March 7, 2016

Grievances and Complaints: Compliance with CMS, TJC & DNV Standards

Speaker

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- sdill1@columbus.rr.com (Call, No email questions)

2

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.

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You Don't Want One of These

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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

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Introduction

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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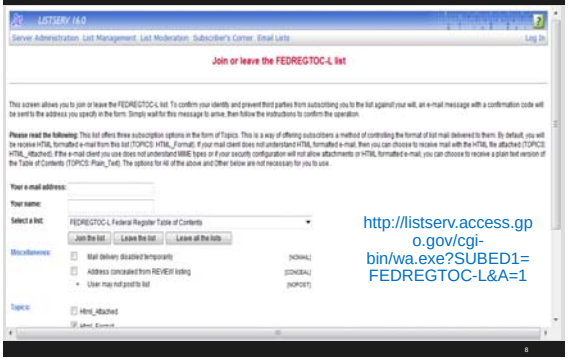
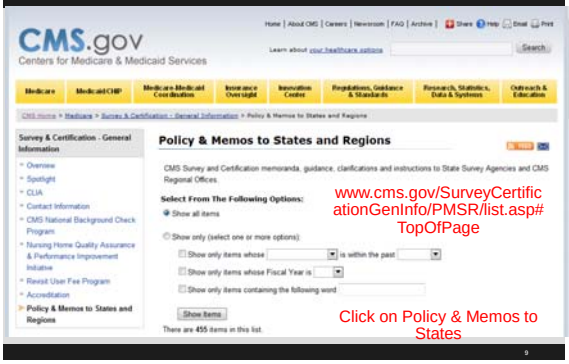


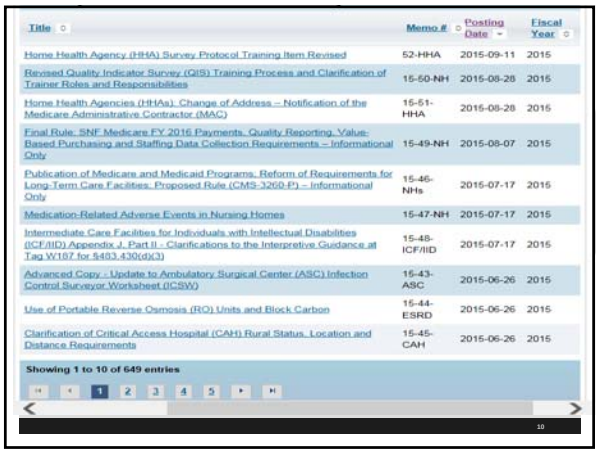
http://listserv.access.gpo.gov/cgi-bin/wa.exe?SUBED1=FEDREGTOC-L&A=1

CMS Survey and Certification Website



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

Click on Policy & Memos to States



Title	Memo #	Posting Date	Fiscal Year
Home Health Agency (HHA) Survey Protocol Training Item Revised	52-HHA	2015-09-11	2015
Revised Quality Indicator Survey (QIS) Training Process and Clarification of Trainer Roles and Responsibilities	15-50-NH	2015-08-28	2015
Home Health Agencies (HHAs): Change of Address – Notification of the Medicare Administrative Contractor (MAC)	15-51-HHA	2015-08-28	2015
Final Rule: SNF Medicare FY 2016 Payments, Quality Reporting, Value-Based Purchasing and Staffing Data Collection Requirements – Informational Only	15-49-NH	2015-08-07	2015
Publication of Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; Proposed Rule (CMS-3260-P) – Informational Only	15-46-NHs	2015-07-17	2015
Medication-Related Adverse Events in Nursing Homes	15-47-NH	2015-07-17	2015
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Appendix J, Part II - Clarifications to the Interpretive Guidance at Tag W187 for §483.430(d)(3)	15-48-ICF/IID	2015-07-17	2015
Advanced Copy - Update to Ambulatory Surgical Center (ASC) Infection Control Surveyor Worksheet (ICSW)	15-43-ASC	2015-06-26	2015
Use of Portable Reverse Osmosis (RO) Units and Block Carbon	15-44-ESRD	2015-06-26	2015
Clarification of Critical Access Hospital (CAH) Rural Status, Location and Distance Requirements	15-45-CAH	2015-06-26	2015

Showing 1 to 10 of 649 entries

1 2 3 4 5

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Medicare State Operations Manual

Appendix

Email questions to CMS at hospitalscg@cms.hhs.gov

- 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. 141, 07-10-15)

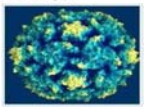
Transmittals for Appendix A

Survey Protocol

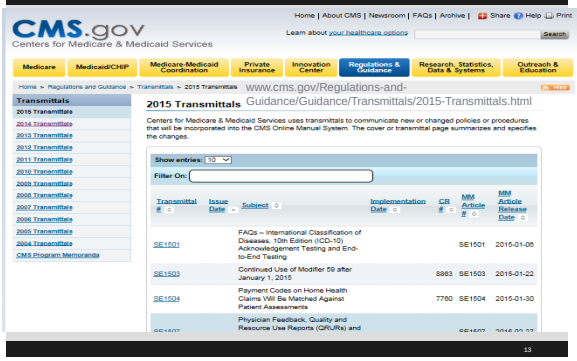
Introduction
- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering/Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module

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



Transmittals

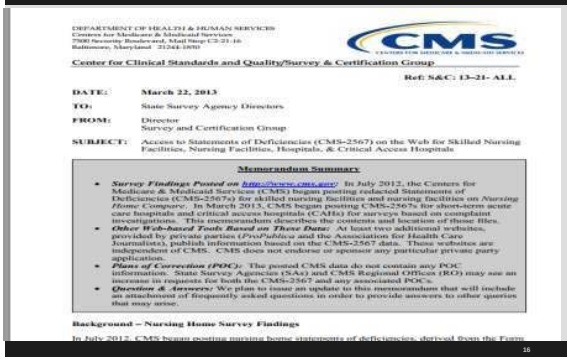


CMS Hospital CoP Deficiency Reports

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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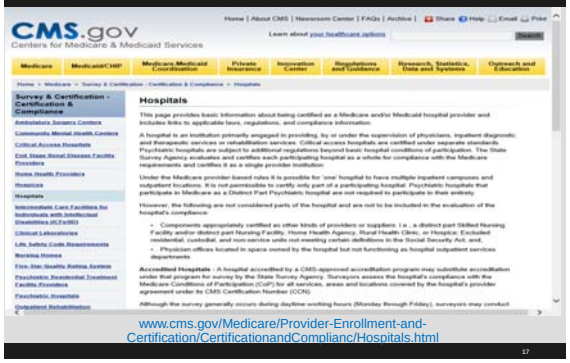
Updated Deficiency Data Reports



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Home > Medicare > Survey & Certification - Certification & Compliance > Hospitals

Survey & Certification - Certification & Compliance

- Ambulatory Surgery Centers
- Community Mental Health Centers
- Critical Access Hospitals
- End Stage Renal Disease Facility Providers
- Home Health Providers
- Hospices
- Hospitals
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)
- Clinical Laboratories
- Life Safety Code Requirements
- Nursing Homes
- Five-Star Quality Rating System
- Psychiatric Residential Treatment Facility Providers
- Psychiatric Hospitals
- Outpatient Rehabilitation

Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers. I.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act, and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct

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

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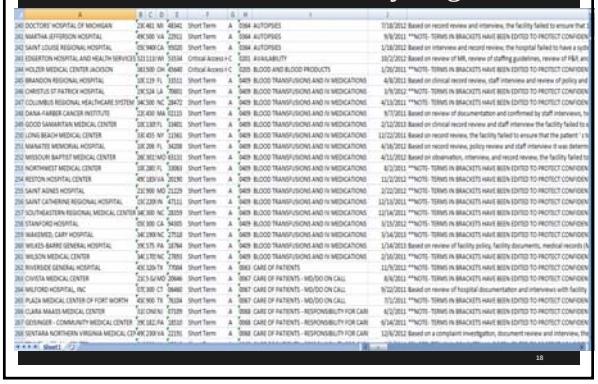
Can Count the Deficiencies by Tag Number



240	DOCTORS' HOSPITAL OF MICHIGAN	23C481	MI	48341	Short Term	A	0364	AUTOPSIES	7/18/2012	Based on record review and interviews, the facility failed to ensure that
241	MARTHA JEFFERSON HOSPITAL	49C500	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	05C968	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	52J110	WI	53534	Critical Access H	C	0381	AVAILABILITY	10/2/2012	Based on review of MR, review of staffing guidelines, review of P&P, an
244	HOLZER MEDICAL CENTER JACKSON	36J300	OH	45640	Critical Access H	C	0385	BLOOD AND BLOOD PRODUCTS	1/20/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
245	BRANDON REGIONAL HOSPITAL	10E119	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	19C524	LA	70601	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	1/9/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
247	COLUMBUS REGIONAL HEALTHCARE SYSTEM	34C500	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	22C450	MA	02115	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	9/7/2011	Based on review of documentation and confirmed by staff interviews, fa
249	GOOD SAMARITAN MEDICAL CENTER	10E130	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	05E455	NY	11561	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	11/22/2011	Based on record review, the facility failed to ensure that the patient' s h
251	MANATEE MEMORIAL HOSPITAL	10E206	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 determ
252	MISSOURI BAPTIST MEDICAL CENTER	26C302	MO	63131	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/11/2012	Based on observation, interviews, and record review, the facility failed to
253	NORTHWEST MEDICAL CENTER	10E280	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	49C185	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	21C900	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	15C209	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	34C300	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	05C300	CA	94305	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	1/15/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
259	WAKEMED, CARY HOSPITAL	34C190	NC	27518	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	5/14/2013	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
260	WILKES-BARRE GENERAL HOSPITAL	39C575	PA	18764	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	1/14/2013	Based on review of facility policy, facility documents, medical records (s
261	WILSON MEDICAL CENTER	34C170	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	45C329	TX	77564	Short Term	A	0963	CARE OF PATIENTS	11/9/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
263	CIVITA MEDICAL CENTER	23C514	MO	63646	Short Term	A	0967	CARE OF PATIENTS - MD/DO ON CALL	8/4/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
264	MILFORD HOSPITAL, INC	07C300	CT	06460	Short Term	A	0967	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	45C900	TX	76104	Short Term	A	0967	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	31C096	NJ	07109	Short Term	A	0968	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	6/2/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
267	GEISINGER - COMMUNITY MEDICAL CENTER	39C182	PA	18510	Short Term	A	0968	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	9/14/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
268	SENTARA NORTHERN VIRGINIA MEDICAL CEN	49C230	VA	22191	Short Term	A	0968	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	12/6/2012	Based on a complaint investigation, document review and interview, the

Sheet1

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Grievance Deficiencies

Tag	Section	JULY 16 2015
118	Pt Rights Grievances	196
119	Review of Grievances	88
120	Timely Referral of Grievances	14
121	Grievance Procedures	19
122	Grievance Review Times	103
123	Notice of Grievance Decisions	270
		Total 690

CMS Hospital CoPs on Grievances

Patient Rights Standards

- 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

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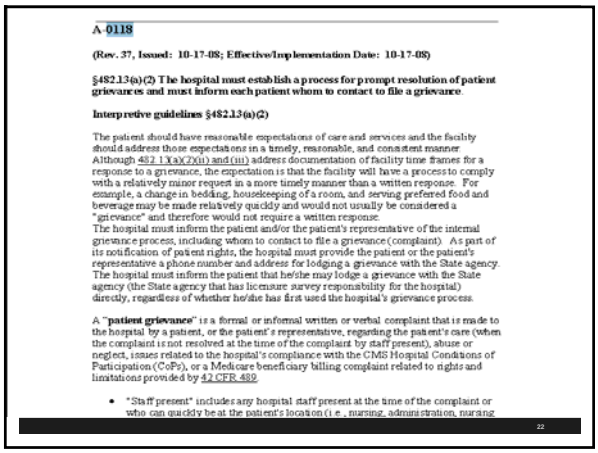

A-0118

(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

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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

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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 understand their medication instruction sheets or understand their discharge instructions

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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
- 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

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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 (Office of Civil Rights)
- Consider if discussing a grievance with a LEP patient (Limited English Proficiency)
- See the Joint Commission standards on patient centered communications

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

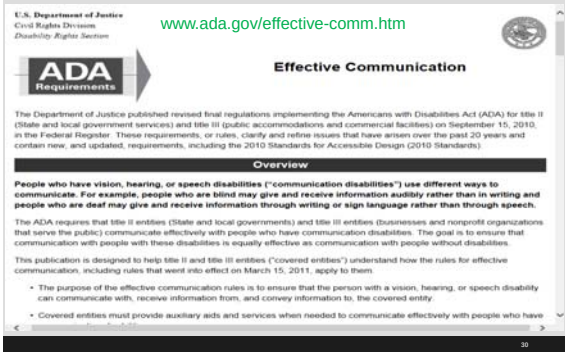
Limited English Proficiency Resources OCR

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

Deaf or HOH Resources OCR

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

ADA Effective Communication 2014



www.ada.gov/effective-comm.htm

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) .

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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

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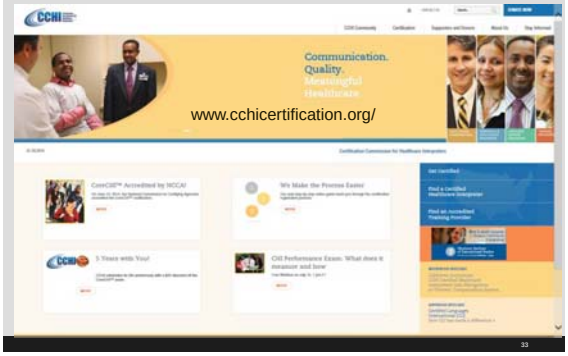
CCHI Certification Commission



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CoreCHI Is Entry Point for Interpreters

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

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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

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National Board of Certification for Medical

www.certifiedmedicalinterpreters.org/

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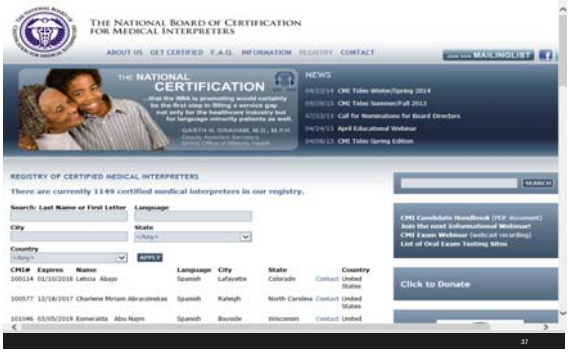
HR Can Check Registry



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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

38

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

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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

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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

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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

42

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
  - Supreme Court ruling requires every state to perform same sex marriages

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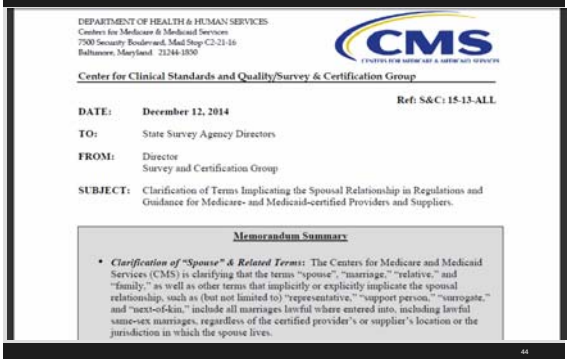
Spouse Includes Same Sex Marriages



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

CMS

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.

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FR Rights Spouse of Same Sex Marriages

Federal Register / Vol. 79, No. 239 / Friday, December 12, 2014 / Proposed Rules 73873

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

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
B. Statutory and Regulatory Authority
II. Provisions of the Proposed Regulation
A. Ambulatory Surgical Centers Condition for Coverage—Patient Rights (§ 416.50)
B. Hospice Care (Part 418)
C. Conditions of Participation for Hospitals (Part 482)
D. Requirements for States and Long Term Care (LTC) Facilities (Part 483)
E. Conditions of Participation: Community Mental Health Centers (CMHCs) (Part 485, Subpart B)
III. Collection of Information Requirements
IV. Response to Comments
V. Regulatory Impact Statement
Regulations Text

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.

45

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 (not competent)
- 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

46

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 (Notice of Privacy Practice)
- 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

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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

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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

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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

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 so use the CMS definition
- 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

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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.

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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

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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

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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
  - Increased penalties for violating HIPAA 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

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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

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Grievances 118

- 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"

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- 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.

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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

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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 QAPI to make sure your facility is following its grievance P&P

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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 (Accreditation Participation Requirements) 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

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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?

62

Grievance Process 119

- 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 level
- Have a process to address complaints timely
- Coordinate data for QAPI and look for opportunities for improvement
  - Data on grievances must be incorporated into the QAPI program (118)
- You must read this section with the next rule
- Most boards will delegate this to hospital staff to do

63

Rule #6 The Board 119-120

- 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

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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

65

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

66

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

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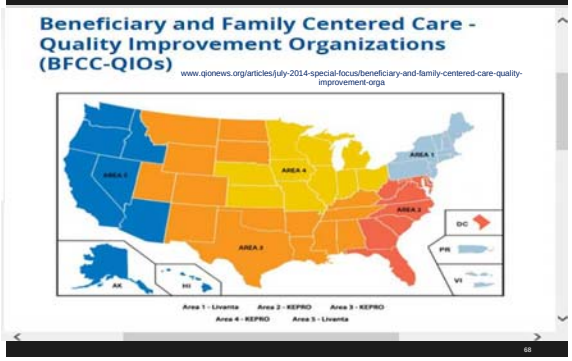
KEPRO and Livanta QIOs



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

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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

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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

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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

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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

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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

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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

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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 a response, if the 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

76

TJC Complaint Standards

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

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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 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

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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.

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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

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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

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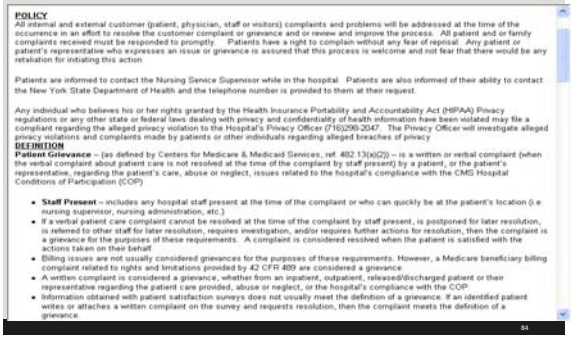
RI.01.07.01 Complaints

- 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

83

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 complaint 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.

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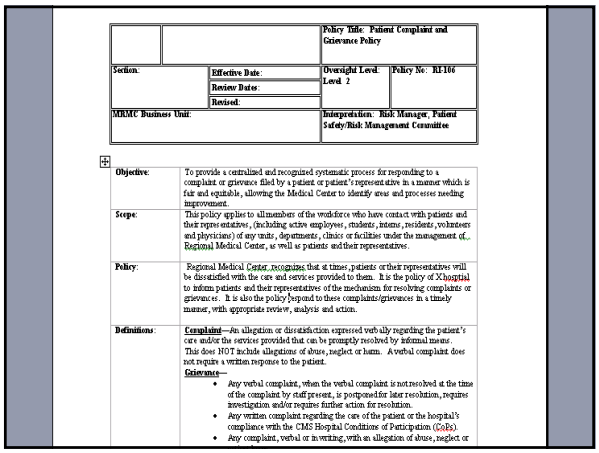
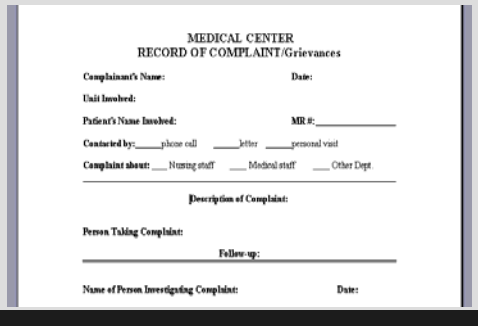


		Policy Title: Patient Complaint and Grievance Policy	
Section:	Effective Date: Review Dates: Revised:	Oversight Level: Level 2	Policy No: RI-106
MRMC Business Unit:		Interpretation: Risk Manager, Patient Safety/Risk Management Committee	

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 Xhospital to inform patients and their representatives of the mechanism for resolving complaints or grievances. It is also the policy beyond 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

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:**

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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

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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

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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

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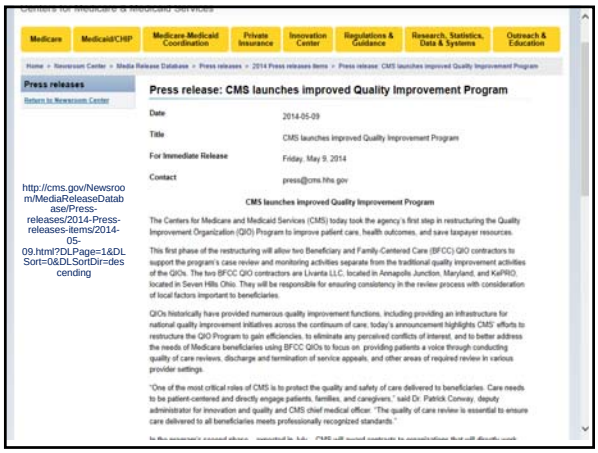
CMS Restructures QIO Program

- 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

90



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

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

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DNV Healthcare NIAHO on Grievances

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

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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

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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

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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

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Consumer Reporting System

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

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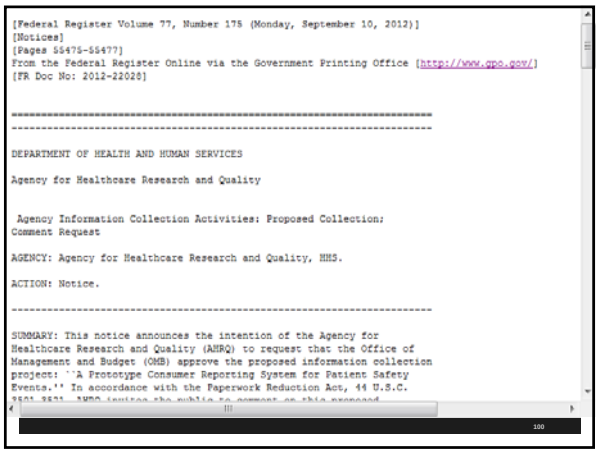

[Federal Register Volume 77, Number 175 (Monday, September 10, 2012)]
[Notices]
[Pages 55475-55477]
From the Federal Register Online via the Government Printing Office [http://www.gpo.gov/]
[FR Doc No: 2012-22028]

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.

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AHRQ Proposal

- A Consumer Reporting System for Patient Safety Events
- AHRQ wants to collect information for this
- Says there is a 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

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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 project

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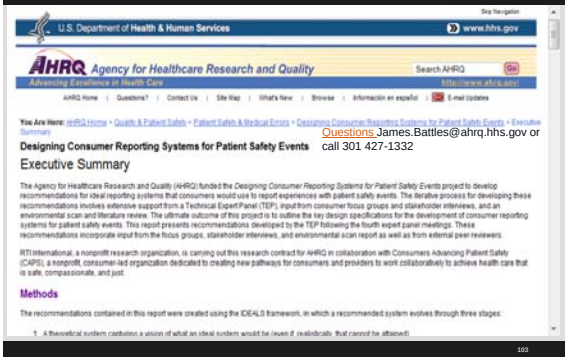
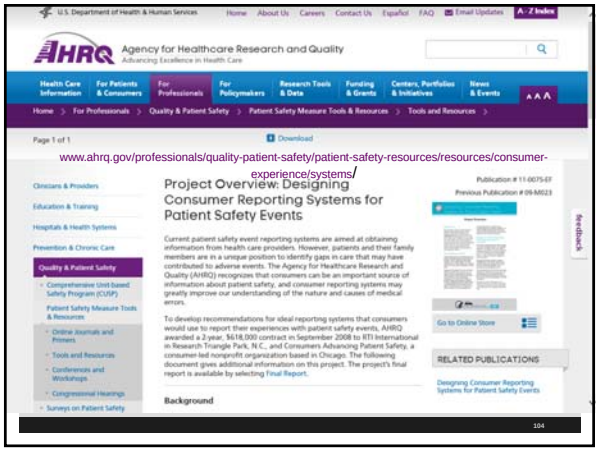
Consumer Reporting Systems for PS Events

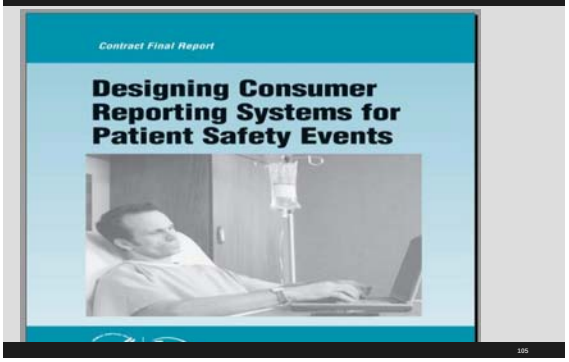


Questions James.Battles@ahrq.hhs.gov or call 301 427-1332



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

Final Report



The End Questions?

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education Consulting
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468
- sdill1@columbus.rr.com

- (Call with questions, No emails)

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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

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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

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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.

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Thanks for attending!

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
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