



# PATIENT GRIEVANCE GUIDELINES & FORMS



This material was prepared by The Southern California Renal Disease Council, Inc. under contract #HHSM-500-2006-NW018C with the Centers for Medicare and Medicaid Services (CMS). The contents presented do not necessarily reflect CMS policy.

#### LEGISLATIVE AUTHORITY FOR THIS PROCEDURE:

*Section 9335 of PL 99-509, the Omnibus Reconciliation Act of 1986 (OBRA), which amended Section 1881 (c) of the Social Security Act relating to ESRD Networks, and requires that an ESRD Network organization implement a procedure for evaluating and resolving patient grievances, and the ESRD Federal Regulations of June 3, 1976: Section 405.2138 which requires that facilities inform patients of their rights and responsibilities, including the grievance process.*

## Mission Statement

*To provide leadership and assistance to renal dialysis and transplant facilities in a manner that supports continuous improvement in patient care, outcomes, safety and satisfaction.*

## PATIENT GRIEVANCE GUIDELINES

A grievance is a request for an investigation of a complaint about a possible risk to the health, safety, or well-being of a patient; or a situation where the patient is unnecessarily at high risk. The situation, event, or condition involves a person receiving care or services for End Stage Renal Disease (ESRD). These services are provided in a chronic dialysis facility or a transplant center. The grievance is to provide an opportunity for discussion and possible resolution of problem(s) between patients and providers of care.

If you, the grievant, have a grievance regarding ESRD treatment, you may exercise your right through the grievance process. The purpose of the grievance is to address concerns alleging that ESRD services were not provided or that they did not meet recognized levels of care.

### PATIENT ROLE AND RESPONSIBILITIES

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- Carefully review ESRD Network #18 statement of Patient Rights and Responsibilities
- Make every attempt to work out the concern informally with facility staff
- Understand and try to use the facility complaint/grievance process first
- May follow-up in writing to confirm a grievance that was submitted via phone or in person; however, a written confirmation is not required
- May designate, in writing, another individual to act on his/her behalf
- May talk to the Network 18 Patient Services staff for assistance
- May withdraw a grievance at any time
- Read carefully what the Network can and cannot do through the grievance process
- Save copy of grievance forms filed

### NETWORK ROLE

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- Keep communication open between patients and their ESRD healthcare providers
- Help patients feel comfortable taking their concerns to an appropriate person without fear of mistreatment or retaliation
- Facilitate a resolution of the concern as quickly as possible
- Assist in the handling of the grievance by acting as expert investigator, facilitator, referral agent, coordinator and/or counselor and educator. In an attempt to resolve a complaint/grievance, the Network may gather information by telephone, site visits, medical records review, and/or interviews with involved parties

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## NETWORK RESPONSIBILITIES

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- Immediately start an investigation upon receipt of a telephone complaint
- Mail the grievance packet, which includes this grievance guideline, the grievance form, a grievance brochure, patient rights and responsibilities and complaint/grievance time table
- Keep patient identity confidential throughout the process, unless otherwise specifically authorized. If the grievance cannot be pursued without disclosing the patient's or grievant's identity, he/she is notified. If disclosure is not allowed, he/she will be advised in writing that the Network will not be able to continue the process, and other alternatives will be provided
- Notify grievant that grievance can be made anonymously but the Network will be unable to report back to them unless contact information is provided. Grievant will also be informed that the provider involved may be able to identify the grievant even when anonymity is maintained
- A representative of Network 18 and/or the Patient Advisory Committee (PAC) will contact the grievant upon receipt/review of the grievance for further information
- Notify the grievant when the grievance investigation has been completed, and when it will be referred to the Medical Review Board for consideration
- Respond in writing if we determine that the problem is not a Network issue or more appropriately handled by another agency
- Send the grievant a final report. The report will be of a general nature and will not detail all the specifics of the investigation. The report will not identify a practitioner, name of another patient, and/or individual without his/her permission. It will indicate if the grievance was resolved or if any recommendations were made to the facility. The report will contain further options if the grievant is not satisfied with the results of the process
- Notify the grievant that the confidential information in the grievance response report pertaining to the grievant may be disclosed by the grievant in any context, including litigation, provided no other patient or provider is identified
- Maintain the confidentiality of all correspondence obtained for the investigation

### What Network 18 CAN and CANNOT Do

**We CAN**

- ❖ Educate the staff and/or you about issues related to the grievance
- ❖ Advocate for the rights of all patients
- ❖ Provide information on Medicare ESRD Coverage

**We CANNOT**

- ❖ Direct a dialysis facility, transplant center, or physician to accept a patient
- ❖ Request that a specific staff member provide your care
- ❖ Change or get involved in facility or personnel policies and procedures
- ❖ Get a physician or staff member “fired” or transferred
- ❖ Investigate the competency/qualifications of a specific staff member
- ❖ Assist with monetary compensation, payment of bills, or transportation arrangements
- ❖ Override State or Federal licensing/certification requirements

### GRIEVANCE TIME FRAMES

Acknowledgement of Grievance	Send a written acknowledgement, within <b>(five) 5</b> business days that the grievance has been received, stating the concerns/complaint
Investigation, Review and Initial Resolution	Advise grievant that the Network has up to <b>fifty (50)</b> calendar days for intake, investigation/review and resolution of grievance
Provider Comment/Response Period	Advise the grievant that once the review is completed we are required to advise the provider/involved practitioner of the determination, and offer them an opportunity to comment prior to the release of the final response to the grievant. <b>Thirty (30)</b> days are allowed for the submission of comments
Final Report/Letter Due to Grievant	Final report due to grievant no later than <b>(five) 5</b> business days after provider’s submission of comments, if any
Total Days to Complete Process	Complete the grievance process within <b>ninety (90)</b> days of receipt of the grievance

**Should you have any questions regarding the grievance process, please contact us at: (323) 962-2020 or (800) 637-4767**



## PATIENT GRIEVANCE FORM

If you are requesting assistance in resolving a problem with your dialysis provider, please fill out the sections that relate to your concern. Return this form to the following address:

Southern California Renal Disease Council, Inc.  
ESRD Network 18  
6255 Sunset Boulevard • Suite 2211  
Los Angeles • CA • 90028  
or  
Fax: (323) 962-2891

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If no phone available, can we leave a message for you at your dialysis facility?

Yes       No

FACILITY ASSOCIATED WITH THIS GRIEVANCE:

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

GRIEVANCE INVOLVES: (check (✓) the one that applies and provide details on page 8)

Treatment Related/Quality of Care

Transfer/Discharge

Other

Please check (✓) one:

- I **have** approached the facility with this grievance and am not satisfied with the outcome or handling. I am not satisfied because *(specify reason)*:

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- I **have not** approached the facility with this grievance because *(specify reason)*:

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Please check (✓) one:

- I choose to represent myself during this grievance process.
- I have chosen a representative to help me during this grievance process.  
*(Complete and submit attached representative authorization form)*

Please check (✓) one:

- I choose to allow the Network to release my identity to the appropriate individuals in the course of processing this grievance.
- I choose to remain anonymous. I understand by remaining anonymous this may result in the inability to fully process my grievance. If this is the case, I will be notified by the Network. *(Refer to the Patient Grievance Guidelines)*

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Signature of Patient/Person Filing Grievance

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Date

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Signature of Patient Representative *(if applicable)*

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Date





PATIENT GRIEVANCE  
REPRESENTATIVE AUTHORIZATION FORM

A patient's Personal Representative is defined by the Medicare End Stage Renal Disease Network Organizational Manual section 790, "as someone who may act for the patient in any capacity that the patient authorizes (e.g., financial actions, health care decisions, or advocacy that may be limited to a single transaction or ongoing responsibility)". Whenever a third party acts as a representative of an adult patient in the filing of a complaint, *the Network will have a copy of the document appointing that person as representative before releasing any confidential information or results of Network activities.*

Dear Network Staff:

I, \_\_\_\_\_, designate \_\_\_\_\_,  
*patient's first and last name* *representative's first and last name*  
who is my \_\_\_\_\_, to represent me in this matter. I understand  
*relationship*

that once I designate a representative, all correspondence will be sent to the representative.

Representative Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Person Filing Grievance

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative (*if applicable*)

\_\_\_\_\_  
Date