AHC Media

Grievances and Complaints: Compliance with CMS and TJC Standards

Tuesday, June 2nd , 2015

Speaker

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- Board Member
  Emergency Medicine Patient Safety Foundation
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- sdill1@columbus.rr.com (Call, No email questions)

Objectives

- Explain CMS regulations for grievances, including the requirement to have a grievance committee.
- Discuss the Joint Commission complaint standards in the patient's right (RI) chapter.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

You Don’t Want One of These

Objectives

- Discuss the requirement that hospitals must follow the CMS CoP regulations on grievances if they receive Medicare reimbursement
- Recall that CMS requires hospitals to have a grievance committee
- Describe that hospital boards must approve the grievance policy and procedure
- Recall that the Joint Commission and DNV Healthcare has standards on complaints/grievances

The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Many revisions since then
  - Manual updated more frequently now
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **survey procedures** [2]
  - Hospitals should check this website once a month for changes and to see if manual updated
  - CMS reserves the right to tinker with the survey memo changes and when final published in a transmittal and then updates the manual

[1]www.gpoaccess.gov/fr/index.html [2]www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

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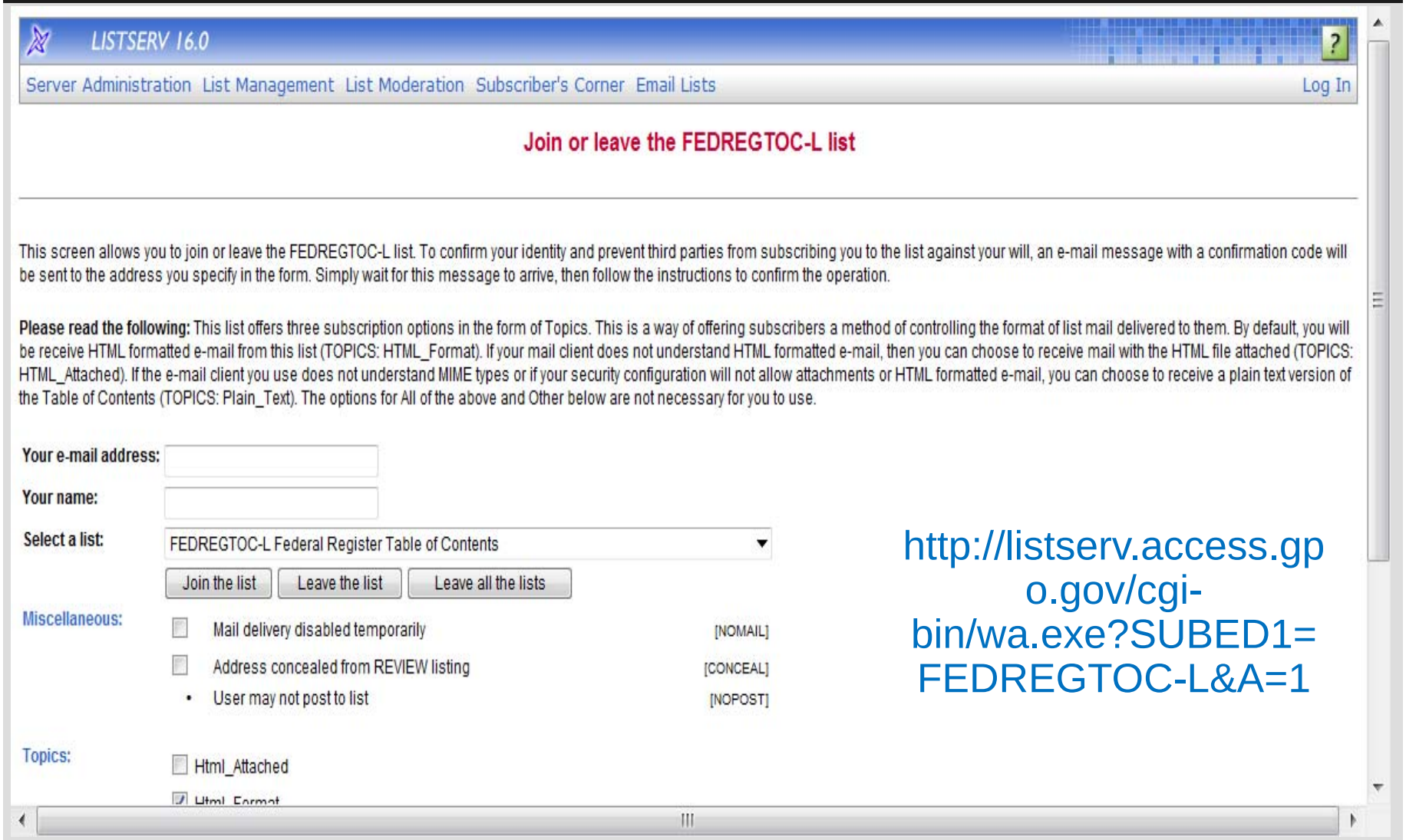


http://listserv.access.gpo.gov/cgi-bin/wa.exe?SUBED1=FEDREGTOC-L&A=1

CMS Survey and Certification Website

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Click on Policy & Memos to States

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
Publication of Final Rule CLIA 'TEST ACT" for Proficiency Testing (PT) Referral - Informational Only	14-23-CLIA	2014-05-02	2014
State Operations Manual (SOM) Chapters 1, 2 & 3 Selected Updates: Medicare Effective Date Determination for Initial Applicants; Survey & Certification Process for Initial Medicare Applicants; Medicaid-only Hospitals; & Deemed Providers/Suppliers	14-24-ALL	2014-05-02	2014
Fiscal Year (FY) 2014 Post Sequester Adjustment for Special Focus Facility (SFF) Nursing Homes	14-20-NH	2014-04-18	2014
Publication of Notice of Proposed Rulemaking (NPRM) for Fire Safety Requirements – Informational Only	14-21-LSC	2014-04-18	2014
Focused Minimum Data Set (MDS) and Dementia Care Surveys	14-22-NH	2014-04-18	2014
Interim report on the CMS National Partnership to Improve Dementia Care in Nursing Homes: Q4 2011 – Q1 2014	14-19-NH	2014-04-11	2014
Advance Copy: Update of State Operations Manual (SOM) Chapter 7 and Survey Process Timeframe Reminder	14-18-NH	2014-03-28	2014
Outcome and Assessment Information Set (OASIS)-C1 Webinar: April 30, 2014	14-17-HHA	2014-03-21	2014
Home Health Agency (HHA) State Operations Manual (SOM) revisions: Appendix B, HHA Enforcement Guidance and revisions to Chapter 2, Certification Process	14-14-HHA	2014-03-14	2014

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop. use the browser "back" button. This is because closing the file usually will also close most browsers

New website at
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

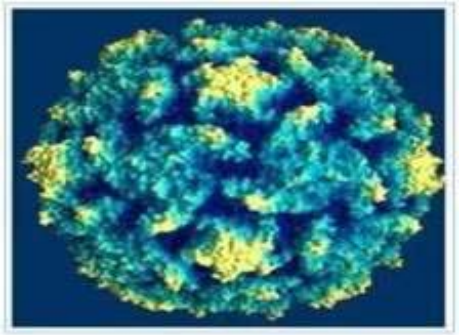
App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

CoP Manual Also Called SOM

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

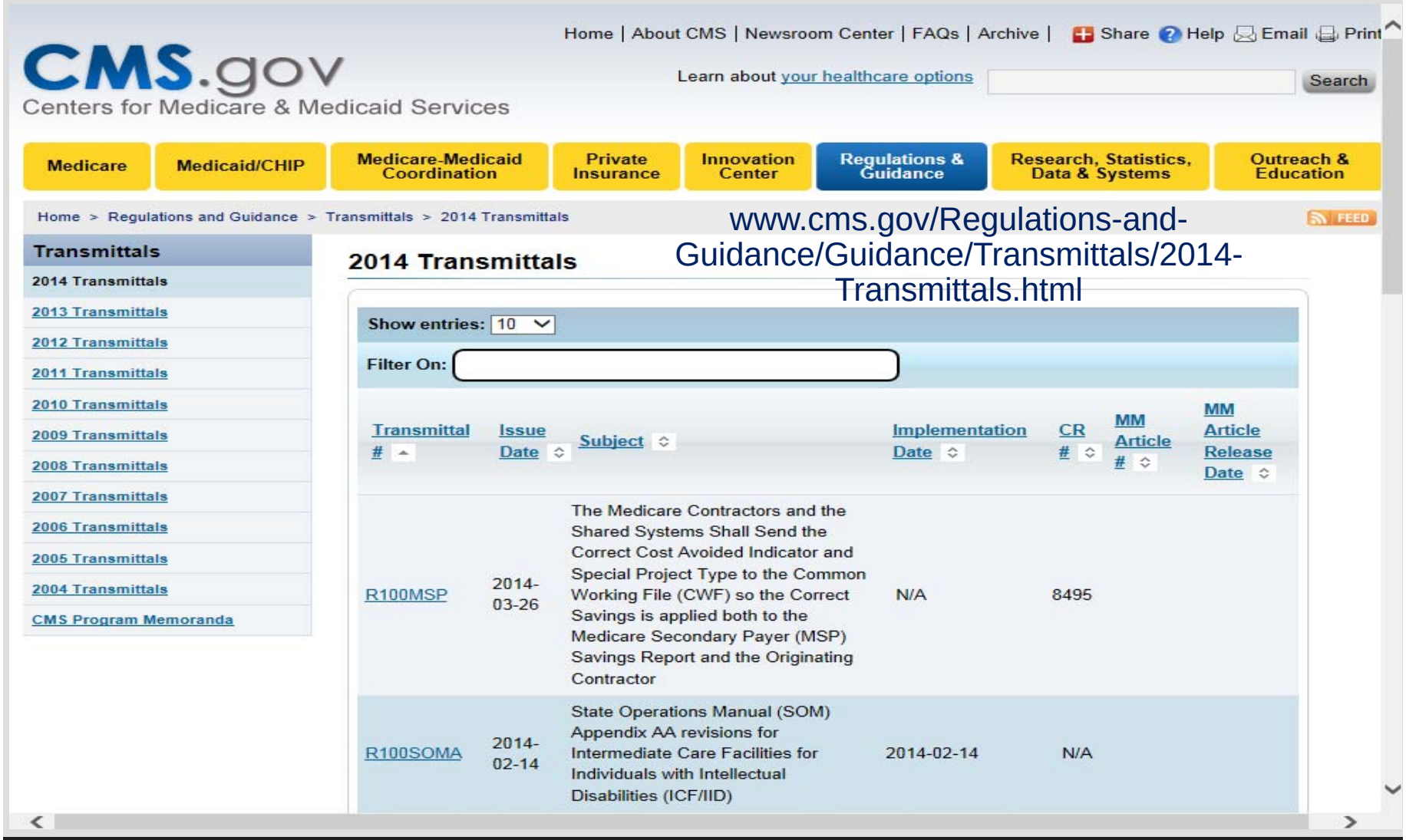
Table of Contents
(Rev. 137, 04-01-15)

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf



§482.12 Condition of Participation: Governing Body

Transmittals



Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data and quarterly since then
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Will update quarterly
  - Available under downloads on the hospital website at www.cms.gov

Access to Hospital Complaint Data

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-21- ALL

DATE: **March 22, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

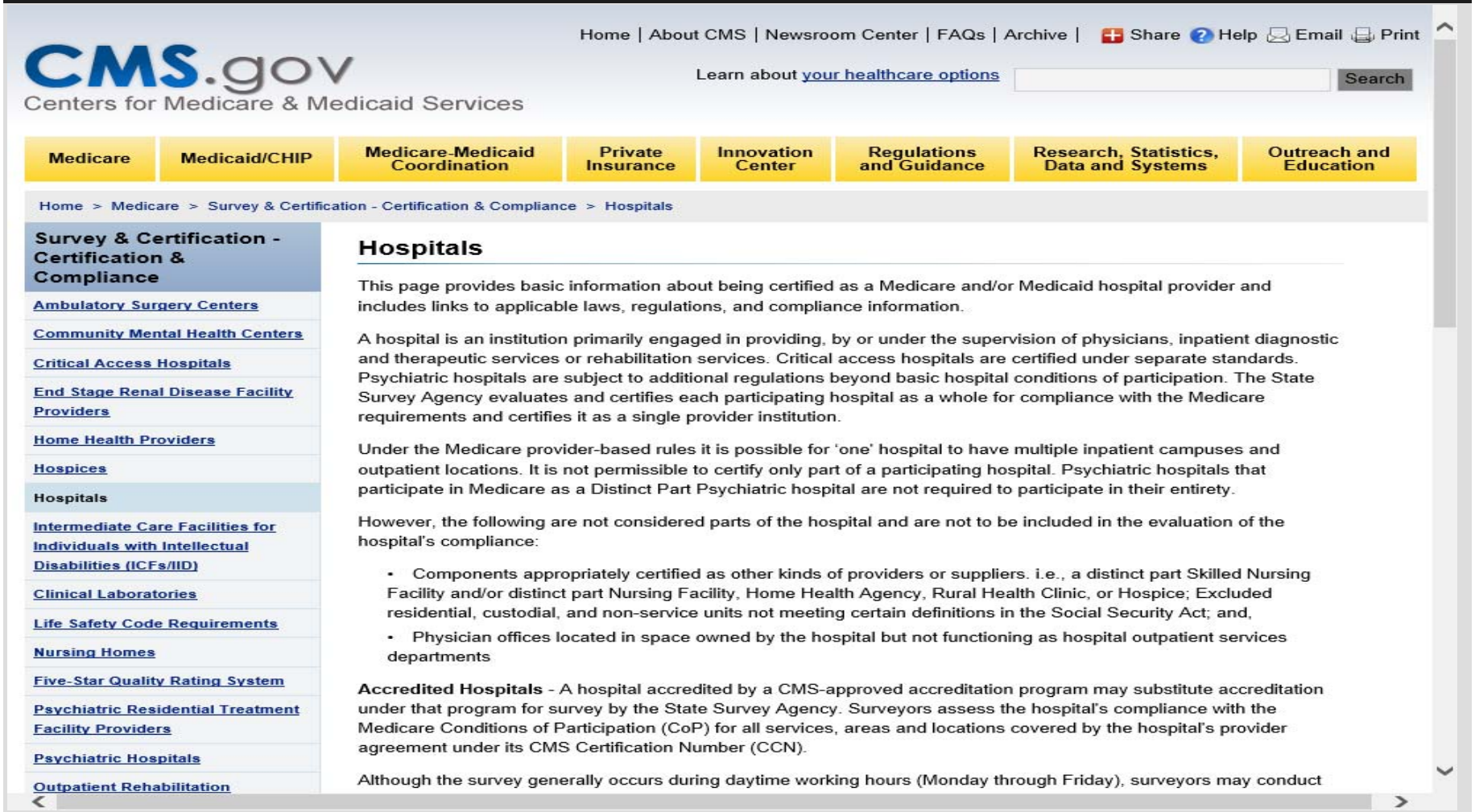
Memorandum Summary

- ***Survey Findings Posted on*** *http://www.cms.gov:* In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on *Nursing Home Compare*. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.
- ***Other Web-based Tools Based on These Data:*** At least two additional websites, provided by private parties (*ProPublica* and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- ***Plans of Correction (POC):*** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.
- ***Question & Answers:*** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form

Updated Deficiency Data Reports



www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

Can Count the Deficiencies by Tag Number

	A	B	C	D	E	F	G	H	I	J	
240	DOCTORS' HOSPITAL OF MICHIGAN	23(	461	MI	48341	Short Term	A	0364	AUTOPSIES	7/18/2012	Based on record review and interview, the facility failed to ensure that 1
241	MARTHA JEFFERSON HOSPITAL	49(	500	VA	22911	Short Term	A	0364	AUTOPSIES	9/8/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
242	SAINT LOUISE REGIONAL HOSPITAL	05(	940(	CA	95020	Short Term	A	0364	AUTOPSIES	1/18/2012	Based on interview and record review, the hospital failed to have a syste
243	EDGERTON HOSPITAL AND HEALTH SERVICES	521	111(	WI	53534	Critical Access H	C	0201	AVAILABILITY	10/2/2012	Based on review of MR, review of staffing guidelines, review of P&P, and
244	HOLZER MEDICAL CENTER JACKSON	361	500	OH	45640	Critical Access H	C	0205	BLOOD AND BLOOD PRODUCTS	1/20/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
245	BRANDON REGIONAL HOSPITAL	10(	119	FL	33511	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/8/2011	Based on clinical record review, staff interview and review of policy and
246	CHRISTUS ST PATRICK HOSPITAL	19(	524	LA	70601	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/9/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
247	COLUMBUS REGIONAL HEALTHCARE SYSTEM	34(	500	NC	28472	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/13/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
248	DANA-FARBER CANCER INSTITUTE	22(	450	MA	02115	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	9/7/2011	Based on review of documentation and confirmed by staff interviews, tw
249	GOOD SAMARITAN MEDICAL CENTER	10(	130(	FL	33401	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/12/2013	Based on clinical record review and staff interview the facility failed to e
250	LONG BEACH MEDICAL CENTER	33(	455	NY	11561	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/22/2011	Based on record review, the facility failed to ensure that the patient ' s te
251	MANATEE MEMORIAL HOSPITAL	10(	206	FL	34208	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/16/2012	Based on record review, policy review and staff interview it was determi
252	MISSOURI BAPTIST MEDICAL CENTER	26(	301(	MO	63131	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/11/2012	Based on observation, interview, and record review, the facility failed to
253	NORTHWEST MEDICAL CENTER	10(	280(	FL	33063	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	8/2/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
254	RESTON HOSPITAL CENTER	49(	185(	VA	20190	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	11/2/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
255	SAINT AGNES HOSPITAL	21(	900	MD	21229	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/22/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
256	SAINT CATHERINE REGIONAL HOSPITAL	15(	220(	IN	47111	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/13/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
257	SOUTHEASTERN REGIONAL MEDICAL CENTER	34(	300	NC	28359	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/14/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
258	STANFORD HOSPITAL	05(	300	CA	94305	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/15/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
259	WAKEMED, CARY HOSPITAL	34(	190(	NC	27518	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/14/2013	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
260	WILKES-BARRE GENERAL HOSPITAL	39(	575	PA	18764	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	1/14/2013	Based on review of facility policy, facility documents, medical records (M
261	WILSON MEDICAL CENTER	34(	170(	NC	27893	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/10/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
262	RIVERSIDE GENERAL HOSPITAL	45(	320(	TX	77004	Short Term	A	0063	CARE OF PATIENTS	11/9/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
263	CIVISTA MEDICAL CENTER	21(	5 GA	MD	20646	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	8/4/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
264	MILFORD HOSPITAL, INC	07(	300	CT	06460	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	9/22/2011	Based on review of hospital documentation and interviews with facility
265	PLAZA MEDICAL CENTER OF FORT WORTH	45(	900	TX	76104	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	7/1/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
266	CLARA MAASS MEDICAL CENTER	31(	ONE	NJ	07109	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	6/2/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
267	GEISINGER - COMMUNITY MEDICAL CENTER	39(	182(	PA	18510	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	6/14/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
268	SENTARA NORTHERN VIRGINIA MEDICAL CEN	49(	230(	VA	22191	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	12/6/2012	Based on a complaint investigation, document review and interview, the

Sheet1

Grievance Deficiencies

Tag	Section	Jan 15 2015	Mar 2014
118	Pt Rights Grievances	179	127
119	Review of Grievances	76	58
120	Timely Referral of Grievances	17	12
121	Grievance Procedures	14	17
122	Grievance Review Times	94	76
123	Notice of Grievance Decisions	243	175
		Total 627	**Total 465**

Patient Rights Standards 0115-0216

- The Patient's Rights section contains the grievance provisions which starts at Tag 118
- Establishes minimum protections and rights for patients
- Examples:
  - The right to notification of rights and exercise of rights
  - The right to privacy and safety, confidentiality of medical records and to be free from unnecessary R&S
  - Right to have advance directives followed
  - The right to pick who will visit them

A-0118

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§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.

Interpretive guidelines §482.13(a)(2)

The patient should have reasonable expectations of care and services and the facility should address those expectations in a timely, reasonable, and consistent manner. Although 482.13(a)(2)(ii) and (iii) address documentation of facility time frames for a response to a grievance, the expectation is that the facility will have a process to comply with a relatively minor request in a more timely manner than a written response. For example, a change in bedding, housekeeping of a room, and serving preferred food and beverage may be made relatively quickly and would not usually be considered a "grievance" and therefore would not require a written response.
The hospital must inform the patient and/or the patient's representative of the internal grievance process, including whom to contact to file a grievance (complaint). As part of its notification of patient rights, the hospital must provide the patient or the patient's representative a phone number and address for lodging a grievance with the State agency. The hospital must inform the patient that he/she may lodge a grievance with the State agency (the State agency that has licensure survey responsibility for the hospital) directly, regardless of whether he/she has first used the hospital's grievance process.

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 complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

- "Staff present" includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e., nursing, administration, nursing

Who Does This Apply?

- All hospitals that participate in the Medicare or Medicaid program
  - Most hospitals in this country except VA hospitals
  - All parts and locations of the hospital
- Includes short term, surgical, psychiatric, rehabilitation, long term care, children's and alcohol drug facilities
- Does not apply to CAH
  - However, CAH should have policy and include most of these requirements
  - Applies whether or not a hospital is accredited by TJC, CIHQ, AOA Healthcare Facilities Accreditation Program, or DNV Healthcare

Standard # 1 Notice of Rights Tag A-0116

- Notice of Patient Rights and Grievance Process
- Hospital must ensure the notice requirement of patient rights is met
- The rights must be provided in a manner and language the patient will understand
  - The issue of low health literacy where 20% of population reads at a sixth grade level
  - Hospital documents written at an 11th grade level
  - 52% of patients could not read medication instruction sheets or understand their discharge instructions

Interpreters Rule #1

- Also the issue of limited English proficiency (LEP)
- There are 55 million patients who primary language is not English
- Must have P&P to ensure patients have information necessary to exercise their rights
- A Studies show that patients with limited English proficiency have a higher rate of readmission
- Need to have interpreter present for critical parts of care such as informed consent and discharge instructions

Interpreters

- A hospital must ensure interpreters are available
- Make sure communication needs of patients are met
- Recommend qualified interpreters or certified deaf interpreters
- Must comply with Civil Rights law and OCR
- Consider if discussing a grievance with a LEP patient
- See the Joint Commission standards on patient centered communications

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Civil Rights

Office for Civil Rights | Civil Rights | Health Information Privacy

OCR Home > Civil Rights > Resources > Special Topics > LEP

- Civil Rights
- Clearance for Medicare Provider Applicants
- Understanding Civil Rights
- Enforcement Activities and Results
- Resources
  - Fact Sheets
  - For Providers
  - Training Materials
  - Laws and Regulations
  - Special Topics
    - Adoption Foster Care
    - Community Living & Olmstead
    - Emergency Preparedness
    - Health Disparities
    - HIV AIDS
    - Hospitals & Effective Communication
    - LEP
    - National Origin Discrimination
    - Temporary Assistance for Needy Families

Limited English Proficiency (LEP)

This section includes documents pertaining to persons with Limited English Proficiency (LEP). This means persons who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language. A person with Limited English Proficiency may have difficulty speaking or reading English. An LEP person will benefit from an interpreter who will translate to and from the person's primary language. An LEP person may also need documents written in English translated into his or her primary language so that person can understand important documents related to health and human services. Information on OCR's work in the area of nondiscrimination on the basis of national origin can be found at www.hhs.gov/ocr/nationalorigin.

LEP Resources and Tools

- Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons– [En Español]
- Questions and Answers Regarding the Department of Health and Human Services Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons
- Summary of the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons
- Fact Sheet on Guidance to Federal Financial Assistance Recipients Regarding

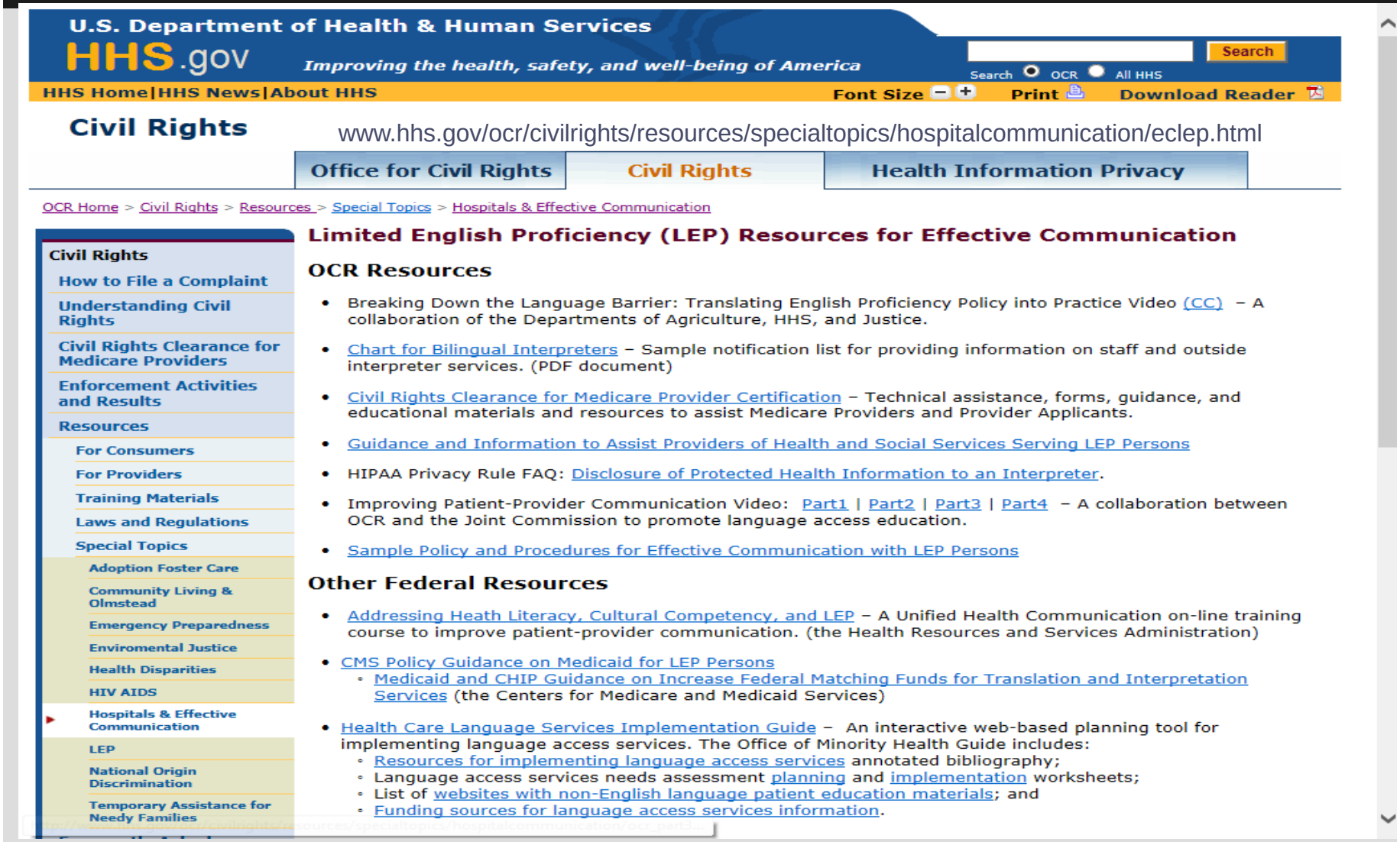
Teaming up for Lanauge Access Education

The Joint Commission

- Improving Patient-Provider Communication Video Part1 Part2 Part3 Part4
  - (CC) video available on request
- HHS Press Release - 11/7/09

www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/

Limited English Proficiency Resources OCR



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Civil Rights

www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication/eclep.html

Office for Civil Rights | Civil Rights | Health Information Privacy

OCR Home > Civil Rights > Resources > Special Topics > Hospitals & Effective Communication

Civil Rights
- How to File a Complaint
- Understanding Civil Rights
- Civil Rights Clearance for Medicare Providers
- Enforcement Activities and Results
- Resources
  - For Consumers
  - For Providers
  - Training Materials
  - Laws and Regulations
  - Special Topics
    - Adoption Foster Care
    - Community Living & Olmstead
    - Emergency Preparedness
    - Enviromental Justice
    - Health Disparities
    - HIV AIDS
    - Hospitals & Effective Communication
    - LEP
    - National Origin Discrimination
    - Temporary Assistance for Needy Families

Limited English Proficiency (LEP) Resources for Effective Communication

OCR Resources

- Breaking Down the Language Barrier: Translating English Proficiency Policy into Practice Video (CC) – A collaboration of the Departments of Agriculture, HHS, and Justice.
- Chart for Bilingual Interpreters – Sample notification list for providing information on staff and outside interpreter services. (PDF document)
- Civil Rights Clearance for Medicare Provider Certification – Technical assistance, forms, guidance, and educational materials and resources to assist Medicare Providers and Provider Applicants.
- Guidance and Information to Assist Providers of Health and Social Services Serving LEP Persons
- HIPAA Privacy Rule FAQ: Disclosure of Protected Health Information to an Interpreter.
- Improving Patient-Provider Communication Video: Part1 | Part2 | Part3 | Part4 – A collaboration between OCR and the Joint Commission to promote language access education.
- Sample Policy and Procedures for Effective Communication with LEP Persons

Other Federal Resources

- Addressing Heath Literacy, Cultural Competency, and LEP – A Unified Health Communication on-line training course to improve patient-provider communication. (the Health Resources and Services Administration)
- CMS Policy Guidance on Medicaid for LEP Persons
  - Medicaid and CHIP Guidance on Increase Federal Matching Funds for Translation and Interpretation Services (the Centers for Medicare and Medicaid Services)
- Health Care Language Services Implementation Guide – An interactive web-based planning tool for implementing language access services. The Office of Minority Health Guide includes:
  - Resources for implementing language access services annotated bibliography;
  - Language access services needs assessment planning and implementation worksheets;
  - List of websites with non-English language patient education materials; and
  - Funding sources for language access services information.

Deaf or HOH Resources OCR

Disability Resources for Effective Communication

OCR Resources

www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication/index.html

- Auxiliary Aids and Services for Persons with Disabilities – Sample policy and procedures for providing effective communication.
- Chart for Sign Language Interpreters Chart – Sample notification list for providing information about staff interpreter and outsider interpreter services. (PDF document)
- Civil Rights Clearance for Medicare Provider Certification – Technical assistance, forms, guidance, and educational materials and resources to assist Medicare Providers and Provider Applicants.
- HIPAA Privacy Rule FAQ: Medical Privacy and Telecommunications Relay Service.
- Improving Patient-Provider Communications YouTube Video: Part 1 | Part 2 | Part 3 | Part 4 – A collaboration between OCR and the Joint Commission to promote language access education.

Other Federal Resources

- ADA.gov – Information and technical assistance on the Americans with Disabilities Act. (the Department of Justice)
- ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings (the Department of Justice)
- ADA Tax Incentives Packet for Businesses – Information on Federal tax credits and deductions available for businesses to help offset costs of improving accessibility for costumers and employees with disabilities. (the Department of Justice)
- American Sign Language (ASL) – Information from the National Institute on Deafness and Other Communication Disorders. (The National Institutes of Health)
- Video Relay Service (VRS) – Consumer facts on Telecommunication Relay Service (TRS) for persons with hearing disabilities to communicate with voice telephone users. (the Federal Communications Commission)

Other Organizational Resources

Please note: External links to other sites are intended to be informational only and do not have the endorsement of HHS and OCR.

- Advancing Effective Communication, Cultural Competence, & Patient-and Family-Centered Care (A Joint Commission resource site)
- Data Collection and Use: Disparities Toolkit – AWeb-based tool to collect race, ethnicity, and primary language data from patients. (The Health Research and Educational Trust)
- The National Association of the Deaf – Resources for communicating with deaf and hard of hearing persons, training programs, captioning agencies, commissions on the deaf and hard of hearing, community services, interpreting agencies, and telecommunications/relay businesses.

ADA Effective Communication 2014

U.S. Department of Justice
Civil Rights Division
Disability Rights Section

www.ada.gov/effective-comm.htm

ADA Requirements

Effective Communication

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

Overview

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities.

This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have

Auxiliary Aids and Services

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified notetaker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.

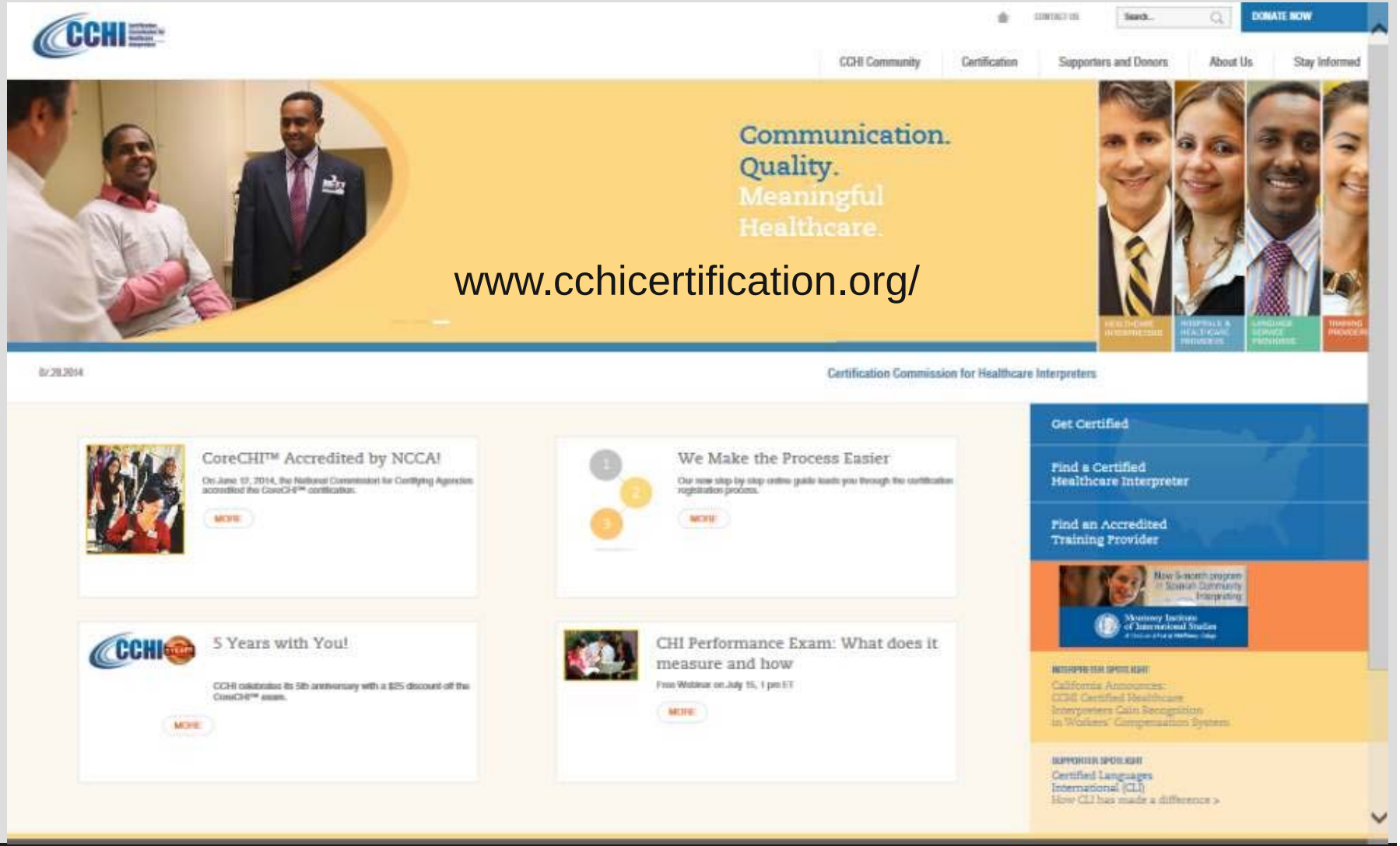
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including 1) assistive listening systems and devices; 2) open captioning, closed captioning, real-time captioning, and closed caption decoders and devices; 3) telephone handset amplifiers, hearing-aid compatible telephones, text telephones (TTYs) , videophones, captioned telephones, and other voice, text, and video-based telecommunications products; 4) videotext displays; 5) screen reader software, magnification software, and optical readers; 6) video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs; 7) accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers) .

Certification CHI CoreCHI

- **National Council on Interpreting in Health Care** and CCHI or the Certification Commission for Healthcare Interpreters (CCHI Associate Healthcare Interpreter credential and has two credentials)
  - **CHI stands for Certified Healthcare Interpreter** (Spanish, Mandarin & Arabic)-best
  - And entry level **Core Certification Healthcare Interpreter** (CoreCHI)
    - Every interpreter needs to have this today and for hospital to show compliance with TJC and National CLAS standard 7
  - Previously had **AHI** which stands for Associate Healthcare Interpreter and in 2014 decided was core professional certification so changed to CoreCHI

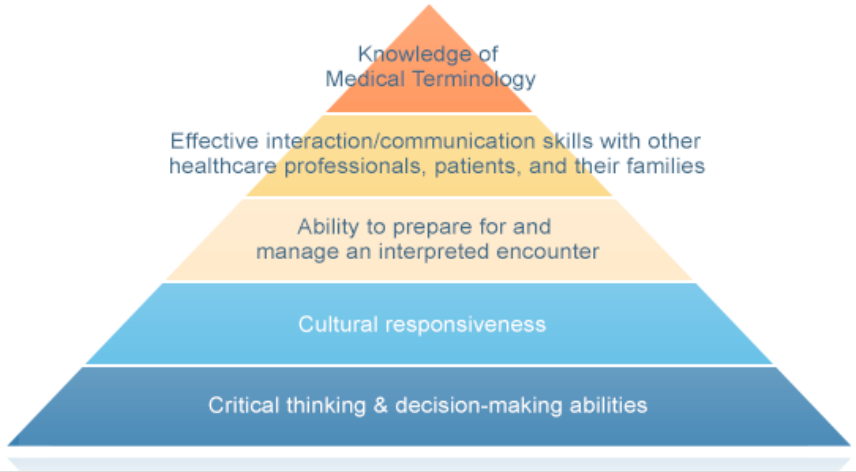
CCHI Certification Commission



CoreCHI Is Entry Point for Interpreters

1. The Core Certification Healthcare Interpreter™ (CoreCHI™) is the entry point into professional certification for healthcare interpreters regardless of the language(s) in which they interpret. ***CoreCHI™ is THE one certification every interpreter of every language needs to have and can have today.*** This certification tests medical interpreters of any language on the core professional knowledge as well as critical thinking, ethical decision-making, and cultural responsiveness skills needed to perform the interpreter's duties in any healthcare setting.**It focuses on the role of the healthcare interpreter** and measures the interpreter's knowledge, abilities and skills related to:

- universal protocols and safety precautions,
- being a partner in a patient's care team,
- culturally-determined patient's behavior which may negatively impact the outcome of the healthcare encounter,
- ethical decision-making,
- U.S. health care system and medical terminology, etc.



CCHI certification of interpreters helps facilitate HR tasks to ensure that individuals who provide language services have specific qualifications and competencies required to perform their job functions in a safe and efficient manner.

www.cchicertification.org/healthcare-providers/ensure

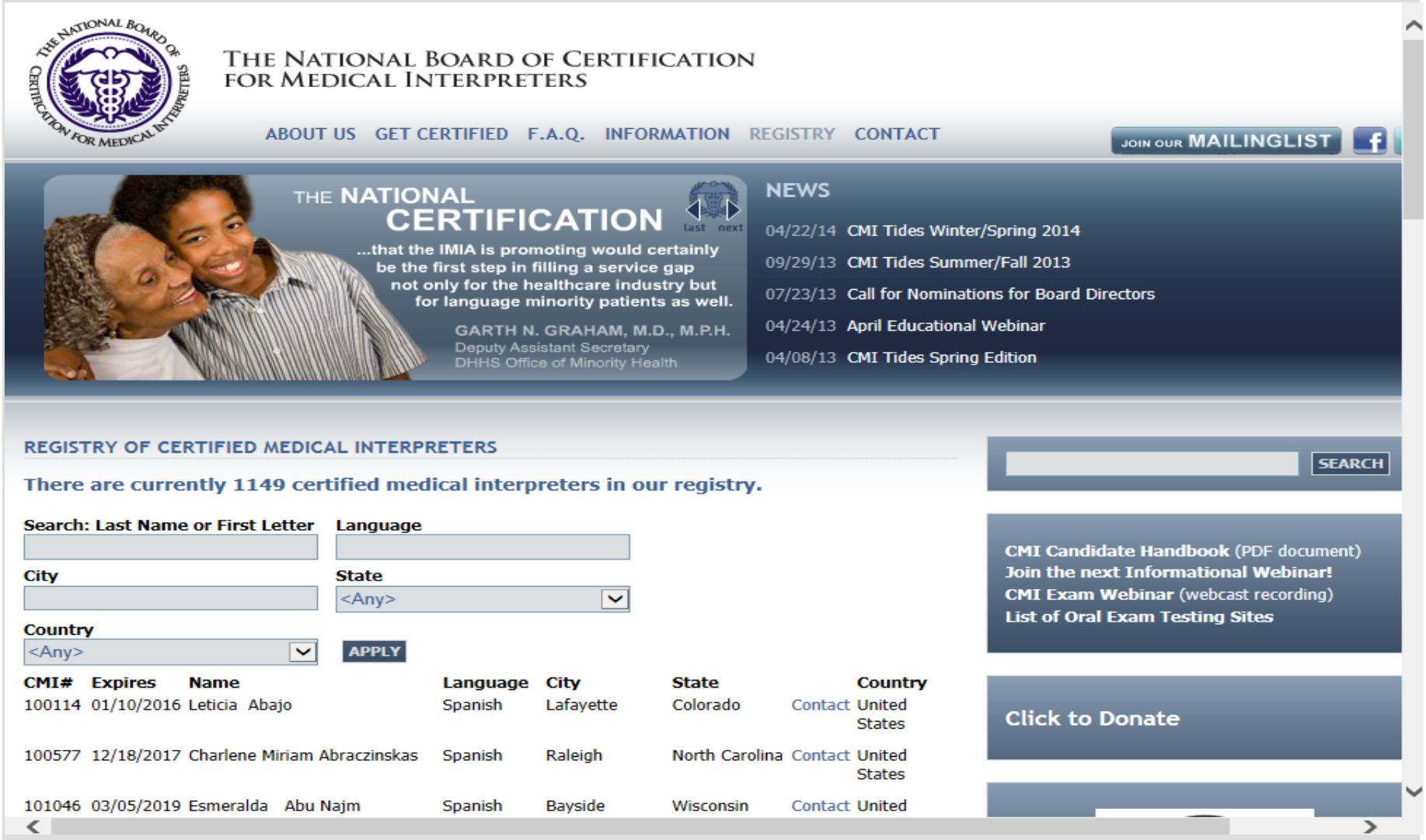
National Board of Certification

- **The National Board of Certification for Medical Interpreters**
  - **CMI or Certified Medical Interpreter** (best)
  - **Qualified Medical Interpreter (QMI)**
    - For minority languages where National Board does not have an exam and an oral exam is done in partnership with another national testing provider
  - Or **Screened Medical Interpreter (SMI)**
    - For newly emerging and indigenous languages and complete written exam
  - Question contact info@certifiedmedicalinterpreters.org

National Board of Certification for Medical

www.certifiedmedicalinterpreters.org/

HR Can Check Registry



CMS Hospital CoPs

- Interpretative guidelines are on the CMS website[1]
  - Look under state operations manual (SOM)
  - Appendix A, Tag A-**0001** to A-**1164**
  - Hospitals should also check the CMS transmittals once a month for changes [2]
  - Critical access hospitals have a separate manual under appendix W
- All the manuals are found on CMS website [2]

[1]www.cms.gov

[2]http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf

3 http://www.cms.gov/Transmittals/01_overview.asp

Notice of Patient Rights 117

- Rule #2 - A hospital must inform each patient of the patient's rights in advance of furnishing or discontinuing care
- Must protect and promote each patient's rights
- Must have P&P to ensure patients have information on their
- **All** patients, inpatients and outpatients, must be informed of their rights
  - Best to do in writing
- Grievance requirements should appear in the written copy of the patient rights

One Hospital's Way to Comply

- One hospital has the registration person initiate four section that are required to show that the information was given
  - Name of person at hospital to contact if any concerns
  - Notice that the patient can contact the state QIO (2 BFCC QIOs) or state agency with concerns or complaints
  - Visitation information provided
  - Patient has a right to discharge planning
- The hospital also has the admitting nurse cover the information with the patient and document this
- This way a hospital can prove to the CMS surveyor that these standards have been met

Notice of Patient Rights 117

- Hospitals are expected to take reasonable steps to determine the patient's wishes regarding designation of a patient representative
  - Patient representative can be the parent of a minor child, the guardian, DPOA of an incapacitated patient, or a patient advocate/support person (care partner)
- If the patient is not incapacitated and has a patient representative, you must give notice of patient rights to BOTH the patient and their representative
  - Patient provides orally or in writing and author highly recommends you get it in writing

Notify Patient of Their Rights

- If the patient is incapacitated and someone presents with an advance directive, then the patient rights information is given to the patient's representative such as the DPOA or support person/visitation advance directive
- If the patient is incapacitated and there is no written advance directive on file, then provide it to whoever asserts they are the spouse, domestic partner, parent, or other family member
  - Thus **they are** the patient representative
  - Cannot demand supporting documentation unless two people claim to be the patient representative

Spouse Includes Same Sex Marriages

- CMS publishes 6 pages in December 14, 2014 Federal Register
- CMS issues ten page survey memo December 12, 2014
- Recognizes the rights of a spouse in legally valid same sex marriages
- Equal rights to the spouse and treated the same as opposite-sex marriages
- Must honor regardless of where the couple resides

Spouse Includes Same Sex Marriages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 15-13-ALL

DATE: **December 12, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Terms Implicating the Spousal Relationship in Regulations and Guidance for Medicare- and Medicaid-certified Providers and Suppliers.

Memorandum Summary

- ***Clarification of "Spouse" & Related Terms*:** The Centers for Medicare and Medicaid Services (CMS) is clarifying that the terms "spouse", "marriage," "relative," and "family," as well as other terms that implicitly or explicitly implicate the spousal relationship, such as (but not limited to) "representative," "support person," "surrogate," and "next-of-kin," include all marriages lawful where entered into, including lawful same-sex marriages, regardless of the certified provider's or supplier's location or the jurisdiction in which the spouse lives.

FR Rights Spouse of Same Sex Marriages

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 416, 418, 482, 483, and 485

[CMS–3302–P]

RIN 0938–AS29

Medicare and Medicaid Program; Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the applicable conditions of participation (CoPs) for providers, conditions for coverage (CfCs) for suppliers, and requirements for long-term care facilities, to ensure that certain requirements are consistent with the Supreme Court decision in *United States* v. *Windsor*, 570 U.S.12, 133 S.Ct. 2675 (2013), and HHS policy. Specifically, we propose to revise certain definitions and patient's rights provisions, in order to ensure that same-sex spouses in legally-valid marriages are recognized and afforded equal rights

Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

This proposed rule is organized as follows:

I. Background

A. United States v. Windsor Decision

In *United States* v. *Windsor*, 570 U.S. 12, 133 S. Ct. 2675 (2013), the Supreme Court held that section 3 of the Defense of Marriage Act (DOMA) is unconstitutional because it violates the Fifth Amendment (*See Windsor*, 133 S.

Notify Patient of Their Rights 117

- Must follow any specific state law
- State law can specify a procedure for determining who can be a patient representative if the patient is incapacitated
- Hospitals must adopt policies and procedures on this
- Staff should be trained on this
- If hospital refused an individual to be treated as the patient's representative then this must be documented in the medical record along with basis for refusal

Notify Patient of Their Rights 117

- Consider having a copy of the patients rights on the back of the general admission consent form and acknowledgment of the NPP
- Include the sentence that patient acknowledges receipt of their patient rights or document when written patient rights statement is given
  - And that if support person is present that have also been give a copy of the patient rights statement
- Can include the required information on visitation
- Document that the patient rights was also given to the patient representative

Survey Procedure 117

- This standard has a survey procedure section
- It is instructions to the surveyor on what they are suppose to do
- The surveyor is to ask patients if the hospital informed them about their patient rights
  - Be sure registration clerk or nurse informs the patient of their rights and this is documented
- Surveyor is to determine the hospital's policy for notifying them of their patient rights
  - This includes both inpatients and outpatients

Grievance Process 118

- Rule #3 - The hospital must have a process for prompt resolution of patient grievance
- Patients should have a reasonable expectation of care and service
- Hospital must inform each patient where to file a grievance
  - Consumer advocate, risk management department etc.
  - Provide phone number to contact designated person
- Patients have the right to have their concerns addressed in a timely, reasonable, and consistent manner

A-0118

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§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.

Interpretive guidelines §482.13(a)(2)

The patient should have reasonable expectations of care and services and the facility should address those expectations in a timely, reasonable, and consistent manner. Although 482.13(a)(2)(ii) and (iii) address documentation of facility time frames for a response to a grievance, the expectation is that the facility will have a process to comply with a relatively minor request in a more timely manner than a written response. For example, a change in bedding, housekeeping of a room, and serving preferred food and beverage may be made relatively quickly and would not usually be considered a "grievance" and therefore would not require a written response.
The hospital must inform the patient and/or the patient's representative of the internal grievance process, including whom to contact to file a grievance (complaint). As part of its notification of patient rights, the hospital must provide the patient or the patient's representative a phone number and address for lodging a grievance with the State agency. The hospital must inform the patient that he/she may lodge a grievance with the State agency (the State agency that has licensure survey responsibility for the hospital) directly, regardless of whether he/she has first used the hospital's grievance process.

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

Grievance Process 118

- CMS provides a definition which you need to include in your policy
  - Use the CMS CoP definition of grievance which is used by DNV Healthcare
  - TJC does not have a definition of complaint in the glossary
- If TJC accredited, combine P&P with complaint section at RI.01.07.01
  - The patient and **family** have a right to have grievances/complaints reviewed by hospital

Grievance Process 118

- **Definition:** A patient grievance is a formal or informal written or verbal complaint
  - When the verbal complaint about patient care is not resolved at the time of the complaint by **staff present**
  - By a patient, or a patient's representative,
  - Regarding the patient's care, abuse, or neglect, issues related to the hospital's compliance with the CMS CoP
  - Or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

Grievances 0118

- Hospitals should have process in place to deal with minor requests in more timely manner than a written request
  - Examples: Change in bedding, housekeeping of room, and serving preferred foods
  - Does not require written response
- If complaint cannot be resolved at the time of the complaint or requires further action for resolution, then it is a grievance
- Then all the CMS requirements for grievances must be met

Patient or Their Representative

- If someone other than the patient complains about care or treatment:
  - First need to contact the patient and ask if this person is their authorized representative
  - If not an authorized representative, then it still may be a complaint under the Joint Commission standard
  - However, the July 1, 2009 changes brought TJC and CMS standards closer but not completely cross walked
  - Note that TJC calls it complaints but CMS uses the terminology of grievances and DNV calls it grievances

Patient or Their Representative

- It is not a grievance by CMS”s definition if the patient is satisfied with the care but a family member is not
- If person is the authorized representative of the patient then need to obtain patient’s permission to discuss medical record information with that person because of the HIPAA law
  - New changes in HIPAA enforcement so need to do this right
  - Document patient’s permission to discuss PHI with their representative
- Be sure to document both of these elements in the risk management file or other file

Grievances Tag 118

- Billing issues are not generally grievances unless a quality of care issue
- A written complaint is always a grievance whether inpatient or outpatient
  - Email and fax is considered to be a written grievance
- Information on patient satisfaction surveys is generally not a grievance
  - Unless patient asks for resolution or unless the hospital usually treats that type of complaint as a grievance

Grievances 0118

- If complaint is telephoned in after patient is dismissed then this is also considered a grievance
- All complaints on abuse, neglect, or patient harm will always be considered a grievance
  - Exception is if post hospital verbal communication would have been routinely handled by staff present
  - This is a minor exception and suggest you use exact language from Tag 118 in your P&P
- If patient asks you to treat as a grievance it will always be a grievance or if patient says it is not a grievance then follow their wishes and document
- Does not have to use the word “grievance”

- Patient complaints that are considered grievances also include situations where a patient or a patient's representative telephones the hospital with a complaint regarding the patient's 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.

- All verbal or written complaints regarding abuse, neglect, patient harm, or hospital compliance with CMS requirements are considered grievances for the purposes of these requirements.

- Whenever the patient or the patient's representative requests that his or her complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital, the complaint is considered a grievance and all the requirements apply.

Grievance Process

- If issue is resolved promptly then it is NOT a grievance
- Conduct in-services on importance of “PR” and Good Customer service and get staff to deal with patient’s request timely
  - Less likely to have complaints and grievance if good patient experience
- Monitor patient satisfaction surveys
- Disgruntled patients will contact CMS, Joint Commission, state department of health, QIO, OIG, OCR, OSHA, DNV, AOA, CIHQ, and others

Grievance Process Survey Procedure

- CMS instructs the surveyors to do the following
  - Review the hospital policy to assure its grievance process encourages all personnel to alert appropriate staff concerning grievances
  - How do you do this?
    - standard form, education in orientation, yearly skills lab etc.
- Hospital must assure that grievances involving situations that place patients in immediate danger are resolved in a timely manner
- Conduct audits and PI to make sure your facility is following its grievance P&P

Grievance Process Survey Procedure

- Surveyor will interview patients to make sure they know how to file a grievance
- Including the right to notify the state agency
  - Provide phone number of state department of health and QIO
  - Remember TJC APR requirements regarding unresolved patient safety concerns
  - So include all three in your patient rights statement
- Should be provided to the patient or their representative in writing
- Patient admission representative points out section in general consent form and NPP on grievances

Grievance Process 119

- Rule #4 The hospital must establish a process for prompt resolution
- Inform each patient whom to contact to file a grievance by name or title
- This must include patient representative and phone number and address of state agency
- Does operator know who to route calls to?
- Do you have a form accessible to all?

Grievance Process A-0119

- Rule #5 The hospital's governing board must approve and should be responsible for the effective operation of the grievance process
  - Elevates issue to higher administrative level
- Have a process to address complaints timely
- Coordinate data for PI and look for opportunities for improvement
  - Data on grievances must be incorporated into the PI program (118)
- You must read this section with the next rule
- Most boards will delegate this to hospital staff to do

Rule #6 The Board 0119-120

- The hospital's board must review and resolve grievances, unless it delegates the responsibility in writing to the grievance committee
- Board is responsible for effective operation of grievance process making sure grievance process reviewed and analyzed thru hospital's PI program
- **Grievance committee** must be more than one person and committee needs adequate number of qualified members to review and resolve
  - CMS does not say what their function is or how many times to meet

Grievance Survey Procedure

- Make sure your governing board has approved the grievance process
- Look for this in the board minutes or a resolution that the grievance process has been delegated to a grievance committee
  - Consider attaching the board minutes or resolution to the policy or reference it to the date of the board meeting
- Does hospital apply what it learns?
  - Remember to evaluate the system analysis theory to determine if system problem

Grievance Process 120

- Rule #7 – The grievance process must include a mechanism for timely referral of patient concerns regarding the quality of care or premature discharge, to the appropriate QIO
- Each state has a QIO under contract from CMS and list of QIOs[1]
- QIO or Quality Improvement Organizations are CMS contractors who are charged with reviewing the appropriateness and quality of care rendered to Medicare beneficiaries in the hospital setting

[1]http://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&name=QIO%20Listings

QIO Quality Improvement Organizations

- QIOs make hospitals aware of fact they have a complaint regarding the quality of care, a disagreement with coverage decision or wish to appeal a premature discharge
- Patient can ask that complaint be forwarded to the QIO by the hospital or can complain directly to the QIO
- Hospitals do not need to forward to the state QIO unless the patient specifically requests
  - Consider in the patient rights section to request patient give you an opportunity to address it first

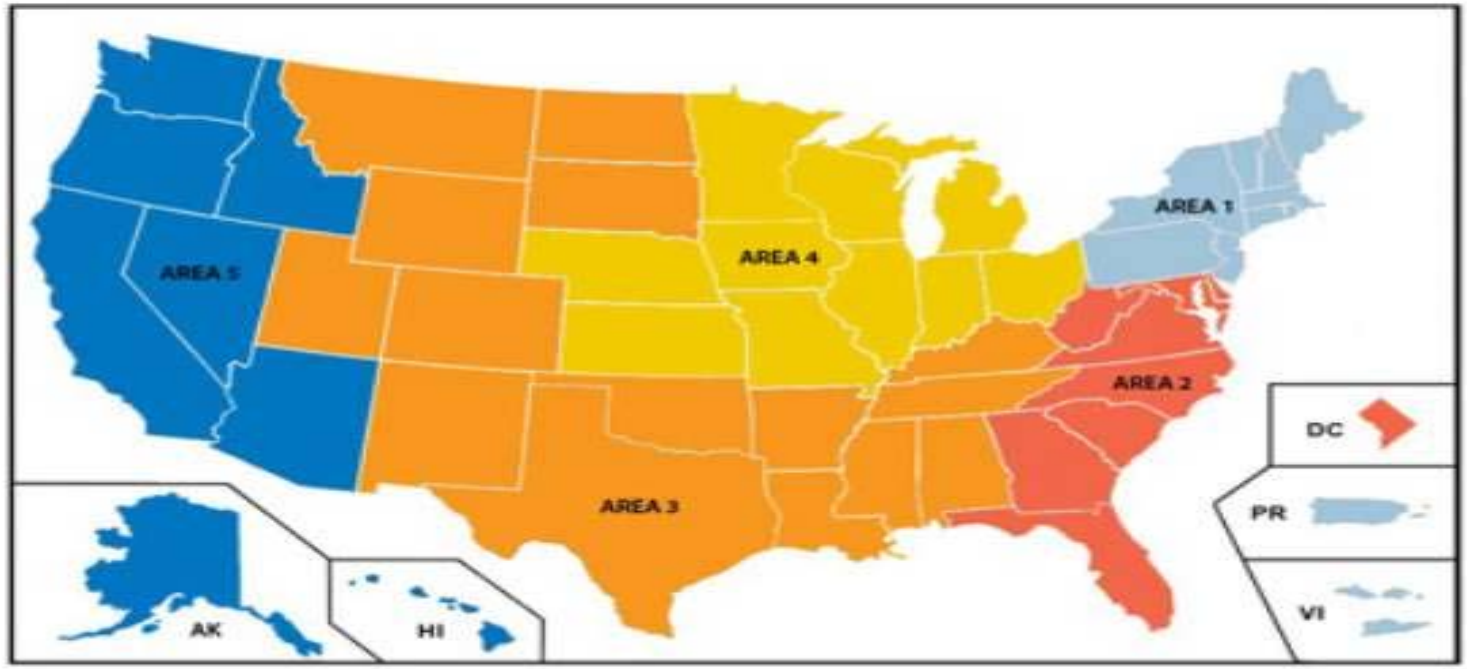
Grievance Procedure 121

- Must have a clear procedure for the submission of a patient's written or verbal grievances
- Surveyor will review information to make sure it clearly tells patients how to submit a verbal or written grievance
- Surveyors will interview patients to make sure information provided tells them how to submit a grievance
- Must establish process for prompt resolution of grievances

KEPRO and Livanta QIOs

Beneficiary and Family Centered Care - Quality Improvement Organizations (BFCC-QIOs)

www.qionews.org/articles/july-2014-special-focus/beneficiary-and-family-centered-care-quality-improvement-orga



Area 1 - Livanta Area 2 - KEPRO Area 3 - KEPRO
Area 4 - KEPRO Area 5 - Livanta

Beneficiary & Family Centered Care QIOs

- **Area 1 – Livanta**
  9090 Junction Drive, Suite 10
  Annapolis Junction, MD 20701
  Toll-free: 866-815 5440
  www.BFCCQIOAREA1.com
- **Area 2 – KEPRO**
  5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
  Toll-free: 844-455-8708
  www.keproqio.com
- **Area 3 – KEPRO**
  5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
  Toll-free: 844-430-9504
  www.keproqio.com
- **Area 4 – KEPRO**
  5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
  Toll-free: 855-408-8557
  www.keproqio.com
- **Area 5 – Livanta**
  9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
  Toll-free: 877-588-1123
  www.BFCCQIOAREA5.com

Beneficiary & Family Centered Care QIOs

- Beneficiary and Family Centered Care (BFCC)-QIOs will manage:
  - All beneficiary complaints,
  - Quality of care reviews,
  - EMTALA,
  - And other types of case reviews
  - To ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families

Hospital Grievance Procedure 122

- Rule #8 – Hospital must have a P&P on grievance
- Specific time frame for reviewing and responding to the grievance
- Grievance resolution that includes providing the patient with a written notice of its decision, IN MOST CASES
- The written notice to the patient must include the steps taken to investigate the grievance, the results and date of completion

Hospital Grievance Procedure

- Facility must respond to the substance of each and every grievance
- Need to dig deeper into system problems indicated by the grievance using the system analysis approach
- Note the relationship to TJC sentinel event policy and LD medical error standards, CMS guidelines for determining immediate jeopardy, HIPAA privacy and security complaints, and risk management/patient safety investigations

Grievances 7 Day Rule

- Timeframe of 7 days is considered acceptable
  - If not resolved or investigation not completed within 7 days must notify patient still working on it and hospital will follow up
- Most complaints are not complicated and do not require extensive investigation
- Surveyor will look at time frames established
- Must document if grievance is so complicated it requires an extensive investigation

Grievances Written Response 123

- Hospital must give patient a written response
- Explanation to the patient must be in a manner the patient or their legal representative would understand
- The written response must contain the elements required in this section and not statements that could be used in legal action against the hospital
- Written response must include the steps taken to investigate the complaint
- Surveyors will review the written notices to make sure they comply with this section

Grievances 123 Top Problem Standard

- Written notice must be communicated in language and manner that can be understood
  - Remember the issue of low health literacy
  - Use interpreter when indicated
- CMS says if patient emailed you a complaint, you may e-mail back response, if hospital allows
- Must maintain evidence of compliance with the grievance requirements
- Grievance is considered resolved when patient is satisfied with action or if hospital has taken appropriate and reasonable action

TJC Complaint Standard

- TJC has complaint standard RI.01.07.01
- Patient and family have a right to have complaints reviewed by the hospital
  - Different from CMS that says the patient or their designated representative
- 20 EPs
- Only 9 EPs are applicable to hospitals
- TJC calls them complaints
- CMS calls them grievances

RI.01.07.01 TJC Complaints

- Standard: Patient and or her family has the right to have a complaint reviewed,
  - TJC calls it complaints and CMS calls it grievances
- EP1 Hospital must establish a complaint resolution process,
  - See also MS.09.01.01, EP1, and
  - LD.04.01.07 that states the board or governing body is responsible for the effective operation of the complaint resolution process
  - Unless it delegates this in writing to the complaint resolution committee

RI.01.07.01 TJC Complaints

- EP2 Patient and family is informed of the complaint resolution process,
  - References MS.09.01.01 EP 1
  - This section states that the hospital has a clearly defined process for collecting, investigating, and addressing clinical practice concerns
  - Based on the recommendations from the Medical Staff-hospital needs to acts on concerns about a physician's practice or competence
- EP4 Complaints must be reviewed and resolved when possible,

RI.01.07.01 Complaints

- EP6 Hospital acknowledges receipt of a complaint that cannot be resolved immediately
  - Hospital must notify the patient of follow up to the complaint
- EP7 Must provide the patient with the phone number and address to file the complaint with the relevant state authority
  - Same as CMS requirement
- EP10 The patient is allowed to voice complaints and recommend changes freely with out being subject to discrimination, coercion, reprisal, or unreasonable interruption of care

RI.01.07.01 Complaints

- EP 18 Hospital provides individual with a written notice of its decision which includes (DS)
  - Name of hospital contact person
  - Steps taken on behalf of the individual to investigate the complaint
  - Results of the process
  - Date of completion of the grievance process
  - Same as CMS guideline

RI.01.07.01 Complaints

- EP19 Hospital determines the time frame for grievance review and response(DS)
- EP20 Process for resolving grievances includes a timely referral of patient concerns regarding quality of care or premature discharge to the QIO
  - QIO is the Quality Improvement Organization
  - Same as CMS
  - Patient can ask hospital to forward complaint to the QIO

Have a Policy to Hit All the Elements

POLICY

All internal and external customer (patient, physician, staff or visitors) complaints and problems will be addressed at the time of the occurrence in an effort to resolve the customer complaint or grievance and or review and improve the process. All patient and or family complaints received must be responded to promptly. Patients have a right to complain without any fear of reprisal. Any patient or patient's representative who expresses an issue or grievance is assured that this process is welcome and not fear that there would be any retaliation for initiating this action

Patients are informed to contact the Nursing Service Supervisor while in the hospital. Patients are also informed of their ability to contact the New York State Department of Health and the telephone number is provided to them at their request.

Any individual who believes his or her rights granted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations or any other state or federal laws dealing with privacy and confidentiality of health information have been violated may file a compliant regarding the alleged privacy violation to the Hospital's Privacy Officer (716)298-2047. The Privacy Officer will investigate alleged privacy violations and complaints made by patients or other individuals regarding alleged breaches of privacy

DEFINITION

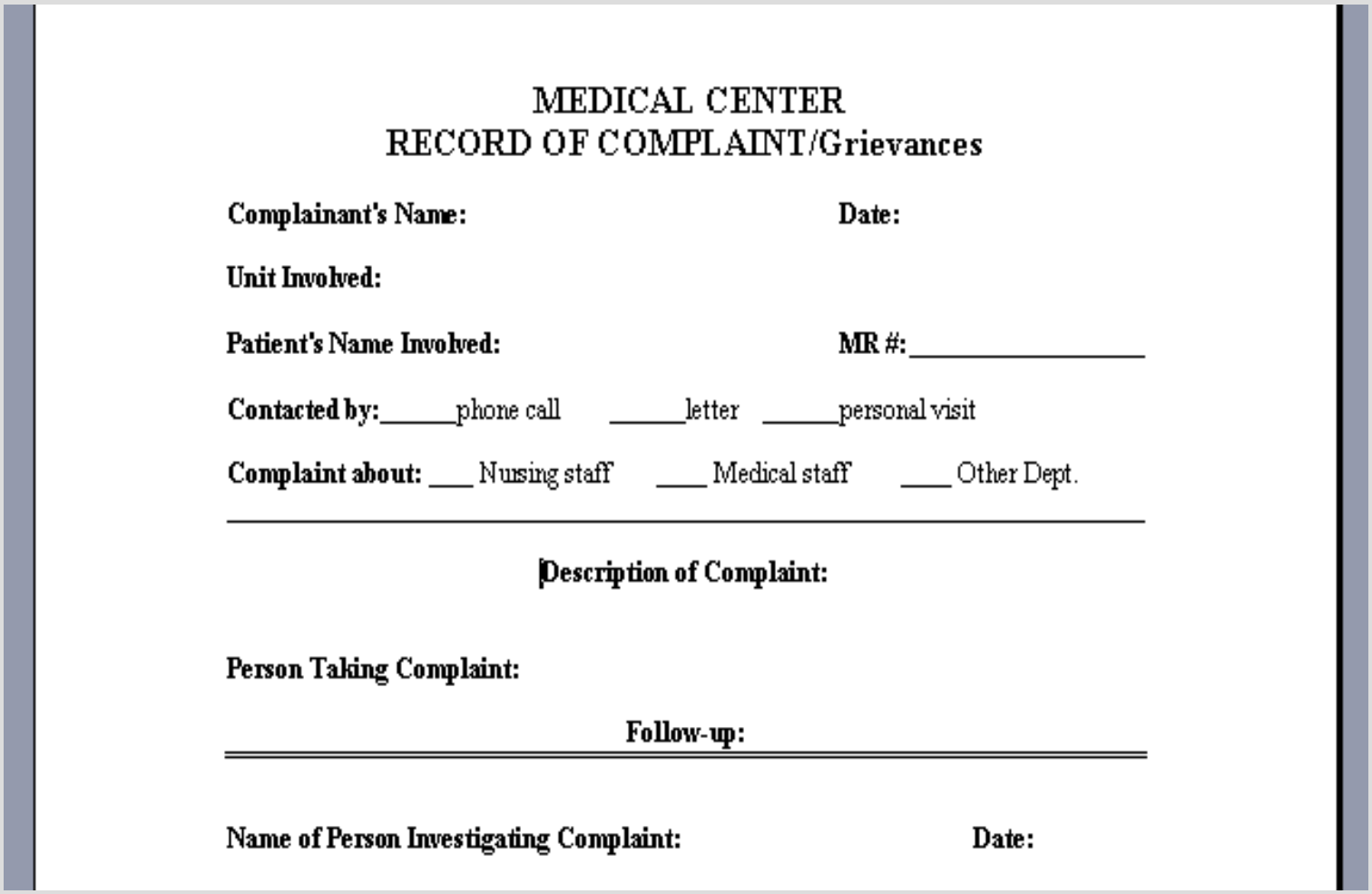
Patient Grievance – (as defined by Centers for Medicare & Medicaid Services, ref. 482.13(a)(2)) – is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (COP)

- **Staff Present** – includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e. nursing supervisor, nursing administration, etc.)
- If a verbal patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements. A complaint is considered resolved when the patient is satisfied with the actions taken on their behalf.
- Billing issues are not usually considered grievances for the purposes of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 are considered a grievance.
- A written complaint is considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with the COP.
- Information obtained with patient satisfaction surveys does not usually meet the definition of a grievance. If an identified patient writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance.

		Policy Title: Patient Complaint and Grievance Policy		
Section:	**Effective Date:**	**Oversight Level: Level 2**	**Policy No: RI-106**	
	Review Dates:			
	Revised:			
MRMC Business Unit:		**Interpretation: Risk Manager, Patient Safety/Risk Management Committee**		

Objective:	To provide a centralized and recognized systematic process for responding to a complaint or grievance filed by a patient or patient's representative in a manner which is fair and equitable, allowing the Medical Center to identify areas and processes needing improvement.
Scope:	This policy applies to all members of the workforce who have contact with patients and their representatives, (including active employees, students, interns, residents, volunteers and physicians) of any units, departments, clinics or facilities under the management of Regional Medical Center, as well as patients and their representatives.
Policy:	Regional Medical Center recognizes that at times, patients or their representatives will be dissatisfied with the care and services provided to them. It is the policy of X hosptial to inform patients and their representatives of the mechanism for resolving complaints or grievances. It is also the policy to respond to these complaints/grievances in a timely manner, with appropriate review, analysis and action.
Definitions:	**Complaint**—An allegation or dissatisfaction expressed verbally regarding the patient's care and/or the services provided that can be promptly resolved by informal means. This does NOT include allegations of abuse, neglect or harm. A verbal complaint does not require a written response to the patient. **Grievance**— • Any verbal complaint, when the verbal complaint is not resolved at the time of the complaint by staff present, is postponed for later resolution, requires investigation and/or requires further action for resolution. • Any written complaint regarding the care of the patient or the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs). • Any complaint, verbal or in writing, with an allegation of abuse, neglect or patient harm.

Use a Form to Collect Information



MEDICAL CENTER
RECORD OF COMPLAINT/Grievances

Complainant's Name: **Date:**

Unit Involved:

Patient's Name Involved: **MR #:**_____

Contacted by:_____phone call _____letter _____personal visit

Complaint about: ___ Nursing staff ____ Medical staff ____ Other Dept.

Description of Complaint:

Person Taking Complaint:

Follow-up:

Name of Person Investigating Complaint: **Date:**

Patient Who Files a Lawsuit

- If a patient advocate is working to resolve a grievance and a lawsuit is filed
- Need to note in file and close file
- Patient advocate cannot have a unilateral discussion with the patient anymore
- Patient advocate should notify risk manager
- Attorney who is assigned to defend the case can be given the information on what has been done on the grievance so far
- Also note no federal peer review statute

CMS Changes to Come with QIO

- 10 years ago a IOM report requested Congress to separate the functions of the QIO to do PI with hospitals and investigate complaints from patients
- Concerned about a conflict of interest with QIOs
- Beneficiary and Family Centered Care (BFCC) program will handle Medicare beneficiary complaints or case reviews and monitoring activities
  - Livanta LLC in MD will handle complaints two regions and in 18 states in western and north Atlantic states and Puerto Rico and Virgin Islands
  - Ohio KePRO will have three regions and the rest of the states and DC

CMS Changes to Come with QIO

- Concern was the recruitment of providers and hospitals to collaborate on quality projects
- And the process of investigating beneficiary complaints about care or fraud
  - Called a ding letter
- IOM found it a conflict in 543 report says working collaboratively with providers and investigating their activities within a single contract
- Now a wall will go up and CMS is restructuring the process and two separate contracts and vendors

CMS Restructures QIO Program

- So in summary, these two companies will review and monitor activities separate from the traditional improvement activities of the QIO
- They will review medical care, improve services, and help beneficiaries with complaints
- CMS will award contract to different groups to work directly with the hospitals and providers to improve the quality of patient care
- CMS issued a press release on this May 9, 2014 so expect some changes to the CoPs on this

Press releases

Return to Newsroom Center

http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-05-09.html?DLPage=1&DLSort=0&DLSortDir=descending

Press release: CMS launches improved Quality Improvement Program

Date	2014-05-09
Title	CMS launches improved Quality Improvement Program
For Immediate Release	Friday, May 9, 2014
Contact	press@cms.hhs.gov

CMS launches improved Quality Improvement Program

The Centers for Medicare and Medicaid Services (CMS) today took the agency's first step in restructuring the Quality Improvement Organization (QIO) Program to improve patient care, health outcomes, and save taxpayer resources.

This first phase of the restructuring will allow two Beneficiary and Family-Centered Care (BFCC) QIO contractors to support the program's case review and monitoring activities separate from the traditional quality improvement activities of the QIOs. The two BFCC QIO contractors are Livanta LLC, located in Annapolis Junction, Maryland, and KePRO, located in Seven Hills Ohio. They will be responsible for ensuring consistency in the review process with consideration of local factors important to beneficiaries.

QIOs historically have provided numerous quality improvement functions, including providing an infrastructure for national quality improvement initiatives across the continuum of care; today's announcement highlights CMS' efforts to restructure the QIO Program to gain efficiencies, to eliminate any perceived conflicts of interest, and to better address the needs of Medicare beneficiaries using BFCC QIOs to focus on providing patients a voice through conducting quality of care reviews, discharge and termination of service appeals, and other areas of required review in various provider settings.

"One of the most critical roles of CMS is to protect the quality and safety of care delivered to beneficiaries. Care needs to be patient-centered and directly engage patients, families, and caregivers," said Dr. Patrick Conway, deputy administrator for innovation and quality and CMS chief medical officer. "The quality of care review is essential to ensure care delivered to all beneficiaries meets professionally recognized standards."

In the program's second phase – expected in July – CMS will award contracts to organizations that will directly work

Who is Your BFCC QIO Contractor?

The geographic Area 1 and Area 5 were awarded to Livanta, LLC.

The contract awards for Areas 2, 3 and 4 were awarded to KePRO.

Area 1: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands

Area 2: District of Columbia, Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

Area 3: Alabama, Arkansas, Colorado, Kentucky, Louisiana, Mississippi, Montana, North Dakota, New Mexico, Oklahoma, South Dakota, Tennessee, Texas, Utah, Wyoming

Area 4: Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin

Area 5: Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington

DNV Healthcare NIAHO Grievances

- DNV Healthcare has section PR 5 on the grievance procedure under the patient rights section
- SR.10 Addresses the submission of a written or verbal grievance and that a P&P is required
  - Must also include in the patient rights statement and inform patient or family in advance of providing care
- PR.5 Requires the hospital to have a formal grievance procedure that provides for the following;
  - List of whom to contact
  - Board's review and resolution of grievance or that it is delegated to the appropriate person or committee

DNV Healthcare NIAHO Grievances

- PR.5 Requires the hospital to have a formal grievance procedure that provides for the following (continued);
  - Referral process for quality of care issues to UR, Peer Review or Quality Management, as appropriate
  - Reasonable timeframes for review and resolution and prompt response
  - Grievance resolution must be in writing to the patient and must include person to contact at hospital, steps taken to investigate, results of grievance process and date of completion

DNV Healthcare NIAHO Grievances

- Uses same definition as CMS
- Needs to be address in timely and reasonable manner
- Written notice is required for initial acknowledgement within 7-10 days (CMS is 7 days)
  - Must include steps taken to resolve, results and date of completion
- If not must notify patient still working on it
- If minor request and immediately resolved do not have put in writing

DNV Healthcare NIAHO Grievances

- Must have procedure to refer Medicare patient concerns to the QIO if patient request, disagreement with a coverage decision, or wish to appeal premature discharge
- Surveyor instructed to verify P&P encourage alert staff if grievance
- Will verify information is given to patient
- Will make sure response is in writing and within time frame and time frame is explained to the patient

Consumer Reporting System

- Could there be a new reporting system for patient safety by consumers?
- The Obama administration wants to create a new system by which patients can report medical mistakes and unsafe practices by doctors and hospitals
- Concern is that medical mistakes go unreported
- Published a draft questionnaire for patients
- AHRQ published a notice in the Sept 10, 2012 Federal Register and comment period ended Nov 9, 2012

[Federal Register Volume 77, Number 175 (Monday, September 10, 2012)]
[Notices]
[Pages 55475-55477]
From the Federal Register Online via the Government Printing Office [http://www.gpo.gov/]
[FR Doc No: 2012-22028]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: ``A Prototype Consumer Reporting System for Patient Safety Events.'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501-3521, AHRQ invites the public to comment on this proposed

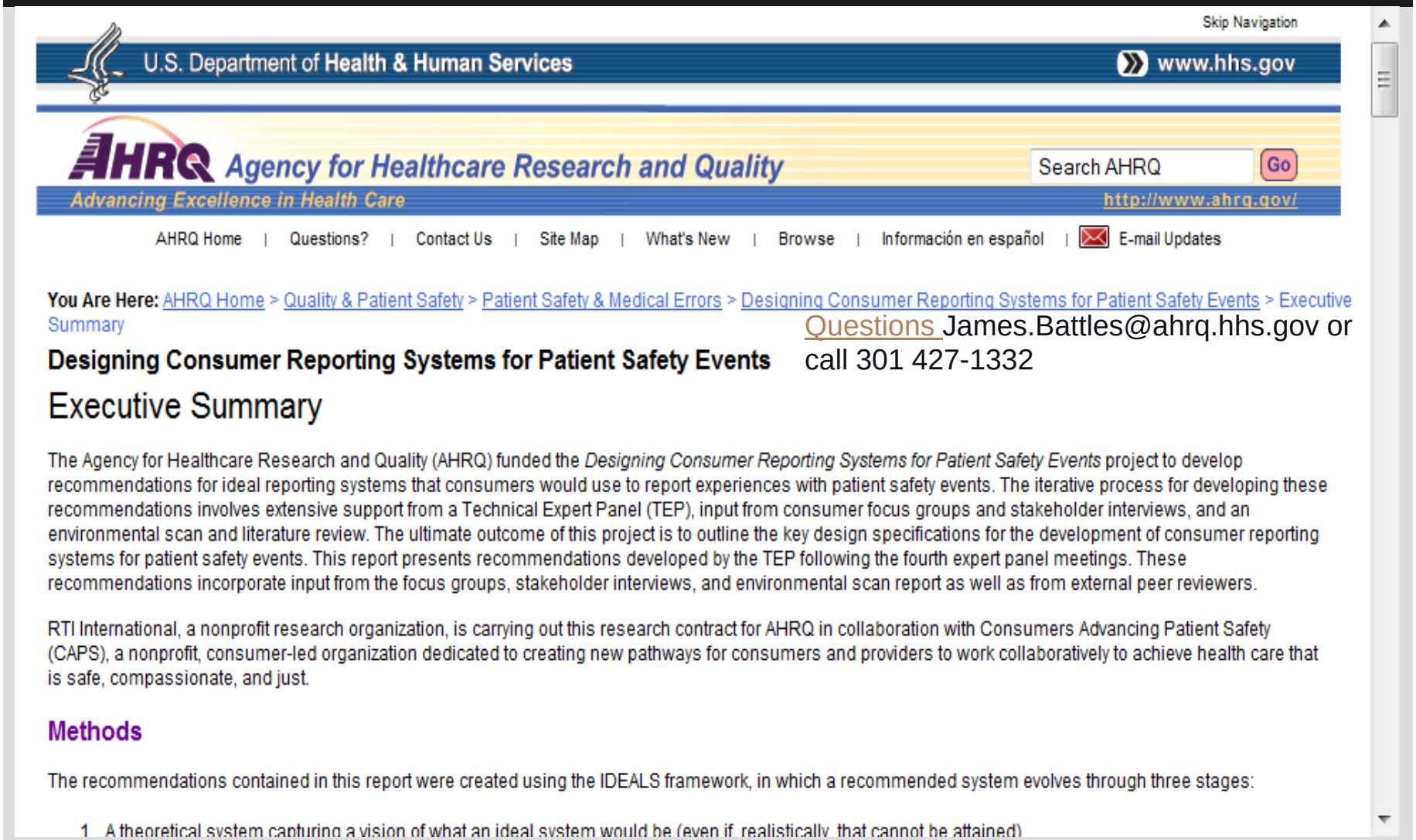
AHRQ Proposal

- A Consumer Reporting System for Patient Safety Events
- AHRQ wants to collect information for this
- States growing body of evidence that many adverse medical events go unreported
- States because information is not elicited from patients
- To realized untapped potential of patients to provide important information about safety events AHRQ has funded a prototype consumer reporting system

AHRQ Proposal

- To collect information about medical errors that resulted in harm or nearly resulted in harm
- Believes this will improve quality of healthcare and improve patient safety
- To test web site reporting and telephone modes of questionnaires patients can answer
- To test the protocols for a follow up survey of healthcare providers when patients consent
- ECRI Institute, Rand Corp., Brigham and Women's Hospital and Dana Farber Hospital are on this

Consumer Reporting Systems for PS Events



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You Are Here: AHRQ Home > Quality & Patient Safety > Patient Safety & Medical Errors > Designing Consumer Reporting Systems for Patient Safety Events > Executive Summary

Questions James.Battles@ahrq.hhs.gov or call 301 427-1332

Designing Consumer Reporting Systems for Patient Safety Events

Executive Summary

The Agency for Healthcare Research and Quality (AHRQ) funded the *Designing Consumer Reporting Systems for Patient Safety Events* project to develop recommendations for ideal reporting systems that consumers would use to report experiences with patient safety events. The iterative process for developing these recommendations involves extensive support from a Technical Expert Panel (TEP), input from consumer focus groups and stakeholder interviews, and an environmental scan and literature review. The ultimate outcome of this project is to outline the key design specifications for the development of consumer reporting systems for patient safety events. This report presents recommendations developed by the TEP following the fourth expert panel meetings. These recommendations incorporate input from the focus groups, stakeholder interviews, and environmental scan report as well as from external peer reviewers.

RTI International, a nonprofit research organization, is carrying out this research contract for AHRQ in collaboration with Consumers Advancing Patient Safety (CAPS), a nonprofit, consumer-led organization dedicated to creating new pathways for consumers and providers to work collaboratively to achieve health care that is safe, compassionate, and just.

Methods

The recommendations contained in this report were created using the IDEALS framework, in which a recommended system evolves through three stages:

1. A theoretical system capturing a vision of what an ideal system would be (even if, realistically, that cannot be attained)

www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/consumer-experience/systems

Clinicians & Providers
Education & Training
Hospitals & Health Systems
Prevention & Chronic Care
Quality & Patient Safety
- Comprehensive Unit-based Safety Program (CUSP)
- Patient Safety Measure Tools & Resources
  - Online Journals and Primers
  - Tools and Resources
  - Conferences and Workshops
  - Congressional Hearings
- Surveys on Patient Safety

Project Overview: Designing Consumer Reporting Systems for Patient Safety Events

Publication # 11-0075-EF
Previous Publication # 09-M023

Go to Online Store

Current patient safety event reporting systems are aimed at obtaining information from health care providers. However, patients and their family members are in a unique position to identify gaps in care that may have contributed to adverse events. The Agency for Healthcare Research and Quality (AHRQ) recognizes that consumers can be an important source of information about patient safety, and consumer reporting systems may greatly improve our understanding of the nature and causes of medical errors.

To develop recommendations for ideal reporting systems that consumers would use to report their experiences with patient safety events, AHRQ awarded a 2-year, $618,000 contract in September 2008 to RTI International in Research Triangle Park, N.C., and Consumers Advancing Patient Safety, a consumer-led nonprofit organization based in Chicago. The following document gives additional information on this project. The project's final report is available by selecting Final Report.

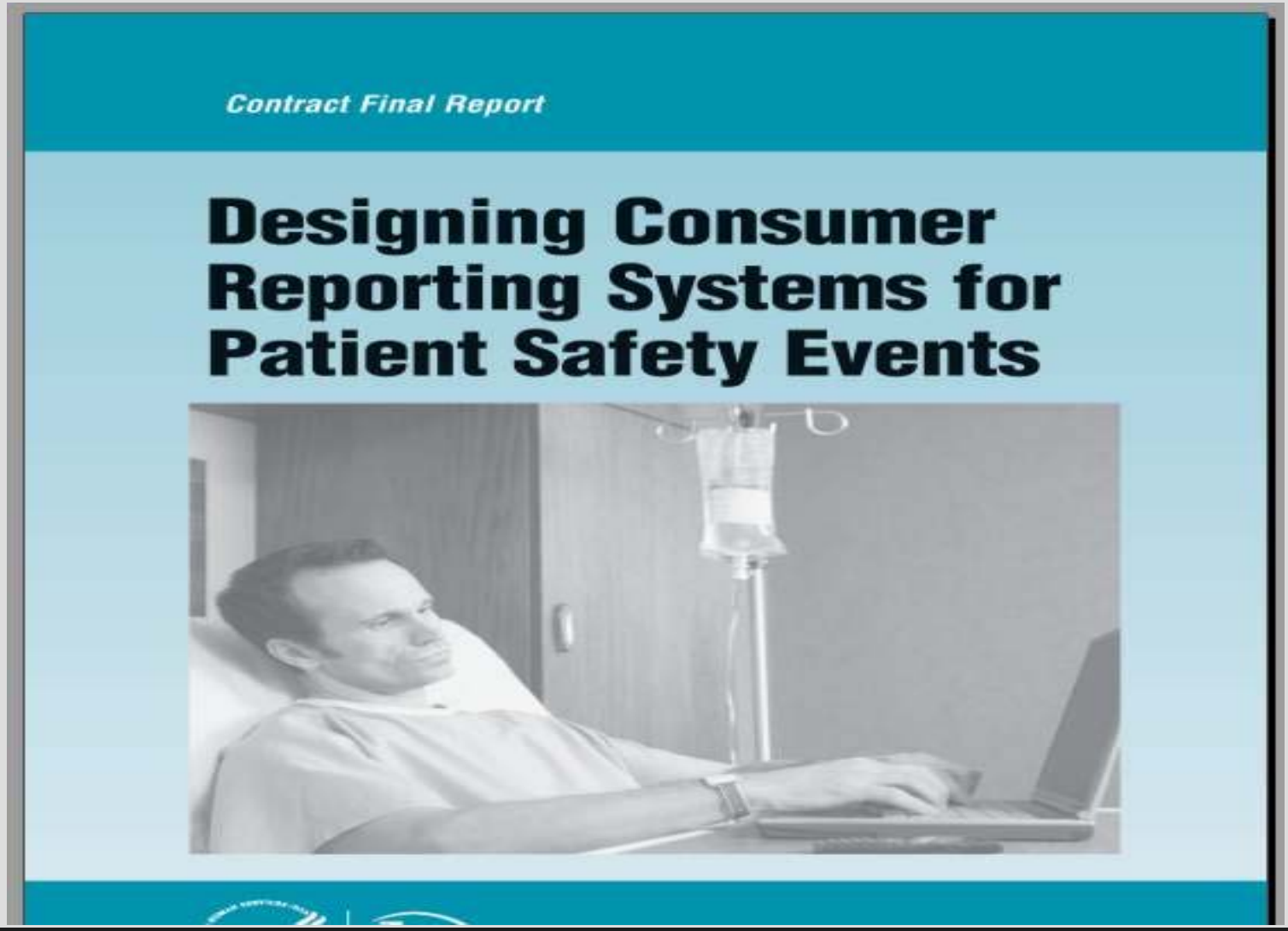
Background

RELATED PUBLICATIONS

Designing Consumer Reporting Systems for Patient Safety Events

feedback

Final Report



The End! Questions?

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education Consulting
- Board Member
  Emergency Medicine Patient Safety Foundation
- 614 791-1468
- sdill1@columbus.rr.com

Changes MR Must Contain

- TJC has a standard to improve patient centered communication by
- Qualifications for language interpreters and translators will be met through proficiency, assessment, education, training, and experience
- Hospitals need to determine the patient's oral and written communication needs and their preferred language for discussing health care under PC standard
- Hospital will communicate with patients in a manner that meets their communication needs

Changes MR Must Contain

- Collecting race and ethnicity data under RC.02.01.01 EP1
- Collecting language data under RC.02.01.01 EP1
- The patient's communication needs, including preferred language for discussing health care
  - If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the MR
- The patient's race and ethnicity

This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.

Thank you for attending!

- Sue Dill Calloway RN, Esq. CPHRM
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- Call with Questions, No emails