Policy Title: Member Grievance Management Process			
Department Responsible: THN Compliance and Privacy	**Policy Code:** **10.5**	**Effective Date:** September 20, 2016	**Next Review/Revision Date:** September 30, 2019
Title of Person Responsible: Chief Compliance Officer	**Approval Council and Date:** THN Compliance and Integrity Committee-July 10, 2017	**Date Approved by THN Board of Managers** August 22, 2017	

POLICY:
Triad HealthCare Network (THN) recognizes that members have the right to voice concerns without fear of discrimination or reprisal and to have these concerns reviewed and addressed in a timely manner. Triad HealthCare Network seeks to provide prompt review and timely resolution of complaints and grievances from any member. The THN Board of Managers shall delegate resolution of complaints and grievances to Triad HealthCare Network management, Office of Patient Experience and/or Medicare Advantage plan process*.

DEFINITIONS:

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b).

Member: Patient who receives services through a contracted provider.

Member, Caregiver or legal representative, as used in this policy, includes the member, the healthcare power of attorney, durable power of attorney, and/or the legal next-of-kin.

Complaint: A verbal complaint from family or member representative that can quickly be resolved at the time of the complaint. A complaint is considered resolved when the member is satisfied with the action taken on his or her behalf. If department leadership is unable to resolve the complaint *or* if the family requests to file a grievance, then it is now considered a grievance.

Member grievance is a written or verbal complaint or the member's representative regarding (1) the member's care, (2) abuse or neglect, (3) issues related to hospital compliance with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (COP), or (4) a Medicare beneficiary billing complaint related to rights and limitations provided by 42 § CFR 489.

Examples of Member Grievances

1. All written complaints (received via fax, e-mail, US mail, interoffice mail, social media, or attached to a survey) regarding member care, abuse and neglect, or COP compliance.

2. A verbal complaint regarding member care from a member or member's representative that cannot be resolved and is either delayed, referred, requires more investigation, or requires further action for resolution.
3. All verbal allegations of abuse, neglect, member harm, release of restricted information, or noncompliance with COP.
4. A complaint that was unresolved during the member inpatient stay that is identified during a transition of care call. A completed member satisfaction survey (on which the member specifically requests resolution in the comments). If a written complaint is attached to a survey, it must be treated as a grievance.
5. All post-visit complaints to the Office of Patient Experience, the THN website, social media platforms or THN leadership.
6. Billing issues are not usually considered grievances. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489 is considered a grievance.

PROCEDURE:
Any change in state or federal requirements will take precedence over this policy.

Members Informed of Procedure
Members and/or their representatives are informed of their rights regarding complaints or grievances through the Member Information Booklet that is given to each member on admission or initiation of services. The information provided also notifies the member of his/her right to contact the following:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

If a member or representative thinks that privacy has been violated or wants to complain to the privacy officer, he/she may contact the Compliance & Privacy Helpline: 1-855-809-3042 or www.conehealth.ethicspoint.com

All Triad HealthCare Network personnel will immediately alert the appropriate administrative staff or the Office of Patient Experience concerning any member grievance.

Receipt of Grievance
Responsibility for the grievance management process lies with the Office of Patient Experience in coordination with the Leadership Alliance member responsible for the area where the grievance occurred.

Response to a Grievance
1. All grievances are forwarded to the Office of Patient Experience and/or Medicare Advantage plan*.
2. The Office of Patient Experience and Medicare Advantage plan ensures the process and timing of the grievance procedure is followed.

3. If a member or legal representative calls the Office of Patient Experience after regular hours to submit a grievance, the caller will be informed that urgent concerns or requests should be referred to the administrative coordinator by calling the switchboard operator. If the urgency of the concern or grievance warrants, the administrator-on-call may be consulted.
4. Within seven calendar days, the member or legal representative will be contacted by the Office of Patient Experience to address resolution or notify the member or representative that further investigation is required. The member will be informed of an expected follow-up time to address the resolution and will be kept informed of the progress on a weekly basis. All grievances will be resolved as soon as possible, with a goal of resolution within seven calendar days and the requirement that it take no longer than 30 days.
5. Risk Management is notified when the concern or complaint involves potential liability in connection with any complaint. This includes allegation of personal injury, property loss or damage, harassment, abuse, or threat of suit. The Office of Patient Experience will close the grievance at that time.
6. If the grievance alleges release of restricted information, the Privacy Officer is notified and the investigation is handled by the privacy officer. The Office of Patient Experience will close the grievance at that time.
7. At the conclusion of the grievance review, the Office of Patient Experience will send written correspondence to the member or legal representative including Cone Health contact person, title, phone number, steps taken in the investigation, finding, and date investigation was completed.
8. The grievance is considered resolved when the member or representative is satisfied with the actions taken. If the member or representative is dissatisfied, the grievance is considered resolved when the facility has taken all appropriate and reasonable actions on behalf of the member.
9. Electronic copies of member letters are maintained in the Office of Patient Experience for the grievance log.

Appeals

If the member or representative is not satisfied with the response to the grievance, the Office of Patient Experience will notify him or her of the appeals process. The hospital president, or Leadership Alliance member of the business unit, and the executive director of the Office of Patient Experience are responsible for appeals.

1. The member or representative is required to provide a written statement requesting an appeal of the grievance that includes why he/she is not satisfied.
2. The appeal is reviewed by the hospital president or the Leadership Alliance member of the business unit, and the executive director of the Office of Patient Experience
3. A letter is sent to the member or representative within thirty (30) business days indicating whether the grievance resolution is supported or overturned. If the appeal is not supported, the member or representative will be notified of state and federal options of filing a grievance. If a resolution is not completed at this point, the member or representative is kept informed of the delay.
4. A copy of the appeal response is forwarded to Office of Patient Experience for tracking.

If the complainant seeks referral to an external source, the referral should be made to the following parties:

1. North Carolina Division of Health Service Regulation: (800) 624-3004
2. For Medicare: Medical Review of North Carolina: Hotline at 800-727-0468. (The MRNC expects to only receive calls relative to serious quality of care issues.)
3. For privacy complaints, referrals should be made, in writing, to the United States Secretary of the Department of Health and Human Services

*See specific Medicare advantage plan workflow and policy for plan specific grievance process guidelines.

REFERENCE DOCUMENTS/LINKS:

1. CONE HEALTH POLICY: Patient Grievance Management Process – **Policy Code:** OP-SER-2000-72

2. CONE HEALTH POLICY: Service Recovery / Patient Complaint Resolution - **Policy Code:** OP-SER-2012-119

RESOURCES:

1. Attachment A: Patient Concern Intake Form
2. Attachment B: Appointment of Representation Form

PREVIOUS REVISION/REVIEW DATES:

Date	*Reviewed*	*Revised*	*Notes*
June 5, 2000			Original effective date.
February 2003			
September 2003			
October 2004			
October 2005			
January 2008			
October 2011			
August 2012			
September 2014			
June 2015		X	Clarified wording related to grievances reviewed within seven days. Added information about informing member of internal appeals process and external appeals bodies. Added clause that officially closed a grievance when it is referred to Risk Management or Privacy Officer.
September 20, 2016		X	Added specific definitions and examples of complaints. Expanded examples of grievances. Updated contacts for DHSR and TJC.
July 10, 2017		X	Updated Cone Health Policy to meet THN needs

This procedure is in compliance with all federal and state requirements and specifically the requirements set forth by the Centers for Medicare and Medicaid (CMS) as outlined in the Medicare Managed Care Manual Chapter 4 – Beneficiary Protections, 42 CFR §§ 417.428, 422.2260, 423.2260, 440.169, and 441.18.