Complaint Channels and Grievance Mechanism Systems in Health Care Institutions

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This empirical study of a random sample of members of the National Society of Patient Representation and Consumer Affairs was initiated to 1) describe their current roles and levels of power, 2) determine the extent to which they fulfill the formal complaint function in hospitals today, 3) compare 1990 and 1970 models of hospital patient grievance mechanisms and 4) compare the empirically determined patient representative model of information flow about consumer complaints with the Gilly model.

Andreason's exhaustive analysis of the literature in consumer satisfaction and complaining behavior points out that there remain major gaps in our knowledge base. The literature has primarily focused on the determinants of satisfaction and responses to dissatisfaction with exchanges. It has only recently focused on institutional response to voiced dissatisfaction (Andreasen 1988).

Studies in the United States, Canada and the United Kingdom all document lower rates of satisfaction in service than product categories. Andreason concludes that the domain of services is one in which more work is needed. The models reported in his review were much less successful in accounting for complaining behavior with respect to services. He hypothesizes that one reason may be a lack of clarity as to appropriate complaint channels. Bryant asserts "Research must model and investigate empirically firm as well as consumer behavior if we are to be successful in understanding consumer dissatisfaction and complaints" (Bryant 1988 p. 725). An idea of how the entire system works is missing in research on consumer satisfaction and dissatisfaction (Gerner, 1988).

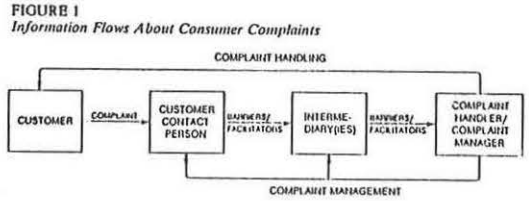
This study of patient representative personnel is an empirical investigation of a major channel (patient representative departments) for receiving complaints and responding to them in health care institutions, a service area.

Background

Patient representatives in healthcare institutions "provide a specific channel though which patients can seek solutions to problems, concerns and unmet needs ...coordinate between departments and recommend alternative policies and procedures" (NSPRCA 1989). The American Hospital Association Guide to the Healthcare Field Code #67 describes patient representatives as "personnel through whom patients and staff can seek solutions to institutional problems affecting the delivery of high quality care and services". The Joint Council for Accreditation of Healthcare Organizations (JCAHO) requirements effective January 1990, go one step further and mandate each hospital to have a mechanism to "receive, respond to complaints and take corrective action when appropriate" (AHA 1990).

Researchers using the information processing model of consumer complaints distinguish between complaint handling and complaint management. Complaint handling is the response to the customer complaint. Complaint management involves decisions about change in policies and procedures to prevent future dissatisfaction for all customers (Fornell and Westbrook, 1979). Gilly draws on and extends this organizational information processing model in her study of the dynamics of complaint management in one hospital (Gilly, 1991). See Figure 1. The study of the roles of patient representatives in healthcare institutions reported here, provides further empirical data to test the Gilly model of information flow about consumer complaints in a service environment.

Figure 1
Information Flows About Consumer Complaints



Many different titles are used for those involved in the formal patient complaint function in healthcare institutions. The most common, currently, is "patient representative". Their professional organization is the National Society of Patient Representation and Consumer Affairs (NSPRCA). Researchers in a study of complaint functions done for the Secretary of Health Education and Welfare's Commission on Medical Malpractice selected the term "patient grievance mechanism" as the most appropriate term to identify the subject of their study (Fry, 1972). This study developed three hypothetical models of patient grievance mechanisms.

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Model One's objectives were to "relieve top level administrators of the task of resolving "minor" complaints and help keep patients in a positive frame of mind while in the institution" (Fry, 1972 p. 103). This would correspond to the traditional complaint handling model designed to satisfy unhappy customers. Model Two assumed the added responsibility of investigating "matters patients complain about and introducing needed changes into the delivery pattern in an effort to reduce malpractice claims and improve the quality of care" (Fry 1972 p.111). This model includes the information flow included in both the complaint handling and complaint management process as described by Gilly (Gilly 1991 p. 300). Model Three adds an information flow to an external independent office that could "oversee and evaluate the processes used to respond to patient complaints and concerns about medical treatment,". This last model was intended to provide the "objectivity" that mechanisms funded by the institutions they monitor may be unable to achieve. Model One was most frequently used in the hospitals of 1972.

The Study

Objectives

The present study was initiated to: 1) describe the current roles and levels of power of patient representatives, 2) determine the extent to which this position is used to fulfill the formal complaint function i.e. patient grievance mechanism in today's hospitals, 3) determine what model is most frequently used in the hospitals of the 1990's and 4) compare the empirically determined model of patient representative complaint handling in healthcare institutions in this study with the Gilly model of information flows about consumer complaints in one hospital (Gilly,1991).

Methodology

The membership list of NSPRCA of the American Hospital Association formed the population base. A one-third random sample was taken by starting with a numeral from a random numbers table and selecting every third name on the membership list. A five-page questionnaire was mailed in March of 1990 with a follow-up letter and duplicate survey form in April. The survey instrument was piloted with a small group of patient representatives and revised according to their comments. Detailed follow-up interviews were conducted with three of these pilot representatives. A 56% sample response rate was achieved; 181 usable surveys were analyzed.

The institutions included 92% not-for-profit hospitals; (four-fifths private, one-fifth government); 5% for-profit; 3% HMOs. One half were teaching hospitals. Patient representatives are thus more heavily represented in teaching hospitals as the ratio of teaching to non-teaching hospitals is approximately 1:4 in the United States. [Council on Graduate Medical Education; 1990.]

Evaluation And Analysis

Staffing Patterns

Almost one-half (47%) of the institutions studied had only one professional representative on staff; 33% had 2-4; 13% had 5-9 and 7% had 10 or more. Every possible combination of professionals, volunteers, and clerical staff was found. Analysis by total staff size and type of hospital revealed no consistency in staffing patterns.

Reporting Patterns

Patient representatives report to a relatively high level of administration of health-care institutions. Seventeen percent reported directly to a top administrator or CEO type. Almost two-thirds of the patient representatives' supervisors reported to a top officer or the board of trustees. These personnel are favorably positioned to seek solutions to problems as well as report concerns about quality of care. One-half of the patient representatives reported in the general administrative functional stream. Others reported through quality assurance/risk management (13%), nursing/medical (13%), marketing (9%), and finance (2%).

Time Allocations

Complaint investigation and information/referral took on average the largest blocks of time but varied greatly from institution to institution; complaint handling from 2% to 70% and information/referral from 1% to 90%. Grouping activities into broader categories as shown in Table 1 presents an even clearer picture of time allocation.

Table 1
Time Departments Spent on Groups of Activities

Activity	Percent (N=113)					
	0-4	5-9	10-14	15-19	20-49	50+
Complaint Handling Complaint Investig. Complaint Analysis Pat. Questionnaire	21	2	10	5	36	34
Information/Referral Information referral Prepare Educ Material Distribute Pat. Bill Rts.	23	7	13	14	29	14
Risk Mgm./Qual. Assur. Risk Management Quality Assurance	54	15	11	1	13	6
Liaison Physician Liaison Community Liaison	79	11	3	3	4	0
Report Writing	44	15	19	3	19	0
Committee Meetings	65	20	11	1	4	0

Complaint Handling

The extent to which patient representatives spend their time in complaint handling reflects the extent to which they can be considered patient grievance mechanisms. On average, complaint activity took 27% of patient representative time; 50% or more of the time of one-fifth of them; less than 10% of the time of only 15% of them. Combining complaint investigation, analysis and patient quality-of-care questionnaire activities, 34% of the departments spent more than 50% of their time handling complaints; 70% spent more than 20% of their time this way.

Whether or not departments spent 50% or more of their time on complaint handling was unrelated to hospital size but was directly related to the number of beds per patient representative.

The types of complaints listed by a weighted average of their frequency are shown in Table 2. Problems of staff attitude and nurse communication were most frequently encountered. Billing was a distant third. Almost every patient representative checked physician communication as a problem; only 40% said it occurred frequently. Non-checklist items mentioned included lost property, room comfort, time waits, bioethical issues and expectations.

Table 2
Frequency of Problem Type

Problem	Percent Frequency				Mean**	Sample	
	Never N/A	1*	2*	3*		No.	%
Staff Attitude	2	2	24	71	2.64	177	98
Nurse Communic.	2	4	26	69	2.60	177	98
Billing/Insur	4	12	30	54	2.33	174	96
Physic Communic.	1	9	50	40	2.28	179	99
Food	8	22	33	37	1.97	166	92
Medical Records	9	31	41	18	1.69	164	91
Scheduling	17	29	35	19	1.56	150	83
Discharge Arr.	19	34	38	9	1.36	146	81
Pharmacist Commun.	27	55	14	2	.95	133	73

*1=Seldom: 2=Occasionally: 3=Frequently
**Mean was calculated using weights Seldom=1,Occasionally=2 and Frequently=3

Information/Referral

Customer contact by patient representatives was not only for the purpose of receiving complaints. Information and referral activities included responding to inquiries, providing information to patients and staff, preparing educational materials, and distributing the Patient Bill of Rights. Either 14% or 43% of the patient representative departments could be called "information/referral" programs depending whether "major focus" is defined as 20% or 50% of time spent.

Risk Management and Quality Assurance

The activity checklist in the survey included both risk management and quality assurance. The lack of a clear definition of these terms makes their relationship to complaint handling unclear, a limitation of the study. One-fifth of the departments spent 20% or more of their time and 6% spent 50% or more of their time on these activities.

Report Writing and Committee Membership

The survey format did not permit allocation of this time to functional areas such as complaint handling. Report circulation and committee participation enhance patient representatives' information brokerage role as a source of power. Forty-four percent of the respondents cited specific policies and/or procedures that had been changed as a result of their reports; 20% felt their reports had minimal or no impact on institutional policy. Committee meetings took, on average, only 3% of department time.

Patient Contact

A Likert-type scale was used to determine the method and frequency of patient contact. Responses are listed in Table 3. Ninety-four percent of the respondents checked personal visit; 59% said contact was made frequently this way. Ninety-one percent listed telephone number; 87% outside mail; 83% switchboard and 78% survey. The listed telephone number was assumed to be the in-house number for the patient representative department.

Table 3
How the Patient Contacts Patreps

Method	Percent				Total Used		
	Never/N/A	1*	2*	3*	Mean*	No	%
Personal Visit	6	3	32	59	2.45	171	94
Listed Number	9	5	24	62	2.39	165	91
Swithboard	17	9	33	40	1.97	150	83
Survey	22	12	27	39	1.84	142	78
Outside Mail	13	20	45	21	1.76	158	87
Comment Cards	41	10	24	24	1.32	107	59
800 Number	90	5	1	4	.19	19	10

*Mean was calculated by weighting
Seldom = 1; Occasionally = 2; Frequently = 3

Types of Power

The power to resolve patient concerns determines the effectiveness of patient representative departments as a patient grievance mechanism, indicating the extent to which they are complaint handlers or complaint managers. Survey participants checked from a list of 30 those acts they were permitted to perform in order to resolve patient complaints. See Table 4.

Table 4
Actions Patient Representatives Can Perform

Actions	Percent
Level 1	
Interview Patients	99
Determine validity of complaint	97
Collect information from staff involved in complaint	96
Explain outcome of grievance procedure to patient	94
Access relevant medical records	93
Access relevant financial records	84
Access relevant accident reports	84
Inspect all premises	83
Level 2	
Recommend corrective action regarding services provided	97
Recommend changes in hospital rules/regulations	95
Recommend change in hospital policy	91
Recommend corrective action regarding physical property	87
Recommend adjustment to patient bills	85
Recommend corrective action regarding financial records	83
Recommend in-service education/staff training for staff	80
Recommend corrective action regarding staff performance	73
Participate in risk management	78
Participate in quality assurance	76
Conduct studies of patient satisfaction	76
Conduct in-service education/training for staff	75
Monitor corrective action	74
Level 3	
Organize an action committee to revise policy	46
Adjust patient bills	43
Order corrective action regarding services provided	33
Order corrective action regarding physical property	29
Order corrective action regarding financial records	29
Require staff attend action committee meetings	21
Order corrective action regarding staff performance	17
Level 4	
Change hospital rules/regulations	12
Change hospital policy	11

Ascending levels of power to respond to complaints are to be able to: 1) collect or access data; 2) recommend corrective action; 3) order corrective action; and, 4) implement change in regulations and policies. Levels 1 and 2 are clearly complaint handling; levels 3 and 4 involve complaint management.

More than 80% of the patient representative departments could perform all actions listed at Level 1. Almost all of them could interview patients, determine the validity of a complaint, collect information from staff and explain the outcome of the grievance procedure to the patient. Only about four-fifths could inspect all premises and access financial and accident reports. More than 80% of the departments could perform at Level 2 with the exception of recommending corrective action regarding staff performance (73%). Less than 50% of the departments had Level 3 power to order corrective action in response to complaints. Surprisingly, about 45% of the patient representatives could organize an action committee and adjust bills; less than one-third could order other corrective action. It was unexpected that so many of the patient representative departments had the power to adjust patient bills. Further inquiry revealed that this power is usually limited to adjustments under a pre-determined dollar amount which varies among hospitals. Only slightly more than 10% of departments had Level 4 to implement change in hospital regulations or policies.

There appears to be an intermediate level of power between the ability to recommend and the ability to order corrective action. Here the patient representatives can conduct studies, educate, train, monitor recommended action, and participate in activities of risk management and quality assurance. This cluster of actions might be classified as the power to take preventative action. About 75% of the departments performed these actions which lie somewhere between complaint handling and complaint management.

SUMMARY AND CONCLUSIONS

The major roles of patient representatives are responding to complaints or providing information/referral. Combining complaint investigation, analysis and patient quality-of-care questionnaire activities, 34% of the departments spent more than one-half of their time handling complaints; 70% spent more than 20% of their time this way. Information/referral took more than one-half of the time of 14% of the department time; 43% spent more than 20% of their time this way. The types of activities that patient representatives can engage in to respond to complaints reflect four levels of power within the institutions. Most can handle complaints, accessing information and recommending action i.e. complaint handling roles. Less than one-half of the group can order corrective action and slightly more than 10% can change hospital rules and regulations and change policy to prevent future dissatisfaction for all customers, the roles of complaint management. An intermediate set of activities to prevent dissatisfaction are performed by three-quarters of the patient representatives. These can be considered either complaint handling or complaint management depending on the purpose for which they were initiated.

These patterns show that the grievance mechanism model has changed dramatically since 1972. At that time hospitals most frequently used a grievance model that emphasized complaint handling to placate unhappy customers, performing only power level 1 and 2 activities (Fry 1972). This 1990 study describes a hospital mechanism that more closely resembles Model Two of the earlier Fry study indicating a shift toward the combination of complaint handling and complaint management functions to change procedures and systems to increase satisfaction of all customers. There is no

evidence in the current study of information flow to an external independent office as recommended in Model Three of the Fry study. However, the new requirements in accreditation standards of JCHAO will provide some external oversight to the grievance processes established. The perception ofconflict of interest inherent in patient representative mechanisms funded by the institutions they monitor has been discussed elsewhere (Charters 1992).

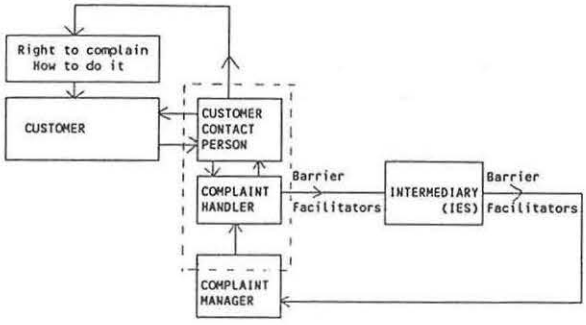
Information Flows About Consumer Complaints

Gilly states "Few studies on consumer services discuss how input from customers and customer contact personnel is communicated to managers who can make decisions regarding policies and procedures (Gilly 1991 p.295). She assumes that customer contact personnel and managers are different people (Figure 1).

Gilly's model includes the following steps: 1) Customer expresses a complaint to a customer contact person (boundary spanner); 2) Customer contact person forwards the complaint (if they cannot handle it) to the complaint handler; 3) The complaint handler responds in an attempt to satisfy the customer; 4) The complaint handler passes information to the complaint manager; 5) The complaint manager directs changes in policy/procedure to prevent further dissatisfaction of all customers; 6) Complaint manager conducts followup to ensure complaint resolution.

This study of patient representatives describes the types of managerial action that they can take to solve problems. It shows that patient representatives, the major customer contact personnel in health care institutions, may also be both complaint handlers and complaint managers. The roles described in this study suggest some modification of Gilly's model of information flow about consumer complaints. See Figure 2.

Figure 2
Patient Representative Model



*Patient Representative role indicated by broken line

The information flow in this model begins with the patient representative (as customer contact person) who informs the customer of their right to complain and how to do it. When the customer reports a complaint, it is communicated to the patient representative who in the simplest situation becomes complaint handler and gives the results back to the customer. This sets up a circular flow including further customer feedback if necessary. The Gilly model shows no feedback to the customer by the contact person.

If handling the complaint involves boundary spanning with intermediaries (i.e. working across departments such as nursing or housekeeping) the patient representative as complaint handler proceeds with this process until the complaint is resolved and reports back to the customer for continuous feedback.

If the resolution of a similar type of complaint for all customers requires a change in policy or procedure i.e. complaint management, the patient representatives can either order corrective action or change policy/procedure depending on their power. In either case the information flow goes back through the complaint handler and customer contact person for feedback to the customer. The complaint manager does not communicate directly with the customer contact person in this model.

The major differences in the models appear to be that in the Gilly model the contact person performs the function of boundary spanner while in the patient representative model this is done by the complaint handler. The Gilly model does not provide the customer feedback loops found in the patient representative model. Implementation of new JCHAO accrediting standards may require even further modification of the model in relation to information about "how to complain" and "take corrective action" i.e. influence policy and procedure. It suggests the possibility of expanding the role of the customer contact person even further into the management role.

Fry researchers recommend that patient grievance mechanisms should report to at least the second level of management to give the needed access to all institution departments. Seventeen percent of the patient representatives in this study report to the first level of institutional management; almost two thirds reported to a second level.

Discussion

Hermann (1988) points out the one-sided nature of the main body of CS/D research that focuses on dissatisfaction rather than satisfaction and suggests that consumer researchers would find it very useful to know what attitudes, knowledge and behaviors lead to satisfaction. A commitment to delivering high quality services which not only satisfy consumers but meet or exceed the

expectations of customers, achieved by a process of continuous improvement and teamwork is called Total Quality Management (TQM). "This continuous improvement is achieved by problem-solving teams who engage in identifying customer problems, finding solutions and then providing ongoing control of the improved process." (Coate;1990.) The patient representative role as revealed in this study provides non-threatening access to information about patient expectations of quality care and how it is delivered in health care institutions. Their liaison role across departments as boundary spanners is similar to the cross-functional management component of TQM which integrates team activities across divisions to achieve institutional goals. Complaint management rather than just complaint handling is required in the TQM process. Leebov says "a hospital that has no patient representatives has a painfully acute case of top-management myopia." (Leebov 1990 p. 136) The variety of activities performed and the low professional staff to bed size ratios shown for patient representatives in this study are not consistent with widespread high priority for this function.

Excellence in the delivery of services in healthcare environments must address key service components of technical competence, environment, people skills, systems and amenities. Consumer groups include patients, visitors, physicians, employees and third party payers.

Further Research Needed

Consumer researchers are currently beginning to give more attention to the service area and health care issues in particular (Gilly et al,1991; Solnick and Hemenway, 1992); health care providers are beginning to pay more attention to grievance procedures (Charters 1992). New accreditation requirements will accelerate the latter trend (JCHAO).

The complexity of the service environment may require the establishment of a series of grievance mechanisms in any one institution. The extent to which patient grievance mechanisms exist in health care institutions in the United States is not currently known. Gerner (1988) points out that what appears to be missing in the research is a clear idea of how the entire system works. A systematic understanding not only of mechanisms for measuring consumer satisfaction and dissatisfaction but also how providers respond to them is required. Further research into the effectiveness of alternative mechanism models and their patterns of information flow is needed in all service areas, not only healthcare.

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