High Desert Health System
POLICY AND PROCEDURE

POLICY NUMBER: 321
VERSION: 1

SUBJECT: PATIENT COMPLAINTS

PURPOSE:

To provide a process and guidelines for documentation, investigation and resolution of patient complaints at all High Desert Health System (HDHS) clinic sites. To provide the best quality health care possible in an atmosphere of professional consideration, respect, and dignity. Complaints are viewed as "windows of opportunity" and will be used to continually improve the services within our organization.

POLICY:

All patient complaints will be handled promptly regardless of race, color, national origin, religion, sexual orientation, gender, age, disability or financial status. Efforts will be made to resolve all complaints at the point of service, through the involvement of a department supervisor or manager when necessary.

Patients who wish to file a formal complaint may either provide a written complaint or speak directly to the Patient Advocate (PA) in the Patient Relations Unit. Patient Relations will either resolve the complaint or coordinate the resolution of the complaint by referral to the appropriate supervisor, manager, or executive staff. Supervisors, managers and executives are responsible for investigating and resolving all complaints referred to them, and for providing written responses to the PA within ten working days, or as specified in the complaint transmittal.

All complaints received from Managed Care Members, including LA Care and Health Net, will be directed to HDHS Patient Relations Unit to be handled according to the DHS Managed Care Services (MCS) Grievance & Appeal Policy and Procedure (MCS-GA.0001).

Member Grievance forms are located at each clinic and can be given to the patient at point of service. Completed forms are directed to the HDHS Patient Relations Unit, who will forward them to the respective Health Plans. The Health Plans files the formal grievance, sends request for response to the MCS Grievance Unit. The MCS Grievance Unit in turn, forwards the request for response to HDHS Patient Relations Unit. The complaints are logged and forwarded to the appropriate HDHS department for investigation.

All HIPAA related complaints will be referred to the HDHS HIPAA compliance Officer.

Upon request, patients will be provided with written responses to their complaints.

PROCEDURE:

1. Within the scope of their responsibilities, all employees have a responsibility to assist patients in resolving informal patient complaints at the point of service.

2. When an employee cannot resolve a complaint at the point of service, the department manager or supervisor should be notified. The manager or supervisor will then attempt to resolve the complaint at the point of service.

3. If the complaint cannot be resolved at the point of service, the manager or supervisor will explain the process for filing a formal written complaint and/or contacting Patient Relations.

4. The manager or supervisor will provide the complainant with the Patient Complaint Form (Attachment A) for non-managed care patients or the LA Care Complaint Form (Attachment B) or the Health Net Complaint Form (Attachment C), and encourage the complainant to document his/her complaint in writing, and will forward all completed forms to Patient Relations. If a manager or supervisor is not available, this information will be provided by the employee assisting the patient.

5. The patient or patient representative can contact the Patient Relations Unit at 661.471.4066

6. Managed Care patients can contact their Health Plans directly at:
   - LA Care at 888.839.9909
   - Health Net at 800.675.6110

7. Patient Relations will review all complaints and determine whether they involve quality of care or administrative issues. In addition, for all complaints that meet the criteria for filing a Safety Intelligence (SI) event report, PA will confirm with the HDHS Risk Manager or the department supervisor or manager that a SI report has been entered. If a SI has not been entered, the Risk Manager will initiate the SI.

8. All quality of care complaints related to providers will be referred to the Medical Director, or designee, for review. All quality of care complaints related to nursing will be referred to the Nursing Director, or designee, for review. Quality of care complaints related ancillary services will be forwarded to the appropriate department manager for review.

9. Patient Relations will forward all administrative complaints, not related to quality of care, to the appropriate department supervisor, manager or executive for investigation and resolution. Examples of administrative complaints include appointment access, billing issues and customer service issues.

10. For all complaints resolved directly by Patient Relations who will document on the Patient Complaint and Tracking Form all steps taken to investigate and

resolve the complaint, including the names of all persons contacted and the dates of the contacts.

11. For all complaints referred by Patient Relations to a supervisor or manager, responses are to be provided to Patient Relations within 10 business days, unless otherwise indicated on the complaint transmittal. If a supervisor or manager requires additional time to complete a complaint investigation an extension should be requested from Patient Relations.

12. If a response, or request for extension, is not received within ten business days, the complaint will be automatically elevated to the next management level for response. Complaints will continue to be elevated through the chain of command, every five business days, until they are resolved.

13. Upon request, patients will be provided with written responses to their complaints. Patient Relations will prepare all written responses, with assistance from supervisors and managers, as necessary. All written responses will be reviewed by the Assistant Administrator. The Director of Quality/Risk Management will be consulted, as necessary, in the preparation of written responses.

14. Patient Relations will maintain a file of all patient complaints, including the actions taken to resolve them, for a period of six (6) years.

REFERENCES

Joint Commission CAMAC RI.01.07.01
Federal Regulations, 42CFR 482.13(a)(2)
California Administrative Code Title 22, Section 7070

ATTACHMENTS

DHS Health Plan Grievance Requests; Managed Care Services; policy MCS-GA.0001
LA Care Complaint/Grievance Form
Health Net Grievance/Complaint Form
Non-Managed Care Patient Complaint Form

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