Policy and Procedure for Evaluation of Complaints and Grievances

Authority

Under the authority of the Center for Medicare and Medicaid Services, each End-Stage Renal Disease Network must implement a procedure for evaluating and resolving patient grievances. The following is a listing of Social Security Act, CMS Conditions for Coverage and other regulations which provide ESRD Network authority.

Section 1881(c) (2) (D) of the Social Security Act requires the Network to implement "a procedure for evaluating and resolving patient grievances."

Under §1881(c)(2)(E) of the Social Security Act, the Network is responsible for "conducting on-site reviews of facilities and providers as necessary [as determined by the Network's MRB or the Secretary of Health and Human Services] utilizing standards of care established by the [Network] to assure proper medical care."

Under §1881(c)(2)(G) of the Social Security Act, the Network is responsible for identifying ESRD providers that are "not cooperating toward meeting [Network goals and assisting them in developing appropriate plans for correction...."

CMS regulations at 42 CFR §405.2112(g) specify "evaluating and resolving patient grievances" as one of the Network's functions.

The ESRD CfCs address "Patients' rights and responsibilities" at 42 CFR §405.2138. A grievance mechanism standard is specified at 42 CFR §2138(e):

"Standard: grievance mechanism. All patients are encouraged and assisted to understand and exercise their rights. Grievances and recommended changes in policies and services may be addressed to facility staff, administration, the [Network], and agencies or regulatory bodies with jurisdiction over the facility, through any representative of the patient's choice, without restraint or interference, and without fear of discrimination or reprisal."

The Omnibus Budget Reconciliation Act of 1989 amended the Social Security Act to provide for confidentiality in the medical review process (see §1160 of the Social Security Act) and a limitation on the Network's liability (see §1157 of the Social Security Act).

Definitions of Grievance

A written or oral communication from an ESRD patient, and/or an individual representing an ESRD patient, and/or another party alleging that a Medicare-covered ESRD service did not meet

recognized standards of safety or civility, or professionally recognized clinical standards of care. The grievant is not required to state that the care did not meet recognized standards.

Grievances that Will Be Evaluated by the Network

During its initial review of the information obtained from the grievant, and any information obtained from the patient if the grievant is not the patient, the Network will determine whether the case:

Should be referred to another agency or organization. If the grievance involves a concern that falls under another agency's or organization's authority, the Network will refer the grievance in accordance with §90, “Referrals to Other Agencies and Organizations.”

Is eligible for Immediate Advocacy. .The Network will initiate Immediate Advocacy in accordance §100, “Immediate Advocacy.”

Involves failure to place, involuntary discharge, involuntary transfer, or a patient at risk for involuntary discharge. The Network will follow the procedures detailed in §180.1, “Network Intervention in Grievances Involving Access to Care.”

Requires a Quality of Care Review. The Network will conduct a Quality of Care Review in accordance with §110, “General Quality of Care Review” or §120, “Patient-Specific Quality of Care Review.”

Determination of Network Responsibility

Grievances will be directed to the Patient Services Department. Network staff will determine whether the grievance is appropriate for Network consideration or should be referred (765.6). If there is a question as to whether or where a grievance should be referred, direction will be sought from the Network COR. The MRB Chairperson or Network President may be consulted when making this determination.

The Patient Services Department will be responsible for determining a grievant’s status and securing the necessary Consent to Disclose Your Identity form (Illinois) and when appropriate the required CMS Appointment of Representative Form or Designation of Personal Representative Form.

Network’s Role in Resolving Grievances

The Network will assume a proactive role in the prevention, facilitation, and resolution of grievances, including implementing educational programs that will assist facility staff in handling difficult situations. The Network will notify patients of their option to file a grievance,

or that the case can be referred to another agency. The Network is authorized to act as an expert investigator, to gather information from grievant and/or facility (with patient consent) by phone, letter, fax, email, and/or to make on-site reviews and to interview other staff and patients (765.8).

The Network's role in investigating grievances will vary according to the issue involved and alternatives for resolution. In most instances it is expected that the Network will serve in one of the following roles (760):

The Renal Network's role in resolving grievances, depending upon the situation, is to act as:

- Expert Investigator: When the quality of care provided to a patient(s) is an issue, the investigation's focus is the individual grievance and any overall patterns of care within the facility related to the grievance.
- Facilitator: When communication between the patient and the facility is problematic, the Network may facilitate communication and the resolution of differences.
- Advocate: The Network will advocate for individual patient rights and/or the rights of all patients at a facility, depending on the situation presented. At all times the safety of patient and staff are taken in to consideration, especially when there is documented violent or threatening behavior.
- Educator: The Network will provide information/education to patients, families, or facility staff when requested or needed about ESRD, treatment of ESRD, or appropriateness of care, it will also provide additional resources as needed.
- Coordinator: When potentially serious quality of care concerns and/or Conditions of Coverage issues are involved, the appropriate state and federal agencies will be involved.
- Referral Agent: If the grievance appears to be of an immediate life threatening nature it will be immediately forwarded to the CMS Regional Office to the attention of the Associate Regional Administrator, Division of Health Standards and Quality and to the appropriate state Department of Health, if warranted. After an initial review, if it is determined that the grievance would be more appropriately handled by another agency, organization, or licensing board, it also will be referred. If the grievance is not a Network issue, the grievant will be given the referral information.

When the Network is contacted regarding a concern, it will attempt to resolve the issue in one of the following ways:

- Assist patients who wish to address the issue on his/her own by helping to organize his/her thoughts about a situation and providing information regarding their rights and responsibilities;
- With permission from the patient, the Network may contact the facility directly to gather information and attempt to resolve the matter;

- The facility may be required to complete an Improvement Plan to correct problems;
- More serious issues may be referred to the Network's Medical Review Board (MRB) for review;
- Life-threatening situations will be referred to the appropriate State Survey Agency for immediate action.
- If the grievance involves a concern that falls under another agency's or organization's authority, the Network will refer the grievance in accordance with CMS established guidelines.

Grievances That Will Be Referred by the Network

The Network may not investigate grievances in non-Medicare certified units or involving non-Medicare eligible beneficiaries unless it is believed that the issue will have an adverse impact upon Medicare patients (765.3). ESRD grievances in non-ESRD related settings will be referred to the appropriate health care organization. For example: grievances involving correctional institutions are referred to the Department of Corrections.

The Network may refer grievances involving hospital inpatient stays, nursing homes, home health agencies, and ambulatory surgical centers to the QIO for peer review in the state where the hospital or service provider is located whether or not the grievance is specifically related to ESRD treatment or services (765.6). The grievance may involve care or services for co-morbid conditions.

If the grievance involves a reimbursement or insurance issue, or denial of services the complainant will be referred to the appropriate carrier, intermediary, or CMS Regional Office (765.6).

If the grievance involves survey and certification issues, the complainant may be referred to the State Survey Agency (SSA). However, the Network may provide Quality Improvement (QI) assistance to the facility even if the grievance is referred to the SSA (765.6).

If the grievance involves potential or alleged fraud or abuse, the complainant will be referred to the Federal or State Fraud Abuse enforcement agencies (765.6).

The Network Board of Directors and the Medical Review Board (MRB) Grievance Committee should consult with legal counsel and CMS prior to investigating a grievance for which legal action is pending or anticipated.

If a grievance is referred to another authority, reasons for referral will be described in a letter to the complainant, along with information as to whom to contact (765.7).

Emergency or Life Threatening Situations

Written or telephone grievances involving immediate life-threatening issues will be reported by telephone or fax to the CMS Regional Administrator, Division of Health Standards and Quality

and State Agency immediately (within 24 hours) and will be followed by written confirmation (email or fax). At the Regional Office's (RO) request, the Network will commence investigation immediately or offer consultative services. The patient will be informed of the ROs involvement. Every effort will be made to complete the investigation as soon as possible (765.9).

Patient Grievances That Are Not Life Threatening

Any patient, family member, or other person who reports a grievance to the Network by telephone or letter thereby accesses the Network's grievance procedures (765.4). If it appears that the caller's grievance can be satisfied with an intervention such as a referral, a transfer, provision of information, or the contacting of facility personnel, Network staff will attempt to facilitate a resolution. The Network conducts patient-specific quality of care review and general quality of care reviews. The Network's impartial, interdisciplinary staff and the Network's Medical Review Board members provide an abundance of resources to assist the Network in the resolution of grievances.

A grievance may be made anonymously or the grievant may give permission to use his/her name in investigating the grievance. Confidentiality is strictly maintained. All written grievances are acknowledged within 5 days of receipt. All grievances are acknowledged on the day they are received, if possible, and are resolved as quickly as possible. CMS provides a 60 day time span for resolution although the Network resolves the majority of its grievances in fewer than 30 days.

The Network will respond to the grievant in writing within five working days of receipt of the grievance. The Network will confirm if the grievant's name may be revealed before the Network begins its investigation (765.4). The Network also will advise anonymous grievants of the limitations involved.

Grievances always incorporate a multi-disciplinary approach to its investigation to encourage fair, accurate and unbiased examinations of problem situations in a timely manner, with well-researched recommendations for solutions.

MRB Grievance Committee

The Grievance Committee consists of Medical Review Board members who represent an array of disciplines (i.e. physician, social worker, technician, nurse, administrator, dietitian) as well as ESRD patients. The Network 9/10 Conflict of Interest Policy binds those involved in grievance processing and resolution. Any individual who has a financial, professional or personal

involvement with the beneficiary or the provider, is excluded from participation on the investigation and resolution of the grievance (795).

MRB Review Process

The Network gathers as much information as is available or is needed in order to fully understand the issues. The information is gathered objectively from both the grievant and the facility who is the object of the grievance by phone, letter, fax, e-mail, in person, or by an on-site visit. MRB Grievance Committee members review the grievance, staff findings, relevant documentation, and the facility's comments. The Committee may be asked to respond with written comments, to deliberate by conference call, or to meet in person (765.8). The Committee will make a determination as to the merit of the grievance, and will suggest any changes that may be recommended to the facility and the grievant. The MRB Grievance Committee may also recommend an Improvement Plan (IP), an on-site review or request additional information prior to making a determination. This may include interviews with patients, providers, or facility staff as appropriate.

Time Allocated For Investigation

The Network will conclude its investigation within 90 calendar days of the receipt of the grievance. In those instances where more than 90 days are required, all parties, including the CMS Project Officer, will be notified in writing of the reason for the delay and the date anticipated for conclusion of the activity (765.14). If potential life-threatening issues are involved, a grievance (whether in written or verbal form) must be forwarded within 24 hours of receipt to the appropriate SSA and RO Associate Regional Administrator (ARA) and the investigation must be concluded as soon as possible (765.9).

Final Reports

A letter containing a grievance report will be sent to the grievant/patient representative, Medical Director and/or Administrator, with the confidentiality of the grievant and the practitioner protected, unless the grievant and/or practitioner has agreed in writing to release his/her name (765.14). All documentation can be viewed onsite by the COR when requested (785).

A general report will also be made to the grievant (770). This report will inform the grievant that a thorough investigation of the grievance has been conducted and will stipulate the extent to which the problem described in the grievance was verified as a result of the investigation. In addition, the report will indicate whether the grievance has been resolved or whether the facility is implementing an Improvement Plan (IP).

The report to the grievant should be of a general nature and should not detail the specifics of the investigation. The Network may disclose facility-specific information but may not disclose practitioner specific-information without written consent. The deliberations of the MRB Grievance Committee are confidential and are not to be released. In addition, a detailed explanation of other options, such as referral to the SSA or COR will be included, which the grievant may pursue if he/she is not satisfied with the investigation. The grievant also will be provided information to initiate an appeal for the Network to reconsider its grievance determination.

Implementation of An Improvement Plan

In those instances in which the MRB Grievance Committee determines that there are opportunities to improve care within the facility, an Improvement Plan (IP) may be implemented (780). The IP will be developed by the facility in conjunction with the Network, subject to the approval of the MRB Grievance Committee. The IP will include the following (780.1):

Confirmation and identification of the existence of the problems and opportunities for improvement:

- A description of all steps to be taken to correct the problems;
- A description of staff and material resources that will be directed to the effort;
- An expeditious timetable including all interim steps and a final completion date; and,
- A methodology that allows periodic Network monitoring of the IP to ensure that the problem is corrected efficiently and that it does not recur.
- Acceptance and Monitoring of Improvement Plan

The facility has 15 calendar days to submit the IP and the Network has 30 calendar days to accept or reject the plan (780.2). IP's must be finalized and implemented within 60 calendar days after the date the Network requested the IP. If possible the IP should be completed within 1-3 months. The Network will maintain a tracking system showing the status of all IPs, which will be reported to CMS in the quarterly progress report (780.3). The Network will contact the facility at least once a month to offer assistance and support (780.4). At the end of the time allowed for implementation of the plan, the Network will determine whether the facility has complied with the plan and if the plan has been adequately addressed (780.5). If the goals of the IP have not been met, the Network may amend the IP, implement focused review, or recommend a sanction. A decision to recommend a sanction must be made by the Medical Review Board with concurrence from the Network Board of Directors. The Network should notify its COR of the facility's non-compliance and the action that will be taken.

Closing a Grievance

A case is closed and Network grievance activities are completed when the grievance has been referred to another agency/organization or when no further action can be taken by or is required of the Network. A grievance is considered resolved when the grievance has been explained, corrected, or settled by the Network and the grievant understands the outcome.

If the problem is part of a recurring trend at a facility, the Network will follow up by checking with the grievant and/or the facility to make sure the problem was actually resolved and the resolution was sustained over time.

When the Network considers a grievance resolved, but the grievant does not accept the Network's findings, the grievant may request an appeal. The Network will open the appeal as a new case linked to the original case.

Confidentiality

Grievant Confidentiality

The complainant/grievant identity will be confidential and will be released only with specific authorization (785.1). If it appears that proceeding with fact-finding or other steps in the grievance resolution process may compromise confidentiality, the process will be suspended and the complainant/grievant notified in writing of the Network's concern. At that point the complainant/grievant will be given any possible alternatives to the Network grievance process (785.1). The process of resolution will be resumed only with the complainant/grievant's written permission and acknowledgment of the potential risk to confidentiality. If a family member or friend contacts the Network, permission is needed by the patient before the Network can contact the facility about a patient issue. A patient's guardian will need to fax or send the appropriate documentation to the Network before information can be released to that person or the facility contacted on behalf of that person. The Network will follow HIPAA guidelines regarding the release of information to other people.

Facility Confidentiality

The identity of facilities that have been involved in a patient grievance is releasable (785.3). Aggregate statistics about the number and types of grievances are releasable, as long as patient confidentiality is maintained.