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AUDIENCE: Acute	APPROVAL DATE:	
OWNER: M. Padilla		APPROVER: T. Overton

POLICY:

A Hospital, as part of its effective Discharge Planning process, must focus on the patient's goals and treatment preferences and include the patient (and/or the patient's representative) and his or her caregivers/support persons as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from the Hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.

The Hospital must inform the patient (and/or the patient's representative) of their freedom of choice in selecting their Post-Acute Provider/Service and of any Disclosable Financial Interest the Hospital has in, or with respect to, such Post-Acute Provider/Service.

The Hospital must assist the patient (and/or the patient's representative) in selecting a Post-Acute Provider/Service by using and sharing data that includes, but is not limited to, SNF, HHA, IRF or LTCH data on quality measures and resource use measures that is relevant and applicable to the patient's care goals and treatment preferences.

The Hospital must respect, when possible, the patient's goals of care and treatment preferences, as well as other preferences, when expressed by the patient and/or the patient's representative.

In the event a patient is discharged to one of the below enumerated types of Post-Acute Providers/Services, a Patient Choice Letter must be presented to the patient:

- SNF
- HHA
- Hospice
- IRF
- LTCH

In addition, per the procedure set forth in more detail below, patients discharged to a SNF, HHA, Hospice, IRF or LTCH must be provided with a list of such Post-Acute Providers/Services in the patient's geographic area.

The discharge or transfer of patients from a hospital's emergency department, and for which the Hospital has obligations under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), is governed by the EMTALA policies.

IMPLEMENTATION:

1. Discharge Planning services may only be performed by Hospital Case Management Personnel.

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Non-Hospital Personnel may **not** perform Discharge Planning services. Excluding Non-Hospital Personnel from those who may provide Discharge Planning services will avoid the opportunity for, and appearance of, their inappropriate influence over the patient's freedom of choice in selecting a Post-Acute Provider/Service.

Please note this Policy is not intended to alter or otherwise limit employees of Hospital or any Affiliate of Hospital who access and utilize pertinent patient information to facilitate patient identification and screening activities that enhance the Discharge Planning process.

2. With respect to Non-Hospital Personnel (such as Post-Acute Provider/Service representatives) who are present in the Hospital, the following safeguards must be implemented to avoid actual or perceived inappropriate influence over patients' freedom of choice:

   - Non-Hospital Personnel shall not be in contact with any patient or patient family/representative regarding Post-Acute Providers/Services until the patient's choice of a Post-Acute Provider/Service has been obtained by Hospital Case Management Personnel (including, if applicable, via a signed Patient Choice Letter) to ensure the patient has exercised freedom of choice.

   - Non-Hospital Personnel should not wear hospital jackets or tags with the Hospital name. Rather, they should wear name tags with the name of the company or organization they represent visible.

   To ensure the safeguards set forth herein are met, Hospitals may adopt additional Hospital-specific policies, procedures, practices or certifications (for example, identifying a Hospital employee who is responsible for monitoring the documentation of patient freedom of choice, creating patient certifications related to freedom of choice, and/or developing annual (or periodic) in-service training to highlight the Hospital's dedication to patient freedom of choice).

3. The Hospital, as part of the discharge planning process, must inform the patient (or the patient's representative) of their freedom to choose among Post-Acute Providers/Services, as soon as possible after a decision has been made to send a patient to any Post-Acute Provider/Service. The Hospital must respect, when possible, the patient's goals of care and treatment preferences, as well as other preferences, when expressed by the patient (and/or the patient's representative). The Hospital must not specify or otherwise limit the qualified Post-Acute Providers/Services that are available to the patient.

4. Only Hospital Case Management Personnel may discuss with the patient (and/or the patient's representative) their right to choose a Post-Acute Provider/Service.

5. Hospital Case Management Personnel must also assist the patient (and/or the patient's representative) in selecting a Post-Acute Provider/Service by using and sharing data that includes,

but is not limited to, SNF, HHA, IRF, or LTCH data on quality measures and data on resource use measures. The Hospital Case Management Personnel must ensure that the data on quality measures and data on resource use measures is relevant and applicable to the patient's goals and treatment preferences, when expressed by the patient (and/or the patient's representative).

6. If the Hospital has established a post-acute provider network, Hospital Case Management Personnel may educate the patient on the potential benefit of receiving care from a Post-Acute Provider/Service participating in the Hospital's post-acute network. Hospital Case Management Personnel should document all these discussions with the patient in the patient's medical record.

7. In the event a patient is discharged to one of the below enumerated types of Post-Acute Providers/Services, a Patient Choice Letter must be presented to the patient:

   - SNF
   - HHA
   - Hospice
   - IRF
   - LTCH

   A Patient Choice Letter containing the patient's (or patient's representative's) signature indicating his/her choice of a Post-Acute Provider/Service must be retained in the patient's medical record. Attached is the required *Patient Choice Letter* for Hospital Case Management Personnel to use for the documentation of patient choice of a Post-Acute Provider/Service. This form should not be modified.

   If the patient chooses specifically to make no choice of a Post-Acute Provider/Service, then the Hospital must notify the patient of the default Post-Acute Provider/Service.

   If the patient comes to the Hospital from a Post-Acute Provider/Service and requests to return to that same Post-Acute Provider/Service upon discharge from the Hospital, the patient (or the patient's representative) is not required to provide written notice of this choice. Documentation that the patient (or the patient's representative) has requested to return to the Post-Acute Provider/Service of origin should be maintained in the patient's medical record.

8. For discharges requiring SNFs, Hospices, IRFs, or LTCHs, the Hospital must also provide each patient with a list of all such SNFs (the "SNF List"), Hospices (the "Hospice List"), IRFs (the "IRF List") or LTCHs (the "LTCH List"), as the case may be, that:
   (i) are available to the patient,
   (ii) participate in the Medicare program, and
   (iii) serve the geographic area requested by the patient.

   The SNF List, the Hospice List, the IRF List, and the LTCH List each must be updated at least

annually.

For patients enrolled in a managed care organization ("MCO"), the Hospital must make the patient aware of the need to verify with the MCO which SNFs, Hospices, IRFs or LTCHs (as applicable) are in the MCO's network. If the Hospital has information on which SNFs, Hospices, IRFs or LTCHs (as applicable) are in the network of the patient's MCO, it must share this information with the patient (or the patient's representative).

The Hospital must document in the patient's medical record that the SNF List, the Hospice List, the IRF List or the LTCH List, as the case may be, was presented to the patient (or the patient's representative).

9. For discharges requiring HHAs, the Hospital must also provide each patient with a list of all such HHAs (the "HHA List") that:
   (i) are available to the patient,
   (ii) participate in the Medicare program,
   (iii) serve the geographic area (as defined by the HHA) in which the patient resides, and
   (iv) have requested that they be listed by the Hospital as available.

   The HHA List must be updated at least annually.

   For patients enrolled in a managed care organization ("MCO"), the Hospital must make the patient aware of the need to verify with the MCO which HHAs are in the MCO's network. If the Hospital has information on which HHAs are in the network of the patient's MCO, it must share this information with the patient (or the patient's representative).

   The Hospital must document in the patient's medical record that the HHA List was presented to the patient (or the patient's representative).

10. In addition, Hospital Case Management Personnel must identify any Disclosable Financial Interest the Hospital has in, or with respect to, a Post-Acute Provider/Service through designation on the Patient Choice Letter.

DEFINITIONS:

Affiliate: means any person or entity Controlling, Controlled by or under common Control with another person or entity.

Control: means the direct or indirect power to govern the management and policies of an entity; or the power or authority through a management agreement or otherwise to approve an entity's transactions (includes Controlled, Controlling).

Dependent Healthcare Professionals (or DHPs): as defined in HCA Healthcare Policy

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COG.PPA.003 (Vetting Dependent Healthcare Professionals and Other Non-Employees), includes individuals not employed by the Hospital who are permitted both by law and by the facility to provide patient care services under an approved scope of practice. These individuals may be employed by a contractor, a temporary staffing agency, a privileged practitioner or practitioner group or be directly contracted by a patient for a specific service.

Discharge Planning: means a process that involves determining the appropriate post-hospital destination for a patient (consistent with the patient's care goals and treatment preferences, as well as other preferences, when expressed by the patient and/or patient's representative), identifying what the patient requires for a smooth and safe transition from the hospital to his or her discharge destination, and beginning the process of meeting the patient's identified post-discharge needs.

Disclosable Financial Interest: means the Hospital's direct or indirect ownership interest in, or Control of, a SNF, HHA, Hospice, LTCH, or ICF or a SNF'sn HHA's, Hospice's, LTCH's, or IRF's direct or indirect ownership interest in, or Control of, the Hospital.

HHA: means home health agency.

Hospital: includes (1) short-term acute-care hospitals, inclusive of any distinct rehabilitation or psychiatric hospital units, (2) LTCHs, (3) IRFs, (4) inpatient psychiatric hospitals, and/or (5) children's hospitals.

Hospital Case Management Personnel: means: (1) employees of the Hospital or any Affiliate of the Hospital, including, but not limited to, case managers, social workers, or nurses involved in Discharge Planning, or (2) independent contractors engaged by, on behalf of, and at the direction of, the Hospital or any Affiliate for Discharge Planning purposes.

IRF: means inpatient rehabilitation hospital, facility or unit.

LTCH: means long-term care hospital.

Non-Hospital Personnel: means independent third-party individuals or entities that are **not** Hospital Case Management Personnel, including, but not limited to, representatives of physicians, payors or insurance plans, Post-Acute Providers/Services, other acute care providers or vendors, DHPs, or external navigators.

Patient Choice Letter: means a form letter (attached and incorporated into this Policy) for Hospital Case Management Personnel to use for the documentation of patient choice of Post-Acute Providers/Services, which shall be maintained in the patient's medical record.

Post Acute Provider / Service: means any and all providers or suppliers of post-acute services, including, but not limited to, post-acute services to inpatients who are: (1) discharged home with an order for post-discharge services, e.g., HHA or other care providers; (2) discharged to a non-acute care setting, e.g., SNF; (3) transferred to another acute care setting, e.g., IRF or LTCH; or (4) discharged to hospice care.

SNF: means skilled nursing facility.

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REFERENCES:

1. 42 U.S.C. § 1395x(ee)(2)-(3)
2. 42 U.S.C. § 1395lll(i)
3. 42 C.F.R. § 482.43

COMMITTEE APPROVALS:

MEC: 4/4/2024

MAYERS MEMORIAL HEALTHCARE DISTRICT

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POLICY:

Patients have the right to express concerns and expect resolution in a timely manner. It is the policy of the hospital not to discriminate on the basis of disability, race, color, religion, sex, sexual orientation, gender identity, national origin, age, genetic information, citizenship, veteran status, military or uniformed services, or other legally protected characteristics or conduct. The hospital has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C 18116) of the U.S. Department of Health and Human Services regulations implementing the Acts. Sections 504 and 1557 prohibit discrimination on the basis of disability in any program or activity receiving federal financial assistance such as through participation in the Medicare and Medicaid programs. The laws and regulations may be examined in the office of the Director of Quality ("the coordinator"), who has been designated to coordinate the efforts of the hospital to comply with Sections 504 and 1557.

Any person who believes they have been subjected to discrimination, or has a concern regarding their care, abuse or neglect, or issues related to the hospital's compliance with the CMS Conditions of Participation ("CoPs") at the hospital may file a grievance under this procedure. It is against the law for the hospital to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Purpose and Responsibilities:

- Provide a standardized process to manage and resolve complaints and/or grievances received by the hospital/agency/practice.
- Provide a process to review, investigate, and resolve a patient's/patient representative's complaint / grievance within a reasonable time frame.
- Provide a process to determine the effectiveness of the complaint and/or grievance process through Quality Improvement monitoring to help identify, investigate, and resolve any deeper, systemic problems indicated by the grievance analysis.

Definitions (see Appendix A):

1. **A grievance** is defined as "a written or verbal complaint (when the verbal complaint 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 CoPs, non-compliance with Sections 504 and 1557, or a Medicare beneficiary

billing complaint related to rights and limitations provided by 42 CFR §489. Billing issues are not usually considered a patient grievance. However, a billing complaint related to rights and limitations contained in 42 CFR §489 is considered a grievance.

- Information obtained from a patient satisfaction survey or comment card does not usually meet the definition of a grievance. However, if a patient attaches a written complaint to a survey and requests resolution, then the written complaint is a grievance. If the information obtained from a patient satisfaction survey or comment card would typically meet the definition of a grievance then the hospital must treat such a complaint as a grievance (e.g., "Hot Comments" from Patient Satisfaction Survey vendor, when comment includes key words which may indicate a serious service failure such as 'bad, awful, rude, legal, unsafe, etc.).
- 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 but would be considered a complaint.
- Patient complaints that are considered grievances also include situations where a patient or a patient's representative telephones the hospital or posts on the hospital's intranet site 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.
- Social media posts are not grievances as they are not made directly to the hospital. However, contacting and communicating with the patient / representative who posted feedback and contact information on social media sites (e.g., YELP, Facebook, Twitter, Reputation.Com, etc.) and the feedback or concern rises to the level of a grievance (e.g. rating 1 or 2 stars), then the hospital must treat such a complaint as a grievance. A grievance may also include situations when the patient/family call or email the hospital after contact by the hospital following a social media post, and the complaint meets the definition of a grievance.
- A grievance may include a situation where the patient or their representative phones the hospital with a concern that constitutes a grievance (i.e., the care provided to the patient, abuse or neglect, or the Hospital's compliance with the CoPs). Post-hospital verbal communications that would routinely have been handled by staff present if the communication had occurred during the hospital stay do not constitute grievances.
- All verbal or written complaints regarding discrimination, abuse, neglect, patient harm, or hospital compliance with CoPs are grievances.
- All instances in which a patient or their representative requests that their complaint be handled as a formal complaint or grievance or where the patient requests a response constitute grievances.

2. **A verbal complaint** is a patient grievance if:
   - It cannot be resolved at the time of the complaint by staff present; or is postponed for later resolution; or
   - Is referred to other staff for later resolution; or
   - Requires investigation and/or requires further actions for resolution.

3. **A written complaint** is always considered a grievance (including e-mail, fax, and hospital internet site), directed to the hospital, whether from an inpatient, outpatient, released or discharged patient or his/her representative as long as the concern expressed in the grievance concerns one of the areas constituting a grievance as defined previously.

4. **Staff Present** refers to 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 supervisors, patient advocates, etc.) to resolve the patient's complaint.

5. A patient complaint or grievance is deemed "resolved" when the patient or their representative is satisfied with the actions taken by the hospital on their behalf. There may be times when the patient or their representative continues to be dissatisfied with the hospital's actions even when the hospital has taken reasonable actions to address the applicable concerns. In these circumstances, the hospital deems the complaint or grievance resolved even though the patient or their representative is not satisfied with the outcome.

NOTE: CMS Interpretative 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. The expectation is that the facility will have a process to implement a relatively minor change in a timelier manner than a written response. For example, a change in bedding, housekeeping of a room, and serving preferred food and beverages may be made relatively quickly without a written hospital response.

- (This section not applicable to a physician's clinic practice) The Governing Board has delegated the Complaint and Grievance process to the Quality Committee. The Committee will monitor effectiveness of the grievance process and review and resolve grievances in an appropriate manner and time frame. The Quality Improvement Committee has designated specific responsibilities to the following roles:

    - Director of Quality: writing and sending response letters to patient/family.
    - Director of Quality: Auditing, aggregating, and analyzing data to present to Quality Committee, Medical Executive Committee and Governing Board for review and recommendation.

- The patient / patient representative shall be informed of whom to contact to file a complaint / grievance. This may be done via a variety of mechanisms:

    - Patient Information / Patient Guide

- Patient Care Conferences / Treatment team meetings
- Staff knowledge of the complaint and grievance process
- Information on the hospital internet web page
- Non-discrimination signage for purposes of Sections 504 and 1557 concerns.

- The Director of Quality ensures the patient is provided written notice of its receipt, investigation, and outcomes regarding a complaint/grievance within 7 days of the receipt of the grievance, even though the hospital's resolution need not be complete within the seven-day limit. The written notice shall contain the following:
  - Name of the Hospital District contact person
  - Steps taken on behalf of the patient to investigate the grievance.
  - Results of the grievance process.
  - Date of completion.

- Inform the Director of Quality of a complaint or grievance responses from the patient or family that indicate legal representation or complaint involving discrimination.

- If the grievance is not yet resolved within the initial, written response of 7 days, the written response will indicate that the hospital is working towards a resolution of the grievance and that a follow-up written response will be provided within a specified time period but not to exceed 30 days until the grievance is resolved. If the grievance remains unresolved after 30 days, additional written follow-up would be indicated within a specified time period but not to exceed an additional 30 days.

- Grievances shall be tracked for the purpose of trending, improving the processes, and ensuring customer satisfaction and service recovery. (See Complaint/Grievance Log)

The Medicare Beneficiary patient / patient representatives shall be informed of whom to contact to file a complaint/grievance or appeal if premature discharge, coverage decision, or qualities of care issues arise upon request.

PROCEDURE

In the event a patient or the patient's family or representative have a comment, complaint, or grievance he / she is encouraged to do one or more of the following:

- Inform or ask any staff member.
- Speak to the Department Director or Manager of the area involved.

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- Request to speak with someone in Administration.
- Other complaints may be received anonymously or from patient / family satisfaction surveys or comment cards.

PROCEDURE FOR USING THE OCCURENCE REPORT

1. When a complaint/grievance is initiated / received from the patient / patient's representative, staff who received the complaint or grievance complete an online grievance form found on the Hospital webpage.

2. If the report contains grievance information of suspected / alleged abuse, the policy and procedure for Suspected Patient Abuse/Neglect is followed in addition to this policy.

3. The Complaint and Grievance reporting includes demographic information, who initiated the complaint or grievance, the method, received by, nature of the service failure, resolution, severity, root causes and corrective actions.

4. The person documenting receipt of the complaint / grievance describes / summarizes the complaint in the patient/patient representative's words as best as possible, indicates the preferred contact for the individual offering the complaint and submits all of that information on the complaint form found on the Hospital webpage.

5. The complaint or grievance form is forwarded to the applicable Director of Quality immediately for review.

6. The Director of Quality completes any investigation, identifying if the issue has been resolved or not resolved, corrective actions taken and any needed notification of other personnel for follow-up. The Department Manager then signs and dates where indicated on the form. When the investigation is complete, the Director of Quality designates the level of harm and finalizes the occurrence report. The information will be documented in RL6 the Hospital's reporting platform for tracking and trending out to the Governing Borad.

7. The Hospital CEO, or designee if the CEO is unavailable, or Practice Manager shall receive the report form Director of Quality within a reasonable time frame (the goal is to have the CEO / Practice Manager in receipt of the completed sections within 72 hours) in order to be aware of any

potential issues concerning the business or care of the Hospital District.

8. The form / trending analysis ultimately resides with the Director of Quality, or Hospital/Physician Management designee, who ensures documentation of the complaint/grievance.

9. (This section not applicable to a physician practice) The Director of Quality or Quality Improvement Director delegates a formal review of a grievance or trend in complaints or grievances, when necessary, by forming a sub-committee of the Quality Committee [e.g. Patient Experience Team, Patient Family Advisory Council].

10. The subcommittee makes recommendations for further actions and provides a summary report of such to the Quality Committee.

11. The Director of Quality is responsible for completing and sending a letter to the complainant in response to a complaint / grievance. The letter shall include the name of the Hospital or Physician Practice contact person, steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. (See Template and Sample Grievance Resolution Letter)

13. When reporting the results of the grievance process to the patient in writing, care should be taken to avoid statements that could appear to admit liability or erode the peer review or quality improvement privileges to the fullest extent available by statute.

- Examples include revealing the outcome of performance improvement teams or peer review activity. Stating a team is investigating or peer review has transpired may be appropriate however it will beg the question of the outcome which is not to be revealed. You may state: state statutes prevent you from revealing the outcome of peer review or quality improvement activities.

- An example that may admit liability is “the nurse administered drug x which caused your mother’s heart attack”. While this may be technically true, the act may have been done without negligence such as in the case the drug was given as ordered and a known side effect was experienced. Stick to facts known, do not make assumptions and do not use words like “caused”.

- A better way to state the above would be: “The nurse did administer drug x which was ordered by her physician and unfortunately drug x has the known rare side effect of MI which your mother experienced.” The first statement reads like the nurse did something wrong when in fact she did not, however a bad outcome occurred which did not involve liability or negligence.

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14. The response letter shall be forwarded to the patient or patient representative **no later than 7 days after receipt of the grievance even** though the hospital's resolution needs are not complete within the seven-day limit.

15. The complaint/grievance log shall be summarized and presented to Quality Improvement Committee, Medical Executive Committee, and the Governing Board on a regular basis for review and recommendations.

Procedures Specific to Concerns Related to Discrimination:

- Grievances alleging discriminatory action must be submitted to the Director of Quality and investigated as described above regarding other types of complaints/grievances.
- The person filing the grievance may appeal the decision of the coordinator by writing to the Chief Executive Officer within 15 days of receiving the coordinator's decision. The Chief Executive Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

The hospital will make appropriate arrangements to ensure that disabled persons are provided other accommodations, if needed, to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing written/printed materials in other formats (i.e., large print, audio, Braille, accessible electronic or other formats, as available) for the blind or persons with limited vision, or assuring a barrier-free location for the proceedings. The coordinator will be responsible for such arrangements.

Section 504 and Section 1557 Coordinator Contact Information:

Mayers Memorial Healthcare District
43563 Hwy 299 E
Fall River Mills CA, 96028
(530) 336-7506

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NOTE: If the person making a complaint regarding discrimination and requests the Office for Civil Rights contact information, providing the following:

Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

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Appendix A:

Below are some situations to help decipher the difference between a complaint and a grievance. In the below scenarios: if these comments are on social media **and** either the author reaches out for resolution **OR** we contact the author for more information; please follow the below categorizations. Comments on social media *on their own* do not constitute a complaint or a grievance.

Scenario	Complaint*	Grievance**	Not a Complaint or Grievance
Posted on Social Media: I was a patient at XYZ hospital recently and my coffee was ALWAYS delivered to my room cold. As much as I was paying for this hospitalization, the very least they could do was get my coffee hot. I asked one nurse to get me hot coffee and he said the hospital was short-staffed and he was too busy. How is that my problem?	Complaint - this posting is an opportunity for service recovery, but it is not a grievance. Even though there was a reference to staffing, it was not brought up by the patient to hospital officials.		
Posted on Social Media: My father was a patient at XYZ hospitals. The nurses were rude and hung out at the desk while my father, who had his leg amputated, got out of bed, and fell. No alarms on beds.		Grievance related to hospital acquired condition and patient neglect.	
Posted on Social Media: When I was a patient at XYZ hospital I was asked what I wanted for food. I don't know why they asked because I never got what I asked for.	Complaint - this posting is an opportunity for service recovery [1], but it is not a grievance		

Scenario	Complaint*	Grievance**	Not a Complaint or Grievance
Posted on Social Media: I was a patient at XYZ hospital and I had to get a CAT scan. They left me in the hallway and forgot about me. I yelled at the X-ray people, and they finally took care of me.	Complaint because the issue was rectified at the time of the incident - this posting is an opportunity for service recovery, but it is not a grievance		
Posted on Social Media: You won't believe the lack of care I got at XYZ hospital. They told me to stay in bed and I had to use the urinal in bed. They spilled the urine on my sheets when they took the urinal away, and they left me in the wet sheets for hours. They treated me worse than you would treat a dog.		Grievance related failure to meet the patient's expectation for care, using the definition of the care a reasonable person would expect in a hospital.	
Posted on Social Media: I was a patient in XYZ hospital and they must have the most incompetent staff anywhere. They hung IV fluids and medication and used an IV pump, but the incompetent staff didn't bother to turn on the pump.		Grievance related to complaint of staff incompetency, and injury related to delay in prescribed IV fluids and medications with probably clotting of the IV access device.	
Posted on Social Media: Don't go to XYZ hospital. It's old and people act too serious.			Neither a complaint nor a grievance. This is simply a comment.

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Scenario	Complaint*	Grievance**	Not a Complaint or Grievance
Satisfaction Survey: Information from patient satisfaction surveys conducted by the organization is not usually considered a grievance. NOTE: If an identified patient writes or attaches a complaint to the survey, but does not request resolution, the organization should treat this as a grievance if the organization would usually treat such a complaint as a grievance.	Complaint	However, if an identified patient writes or attaches a written complaint on the survey and requests resolution, the complaint must be treated as a grievance.	

SUBJECT/TITLE:	Patient Complaint and Grievance Policy 09.01.04	POLICY #COM022
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REFERENCES:

Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973 (29 U.S. C. 794) Age Discrimination Act of 1975; Title 45 Code of Federal Regulations Parts 80, 84, and 91 Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116

ACHC Critical Access Standards for Patient Rights, 2023.

Agency for Healthcare Research and Quality (AHRQ). Service recovery programs. 2015 Jul [cited 2020 Aug 6]. http://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer- service/strategy6p-service-recovery.html

CMS Condition of Participation Standard **§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**. State Operations Manual Appendix A - Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals February 2020

ECRI Institute. Managing patient complaints and grievances. *Healthcare Risk Control*. 2016 Aug 17. https://www.ecri.org/components/HRC/Pages/PtSup1.aspx

CMS State Operations Manual: Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Rev 200, 02-21-20. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf accessed August 6, 2020.

CMS SC Letter 05-42. Revisions to Interpretive Guidelines for Centers for Medicare and Medicaid Services Conditions of Participation 42 CFR 482.12. .https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter05-42.pdf accessed August 6, 2020.

Wright, David r., Adapted from a letter from David R. Wright, CMS Director Quality, Safety, Oversight Group June 2020) addressed to State Agency Directors June 1, 2020.

COMMITTEE APPROVALS:

MS Quality: 4/22/2024

SUBJECT/TITLE:	Quality Assessment & Performance Improvement Plan	POLICY #QUA009
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Appendix 1 Departmental Performance Improvement Activities

SCOPE

To establish the foundation the Quality Improvement Committee has for continuous improvement of quality of care, treatment, and services, to its patients.

POLICY

1. Section 1 - Quality Assessment and Performance Improvement [QAPI] Plan
    a. Goals of the QAPI Plan
        i. Provide services in a safe, effective, patient-centered, timely, equitable, and recovery-oriented manner.
        ii. Commitment to ongoing and continuous improvement of the quality of care, as evidenced by outcomes of care.
        iii. The treatment provided incorporates evidence-based, effective practices.
        iv. Treatment and services are appropriate to each consumer's needs, and available when needed.
        v. Treatment and services are designed to minimize risk to consumers, providers, and others, and to prevent medical errors and patient harm.
        vi. Consumer's individual needs and expectations are respected with patients having the opportunity to participate in decisions regarding their treatment and providing services with sensitivity and care.
        vii. Procedures, treatment, and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.
        viii. Implement quantitative measurements to assess key processes or outcomes.
        ix. Bring managers and staff together to review quantitative data and major adverse occurrences to identify process issues and develop plans for improvement and prevention.
        x. Meet internal and external reporting requirements.
        xi. Provide education and training to managers and staff.
        xii. Develop or adopt necessary tools, such as practice guidelines, consumer surveys, and quality indicators.
    b. Quality Assessment and Performance Improvement is a systematic approach to assessing services and improving on a priority basis.
    c. QAPI Principles

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i. Customer focused – focusing on internal and external customers and meeting / exceeding needs and expectations.
ii. Recovery-oriented – services are characterized by a commitment to promote and preserve wellness and to expanding choice.
iii. Promote choice – Promotes maximum flexibility and choice to meet individually defined goals and permit person-centered services.
iv. Employee Empowerment – involves people at all levels of the organization in quality and performance improvement.
v. Leadership involvement – strong leadership, direction and support of quality and performance improvement activity by the governing body, Medical Director, and CEO to assure that quality assessment and performance improvement initiatives are consistent with the mission and strategic plan.
vi. Data informed – creates feedback loops, using data to inform practice and measure results to make fact-based decisions.
vii. Statistical Tools – use of tools and methods to foster knowledge and understanding of data and create information from data. Tools used can include, but are not limited to run charts, cause and effect diagrams, flowcharts, pareto charts, histograms, and control charts.
viii. Prevention over correction – seek to design good and stable processes to achieve excellent outcomes, rather than correct processes after errors have occurred.
ix. Continuous improvement – continually reviewing processes to continually improve care, treatment, services, and outcomes.

d. Leadership
    i. The Quality Improvement Committee

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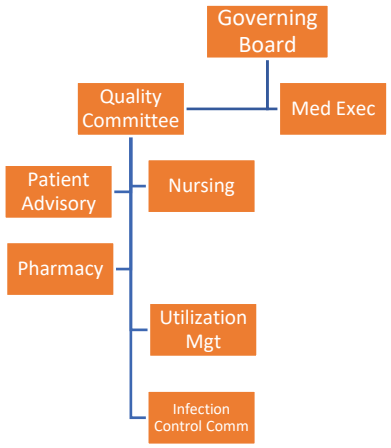
Appendix 1 Departmental Performance Improvement Activities

ii.



1. Provide operational leadership to the QAPI process, allocating resources, and providing vision and direction.
2. Meets monthly, at minimum ten times per year.
3. Membership
    a. Physician Chair
    b. Chief Executive Officer
    c. Chief Operating Officer
    d. Chief Nursing Executive
    e. Assistant Nursing Executive
    f. Quality Director
    g. Medical Staff Members
    h. Other Clinical Leaders as needed.
4. Responsibilities
    a. Develops and approves the Quality Assessment and Performance Improvement Plan
    b. Establishes measurable objectives and quality improvement initiatives each year based upon priorities identified using established criteria for improving quality and safety of care.
    c. Developing indicators of quality on a priority basis.

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d. Assessing data and information on quality indicators, acting as evidenced through quality improvement initiatives to solve problems and pursue opportunities for improvement.
e. Support and guide implementation of the QAPI Plan and quality improvement activities.
f. Formally adopting a specific approach to continuous quality improvement – PDCA Model [Plan, Do, Check, Act]
g. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, patients, and family members have knowledge of and input into ongoing QI initiatives. This may occur through:
    i. Ongoing report of quality improvement results to the Board of Directors and staff.
    ii. Story boards and / or posters displayed in common areas.
    iii. Sharing the annual QAPI Plan Evaluation.
    iv. Newsletters and / or handouts.
    v. Posting contact information for members of the Quality Council in the operating room, recovery room, OR bathroom area, and encourage patients to openly express their thoughts, experience, and expectations.

2. Section 3 – Quality Assessment and Performance Improvement Methodology
    a. The process of regularly assessing the results produced by the program. Involving identification processes, systems, and outcomes that are integral to the performance of the delivery system; selecting indicators of these processes, systems, and outcomes; and analyzing information related to these indicators on a regular basis.
    b. Continuous quality improvement involves acting as needed, based on the results of data analysis and opportunity for improvement.
    c. Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at the expected level.
    d. Assess the outcome of care provided.
    e. Assess whether a new or improved process meets performance expectations.
    f. Selection of prioritized performance or outcome indicators that evaluate the performance of processes, systems, services, functions, and / or outcomes.

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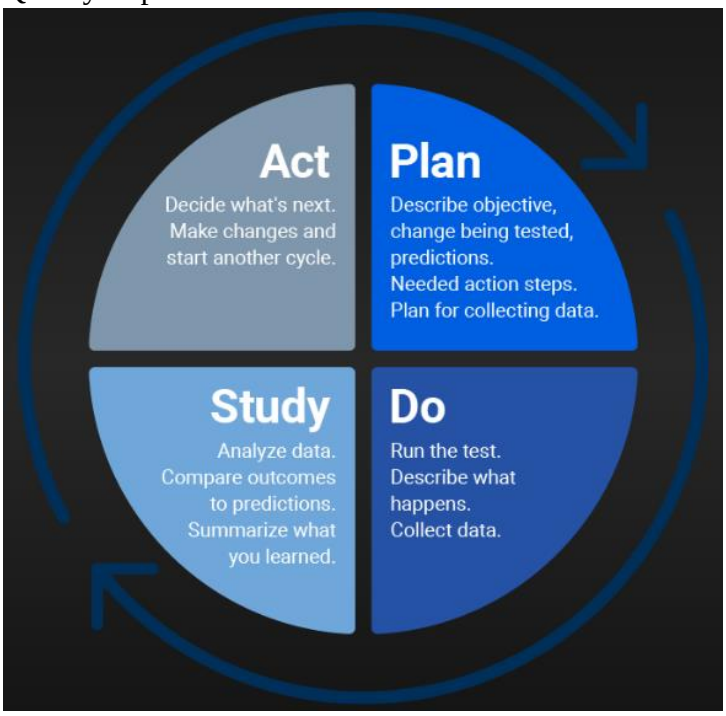
g. Measurement and assessment involve:
    i. Aggregating data so that it is summarized, analyzed, and quantified to measure a process or outcome.
    ii. Assessment of performance regarding these indicators at planned and regular intervals.
    iii. Taking action to address performance discrepancies when results indicate a process is not stable, is not performing at the expected level or represents an opportunity for quality improvement.

h. Indicator data measured is assessed, analyzed, prioritized, and used to identify quality improvement initiatives to be undertaken.
    i. Quality improvement initiatives follow the PDCA Model



3. Section 6 – Integration of Risk Management
    a. The risk management portion of the QAPI Plan reviews data to identify potential risks to patients and develop mitigation strategies to prevent future occurrences. Data includes, but is not limited to:
        i. Unanticipated patient adverse events.

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ii. Deaths.
iii. Complaints and Grievances
iv. Patient Falls
v. Restraint logs
vi. Medication Errors and adverse events
vii. Medical malpractice claims

4. Section 5 – Annual Quality Assessment and Performance Improvement Plan Evaluation
    a. An evaluation of the QAPI is completed at the end of each calendar year, conducted by the Quality Council, reported to the Board of Directors and staff, and kept on file in the Westwood office.
    b. The evaluation summarizes the goals and objectives of the QAPI Plan, the quality improvement initiatives / activities conducted during the past year, performance indicators utilized, and the results of data aggregation and analysis.
    c. For each QAPI Plan goal, a summary of progress toward meeting the goal and objective is provided.
    d. 2024 QAPI Activities – see Appendix 1

REFERENCES:

ACHC Accreditation Standards, CMS Conditions of Participation.

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Department	PI Measure or Activity	Goal	Frequency of Reporting to Quality Committee
Administration	Evaluating the Quality of Clinical Contracts – see contract list for vendors a		Quarterly with Annual Evaluation
Administration	Patient Experience / Satisfaction Survey		Quarterly
Administration	Results – Culture of Safety Survey		Annually
Anesthesia	Use of reversal agents		Quarterly
Case Management	Denials		Quarterly
Case Management	High Risk Discharges / Avoidable Days / LOS		Quarterly
Dietary: Nutrition	Screening (RN) and Assessment (RD) within 48 hours		Quarterly
Dietary: Kitchen	Tray line accuracy		Quarterly
Emergency Dept	LOS Admitted / LOS Discharged		Quarterly
Employee Health	Vaccine compliance		Quarterly
Environmental Services	Linen management		Quarterly
Facilities Mgmt	Emergency Management Plan risk assessments and PI activities [including risk assessments, drills, inspections, and testing]		Quarterly
Facilities Mgmt	Life Safety Plan risk assessments and PI activities [including risk assessments, drills, inspections, testing, and repairs]		Quarterly
Infection Control	See IC plan for list of outcome measures and goals		Quarterly
Infection Control	Risk assessments		Annually
Infection Control Rounds	See IC Plan for list of monthly, quarterly, and annual inspections		Quarterly

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Laboratory	Blood Bank: crossmatch to transfusion ratio	< 2.0	Quarterly
Laboratory	Transfusion Reaction Report	Zero	Quarterly
Nursing	Care plan individualization / completion	90%	Quarterly
Nursing	PRN medication reassessment compliance	90%	Quarterly
Nursing	Required blood transfusion documentation compliance	90%	Quarterly
Nursing	Restraint rate per 1,000 patient days	0.00	Quarterly
Pharmacy	Inspection results: Security of medication on patient care units	N/A	Quarterly
Quality	Publicly reported quality data		As published by CMS
Quality	Mortality Review Summary	N/A	Quarterly
Radiology	High dose monitoring		Quarterly
Respiratory Therapy / Cardiopulmonary	Smoking screening and cessation		Quarterly
Risk Management	Restraint Deaths	0	Quarterly
Risk Management	Patient complaint and grievance summary	N/A	Quarterly
Risk / Pharmacy	Medication Error Report	N/A	Quarterly
Risk Management	Adverse Event Report	N/A	Quarterly
Surgery	Use of reversal agents		Quarterly