The Center for Patient and Professional Advocacy (CPPA)
Vanderbilt University Medical Center (VUMC)

History and Mission
In 2002, Vanderbilt University Medical Center (VUMC) Leadership established the Center for Patient and Professional Advocacy (CPPA) and charged Center faculty to promote safe, compassionate and reliable healthcare. The vision for CPPA grew from a tragedy involving a patient, his family, medical team members and a prominent VUMC faculty member. In retrospect, institutional leaders were aware that the physician was challenging and disrespectful to others, but no actions were taken until it was too late.

A group of respected faculty, risk and legal experts and institutional leaders were assembled and instructed: “not again.” VUMC leadership committed to support development of a Center where clinicians, researchers, educators and scholars from varying disciplines could collaborate. CPPA leaders were to develop preeminent programs in research, education and service in support of the pursuit of professionalism and risk prevention. Center goals were to better understand how to promote and support professionalism among clinical team members, to identify and develop best practices for intervening with clinicians who model patterns of disrespectful, unprofessional behaviors that threaten outcomes of care, and to assess their achievement of consistent professional practice. CPPA’s research is largely related investigations related to our Patient Advocacy Reporting System® (PARS®) and Co-worker Observation Reporting SystemSM (CORSSM) programs.

CPPA’s Research
CPPA team members and individuals from CPPA’s partner sites throughout the U.S. have come together to conduct studies examining:

- Impacts of unprofessional/disruptive clinician behavior on outcomes of care;
- How best to identify the small subset of clinicians who, due to disrespectful, unprofessional workplace behaviors, increase their risk for adverse outcomes, patient and staff dissatisfaction, and high malpractice claims experience;
- Strategies to create awareness among high-risk clinicians to promote risk-reducing practice changes;
- How a tiered intervention strategy can be used to address unprofessional conduct as well as a host of quality and safety challenges ranging from improving hand hygiene practice to promoting adherence to best practices in medical and surgical care.

CPPA’s original 2002 charge included translating what was learned to improve bedside and clinic practice. Toward that end, CPPA faculty and colleagues have published over 170 peer reviewed studies in leading research journals, book chapters, and invited commentaries (Click here for CPPA faculty publication list). CPPA remains committed to understand how best to support clinicians who, for whatever reason, are challenged in working with fellow team members and patients. Recent publications include:

- JAMA Surgery (2017): Patients whose surgeons have
high numbers of unsolicited patient complaints about rudeness, unclear communication, and poor post-visit responses to concerns in the 24 months prior to an operation have increased risk of complications.

- **JAMA Ophthalmology** (2018): Older ophthalmologists are less likely to receive unsolicited patient complaints than younger ones. The findings have practical implications for patient safety, routine surveillance, clinical education, and practice management.
- **American Journal of Geriatric Psychiatry** (2018, in press): A team of multi-center collaborators content analyzed patient complaints (stories) for key words (e.g., forget, odd, confuse, uncomfortable) and were able to identify physicians with evidence of early cognitive decline. One implication is that patients’ reports may help leaders identify clinicians with early cognitive impairment.

Other studies currently underway that have the potential to translate theory into practice include:
- Relationships between co-worker reports of concerns about unprofessional physician behavior, risk management experience, and patient outcomes. This line of research complements and extends CPPA’s research on unsolicited patient complaints;
- Reliability of natural language processing for computerized coding of narrative patient complaints. This research has great potential to permit effective, efficient mining of narrative reports of concerns from patients and co-workers, permitting early (near real-time) identification and intervention of high-risk clinicians;
- Relationships between physician burnout and patient complaints before and after intervention. This research has potential for suggesting both how burnout affects care and how organizations can move to identify and intervene effectively with clinicians experiencing burnout.

**CPPA’s Process**

What follows is an explanation of the seven steps in CPPA’s process for promoting professionalism. (1) CPPA currently partners with more than 140 hospitals and medical groups nationally who have contracted with CPPA and executed Business Associates Agreements to provide PARS and CORS services. These partnerships have led to creation of CPPA’s national repository of more than 1.5 million patient complaint
reports and co-worker concerns associated with the practices of more than 75,000 physicians and advanced practice professionals. (2) CPPA employs computerized natural language processing to screen reports for clinician-related concerns, after which trained staff read and code all remaining reports for specific types of complaints and concerns. We assess coder reliability twice annually. (3) CPPA calculates separate PARS and CORS scores for each clinician using algorithms that weight codes by recency and severity. (4) All reports for clinicians with high-risk PARS or CORS scores undergo multiple levels of review by CPPA staff, CPPA clinicians, and key partner site clinicians. When systematically aggregated, the codes identify the small subset of clinicians whose practices generate disproportionate dissatisfaction, but virtually all of whom remain unaware without feedback. (5) CPPA produces feedback materials to create awareness of evidence of risk status, and (6) provides the materials to partner sites’ peer messengers who received CPPA training. (7) Confidential interventions commence. Finally, (1-7) the cycle continues with feedback about progress or, if performance fails to improve, suggestion of escalation based on Vanderbilt’s widely adopted “Promoting Professionalism Pyramid.”

The Vanderbilt Professionalism Pyramid
The pyramid illustrates a tiered intervention approach that supports pursuit of professional accountability. CPPA designed PARS and CORS to promote successful self- and group-regulation. The Pyramid reminds us that most clinicians do great work and are never or only rarely associated with a complaint. Recorded reports are reviewed to ensure they do not require mandated reviews or investigations, but can simply be shared in a respectful, non-directive fashion during an informal conversation such as one might have with a colleague over a cup of coffee. When patterns appear to emerge, CPPA supports peer-delivered Level 1 Awareness interventions with local and national peer comparisons as described above. Most clinicians respond to awareness interventions. Some, however, are unable or unwilling, and these clinicians are escalated to Guided Interventions by Authority (Level 2). Level 2 interventions include a written corrective plan developed by the individual’s authority figure (a department chair, Chief Medical Officer or other leader). A very small number may not respond to the plan, so are elevated to a Level 3 disciplinary action as defined by the organization.

The Patient Advocacy Reporting System® (PARS®) Program
CPPA’s early work focused on developing the Patient Advocacy Reporting System (PARS). PARS leverages the value of patient/family observations and experiences reported as unsolicited patient complaints (UPCs) to Offices of Patient Relations to identify and address the small subset of clinicians with excess risk of malpractice claims. In brief, PARS:

- Provides national, discipline-specific, peer-comparative benchmarks for effective peer-delivered interventions that support improvements in care delivery. For example, the panel on the left shows a high-risk physician’s rank (represented by the dots) relative to all active physicians in the PARS database (the black line) and to physicians within their specialty (the blue line). CPPA’s data also yields sub-specialty comparisons, such as individualized graphs of orthopedic sub-specialists in spine, ankle, shoulder, or wrist surgery. CPPA similarly benchmarks other specialties and their subspecialties.
PARS also:
- Supports medical groups as they pursue professionalism and professional accountability;
- Provides national patient relations benchmarks that promote best practices in service recovery;
- Enables surveillance system-wide for disrespectful/unsafe behaviors that undermine a safety culture;
- Identifies surgeons at greater risk for surgical complications and patient/team dissatisfaction.

The Co-worker Observation Reporting System℠ (CORS℠ Program)
Organizations routinely capture staff-reported concerns about co-workers. CPPA faculty speculated that the same processes, systems, and tiered interventions could be applied in support of teamwork and patient safety. CPPA’s CORS program became operational in 2013 and now supports more than 22,000 clinicians. These clinicians manifest, as with PARS scores, the same non-random distribution of CORS scores (panel at right). PARS and CORS processes are similar with two exceptions: 1) patient relations specialists promptly share each PARS report vs. peer clinicians deliver each CORS report; and 2) PARS Level 1 and 2 interventions occur annually while CORS interventions occur as soon as a clinician’s CORS Index exceeds thresholds. Those receiving PARS and CORS interventions are similarly responsive (pie graph below).

Does It Work?
Yes. To date, CPPA’s interventions reduced future complaint reports for 1,407 of 1,804 (78%) PARS and 191 of 233 (82%) of CORS intervention recipients. While interventions have reduced risk management expenses and yielded positive returns on investment, CPPA programs’ principal benefits include promoting an organization’s patients’ experiences and inter-professional teamwork consistent with its aspirational values.

In addition to addressing patient and co-worker concerns, CPPA’s Professionalism Pyramid and process have improved sustained adherence to OR timeouts, surgical bundles, checklists, and other safety, quality and risk prevention initiatives. For example, VUMC’s hand hygiene initiative received national recognition from the Society for Healthcare Epidemiology in America.
How Many Receive Interventions?
Based on 20 years of experience tracking 67,000 physicians, 37,000 received at least one patient complaint associated with their practice. Of clinicians tracked in our review, only 3% proceed to develop a pattern and, as the pie graph shows, most benefit from a Level 1 Awareness Intervention. Specifically, as a result of 2,000 Level 1 interventions, only 267 (0.4% of the entire group) required Level 2 Authority guided interventions. Finally, of the 267 tracked in our analysis, 84 (0.1 %) of the total group required Disciplinary action due to a persistent pattern. Finally, 144 (0.2%) departed their group or organization without demonstrating improvement after receiving Level 1 or Level 2 interventions.

CPPA’s Phased Approach
The PARS and CORS programs are combined and are rolled out in three phases designed to assess and assure cultural and logistical readiness to launch CPPA’s programs and, on an ongoing basis, provide a robust overall organizational infrastructure for sustaining effectiveness and demonstrating outcomes:

- **Phase 1 Assessment:** Review of organizational infrastructure is critical to program success;
- **Phase 2 Infrastructure Development:** Phase 2 is designed to promote leadership engagement in PARS and CORS, benchmark existing data and operations against best practice metrics, and review robustness of organizational policies and procedures that influence and impact CPPA programs. Elements deemed to be in need of attention are, by mutual agreement and mutual effort, further developed until sufficient to support a successful effort;
- **Phase 3 Full Program Implementation:** When a decision is made by mutual agreement to proceed to implementation, CPPA trains peer messengers and leaders for the first round of interventions, then tracks responses, continues the 7-step process outlined previously, and follows up with reports of progress.

Finally, CPPA faculty are often called upon to present at regional, national and international meetings, leadership conferences, Board retreats, grand rounds and symposia. Notable presentations and publications appear at this [link](https://ww2.mc.vanderbilt.edu/cppa/).

Please visit CPPA’s website at: [https://ww2.mc.vanderbilt.edu/cppa/](https://ww2.mc.vanderbilt.edu/cppa/)