# What Every Patient Advocate Must Know about Patient Complaints and Grievances

DukeHealth

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April 3, 2019

# Conditions of Participation

- Conditions of Participation (CoPs) are the guidelines that hospitals must follow to receive Medicare funding under Centers of Medicare and Medicaid Services (CMS)

- 482.13(2)(b)

- Original guidelines became effective in August 1995
- Revised in 2004

# Interpretative Guidelines

- Captain David Eddinger of the CMS reviewed and revised the interpretative guidelines
- Guidelines then modified by Society for Healthcare Consumer Advocacy Board
- Comments sent to CMS in February 2005
- Revised Guidelines became effective in August 2005

# Defining Patient Grievance

A Patient Grievance is a written or verbal complaint by a patient, or the patient's representative, regarding the patient's care (when the complaint has not been resolved at that time by staff present), abuse or neglect, or the hospital's compliance with the CMS Hospital Conditions of Participation (CoP).

# Joint Commission

- RI.01.07.01
- LD. 04.01.07 EP 1
- Much like CMS but JC calls them complaints
- JC reviews complaint resolution process
- Requires organizations to inform patient's and their representatives about the complaint resolution process (Patient Rights)
- If a patient representative complains, the patient is the only one who can grant permission for medical record information to be discussed with the patient representative. (unless patient is not able and has previously granted that permission). Documentation of that permission must be evident.
- Data collected regarding patient  grievances, as well as other complaints that are not defined as grievances (as determined by the organization) must be incorporated in the organizations Quality Assessment and Performance Improvement process
- Annual report to the Board of Directors or designated committee or department

# Who is Staff Present?

- Staff present includes any hospital staff member who is immediately available to take care of the patient's complaint
- Staff present has been broadened to mean all involved in resolving the issue that moment or that day.
- If a staff member is available to address the concern, the complaint is not considered a grievance.

# Complaint Process


- **Complaints**
  - Issues that are handled “on the spot”
  - Billing issues (with no care issues)
  - Lost and found issues
- **Follow-up on complaints:**
  - May be by phone, in person or by letter
  - Letter is not required

# Grievance Process

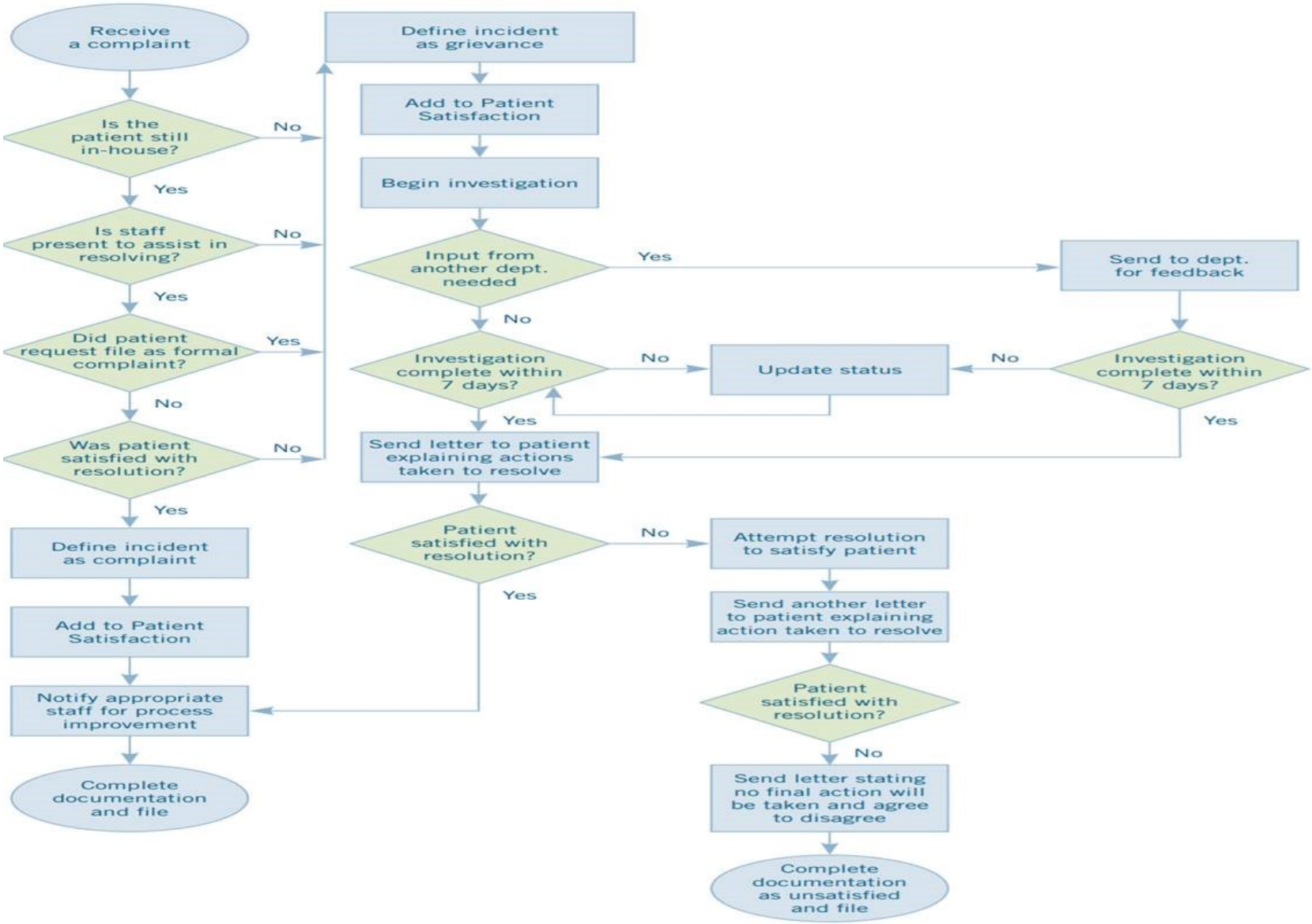
- **Grievances**
  - Issues not handled “on the spot”
  - Any letter, e-mail, fax that comes after the patient has received care
  - Any attachment or letter with a patient survey
  - Any request by patient or patient representative to file a formal complaint/grievance
  - Any verbal or written complaint regarding abuse, neglect, patient harm or hospital compliance with CMS requirements
  - Medicare beneficiary billing complaints
  - Billing issues if the patient or their representative states they will not pay because of care or treatment issues
- **Follow-up on Grievances:**
  - CMS feels that the majority of an organization’s grievances should be resolved and responded to, in writing within 7 (calendar) days
  - Follow-up is required in writing in accordance with CMS standards and guidelines, and your organization’s grievance policy

# Patient Concern Becomes a Grievance

If the concern cannot

- be resolved at the time,
- is postponed for later resolution,
- is referred to another staff for later resolution,
- requires investigation, and/or further actions to resolve concern

# Complaint-Grievance Flow Chart



# Grievance Committee

- Standing Committee
- Ad-Hoc

# CMS Grievance Exceptions

- Not required to provide information that can be used against the hospital. These are designated as Risk Management "WATCH" files.
- Anonymous surveys – but required to investigate and internally address issues.
- Anonymous calls - but required to investigate and internally address issues.

# Responding to the Patient

- Resolution is requested to be sent in writing within 7 (calendar) days.
- CMS will review to be sure that a response is sent on an average of 7 (calendar) days (while it is not in writing – CMS prefers an average of 80% of grievances are resolved within 7 days)
- If cannot resolve within 7 (calendar) days, send an acknowledgement letter with date when resolution/response letter will be sent (in accordance to hospital grievance policy)

# Responding to the Patient

- Resolution is to be communicated appropriately, in a language and manner the patient or patient's legal representative understands
- The hospital may use additional tools to resolve a grievance- i.e. meetings with the family, or telephone conversations
- In all cases a written notice must be provided
- If a patient communicates to the hospital via e-mail or requests a resolution by e-mail, an e-mail response is acceptable

# Responding to the Patient


The hospital is not required to include statements that could be used in a legal action against the hospital.

The hospital must provide:

- the name of the hospital contact person
- steps taken on behalf of the patient to investigate grievance
- results of the grievance process on all grievance letters.
- date of resolution

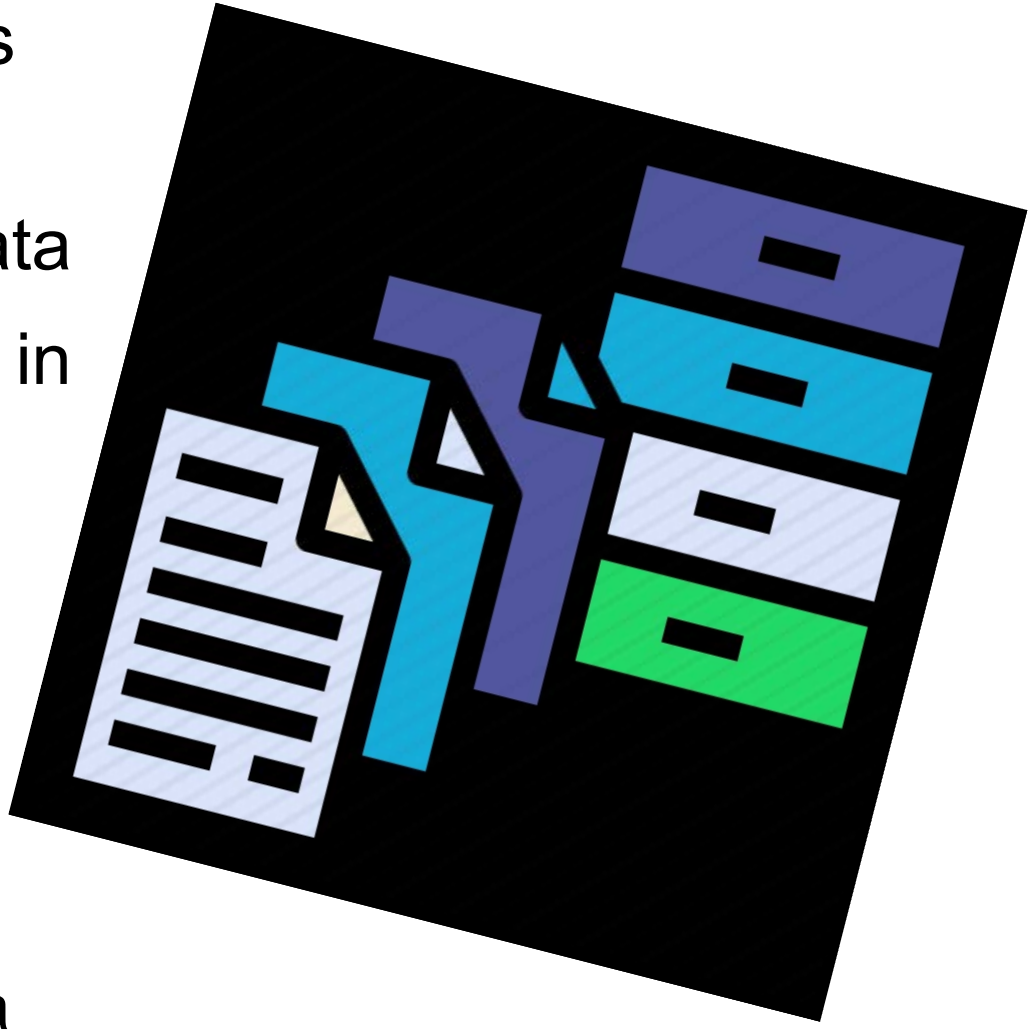
# When is a Grievance Resolved?

- A grievance is considered resolved when the patient is satisfied with the actions taken on their behalf

- There may be situations where the hospital has taken appropriate actions on the patient's behalf in order to resolve the grievance and the patient or patient's representative remains unsatisfied. In these situations the hospital may consider the grievance resolved for the purposes of this requirement.

# Data Management

- Filing grievance reports and letters
- Systems used to file data
- What are the purposes in keeping a central data file?
  - File approved letters written to patient or families regarding the grievance
  - Creating /maintaining a central grievance log



# Helpful Hints

- Post patient rights that can be readily viewed by patients/representatives
- Provide signage in a patient room or patient guide to address your process
- Reference Joint Commission and CMS in your grievance policy
- Be able to show trending, analysis and projects based on your data
- Educate staff on the grievance process

# Taking it a step farther….Disrespect as harm

- “I was taken to the wrong room in the ED and witnessed another patient being treated.  She was yelling out in pain.  It was traumatic for me.”
- “It didn’t seem like they cared that I had taken a day off work and they cancelled my appointment without telling me.”
- “They just left me in the hallway where everyone could see me, and I was vomiting in the pan they gave me.”
- “We were praying for improvement and the doctor just walked in and said, “There is nothing more we can do, you need to prepare to die”.

# Emotional traumas associate with healthcare delivery as a harm

- Using Beth Israel Deaconess Medical Center (BIDMC) model, Duke has adopted a method to identify dignity and respect events that result in emotional harm
  - Building organizational sensitivity to dignity and respect
    - Dignity: each person has intrinsic, unconditional value
    - Respect: the actions that protect, preserve and enhance dignity
- Setting a significance level to these disrespects
- Establishing a compensation model as appropriate
- Requiring deeper investigations (LFD, RCA) for serious acts of disrespect
- Enhancing use of complaint data for process improvement


WHO WANTS TO BE A
MILLIONAIRE
WHO WANTS TO BE A

# WHO WANTS TO BE A MILLIONAIRE

Test your knowledge and earn some extra credit

## Title of Game

### Game Rules

- Form two teams
- One teams starts and plays until they miss a question, then play switches to opponent
- Players on each team will rotate to answer questions individually (without HELP)
- Each team has one 50:50, one “call-out”, and one “Team-help” during each game
- Whichever team wins the $1 MILLION question wins the extra credit points

| | |
|---|---|
| 15 ► | $1 MILLION |
| 14 ► | $500,000 |
| 13 ► | $250,000 |
| 12 ► | $100,000 |
| 11 ► | $50,000 |
| 10 ► | $25,000 |
| 9 ► | $16,000 |
| 8 ► | $8,000 |
| 7 ► | $4,000 |
| 6 ► | $2,000 |
| 5 ► | $1000 |
| 4 ► | $500 |
| 3 ► | $300 |
| 2 ► | $200 |
| 1 ► | $100 |

# WHO WANTS TO BE A MILLIONAIRE

## Title of Game

| | | | |
|---|---|---|---|
| TEAM 1 | 50:50 | Phone | Team |
| TEAM 2 | 50:50 | Phone | Team |

### Extra Credit Points

- ✓ No missed questions = 5 points
- ✓ 1 missed question = 4 points
- ✓ 2 or more missed questions = 3 points

| | |
|---|---|
| 15 ► | $1 MILLION |
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| 5 ► | $1000 |
| 4 ► | $500 |
| 3 ► | $300 |
| 2 ► | $200 |
| 1 ► | $100 |

# $100 Question

Question – The definition of a grievance is:

50:50

Team

A. Patients complain about their care

B. Any concern that is voiced by a patient or their representative that cannot be resolved by staff present.

C. Patients complain about their bill

D. A written or verbal complaint

50:50

Team

## $200 Question

In addition to informing the patient of a process within the hospital for patients and their representatives to file a concern – the hospital must also inform the patient and their representative of what?

A. A phone number and address for lodging a grievance with the State Agency

B. A phone number and address for lodging a grievance with the Office of Civil Rights

C. Both A & D

D. A phone number and address for lodging a grievance with the Joint Commission if the hospital is accredited by JC

# $300 Question

"Staff present" includes who?

50:50

Team

A. Any hospital staff present at the time of the complaint or who can quickly be at the patient's location to resolve the patient's complaint

B. The person who discovers the patient's concern

C. The Patient Advocate

D. The nurse caring for the patient

## $500 Question

The following would not be a grievance

50:50

Team

A. Medicare beneficiar billing complaint related to rights and limitations

B. A complaint about serving preferred food

C. A written complaint

D. A complaint received via e-mail

50:50

Team

## $1000 Question

Who must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibilithy in writing to a grievance committee?

A. The CEO/President of the hospital

B. The nurse taking care of the patient

C. The physician taking care of the patient

D. The hospital's governing body

50:50

Team

## $2000 Question

On an average Centers for Medicare and Medicaid (CMS) consider a timeframe of _____ is appropriate for the resolution and response to a grievance?

A. 30 days

B. 7 days (Business days)

C. 7 days (Calendar)

D. 10 days

50:50

Team

## $4000 Question

If the investigation is not or will not be completed within 7 days, the hospital must do what?

A. Call the patient to let them know that the hospital is still working on the investigation and will call them back when the investigation has been completed.

B. Send a text to the patient, letting them know the hospital has not completed the investigation, but as soon as they have finished they will follow-up in writing with a resolution

C. Send a letter to the patient letting them know the hospital is still working to investigate their concerns and they will give them a call to discuss the findings when the investigation is completed.

D. Send a letter to the patient or the patient's representative that the hospital is still working to resolve the grievance and will f/u with a written response within a stated number of days, in accordance to the hospital's grievance policy

50:50

Team

## $8000 Question

A resolution letter to the patient must contain the following information?

A. Information must be communicated in a manner the patient or patient's legal representative understands and must contain the name of the hospital contact person, the steps taken on behalf of the patient, the results of the grievance process and date of completion

B. Information must be communicated in English, and must contain the name of the hospital contact person, the steps taken on behalf of the patient, the results of the grievance process and date of completion

C. Name of the hospital contact person, steps taken on behalf of the patient, including statements to be used in legal action, and the results of the investigation and the date of completion.

D. Name of the hospital contact person, steps taken on behalf of the patient, including an exhaustive explanation of every action the hospital has taken to investigate the grievance, and the results of the investigation and the date of completion.

# $16,000 Question

## A grievance is considered resolved when

50:50

Team

A. When the patient seems satisfied, no matter how many steps the hospital has to take.

B. When Risk Management says the grievance is resolved.

C. When the patient and their representative are satisfied, no matter how many steps the hospital has to take.

D. When the party who filed the grievance is satisfied with the response, or when the healthcare facility has taken “appropriate and reasonable” actions to resolve the grievance even if the patient or patient’s family is unsatisfied with the response.

50:50

Team

## $25,000 Question

CMS interpretive guidelines clarify that all of these scenarios are considered grievances except:

A. Written complaints, including those submitted via e-mail, fax, complaints accompanying a patient satisfaction survey and all written or verbal allegations of abuse, neglect or noncompliance with CMS requirements

B. Verbal complaints that 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 or requires investigation and or further action

C. Verbal complaints that are able to be resolved by staff present.

D. Requests by a patient or their representative for a response from the hospital or requests by a patient or patient's representative that his or her concern be treated as a formal complaint or grievance

# $50,000 Question
## A grievance committee:

50:50

Team

A. Must meet on a monthly basis to review and resolve grievances in a manner that complies with CMS Grievance process requirements.

B. Must meet on a weekly basis to review and resolve grievances in a manner that complies with CMS Grievance process requirements.

C. Must be comprised of more than one person and should have adequate numbers of members to review and resolve the grievances in a manner that complies with the CMS Grievance process requirements. Committee may be ad-hoc

D. Must be comprised of members of the hospital's governing body to review and resolve the grievances in a manner that complies with the CMS Grievance process requirements.

50:50

Team

## $100,000 Question

The third most problematic standard for hospitals is…..(A recent report found that more than 1,000 U.S. hospitals were out of compliance)

A. Grievance Requirements

B. Restraints

C. Advance Directive Requirements

D. Medication Reconciliation

$250,000 Question

If a surveyor shows up at your hospital, you can expect him/her to ask .....

50:50

Team

A. Where is your patient advocate's office located?

B. Do your hospital's policies and procedures encourage all personnel to alert appropriate staff concerning any patient grievance? Do your patients and their representatives know how to file a complaint and with whom?

C. What program are you documenting your patient complaints and grievances in?

D. Does your hospital's governing body review all of the patient grievances?

50:50

Team

## $500,000 Question

A billing issue would be considered a grievance when…..

A. When the complaint is a Medicare beneficiary billing complaint

B. When the complaint is related to the quality of care the patient received

C. Both A & B

D. When the patient is upset their insurance company has denied coverage

# $1 MILLION Question

Patient complaints that become grievances also include situations where a patient or patient's representative telephones the hospital with a complaint regarding their patient care. These 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……

50:50

Team

A. grievances because they were reported after the patient received care

B. referred to Risk Management

C. grievances because they were not addressed by staff present at the time of care

D. not grievances, should be considered a complaint

# Questions?

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