HealthInsight
ESRD ALLIANCE | NETWORK 18

PATIENT GRIEVANCE GUIDELINES

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.

To file a grievance about your dialysis facility, contact HealthInsight: ESRD Network 18 at 800-637-4767
700 N Brand Blvd. Suite 405, Glendale, CA 91203 www.esrdnetwork18.org

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.

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

- 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 grievance process first.
- May file the grievance in writing using the attached form or by placing a phone call to the Network's Patient Services Department at 800-637-4767.
- 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 a copy of grievance forms filed.

NETWORK ROLE

- 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 grievance, the Network may gather information by telephone, site visits, medical records review, and/or interviews with involved parties.

WHAT NETWORK 18 CAN AND CANNOT DO

We CAN:

- Investigate claims filed by patients, family members, or patient representatives in an effort to resolve any existing issues the patient is experiencing at the dialysis facility or transplant center.
- Provide individualized interventions and recommendations to both treatment teams and patients on how to rebuild a positive patient-provider relationship.
- Advocate for patient rights.
- Assist with locating a facility if necessary through Dialysis Facility Compare.
- Provide resources such as educational materials and contact information for kidney-related organizations.

We CANNOT:

- Require a dialysis facility, transplant center, or physician to accept a patient.
- Change or become involved in facility or personnel policies and procedures.
- Facilitate in the firing or transfer of a physician or staff member.
- Directly provide patients with monetary compensation, payment of bills, or transportation arrangements.
- Override State or Federal licensing/certification requirements.
- Assist in the pursuit of legal action.

Should you have any questions about the grievance process, please contact us (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:

HealthInsight: ESRD Network 18
700 N Brand Boulevard Suite 405
Glendale, CA 91203
or
Fax: (855) 580-4876

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: Please check (✓) the one that applies and describe the grievance in detail on page three (3).

❑ 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):

_____

_____

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

_____

_____

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 the 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.

_____ _____

Signature of Patient/Person Filing Grievance Date

_____ _____

Signature of Patient Representative (*if applicable*) Date

Describe Your Grievance In Detail:

List dates and approximate times when incident or action occurred. Please remember to restrict your comments to the facts associated with this grievance. Attach additional sheets if necessary.

Appointment of Representative Form

Section 1: Appointment of Representative

I, _____ designate_____
(Print Name of Patient) (Print Name of Representative)
to represent me in filing a grievance related to my dialysis or kidney transplant care.

I understand that by signing this form, I give permission for personal medical information related to my grievance to be disclosed to my representative.

I understand that once I designate this person as my representative, he or she will act on my behalf with regard to my grievance.

I understand that I can withdraw this appointment at any time.

Signed:

_____ Date: _____
(Signature of Patient)

_____
(Print Name of Patient)

Section 2: Acceptance of Appointment (To be completed by the Representative):

I accept the above appointment.

_____ Date: _____
(Signature of Representative)

_____
(Print Name of Representative)

_____
(Relationship of Representative to Patient. For example: Family member, friend, social worker.)