within hospitals to improve patients’ experiences. Furthermore, there is neuroscience evidence that people are conditioned to learn lessons through stories (15). In comparison to HCAHPS surveys, which permit the quantification of patient experience feedback without the full breadth of the patient’s true experience, patient stories can offer a richer perspective. When complaint and grievance details are utilized as a driver to improve patient experience, it is based on unsolicited information; in essence, a more complete story from which leaders can apply lessons.

Just as important as understanding patient stories to drive patient experience, grievance, and complaint data can also be utilized to drive safety and quality. One of the hallmarks of a high reliability system is the willingness to identify defects and eliminate them (16). Typical patient satisfaction surveys lack detail to customize meaningful improvements, but by incorporating patient complaints, the organization can identify defects which leads to more reliable outcomes and safer care. One way we operationalize this high reliability approach in a large academic medical system is to share specific examples of escalated patient experiences, sourced from patient complaints, with executive leadership on a monthly basis. We also elevate patient concerns and issues to hospital system executives daily at our tiered daily huddles (17). Complaints are shared at the executive level to bring an urgency to patients’ poor experiences and to discuss solutions. These discussions often lead to policy development, resource reallocation, and personal outreach and support to employees who experienced a difficult patient situation.

US hospitals have used publicly reported surveys as a barometer for patient experience for the past decade. The standardization of surveys, ease of information available, and the financial incentives attached provide more than enough motivation for surveys to be the bellwether of how an organization is performing. Even more, positive patient experiences are associated with better health outcomes and increased patient self-management over their own care (18). All hospitals have interest in better patient outcomes and should seek ways to capture information to drive such improvements. Therefore, for grievance data to have impact, standardization of data must be established.

Taken together, patients’ perspectives, gathered via HCAHPS surveys and complaints and grievances, provide valuable benchmarks that enable leaders to assess how well we are caring for our patients. Are we keeping our patient-centered promises? Are we staying true to our organizational values of teamwork, empathy, safety, and ease? These questions drive our medical center’s patient experience framework, which aligns CAHPS survey items with our patient-centered promises and organizational values (5).
patient outcomes, and improve patient experience. Given the focus on HCAHPS, hospitals often have tunnel vision for survey results, but may miss out on incorporating detailed, real-time complaint and grievance data into their process improvements. Creating and sharing national complaint and grievance benchmarks will be a major step to improve hospital data, but also, and more importantly, in efficiently and powerfully improving patient experience.

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References
1. Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. National Academies Press, 2001.
2. Elliott MN, Lehrman WG, Goldstein EH, Giordano LA, Beckett MK, Cohea CW, et al. Hospital survey shows improvements in patient experience. Health Aff. 2010;29:2067-7.
3. LaVela SL, Gallan AS. Evaluation and measurement of patient experience. Patient Exp J. 2014;1:28-36.
4. Centers for Medicare Medicaid Services. Medicare program; hospital outpatient prospective payment system and CY 2007 payment rates; CY 2007 update to the ambulatory surgical center covered procedures list; Medicare administrative contractors; and reporting hospital quality data for FY 2008 inpatient prospective payment system annual payment update program—HCAHPS survey, SCIP, and mortality. Final rule with comment period and final rule. Fed Regist. 2006;71:67959-8401.
5. Boissy A. Getting to patient-centered care in a post–Covid-19 digital world: a proposal for novel surveys, methodology, and patient experience maturity assessment. NEJM Catal Innovat Care Deliv. 2020;1:1-26.
6. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. JAMA. 2002;287:2951-57.
7. Centers for Medicare and Medicaid Services (CMS). State operations manual. Appendix A—Survey protocol, regulations and interpretive guidelines for hospitals. 2020. Accessed 22 February 2021. https://www.cms.gov/RegulationsGuidance/Manuals/downloads/som107ap_a_hospitals.pdf
8. Zgierska A, Miller M, Rabago D. Patient satisfaction, prescription drug abuse, and potential unintended consequences. JAMA. 2012;307:1377-8.
9. National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). NCC MERP taxonomy of medication errors.1998. Accessed 18 January 2021. https://www.nccmerp.org/sites/default/files/taxonomy2001-07-31.pdf
10. World Health Organization World Alliance for Patient Safety. WHO Draft Guidelines for Adverse Event Reporting and Learning Systems From information to action. 2005. Accessed 18 January 2021. https://apps.who.int/iris/bitstream/handle/10665/69797/WHO-EIP-SPO-QPS-05.3-eng.pdf;jsessionid=4EE173E948928E1C4419EC7313BD1ABB?sequence=1
11. Cooper J, Williams H, Hibbert P, Edwards A, Butt A, Wood F, et al. Classification of patient-safety incidents in primary care. Bull World Health Organ. 2018;96:498-505.
12. Healthcare Performance Improvement, LLC. The HPI SEC & SSER Patient Safety Measurement System for Healthcare. 2011. Accessed 18 January 2021. https://www.pressganey.com/docs/default-source/default-document-library/the-hpi-sec-amp-sser-patient-safety-measurement-system-for-healthcare.pdf
13. Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic review and coding taxonomy. BMJ Qual Saf. 2014;23:678-89.
14. Clay-Williams R, Colligan L. Back to basics: checklists in aviation and healthcare. BMJ Qual Saf. 2015;24:428-31.
15. Zak PJ. Why inspiring stories make us react: the neuroscience of narrative. Cerebrum. 2015;2015:2.
16. Chassin MR, Loeb JM. High-reliability health care: getting there from here. Milbank Q 2013;91(3):459-90.
17. Cleveland Clinic. Tiered huddles improve quality across the system. 2018. Accessed 23 September 2019. https://consultqd.clevelandclinic.org/tiered-huddles-improve-quality-across-the-system
18. Browne K, Roseman D, Shaller D, Edgman-Levitan S. Analysis & commentary. Measuring patient experience as a strategy for improving primary care. Health Aff. 2019;29:921-5.

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