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Hidden compliance risk area: Patient grievances

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Healthcare facilities should want to hear patient concerns in an effort to improve service. It is good business to address patient concerns and determine how processes and, ultimately, patient safety can be improved. Healthcare organizations that accept Medicare and Medicaid funding are required to meet patient grievance requirements published in the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs).[1] CMS has also published Interpretive Guidelines (Appendix A of the State Operations Manual[2]) on the CMS website to assist organizations in developing a compliant patient grievance process. A robust patient grievance process can also prevent a negative outcome from a state Department of Public Health survey, reduce civil monetary penalties, improve patient safety, and improve the quality of care patients receive by addressing any systemic issues.

An in-depth compliance review of the grievance process can assist a facility in determining whether Medicare CoPs are consistently met and whether the organization is prepared in the event of a state survey. This article explores CMS's expectations for a grievance program, based on experience gleaned from an Alabama Department of Public Health survey that was performed by two registered nurse surveyors across two days at our facility.

Definitions

Understanding the CMS definition of a grievance versus a complaint is key to determining compliance. According to 42 C.F.R. § 482.13(a)(2), 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 CoPs, or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 C.F.R. § 489.

The Interpretive Guidelines for Hospitals, which a state's Department of Public Health will use when conducting a survey of the patient grievance process, provides healthcare providers with additional details related to the definition of a patient grievance:

- "Staff present" includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (e.g., nursing, administration, nursing supervisors, patient advocates) to resolve the patient's complaint.
- If a 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 written complaint is always considered a grievance.

- Information obtained from patient satisfaction surveys usually does not 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.

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.

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 their 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.

Data collected regarding patient grievances, as well as other complaints that are not defined as grievances (as determined by the hospital), must be incorporated in the hospital's Quality Assessment and Performance Improvement (QAPI) program.

In contrast to a patient grievance, a patient complaint is an issue that can be resolved promptly or within 24 hours and involves staff who are present (e.g., nursing, administration, patient advocates) at the time of the complaint. Complaints will typically involve minor issues such as room cleanliness, food preferences, lost personal belongings, or room temperature. In contrast, examples of grievances include failure to protect the patient's privacy, allegations of abuse by personnel, failure to provide needed medication(s), or failure to meet the patient's care expectations. Both complaints and grievances should be captured by the facility as part of quality improvement activities.

It is possible to stop a complaint from escalating into a grievance by having dedicated staff to solve small problems and employing a proactive approach to customer service. Many hospitals have a service recovery protocol to protect their reputation and restore patient and family trust. For example, our hospital has incorporated HEATT into our grievance program. The acronym stands for the following and is used by many hospitals:

- **Hear** the patient and listen to the concerns expressed.
- **Empathize** with the patient and/or family members.
- **Apologize** sincerely for inconvenience, misunderstandings, and negative experiences and address the patient's perceptions.
- **Take action** to correct issues quickly, fairly, and consistently.
- **Track and trend** by documenting the event for performance improvement.

Regardless of the service recovery model used, training is vital to the success of customer service recovery efforts. Frontline staff should feel empowered to act as the first line of defense against complaints and move toward swift resolution. Interviews with staff can assist the compliance professional in understanding whether patient concerns are appropriately categorized as complaints versus grievances, whether a service recovery model is used to assist in decreasing the number of grievances by timely addressing patient complaints at the bedside, and whether staff understands documentation requirements for grievances and complaints. Understanding expectations for a facility's grievance program is one of the first steps in reviewing the program.

Policy and procedures

Another early step in reviewing a grievance program is examination of the hospital's grievance processes and associated policies. Verify that facility policy and procedures address the minimum requirements as shown at 42 C.F.R § 482.13(a)(2). Interpretive Guidelines at 42 C.F.R. § 482.13(a)(2) state "the hospital's governing body must review and resolve grievances, unless it delegates this responsibility in writing to a grievance committee." When our facility was surveyed, the state surveyor asked for the document where the governing body delegated the responsibility to a grievance committee. Even if the delegation occurred years prior, the surveyor expected to see proof of the delegation in writing. One of the first steps in reviewing a grievance program should be examination of board minutes delegating the grievance responsibility to a grievance committee at the facility. This document should be readily available for review and is often attached to the grievance policies and procedures for ease of access.

Next, the state surveyor examined documents our patients are given that "inform each patient whom to contact to file a grievance." At a minimum 42 C.F.R. § 482.13(a)(2)(i) states "the hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital." There are several methods used to educate patients on the grievance process. Typically the process is included in the notification of patient rights. Depending on facility size, there may be a separate document in a new patient packet, volunteers or employees may be enlisted to visit patients to verbally explain the process, and the process may be posted on the hospital's internet site.

In addition to reviewing printed material provided to patients on how to submit a grievance, the state surveyor interviewed patients and clinical staff. Patients were interviewed to determine whether they clearly understood the hospital's grievance process and their rights to file a grievance. Staff was interviewed to determine whether they understood the process and could answer patient questions. Grievance material should incorporate contact details if the patient chooses to lodge a grievance with the hospital or the state Department of Public Health. It should also explain the patient's right to seek review by the Quality Improvement Organization (QIO) for quality of care issues, coverage decisions, and to appeal a premature discharge.

Training

Staff should be adequately trained on all aspects of the grievance process, from how to handle a patient complaint at the bedside to how to communicate the complaint or grievance to appropriate personnel. If software is used to capture patient complaints and grievances, staff should receive routine training on the software application. Additionally, employee training should focus on the types of patient interview questions that should be asked. The intake process for complaints and grievances is an opportunity to obtain as much information as possible from the patient to assist in prompt resolution of the issue(s). Employee training should involve any processes that deviate from the norm, such as the process for when a patient alleges harm, abuse, or neglect—all of which should be escalated to appropriate leadership for swift investigation and resolution.

Documentation

To determine program effectiveness, the surveyor examined grievances made by patients and documentation to support resolution of the grievance in conjunction with the patient's medical record to fill in any gaps. A deep dive into the Interpretive Guidelines at 42 C.F.R. § 482.13(a)(2)(ii) reveals that"the hospital should make sure that it is responding to the substance of each grievance while identifying, investigating, and resolving any deeper, systemic problems indicated by the grievance."

Documentation is key to proving that the organization resolved the grievance with thoughtful consideration of

the issues in a timely manner. Documentation captured in real time as the investigation develops and staff are interviewed is helpful to allow all involved to see the progress of the issue. It is important to capture dates and times when documenting so surveyors have a clear audit trail of the entire process. Documentation is vital to supporting the hospital's position that the grievance was investigated timely. Clinical staff should be reminded to provide only facts and avoid opinions when documenting a patient grievance or complaint.

The Interpretive Guidelines at 42 C.F.R. § 482.13(a)(2)(ii) state that hospitals "must review, investigate, and resolve each patient's grievance within a reasonable time frame." CMS does not require a specific "reasonable time frame," but the expectation is set forth in the guidelines as "on average, a time frame of 7 days for the provision of the response would be appropriate." Time frames for review to resolution should be documented in the grievance policy. If policy dictates resolution within a time period of seven days, the state surveyor will review documentation to ensure the hospital is meeting the requirements set forth by the organization's policy. If the facility is not meeting the deadline in all instances, there is an expectation that documentation clarifies the reason for the deviation. For example, if the investigation is delayed because a key employee is out of the office and cannot be reached, documentation should denote this fact. An internal review of documentation requirements and training should prevent any surprise negative findings during a survey.

Interview personnel to gain an understanding of the process followed when a patient states that they have hired an attorney. These types of grievances should be forwarded to the risk management department and/or general counsel for guidance. Determine whether this process is included in documented policies and procedures. In cases where a patient has retained an attorney, the patient's attorney is considered a patient representative. Correspondence such as the closing letter should be reviewed by the risk manager or general counsel prior to mailing. If there is a regulatory implication, the compliance department should also be notified. Discussions with employees responsible for the grievance process will assist in determining whether these concerns are being submitted and reviewed by appropriate personnel.

Depending on organization size, a facility may or may not use specialized software for capturing grievance documentation, including tracking and trending of results. There are numerous positives to using specialized software, including performing data analytics on the types and location of complaints and grievances, assigning complaints and grievances to responsible parties, and using a worklist that can be cleared when all documentation has been filed and the concern has been closed. Software ensures consistency in the patient grievance process.

The final step in investigating a patient grievance is written communication to the patient. At a minimum, 42 C.F.R. § 482.13(a)(2)(iii) states:

> In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

The letter should be written in plain language that can be easily understood by the patient or the patient's representative. It is important to document all telephone and in-person encounters to discuss issue(s), but these modes of communication are not a substitute for the requirement that the hospital provide the patient with a written response. A review of final correspondence documents should assist compliance professionals in determining whether all elements in this requirement are being addressed by the hospital's letter. If a form letter is used and routinely edited, it is important to verify that the person editing the letter understands the content requirements.

The last set of documents that the surveyors requested was grievance committee minutes. Recall that the governing body is responsible for the grievance process unless the governing body delegates the responsibility in writing to a grievance committee. Examine the formal charter for the grievance committee to assist in determining the committee's responsibilities. Compliance should review who sits on the grievance committee and whether the members can effect change when change is necessary. Examine the metrics presented in the committee meetings and related discussions shown in the minutes to verify that root cause analysis for grievances is being performed and corrective action is implemented when necessary. Based upon examination of the minutes, determine the number of times that the committee meets. Determine whether the number of meetings is sufficient to address systemic issues. Verify that the number of meetings matches the number listed in a committee charter and/or policy. Committee reports should be provided to the quality assurance and performance improvement committee. Results from grievance committee meetings should also be communicated to the board of directors (governing body). Minutes from the involved committees should provide written evidence for surveyors.

Additional compliance considerations

Compliance professionals can develop an awareness of the types of grievances received at their facility through attendance at the grievance committee meetings or routine review of grievance documentation. A thorough review can reveal compliance issues hidden in patient complaints and grievances.

HIPAA privacy concerns

Compliance may review the intersection of HIPAA Privacy and the grievance process. For example:

- Verify that staff does not disclose the patient's protected health information (PHI) to those who do not have a need to know when attempting to resolve a complaint or grievance.
- Verify that complaints and/or grievances involving confidentiality are routed to the hospital's privacy officer for investigation and resolution.
- Train staff to direct callers to the appropriate staff to prevent a patient or the patient's representative from having to repeat their grievance. This may better safeguard PHI.
- Determine whether trends related to patient privacy complaints and grievances exist. If so, examine corrective action plans such as HIPAA re-education for a provider or clinical staff.
- Verify that any grievances determined by the privacy department to be a HIPAA breach (as defined by the HIPAA Privacy Rule) were reported to the patient and the Office for Civil Rights in accordance with breach notification rules.

Write-offs and refunds

A patient or a patient's family member may ask for a waiver of a copay or deductible in response to a bad patient experience. Patient advocate groups in social media encourage patients to ask for write-offs and refunds for complaint resolution in hospitals. Verify that Medicare copays and deductibles are not routinely written off as a method of resolving a patient grievance. The CMS regulations and guidance handbooks state:

> Physicians or suppliers who routinely waive the collection of deductible or coinsurance from a beneficiary **constitute a violation of the law** pertaining to false claims and kickbacks.[3]

Coding and billing issues

Review a sample of billing complaints to determine whether compliance issues exist. For example, are patients complaining that they did not see a physician in the emergency room? This may result in questions to ensure coding and billing accurately reflects the face-to-face encounter between a nurse practitioner and the patient.

Alleged discrimination

Some grievances may suggest violations of federal laws, such as an indication in the body of a grievance that the patient was discriminated against based on a disability, age, or race. A patient may complain that an interpreter was not provided in a timely manner implicating Title VI of the Civil Rights Act of 1964.[4] A patient may have filed a grievance alleging treatment discrimination based on the ability to pay, implicating the Emergency Medical Treatment & Labor Act (EMTALA).

Pain management

Grievances may reveal a trend that patients on a particular nursing unit do not feel their pain is being controlled. An analysis could reveal a drug diversion issue.

One or two similar patient grievances do not make a trend, but several patient grievances can point to a systemic issue, which is why metrics taken from the data are vital to the success of a patient grievance program. Surveyors look for evidence that a properly managed grievance process is working to not only improve the patient experience but also improve patient safety.

Conclusion

Risk affects all aspects of healthcare organizations, and the patient grievance process is one area of risk that can go unnoticed by compliance. As a compliance professional, ask the quality department if they have performed a mock survey in this area and discuss results, review metrics from grievance committee material, attend a patient grievance committee meeting, and discuss processes with key personnel. A review of this area will assist in determining where the grievance process risk ranks within the compliance risk assessment model and may prevent significant findings from a state survey.

Takeaways

- Patient grievances can present a risk to the organization, especially when the patient chooses to report the grievance to an external body.
- Compliance professionals should understand the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) as it relates to a patient grievance process.
- The grievance and complaint review should reveal if the process is functioning consistent with documented policy and procedures.
- Metrics should be reported to the facility grievance committee to address systemic issues with corrective action plans.
- State surveyors review the grievance and complaint process to determine whether the process addresses patient safety and quality of care issues.

[1]42 C.F.R. § 482.
[2] CMS, "Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," State Operations Manual, October 12, 2018, https://go.cms.gov/1Ryqelk.
[3] CMS, Medicare Claims Processing Manual, 80.8.1 – Waiver of Deductible and Coinsurance (Revision 1, 10-01-03)
[4]42 U.S.C. § 2000d.