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Origination Date	7/28/1997	Owner	Leslie Robinson: Risk Management Director
Last Approved	6/12/2023	Policy Area	Risk Management
Effective	6/12/2023	References	ASC, CARF, CHAP, DNV, Policy
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Next Review	6/11/2024		

Customer Feedback and Grievance Policy

POLICY:

It is the policy of Confluence Health (CH) including the Ambulatory Surgical Centers (ASCs), to respond to patient concerns and grievances in a timely, efficient, and consistent manner. Patients are encouraged to communicate concerns about the quality of services provided, potential safety issues, potential actions prohibited by Federal or state law or any other matter that relates to patient service. The information received will be utilized as part of CH's continuous quality improvement of patient service and satisfaction.

Any person who believes a patient has been subjected to unlawful discrimination may file a grievance under this policy and procedure. It is against the law for Confluence Health to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

DEFINITIONS:

A. **Patient Complaint**: A complaint is a concern that can be readily resolved, includes most billing issues (simple questions regarding their bills, requesting clarification on a bill, etc.), is related to lost/damaged patient belongings (an item that is found and returned at time of concern), or involves a minor complaint about quality of services provided.

B. **Patient Grievance**: A patient grievance is a written or verbal complaint that is made to CH by a patient or the patient's representative, regarding the patient's care, abuse or neglect, unlawful discrimination, or issues related to CH's compliance. A patient care complaint is considered a grievance when it 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. Billing issues may rise to the level of a grievance if the complaint centers on 42 CFR 489 which concerns basic Medicare

applicability and agreements.

C. **Sources of Feedback and Grievances**: Customer/patient comments, compliments, complaints and grievances are collected via written "How Are We Doing?" forms, telephone calls, written complaints, in person concerns, and patient surveys.

PROCEDURES:

A. **Patient Complaint:** If the customer concern can be immediately and satisfactorily resolved by the initial recipient, the complaint is considered resolved and no further action is necessary. In these instances, enter a RLDatix Feedback Report for tracking and trending of the issue. Mark "yes" to the question "was this handled at the time of instance" and the feedback will be closed.

B. **Patient Grievance:** If the concern cannot be immediately resolved the following procedure will be followed:

1. The grievance is received by a CH employee and entered to the RLDatix Feedback database. CH's governing board has delegated the resolution of the concern to a grievance committee. CH has designated this responsibility to the Care Incident Review Committee.
2. The director or manager of the area from which the concern originated will be assigned leading investigator(s) in the RLDatix Feedback database. The investigation is considered resolved when the patient/designee is satisfied with the actions taken on his/her behalf. There may be situations where CH has taken appropriate and reasonable actions on the patient's behalf to resolve the concern but the patient or their representative remains dissatisfied with CH's actions. In these situations, CH may consider the complaint closed.
3. Investigations of grievances will be thorough, affording all interested persons an opportunity to submit evidence relevant to the issue. Investigation records, including all attempts to resolve the complaint will be maintained in the RLDatix Feedback database. To the extent possible the investigator or investigatory team will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
4. Initial contact will be made by CH to the complainant within 5 calendar days in writing via letter or email.
5. Timely resolution of a concern is defined as 30 days from receipt of concern to resolution response. If the concern will not be resolved in this time frame, or the investigation will not be completed within 30 days, CH will inform the patient or his representative that the hospital is still working to resolve the concern in writing via letter or email. In addition, CH will inform the patient or his representative of an estimate of the number of days remaining to resolve the concern.
6. A letter providing notice of CH's decision will be sent to the patient or his representative. This letter will include the name of the CH contact person, the steps taken on behalf of the patient to investigate the concern, the results of the investigation, and the date of completion of the investigation.
7. Complaints/Grievances that involve Quality of care, service Recovery, Medical Legal

Issues, or provider related will be referred to the Care Incident Review Committee.

8. For complaints/grievances that involve allegations of unlawful discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, creed, religion, marital status, veteran or military status, or any other status protected by law, the following additional requirements shall apply:
    a. The investigation will be coordinated by Confluence Health's Civil Rights Coordinator.
    b. Any written notice of resolution to such a grievance will include information to the complainant of their right to pursue further administrative or legal remedies by the Confluence Health's Civil Rights Coordinator.
    c. The person filing the grievance may appeal the decision of Confluence Health by writing to the Chief Compliance Officer within 15 days of receiving a written decision. The Chief Compliance Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.
9. The patient has the right to contact the following if they are not satisfied:

Washington State Dept. of Health Health Systems Quality Assurance P.O. Box 47857 Olympia, WA 98504-7857 Phone: 1-800-633-6828 HSQA Complaint Intake @doh.wa.gov	***For Ephrata Clinic*** **The Compliance Team, Inc.** 888-291-5353 PO Box 160 Spring House, PA 19477	**Office for Civil Rights** **U.S Dept. of Health & Human Services** 200 Independence Ave SW, Room 509F, HHH Bldg. Washington, D.C. 20201 Phone: 800-368-1019 (voice) 800-537-7697 (TDD)

C. **Accommodations**: Confluence Health will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance, providing recorded material for individuals with low vision, or assuring a barrier-free location for the proceedings.

D. **RLDatix System Process:**

1. Confidentiality: All RLDatix information is deemed confidential and non-discoverable under the protection of our Coordinated Quality Improvement Program, per WAC 246-50-020, RCW 43.70.510 and RCW 70.41.200. Information will not be copied or otherwise disseminated unless authorized by the Risk Management Department, or procedurally required or designated.
2. RLDatix Process:
    a. All tickets entered into RLDatix are available for trending and analysis within 24 hours of the receipt or knowledge of a concern issue will be

entered into RLDatix.

b. All CH staff are trained to enter service incident information.

c. Assignment will be made by the Risk Management department for follow up.

d. Managers, Directors and Administrators are trained to enter initial and follow up activity into RLDatix.

    i. Assignments will be expected to be completed prior to or on the assignment due date. If not, the following escalation process will occur.

        a. Risk team to send email to assignee as first notice.

        b. If assignment is still not completed the following week, a second notice will be sent by the Risk team to the assignee and their direct super.

        c. If a third notice is necessary, notice will be sent to the assignee, direct super and the next chain of command above them.

        d. If a fourth notice is warranted, the case will be referred to the Care Incident Review Committee.

e. All supporting documentation is retained to complete the review, resolution, and coding.

f. Regular reports are made available to the Board, Confluence Health Leadership, and the Medical Executive Team as part of continuous quality improvement activities.

REFERENCES AND RELATED DOCUMENTS:

A. Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92

B. WAC 246-50-020

C. WAC 246-330-115

D. RCW 43.70.510

E. RCW 70.41.200

F. 42 CFR 482.13(a)(2)

G. NIAHO Standard PR.5

H. CHAP Standard: HMEII.12, HPFC.6.D, PCC7.I, ITNI.4

I. 2023 CARF Medical Standards Manual Section 1. K

J. Related policy: Confluence Health Patient Nondiscrimination Policy

ADDITIONAL REVIEW AND APPROVAL BY:

ASC Governing Committee November 15, 2022

Note: policy must be published on the Confluence Health website as updates occur.

Approval Signatures

Step Description	Approver	Date
PolicyStat Administrator	Crista Davis: Regulatory Standards Coordinator	6/12/2023
EVP/CMO	Jason Lake: Chief Medical Officer	6/12/2023
VP	Sarah Brown: VP Risk and Regulatory	6/12/2023
Director	Leslie Robinson: Risk Management Director	6/8/2023
	Leslie Robinson: Risk Management Director	6/8/2023