

ABC Health System

Customer Grievances Policies and Procedures

SCOPE

System wide policy

PURPOSE

ABC Health System is committed to the protection and promotion of the rights of each patient who receives care and services at any ABC location. This policy has been developed to establish ABC's process for receiving, investigating and resolving patients, families, visitors and physician complaints and grievances. Each patient will be clearly advised of his or her right to make a complaint or file a grievance in writing or verbally upon admission or registration to any service or facility within the ABC System.

As part of its notification of patient rights, ABC must provide the patient or the patient's representative the phone numbers and addresses for lodging a grievance with the State of Alabama Department of Public Health (State), The Joint Commission (TJC), and the CMS Quality Improvement Organization (QIO). ABC must inform the patient that he/she may lodge a grievance with the State, TJC, and CMS QIO directly, regardless of whether he/she has first used the hospital's grievance process. At this time all patients and /or the patient representative should be informed of ABC's internal grievance process and how to contact a Patient Liaison to file a grievance. ABC must ensure that all patients are aware of their right to seek review and/or appeal by the Quality Improvement Organization (QIO) for quality of care issues, coverage decisions and to appeal a premature discharge and inform the patient that they may contact the QIO to lodge a complaint. Patients, family members, significant others, and visitors to ABC are encouraged to promptly express their concerns to hospital personnel.

Efforts will be made to resolve concerns at the time they are reported by staff that is present. If that is not possible, concerns will be referred to the Department Manager or designated Patient Liaison or the Administrative Supervisor for investigation and resolution. If the Patient Liaison (or designee) is unable to resolve the matter to the satisfaction of the complainant, a Grievance Review Committee meeting may be convened to review and rule on the issue. All complaints received will follow the principles of complaint management: **Assessment, Investigating, Response, Documentation, Trending Analysis and Reporting for quality improvement purposes.**

POLICY

ABC is committed to meeting or exceeding our customer's expectations of care and service. Providing quality service is the responsibility of every ABC employee. All employees are expected to participate in the complaint and grievance resolution process by adhering to service recovery principles and following the guidelines outlined herein. It is the policy of ABC that complaints, grievances and /or concerns from patients and/or family members are investigated and answered in a confidential and timely manner. Effective and prompt resolution of complaints and grievances are key factors in achieving excellent customer service. ABC's customers are encouraged to express their concerns without fear of retaliation or fear of their care being compromised. Every member of the ABC healthcare team plays a vital role in supporting patients toward optimal health. Each employee should make every effort to resolve the patients concerns and grievances within his/her authority or scope of practice that falls within their credentials.

The Patient Liaison is responsible for the effective facilitation of the complaint/grievance process and for conducting and /or coordinating the review and resolution of complaints/grievances except for those complaints/grievances relative to Quality, Privacy or Risk Management. All patients and guests should be assured that their complaints will be investigated and resolved in a prompt, reasonable and consistent manner. Complaints and grievances will be entered into MIDAS Patient Relations Module which is the complaint database. Data collected regarding patient complaints and grievances, as well as some other complaints that are not defined as grievances (as determined by the hospital) must be incorporated in the hospital's Quality Assessment and Performance Improvement Program (QAPI). Complaints and grievances received after business hours, on weekends and holidays will be handled by the Administrative Supervisor who will act as the coordinator for the complaint and grievance management process in the absence of the Patient Liaison. The Administrative Supervisor should enter all feedback into MIDAS and Patient Liaisons should be notified of such complaints by the next business day if needed.

DEFINITIONS

A. A "Compliment" for purposes of this policy includes:

1. Any comment that commends the organization or individual associated with the organization.

B. A "Complaint" for purposes of this policy includes:

1. A concern or complaint regarding hospital services or patient care expressed by the patient or patient representative that **can be resolved at the point of service** by staff present.
2. A post hospital-stay verbal communication regarding hospital services or patient care that would have been routinely handled by staff present if the communication had occurred during the hospital stay or visit.

3. A relatively minor issue that can be resolved quickly by the person receiving the information and does not require intervention by management or the Patient Liaison (i.e. change in bedding, housekeeping of a room, diet or serving preferred food and beverage, parking, lost and found issues) which can be addressed by staff present and promptly resolved to the patient's satisfaction.
4. A concern expressed to Administration or Patient Liaison prior to attempting to resolve the matter with the staff present at the time of the incident.
5. A concern or complaint first made known to Administration or Patient Liaison via a written survey or comment card but not made known to the staff during the stay or visit. Information obtained from patient satisfaction surveys usually does not meet the definition of a grievance.
6. A billing issue that does not include patient quality of care issues or Medicare beneficiary complaints relative to rights and limitations provided by 42CFR489.
7. A privacy issue or an issue involving use or disclosure of Protected Health Information (PHI) that does not include patient quality of care issues.

C. A "Grievance" for purposes of this policy includes:

1. A "**patient grievance**" is 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 verbal complaint about patient care is not resolved at the time of the complaint by staff present)** abuse or neglect, patient harm, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoP's) or a Medicare beneficiary billing complaint related to rights and limitation provided by 42CFR489.
2. If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to the other staff for later resolution, requires further investigation and/or requires actions for resolution or coordination with other hospital departments, then the complaint is a grievance for the purposes of this document.
3. **A written complaint is always considered a grievance.** A complaint communication in writing (letter, fax, or email) that may come in from an inpatient, outpatient, released/discharged patient or a patient's representative regarding the care provided or abuse and neglect or the hospitals compliance of CoP's. For the purposes of this requirement, an email or fax is considered "written."
4. Any complaint that is requested by the patient or a patient's representative to be handled as "**formal complaint**" and the patient has requested a response from the hospital.

5. When an identified patient/patient representative writes or attaches a written complaint to a patient satisfaction survey or comment card and requests resolution, the complaint meets the definition of a grievance. If an identified patient writes or attaches a complaint to the survey or comment card but has not requested resolution, ABC must treat this as a grievance if it would usually treat such a complaint as a grievance.
6. Any complaint, whether verbal or written where a patient or patient representative complains regarding a quality of care, disagrees with a coverage decision or they wish to appeal a premature discharge is a grievance. In the event that this occurs the patient or patient representative may contact the (QIO) to lodge a complaint along with following the hospitals internal grievance process. ABC is required to have procedures for referring Medicare beneficiaries concerns to the QIO's; additionally, CMS expects coordination between the grievance process and existing grievance referral procedures so that the beneficiary's complaints are handled in a timely manner and referred to the QIO at the beneficiary's request.
7. Patient complaints that are considered grievances also include situations where a patient or patient representative telephones the hospital with a complaint regarding the patients care or with an allegation of abuse or neglect, or failure of the hospital to comply with one or more CoPs, or other CMS requirements. Those post hospital verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.
8. Any complaint or concern thought to have been resolved which returns to Administration or Patient Liaison as unresolved to the patient's satisfaction escalates to a grievance.
9. Billing issues where the patient/patient representative states they will not pay because of care or treatment issues.
10. Any concern or complaint filed directly with a (regulatory agency) the State, TJC or CMS.
11. Any complaint determined by the Patient Liaison to be serious enough to warrant the review of the Grievance Committee.

Note: it is not a grievance by CMS's definition if the patient is satisfied with the care, but the family member is not.

D. MIDAS Patient Relations Module for purposes of this policy include:

The electronic system used to document, manage, analyze, track and report feedback from our patients, families, visitors and physicians. All feedback is entered into MIDAS or sent to a centralized contact (i.e. Patient Liaison) where it is recorded and sent to the appropriate department for action and resolution. Once the issue has been resolved the information will be sent back to Patient Liaison for review and closure of the patient's file.

E. Resolution for purposes of this policy includes:

A complaint or grievance is considered resolved when the complainant is satisfied with the actions taken on the patient's behalf or the hospital has taken all reasonable and appropriate steps to resolve the matter, even though the patient or patient representative remains unsatisfied.

F. Staff Present for purposes of this policy includes:

"Staff present" includes any ABC staff that is present at the time of the complaint or who can quickly be at the patient's location that can assist with resolving the patient's concern or complaint (i.e. this includes but is not limited to physicians, nurses, administrative staff, nursing supervisors, patient liaisons and other staff.)

G. Patient Representative for purposes of this policy includes:

An adult authorized by a competent patient's verbal or written consent to be their representative. An adult with legal authority to make health care decisions on behalf of an incompetent patient is also called a surrogate. An adult appointed by the patient in an advance directive to make health care decisions for an incompetent patient is called a health care agent. A health care agent's decision takes precedence over other surrogates.

H. Protected Health Information (PHI) for purposes of this policy includes:

PHI is any information about health status provision of health care or payment for health care that can be linked to a specific patient.

I. 42 CFR part 489 27 for purposes of this policy includes:

This regulation states that during admission or registration to the hospital all Medicare beneficiaries should be made aware of the fact that if they have a complaint or grievance regarding quality of care, disagree with a coverage decision (i.e. Non-covered continued stay) or wish to appeal a premature discharge or billing issue related to rights and limitation may file a complaint or grievance by following the outlined grievance process.

J. Quality Improvement Organizations (QIO) for purposes of this policy includes:

CMS contractors (health quality experts, clinicians, and consumers) charged with reviewing the appropriateness and quality of care rendered to Medicare beneficiaries in the hospital setting. The QIO's are also tasked with reviewing utilization decisions.

Part of this duty includes reviewing discontinuation of stay determinations based upon a beneficiary's request.

K. Grievance Committee (GC) for purposes of this policy includes:

The Governing Body of ABC has delegated responsibility to review and resolve grievances, to analyze the grievance procedure, and to make recommendations for performance improvement to Patient Liaisons and the Grievance Committee. Multi-disciplinary representation includes but is not limited to patient liaison, risk management, clinical staff, care management, and administration and others as needed. The Grievance Committee will be under the administrative direction of the General Counsel at RMC and NMC.

L. Service Recovery Protocols for purposes of this policy includes:

All service failures are addressed immediately and the Complaint and Grievance policy along with the service recovery protocols are adhered to simultaneously by ***“Taking the HEATT”***.

1. **H = (Hear them out)** Listen attentively for at least two minutes and show compassion regarding their concerns.
2. **E = (Empathize)** Put yourself in their shoes.
3. **A = (Apologize)** Sincerely apologize for the inconvenience, misunderstanding or negative experience on behalf of the organization.
4. **T = (Take Action)** Resolve the issue quickly and fairly. Inform your immediate supervisor.
5. **T = (Track & Trend)** Enter comments into MIDAS. Follow up and keep promises.

PROCEDURE

The ultimate goal of the Complaint and Grievance resolution process is to provide a real time response to expressions of dissatisfaction from patients or visitors. All employees are expected to identify sources of patient or visitor dissatisfaction and provide timely and effective service recovery when needed.

A. Complaint Resolution Process

Staff present should attempt to resolve complaints at the time they are expressed by using their Service Recovery Protocols and ***“Taking the HEATT”***. If staff is unable to resolve an issue to the complainant(s) satisfaction, the issue should be referred to the Department Manager, Administrative Supervisor or Patient Liaison (or designee). If someone other than the patient complains about care or treatment, the staff will first need to contact the patient and ask if this person is their authorized representative. If the person is not an authorized representative, then it still may be a complaint under TJC standards. If a person is an authorized representative of the patient, then staff will need to obtain the patient’s permission to discuss medical record information with that person because of the HIPAA laws. Staff should document the patient’s permission to discuss PHI with their representative in the complaint system.

All complaints that are received within the Patient Liaison Department should follow this process:

1. Customer Service reviews all complaints and enters the feedback into MIDAS which alerts the appropriate Manager, Director or VP involved.
2. The manager involved facilitates any necessary investigation, follow up actions and response to the patient.
3. The manager involved documents all follow up and resolution into MIDAS and forwards the file to Patient Liaison for review and closure.

All complaints that are sent directly to the nursing units or departments should follow this process:

1. If the issue can be addressed or resolved immediately by the staff present, the staff member who receives the complaint should:
 - a. Use his or her best judgment to respond to the issue as soon as possible. Make every attempt to resolve the issue at the point of service. All complaints should be handled at the level that is closest to the care of the patient.
 - b. Once the issue is resolved, the staff member identifying the issue will report the issue to the appropriate manager.
 - c. The manager involved will document all follow up and resolution in to MIDAS and will forward the file to Patient Liaison for review and closure.
2. If the issue cannot be addressed or resolved immediately by staff present, the staff member who receives the complaint should report the issue to the appropriate manager.
3. The manager should continue to follow the complaint/grievance process by assessing the complaint, facilitating any necessary investigation, responding to the complainant and documenting any follow up actions in MIDAS.
4. All files will be forwarded to Patient Liaison for review.
5. Patient Liaison will review the complaint to determine if further actions can be taken in order to meet the satisfaction level of the patient/patient representative.
 - a. If the complaint required additional investigation or follow up actions to satisfy the patient or patient representative, Patient Liaison will notify the manager or department involved that the complaint is being handled as a grievance.
 - b. If the complaint does not require additional investigation or follow up actions Patient Liaisons will close the file.
 - c. A complaint is considered resolved when the patient is satisfied with the actions that the staff has taken on their behalf.

B. Grievance Resolution Process

The hospital must review, investigate and resolve each patient's grievance within a reasonable time frame. Grievances about situations that endanger the patient, such as abuse, neglect or patient harm, should be reviewed immediately, given the seriousness of the allegations and the potential for harm to the patient(s). However, regardless of the nature of the grievance, the hospital should make sure that it is responding to the substance of each grievance while identifying, investigating and resolving any deeper, systemic problems indicated by the grievance. Managers should continue by following the Complaint and Grievance Resolution Process guidelines.

All written grievances that are received within the Patient Liaison Department should follow this process:

1. Patient Liaisons will review all grievances and enter the feedback into MIDAS which alerts the appropriate Manager, Director, AVP and VP involved. All grievances involving multiple units/departments will be assigned a point of contact by Patient Liaison.
2. The manager(s) involved will immediately begin to follow the grievance process by assessing the complaint, facilitating any necessary investigation, responding to the complainant and documenting any follow up actions in MIDAS. Upon completion all follow ups will be forwarded to Patient Liaison.
3. Patient Liaisons will review the grievances for final review and closure along with a representative from the Grievance Committee. Patient Liaison will communicate the resolution actions with the assistance of the involved parties to the complainant in writing as soon as reasonably possible. (Exception – ABC is not required to provide information that can be used against the hospital in legal proceedings.)
4. Grievances will then be reviewed by the ABC Board of Directors and Patient Safety and Quality Committee.

All written grievances that are sent directly to the nursing units or departments should follow this process:

1. Any employee identifying a grievance should report the patients concerns immediately to the appropriate Manager, Director or VP and the patient liaison.
2. The manager involved is to immediately begin the grievance process and enter the feedback into MIDAS which alerts the appropriate Manager, Director and VP involved. **All grievances involving multiple units or departments should be assigned a point of contact by the manager entering the feedback. The manager may contact Patient Liaison for assistance if needed.**

Upon receipt of a grievance the appropriate manager should:

1. Review the grievance and respond by phone or letter within seven (7) calendar days to the complainant acknowledging receipt of the grievance and stating the patient's concerns are being investigated and a member of the staff will contact the patient or the patient's legally authorized representative. If the complainant cannot be reached after making three (3) attempts by phone a letter must be sent. An approved letter is located in MIDAS for use. The letter must state that we have made several attempts to reach the complainant by phone and if we have not heard a response from complainant in seven (7) calendar days the file will be closed. If a letter is sent it should contain the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the outcome of the grievance process, and the completion date. **All letters will be written by the Patient Liaison for consistency purposes.**
 - a. Any grievances alleging these accusations will follow the protocols below:
 - I. Abuse, Neglect or Injury to a patient or visitor should be sent to the Assistant VP, Director, Quality and Patient Liaison. Escalate to Risk Management if needed.
 - II. Quality of care and safety issues should be sent to the Assistant VP, Director and Quality and Patient Liaison. Escalate to Risk Management if needed.
 - III. A complaint regarding a physician or care provided by a physician should be sent to the CMO or VMPA, Assistant VP, Director and Patient Liaison.
2. Investigate the concerns in order to determine the most appropriate resolution. All efforts should be made to resolve the grievance and to follow with a letter as promptly as possible. The following guidelines prescribe a timeframe for resolution and helpful hints in responding to the patient/patient representative.
 - a. All allegations of abuse, neglect or endangerment of a patient should be reviewed and investigated immediately with the findings within three (3) calendar days or with an indication of a date when a resolution is expected. If the matter cannot be resolved within three (3) calendar days, then the patient/patient representative should be notified that the hospital is still working to resolve the issue. The patient/patient representative should also be given an anticipated timeframe for resolution in all cases alleging abuse, neglect, endangerment of a patient or injury to a patient or visitor. Written responses must be coordinated through the General Counsel.
 - b. Most grievances should be resolved within seven (7) calendar days; and a response provided to the patient/patient representative within seven (7) calendar days. If the grievance cannot be resolved in seven (7) days or if the investigation cannot be completed within seven (7) calendar days a follow up phone call or written acknowledgement of receipt of the grievance with a plan of action, including an anticipated date of a written response within 30 days should be provided to the patient/patient representative with the exception of those occasional grievances that require extensive investigation, review, and

or input from multiple individuals or additional effort due to staff scheduling and fluctuation in the number and complexity of the grievances can affect the timeframe for the resolution of a grievance and the provision of a written response. **Per CMS, it is not required that every grievance be resolved during the specified timeframe although most should be resolved.**

- c. Once the investigation is completed a written response to the complaint must be provided to each patient's grievance by the Patient Liaison with the assistance of the involved parties and include the name of the contact person at the hospital, the steps taken to investigate the grievance, the result of the grievance process and the date the process was completed.
- d. If the resolution action of the Patient Liaison is unacceptable a Grievance Committee meeting may be convened. The committee may include any pertinent personnel but at a minimum should include the Patient Liaison (or designee), the Department Manager, Quality, Safety and a representative from Administration. Further referrals (e.g. Utilization Review) may be made by the Grievance Committee.
- e. If an apology seems appropriate, it should be blameless (i.e. it should not place blame on any one person or department). Apologies must address the patient or visitor's experience only and should NEVER address a particular act (e.g. we regret that your experience in our hospital was less than favorable...NOT I am sorry that our employee did not...).
- f. Written responses DO NOT include statements that could be used in a legal action against the hospital and DO NOT provide an exhaustive explanation of every action taken to investigate and resolve the grievance or actions taken by the hospital. A brief synopsis of the process and the result is sufficient.
- g. Whenever a written explanation of the hospital's determination regarding the grievance is provided to the patient/patient representative such responses should be in language that is understandable to the average layperson. When suitable a meeting may be called with the patient/patient representative.
- h. Whenever a patient communicates a grievance to the hospital via email, the hospital may provide its response via email per the hospital's policy. In these circumstances and when the email response contains the information stated in this requirement the email meets the requirement for a written response.
- i. All letters should thank the complainant for bringing their concerns to the hospital's attention.
- i. Document all follow up and resolution in MIDAS and forward to Patient Liaison for review and closure.
- j. Patient Liaison will review the grievance to determine if further action can be taken in order to meet the satisfaction level of the patient/patient representative and CMS requirements.

- k. If the grievance requires additional investigation or follow up actions to satisfy the patient/patient representative, Patient Liaison will notify the manager or department involved. The complaint should continue to follow the grievance process. Once the investigation has concluded, follow up has taken place, and the resolution meets CMS requirements, Patient Liaison will review the file to determine if the desired outcome has been achieved. Next, Patient Liaison will review the grievances for final review and closure along with a representative from the Grievance Committee. Patient Liaison will communicate the resolution actions with the assistance of the involved parties to the complainant in writing as soon as reasonably possible. (Exception – ABC is not required to provide information that can be sued against the hospital in legal proceedings.) Grievances will then be reviewed by the COO, PSQI and ABC Board of Directors.
- l. If the grievance does not require any additional investigation or follow up actions to satisfy the patient/patient representative, Patient Liaison will review the file to determine if the desired outcome has been achieved. Next, Patient Liaison will review the grievances for final review and closure along with the Grievance Committee. Once the committee has reviewed and approved all grievances Patient Liaison will communicate the resolution actions with the assistance of the involved parties to the complainant in writing as soon as reasonably possible. (Exception – ABC is not required to provide information that can be used against the hospital in legal proceedings.) Grievances will then be reviewed by the COO, PSQI and ABC Board of Directors.
- m. A complaint or grievance is considered resolved whenever:
- n. The patient/patient representative is satisfied with the actions taken on their behalf or satisfied with the response of the complaint or grievance or
- o. The hospital has taken all reasonable and appropriate steps to resolve the matter, even though the patient or patient representative remains unsatisfied. If this occurs the hospital should consider the grievance closed. Patient Liaison will maintain documentation of the hospitals actions to address each grievance on file for a minimum of seven (7) years to demonstrate compliance with CMS requirements.

C. Privacy & Billing Issues

- 1. Complaints or grievances regarding privacy or PHI are referred to the Privacy Officer for investigation and resolution.
- 2. A billing issue is not usually considered a grievance for the purposes of these requirements. However, a Medicare Beneficiary billing complaint related to rights and limitations provided by 42CFR489 are considered grievances.
 - a. Billing complaints or grievances that do not involve patient quality of care issues are referred to the appropriate staff in the Financial Services Division.

D. Legal Issues

When a patient or patient representative threatens with legal action staff should:

1. When the complainant states they are seeking legal counsel (attorney) or mentions they want to sue any facility associated with ABC, Risk Management must be alerted immediately.
2. At this point, the General Counsel or (designee) will determine if the manager should continue following the grievance guidelines or if the grievance will be handled by Risk Management.

REPORTING

Patient Liaison identifies and communicates opportunities for improvement to Department Heads, Nursing Leadership, Physicians and Hospital Administration by providing monthly, quarterly and annual complaint and grievance reports. Additionally, annual reports on complaints and grievances are distributed to the Grievance Committee, PSQI and ABC Board of Directors.

Informing Patient/Visitors of Rights to Complain:

The Patient Rights and Responsibilities brochure, facility signage of the Patient Rights and Responsibilities, and instructions on the ABC Public Website are mechanisms for informing patients, and/or the patients' representatives about their right to file a complaint. Additionally, the phone numbers and email address of the Patient Liaison Department are included in these resources. All patients receive this information at time of registration and verify that they have received this information by signing the Patient Agreement and Acknowledgement (PAA) form. Patients receive the Notice of Privacy Practices which provides them information on how to file a complaint if the patient believes their privacy rights have been violated and contains the Privacy Officers contact information. The Patient Rights and Responsibilities brochure and admission/discharge packets include information for Medicare beneficiaries of their right to seek review by the QIO.

Committee Review of Patient Grievances:

The Manager, Director, Vice President and/or Patient Liaison may convene an ad hoc committee to address and/or review a grievance. This committee will abide by the grievance process as stated above. Additionally, these committee members may be asked to serve on the Grievance Committee. The Governing Body of ABC has delegated responsibility to review and resolve grievances, to analyze the grievance procedure, and to make recommendations for performance improvement to Patient Liaison Department and the Grievance Committee. Such committee members may include but is not limited to the following departments/personnel: Patient Liaison, Quality/Patient Safety, Risk Management, Case Management, Other (e.g. Human Resources, Nursing Service, etc.).

REFERENCES

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08) Electronic Code of Federal Regulations, Title 42, Part 482 Sec. §482.13 Condition of Participation: Patient's Rights. §482.13 (a) Standard: Notice of Rights.

A hospital must protect and promote each patient's rights.

1. **A-0115 Interpretive Guidelines §482.13:** The requirements apply to all Medicare or Medicaid participating hospitals including short-term, acute care, surgical, specialty, psychiatric rehabilitation, long-term, children's and cancer, whether or not they are accredited. This rule does not apply to critical access hospitals (See Social Security Act (the Act) §1861(e).)
2. **A-0116 Interpretive Guidelines §482.13(a):** The hospital must ensure the notices of rights requirements are met.
3. **A-0117 Interpretive Guidelines §482.13 (a) (1):** A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.
4. **A-0118/19 Interpretive Guidelines §482.13 (a) (2):** The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's grievance process must be approved by the governing body. The hospital's governing body must approve and be responsible for the effective operation of the grievance process. This includes the hospital's compliance with all of the CMS grievance process requirements. The hospital's governing body must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. A committee is more than one person. The committee membership should have adequate numbers of qualified members to review and resolve the grievances the hospital receives (this includes providing written responses) in a manner that complies with the CMS grievance process requirements.
5. **A-0120 Interpretive Guidelines §482.13 (a) (2) continued:** The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organizations.
6. **A-0121 Interpretive Guidelines §482.13 (a) (2) (i):** The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.
7. **A-0122 Interpretive Guidelines §482.13 (a) (2) (ii):** The grievance process must specify time frames for review of the grievance and the provision of a response.
8. **A-0123 Interpretive Guidelines §482.13 (a) (2) (iii):** In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and date of completion.

Electronic Code of Federal Regulations, Title 42 Part 489

CMS website www.cms.gov

The Joint Commission website www.jointcommission.org

Society for Healthcare Consumer Advocacy website www.shca-aha.org

Complaint and Grievance Responsibility:

1. **All ABC Employees and Medical Staff:** It is the responsibility of all staff to adhere to the provisions of this policy and implement ABC Recovery protocols by "*Taking the HEATT*" when needed.
2. **Quality & Safety:** Investigates all grievances made directly to TJC, CMS and 3rd party payers.
3. **Patient Liaison:** Investigates complaints and grievances made directly to them or where a Patient Liaison has been requested by a patient or Quality Council, ABC Board of Directors and hospital department leaders.
4. **Grievance Committee:** This committee is responsible for the effective operation of the hospital's grievance process. The committee will review all unresolved grievances. Additionally, this committee will review complaints and grievances data and reports findings on a monthly basis.
5. **Risk Management:** Investigates complaints and grievances made by patients or patient's representative when they threaten to bring legal actions against the hospital or wish to have their bill waived.
6. **Corporate Compliance/Privacy Officer:** Investigates and manages grievance that pertain to HIPAA.

EXTERNAL CONTACT INFORMATION:

ADPH (Alabama Department of Public Health)

The RSA Tower

201 Monroe Street

Montgomery, AL 36104

1-800-356-9596 or 1-334-206-7991

www.adph.org

Office of Quality Monitoring

The Joint Commission

One Renaissance Boulevard

Oakbrook Terrace, IL 60181

1-800-994-6610

patientsafetyreport@jointcommission.org

Medicare beneficiaries may contact the QIO to lodge a complaint if they have a concern about quality of care, if they disagree with a coverage decision, or if they wish to appeal a premature discharge.

Medicare QIO

KEPRO

5700 Lombardo Center Drive, Suite 100

Seven Hills OH 44131

1-844-430-9504.

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Review: 08/13

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