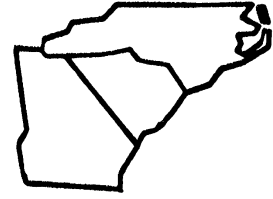


# **Southeastern** *Kidney Council, Inc.*



## **Complaint and Grievance Procedure**

**Southeastern Kidney Council, Inc.  
1000 St. Albans Dr. Ste # 270  
Raleigh, NC 27609**

**For Patients and Family  
Toll-Free 1-800-524-7139**

**For Staff  
919-855-0882**

**Fax: 919-855-0753  
Info@nw6.esrd.net**

# **The Southeastern Kidney Council (ESRD Network 6)**

## **Complaint and Grievance Procedure**

**Based on Sections 750-790 of the Centers for Medicare & Medicaid Services Manual for End Stage Renal Disease Network Organizations**

### **Forward**

The Centers for Medicare & Medicaid Services (CMS) contracts nationwide with End Stage Renal Disease (ESRD) Network Organizations located in 18 geographically designated areas. The Networks were established for purposes of assuring effective and efficient administration of the benefits provided under the Social Security Act for individuals with ESRD.

The Network is responsible for implementing a procedure for receiving, evaluating and resolving complaints and/or grievances involving patient care, conducting on-site reviews of facilities as necessary, and utilizing current standards of medical care to assure proper treatment of ESRD patients. In addition, the Omnibus Budget Reconciliation Act in 1989 provides the Network Organizations with confidentiality in the medical review process and a limitation on their liability. It is the responsibility of the Network to assure that the impartial review of complaints and grievances by Network staff and the Medical Review Board occur without conflict of interest.

### **Confidentiality and Disclosure of Information**

The complainant's identity is confidential information and may not be released unless the complainant or a legal representative has specifically authorized release/use of his/her name. If the complainant is not the patient, the patient's name cannot be released without the patient's or a legal representative of the patient's consent. The Network will ask the complainant and the patient if his/her name can be revealed before the investigation is initiated. The Network will document the complainant's and the patient's position on maintaining confidentiality and when possible obtain a written authorization. The Network is subject to the Social Security Act and 42 CFR Part 480 and will comply with these disclosure requirements, which permits disclosure of the patient's identity to the State Agency on request of the State Agency.

The Network will maintain all complaint investigation, resolution, correspondence and documentation (not in the database) in a confidential file in locked cabinet. On request, the Network will provide the CMS Regional Office Project Officer with the complaint or grievance files and documentation for on-site review. The CMS Regional Office Project Officer will advise the CMS Area Regional Administrator (ARA) or the ARA designee at the appropriate CMS Regional Office about a complaint or grievance when the situation requires ARA involvement.

**Identity of the Complainant-** The complainant will be asked if they may be identified as the complainant during the course of the investigation and resolution process. If the Network is unable to pursue resolution of the complaint or grievance without releasing the patient or complainant's identity, the complainant will be notified immediately. The patient or

complainant may reconsider and authorize release of his/her name. If the patient or the complainant still does not wish the Network to release his/her identity, the Network may decide to investigate or refer the complaint or grievance as an anonymous complaint or grievance. If the complaint or grievance has become unresolvable due to the complainant's or the patient's refusal to allow the Network to release his/her name, the complainant will be advised in writing that the process cannot be continued and other available alternatives will be given. A potentially unresolvable complaint or grievance can occur when a patient refuses to authorize release of his/her name and the facility does not know where to focus its corrective action. Occasionally, however, the problem may be resolved without release of the patient's name, if by having raised the concern, the facility becomes sensitive to the issue and makes an effort to correct the situation generally.

**Facility Identity**- The identification of facilities, which have been involved in complaints or grievances with substantiated care issues, can be released upon request to CMS. In addition, the Network may release aggregate statistics about the number and types of complaints and grievances as long as individual patients and/or complainants are not identifiable implicitly or explicitly.

### **The Complaint and Formal Grievance Process**

The Network is responsible for implementing a procedure for receiving, evaluating and resolving **complaints and grievances** by determining the appropriate action(s) needed to assist the complainant and to resolve the concern.

A **complaint** is a written, verbal, or electronic request for assistance regarding care, treatment or provider issues initiated by or on behalf of an ESRD patient(s). The Network will document all complaints in a centralized database and strives to resolve all complaints efficiently. In resolving a complaint involving patient care, the Network may gather information on the telephone, by letter/email, or by conducting on-site reviews or performing other investigative activities concerning care provided by a facility or a provider as appropriate (as determined by the Medical Review Board and regulation). In making a determination, the Network will utilize recognized standards of care to assure proper treatment of ESRD patients.

A **grievance** is a request for a formal investigation or a serious complaint involving a facility, physician, or other provider. A grievance requires action by the Network, including investigation, a formal review of the information, evaluation of the grievance, and a summary report. Like complaints, the Network will document all grievances in a centralized database. In resolving a formal grievance involving patient care, the Network will perform similar tasks to gather information and investigate the grievance. However at the completion of the investigation, the Network is required to send a report of the findings to the facility and/or provider for comment at least 30 days prior to sending a final report of the findings to the complainant.

If the **complaint** can be resolved through the Network's intervention as an advocate, facilitator or educator and there is resolution of the complaint, the informal complaint process will be used and the formal grievance process is not required. However, the formal **grievance** process may be utilized if the Network is requested by the beneficiary to conduct a formal review and

evaluation, or if the Network believes that the complaint is egregious and the formal process would best suit the situation.

### **The Role of The Network in Resolving Complaints and Grievances**

The role of the Network in resolving complaints and grievances will vary, depending upon the situation. The following are examples of different roles that may be assumed.

- A. Network As Expert Investigator- When the quality of care provided to a patient(s) is an issue, the investigation's focus is the individual complaint or grievance and any overall patterns of care within the facility related to the complaint or grievance. For example, if a patient complains about the procedures used to initiate dialysis, the complaint or grievance will be investigated by reviewing the techniques used by the facility to initiate dialysis on potentially affected patients.
- B. Network As Advocate- When communication between the patient and the facility is problematic, the role of the Network may be to assist by making communication easier in order to help the involved parties to arrive at a mutual understanding and/or a resolution of differences or to find a solution to the problem. The Network will advocate for patients' rights. When possible, the Network may facilitate expedient resolution of the complaint or grievance with calls, letters, on-site visits, etc. as necessary and appropriate.
- C. Network As Referral Agent- Issues which are not specifically ESRD Network issues such as staff safety, compliance with Conditions for Coverage, and fraud are more appropriately handled by either State Agencies or other local, State or Federal agencies. Therefore, when appropriate or requested the Network will refer the complaint or grievance to the appropriate agency immediately. The Network will maintain a list of appropriate local, State and Federal resources to use as referrals for beneficiaries and/or complainants in need of assistance.
- D. Network As Coordinator- Where potentially serious quality of care concerns and/or compliance with Conditions for Coverage are involved, the Network will alert the appropriate CMS Regional Office and Project Officer immediately. The Regional Office for CMS will determine the role of the State Agency and the Network investigation.
- E. Network As Educator- When patients, families or facility staff request or require information/education about ESRD, treatment of ESRD or appropriateness of care, the Network may act as an educator providing the requested information or a referral to an appropriate resource.

**Facility Awareness of the Complaint and Grievance Process-** The Network will provide all ESRD patients in North Carolina, South Carolina and Georgia information about patient's rights and how to file a complaint or grievance with the Network and the State Survey Agency. The Network has a toll-free telephone number (1-800-524-7139) and will assure that each dialysis facility is aware of its responsibility to inform its patients of the facility's grievance procedure and the Network's toll-free telephone number.

**Use of Facility Grievance Process -** All ESRD patients should be informed by their facility about the facility's grievance process and are encouraged to use it before requesting assistance from the Network. However, there may be instances when the patient does not wish to approach the facility staff or provider and requests Network assistance. It is not mandatory that patients

utilize the facility's grievance process before contacting the Network. The Network will receive and act on all complaints or grievances that are brought to their attention. For example, a patient may be concerned about the cleanliness of the facility, but is afraid to approach the facility staff for fear of retribution. In this instance, the Network may investigate and resolve the problem. If the problem is severe or the facility is resistant to correcting the problem, the Network may refer the complaint to the State Survey Agency and/or notify the CMS Project Officer. The Network may work with the State Survey Agency to settle the complaint or grievance and ensure that the facility is in compliance and the problem is resolved.

**Determination of Network Involvement** - The Network has the authority to act on all complaints and grievances made by Medicare beneficiaries who allege a facility's failure to provide the care or services to which beneficiaries are entitled. All complaints and grievances alleging a situation that could affect the health or safety of Medicare beneficiaries will be investigated by the Network or referred to the State Survey Agency or other appropriate authorities. The State Survey Agency has the authority and responsibility to act on complaints and grievances within the scope of the Conditions for Coverage. State law enforcement agencies, CMS and the Health and Human Services Office of Inspector General have the authority to investigate cases of alleged Medicare fraud and abuse.

The Network will determine if the complaint or grievance is an issue appropriately handled by the Network or if it should be referred. The Network will make a preliminary determination when the complaint or grievance is first received and then a final determination after information has been gathered about the complaint or grievance. The complaint or grievance may be referred to an outside agency at anytime during the complaint or grievance process.

**Receiving Complaints and Grievances**- The Network may receive a written or verbal inquiry, complaint or grievance from an ESRD patient, patient representative, a family member, a friend, a facility employee, a physician, a federal or state agency, a patient advocate, or a concerned individual. In addition, other sources, such as the media, may make the Network aware of quality of ESRD care issues that could prompt an investigation. The Network may also prompt an investigation when asked by the CMS Project Officer to do so. Complaints or grievances may involve ESRD services provided in a dialysis facility, an acute care hospital, a nursing home, a home setting, or by a physician. The Network may also receive referrals of complaints or grievances affecting or made by ESRD patients from Quality Improvement Organizations, State Agencies, other ESRD Networks, the Medicare 1-800 Hotline numbers and Medicare Federal Intermediaries.

When a complainant contacts the Network with a problem there are three options of handling any given situation:

1. An **informal complaint process**, which allows the Network (with the complainant's permission) to communicate with the facility or practitioner by phone, letter, fax, email, or in person and to work with the involved parties to resolve the problem.
2. A **formal grievance process**, which is a longer process involving investigation, a grievance determination, and a final report.

3. A **referral** to an appropriate agency, which is done when the issue falls under that agency's authority. For example, a facility's failure to meet the Conditions for Coverage would be referred to the State Survey Agency for action.

The Network may recommend one of the above options to the complainant, and will assist the complainant in choosing the option that will best address the issues at hand.

**Request of a Complaint or Formal Grievance in Writing-** Whenever possible, a complaint or grievance received via telephone or in person should be confirmed by the complainant in writing; however, a written confirmation is not required. When appropriate, the Network will start the investigation of a complaint or grievance while waiting on the written statement. For a potential life-threatening situation, the Network will refer the grievance to the State Survey Agency and notify the CMS Regional Office immediately.

**Written Acknowledgement of a Complaint or Formal Grievance-** When a complaint or grievance is received, acknowledgement will be provided within 5 business days. Acknowledgement of a complaint will be made by phone unless a phone number is not available, in which case acknowledgement will be made in writing. Acknowledgement of a formal grievance will always be provided in writing. The acknowledgement will

- Reiterate the complaint or grievance
- Advise the complainant that the Network will look into the issues of the complaint or grievance
- In the case of the grievance, explain the disclosure provisions that will govern the final response of the formal grievance process.
- Explain the review process and provide approximate time frames.
- Inform the complainant that they may provide additional information at any time and the name, address and toll-free telephone number of the Network will be included.

If it is determined that the complaint or grievance is more appropriately handled by another agency, a referral will be made, and the complainant will be informed of the referral in writing. The letter will include the reason for the disposition, as well as the name, address, and telephone number of an agency contact person.

**Referring Complaints and Grievances-** The Network is responsible for reviewing the issue(s) raised by a complaint or grievance and determining the action required (investigation or referral). If there is a question as to whether or where a complaint or grievance should be referred, the Network will seek direction from the CMS Regional Office Project Officer. If the Network or the CMS Regional Office determines that a complaint or grievance concerns an issue that would more appropriately be handled by another agency, organization, or licensing board, the complainant will be advised and given the referral information or the Network will make the referral to:

- ◆ **Carriers and Federal Intermediaries (FI)-** If the complaint or grievance concerns a payment or denial of services, the Network will refer the complainant to the appropriate carrier or intermediary or the CMS Regional Office representative who works with carriers or intermediaries. For example, an ESRD patient who expressed concern that his/her Medicare statement is not an accurate reflection of the care received should be referred to the carrier or Federal Intermediary, as appropriate. Another example would

be, an ESRD patient who complains about the denial of services should be referred to the Federal Intermediary or carrier.

- ◆ State Survey Agencies (SA)- If the complaint or grievance is a survey and certification issue, (for example, water quality/treatment, dialyzer reuse, infection control/prevention techniques, staffing, or other items included in the Conditions for Coverage) the complaint or grievance may be referred to the State Survey Agency.
- ◆ Quality Improvement Organizations (QIO)- Complaints or grievances involving hospital inpatient stays, and other health care settings, except for outpatient dialysis and Managed Care, will be referred to the QIO for peer review in the state where the hospital or service provider is located whether or not they specifically relate to ESRD treatment or services. For example, an ESRD patient complains that he received poor care while in the hospital and as a result suffered complications incurring an extended hospitalization. The Network would refer this complaint or grievance to the QIO responsible for the area where the hospital is located.
- ◆ CMS Regional Office- Complaints or grievances that are potential or alleged fraud or abuse cases will be referred to the CMS Regional Office. For example, a Medicare ESRD patient complains that a physician is submitting charges to Medicare for treatments that have not been given. The Network would refer this complaint or grievance to the CMS Regional Office.
- ◆ State Licensing Boards- Any complaints or grievances about physicians or other provider services furnished in private offices, clinics or other ambulatory settings (not dialysis facilities) will be referred to the appropriate accreditation, licensing or certification agency and/or the QIO for investigation. For example, a relative of an ESRD patient complains that her father's doctor failed to treat his decubitus ulcer, which became infected and resulted in fatal septicemia. Since the alleged lack of care resulted in the death of the complainant's father, the Network will refer the case to the QIO for peer review and discuss the case with the CMS Regional Office Project Officer to determine if referral to the State Board of Medical Examiners is appropriate.
- ◆ Managed Care Organizations- If the patient is a known managed care patient, the Network may refer complaints or grievances about services furnished contractually for the Managed Care Organization to the Managed Care Organization's department for patient complaints. If the complaint or grievance is about the Managed Care Organization itself, the complaint or grievance will be referred to the CMS Regional Office. For example, a patient complained that their Managed Care Organization is preventing them from receiving a transplant by requiring them to use an out-of state transplant center when a local Medicare certified transplant center is available. The patient will be referred to the CMS Regional Office.

**Investigation of Complaints and Grievances**- The focus of an investigation is to gather information objectively in order to determine the validity of the allegations stated in the complaint or grievance. The Network will begin the investigation by obtaining as much information as is available and/or necessary in order to fully understand the issue(s). Information may be gathered from the complainant and/or facility by phone, letter, fax, email, in-

person, or on-site visit. During the investigation of a complaint or grievance the Network staff may interview the complainant, patients, providers, and facility staff and may review medical records or other records to make determinations about the quality of care provided.

**Life-Threatening Situations-** If the complaint or grievance appears to present an immediate and serious threat to patient health and safety, it will be forwarded immediately (within 24 hours of receipt or determination) to the appropriate State Survey Agency and CMS Regional Office. The Network will keep the CMS Regional Office Project Officer informed by telephone and then in writing for confirmation of the situation either by email or fax. Confidentiality of the complainant will be maintained as per the complainant's request. If the CMS Regional Office requests Network assistance, the services will be available in a consultative manner and/or will begin an investigation immediately. The findings will be reported to the CMS Regional Office as soon as possible.

**Challenging Patient Situations-** If a complaint or grievance involves the discharge of a disruptive, abusive, or violent patient, the Network will investigate the situation by obtaining information from all involved parties. In all cases the safety of all patients and/or staff will be the primary concern during the resolution process. The Network will try to determine what the facility and the patient have done to resolve the problem. The Network may facilitate communication between the patient and/or complainant and the facility staff, but will not provide services that are the responsibility of the facility staff (for example, finding placement in another facility). If the facility is in violation of the Conditions for Coverage, the complaint or grievance will be referred to the State Survey Agency.

**Advocating for Patient Rights-** The Network will advocate for patient rights with the understanding that the patient is responsible for his/her behavior. Patient rights can be found in the Conditions for Coverage and/or can be obtained from the Network. If attempts to resolve the problem(s) at the facility fail and the facility wants to discharge the patient, the facility should contact the Network. The Network may request that the facility provide a 30-day discharge notice and assistance with alternate placement. The patient's Nephrologist should be involved in the discharge and transfer planning. If requested, the Network will provide the patient with a list of alternate facilities.

**Resolution of a Complaint or Formal Grievance-** The Network will resolve complaints and grievances in accordance with the roles that were listed above. The Network will assist in the resolution of the complaint or grievance by acting in the appropriate capacity between the complainant and the facility, physician, provider, or supplier. The facility and practitioner will be advised that the Network will be responding to the complainant. When appropriate, a complaint or grievance may be resolved by negotiating an improvement plan (IP) with the facility and monitoring the progress the facility makes to correct the problem or improve the problem area (see Improvement Plans). At the conclusion of the investigation of a complaint, the complainant will receive a written acknowledgement of the complaint and a summation of its resolution.

**Follow-Up of a Complaint or Formal Grievance-** After resolving a complaint or grievance, the Network will follow-up with the complainant if there are concerns about the correction or recurrence of the problem. At this time the Network will try to determine if the outcome of the complaint or grievance process was satisfactory.

## Potential Outcomes of the Complaint and Formal Grievance Process

There are several possible outcomes for the resolution of beneficiary complaints and grievances.

- A. The complaint or grievance is resolved: A complaint or grievance is resolved when the complaint or grievance has been explained, corrected, or settled by the Network so that the complainant is satisfied with the determination or outcome.
- B. The complaint or grievance is closed: A complaint or grievance is closed when the complaint or grievance has been referred, investigated and acted on by another agency or when no further action can be taken by or required of the Network.
- C. The complaint or Grievance is reopened: A complaint or grievance is reopened when the complaint or grievance that had been previously resolved or closed has reoccurred. The case will be opened as a new case but is linked to the original case so that the Network can have the benefit of the original casework and determine if a pattern may exist.
- D. The complaint or Grievance is referred: A complaint or grievance is referred when the complaint or grievance has been sent to the agency or individual that can most appropriately respond to the complaint or grievance. Or the complainant has been given the appropriate contact information for the best agency or individual to assist him or her with their concern and will make the contact himself/herself.

## Formal Grievance Conclusions and Reports

**Conclusion of the Formal Grievance Investigation**- The Network will advise the facility, physician, and/or involved practitioners of the Network's findings and recommendations. This will occur at the completion of the grievance investigation, upon making a preliminary determination and at least 30 days prior to the release of a letter of response to the complainant.

The Network will provide all the involved parties with an opportunity to submit additional information or comments relating to the grievance either in writing, or verbally in a face-to-face meeting, or in a telephone discussion before the Network staff makes a final determination and writes the report letter to the complainant. The Network will afford the involved practitioner 15 calendar days (within the 30-day time period prior to sending the response letter to the complainant) to respond. The Network will advise the physician and the facility that a final report will be sent to the complainant. The Network will also advise the physician that his/her response, if there is one, must be received prior to the release of the report to the complainant if it is to be included in the response letter.

The Network will send a letter containing a grievance report to all of the involved parties. The Network will protect the confidentiality of the complainant and the practitioner, unless the

complainant and/or the practitioner have agreed to the release of his/her name. The Network will conclude a formal grievance investigation within 90 calendar days of receipt of the inquiry. In those instances where more than 90 days are required for a grievance determination, the Network will notify all parties including the CMS Regional Office Project Officer, of the reason for the delay and the anticipated date for the conclusion of activity.

**Contents of the Formal Grievance Report to the Complainant-** The Network's report will provide a brief description of the grievance and the investigation conducted. The Network will inform the complainant whether or not the problem described in the grievance was substantiated as a result of the investigation. In addition, the report will indicate whether the grievance has been resolved or whether the facility has received recommendations from the Network for correction and whether or not the facility is implementing an Improvement Plan.

The Network's report to the complainant will be of a general nature and will not detail all the specifics of the investigation. The Network may disclose facility-specific information but may not disclose practitioner-specific information without the consent of the practitioner(s) at issue. In addition, the report will include a detailed explanation of other options, such as referral to the State Survey Agency or CMS Regional Office, which the complainant may pursue if he/she is not satisfied with the investigation.

**Practitioner Identity-** The identity of a practitioner will not be used in the grievance report letter without the consent of the practitioner at issue.

### **Improvement Plans**

The Network will request an Improvement Plan if it is determined that a single problem or pattern of substandard care exists which has, or may have, an impact on the health or well being of Medicare beneficiary(s). The intervention designed must correct the problem that the Network identified. The facility or provider will develop the intervention. However, if requested, the Network will participate in the development of the intervention. When an Improvement Plan has been requested of a facility, the Network will inform the CMS Regional Office Project Officer and enter the information into the database. Improvement Plans may be shared with the CMS Regional Office and the State Survey Agency on request.

**Content of Improvement Plans-** A facility must submit their Improvement Plan in writing (Improvement Plan template attached to the end of this document). The Improvement plan should:

- ◆ Identify and confirm an opportunity of improvement;
- ◆ Develop and describe implementation of an intervention activity to correct the problem;
- ◆ Describe the staff and material resources that will be dedicated to the intervention;
- ◆ Provide an expeditious timetable including all interim steps and a final completion date; and
- ◆ Propose a methodology that will allow the Network to periodically monitor the intervention activities and outcomes, as necessary indicated by the nature

of the grievance, to ensure that the problem has been corrected efficiently and that it does not recur.

**Time Period for Review and Acceptance or Rejection of Improvement Plans-** The facility has 15 calendar days to submit an Improvement Plan after it has been requested and the Network has up to 30 calendar days to accept or reject the plan. The Improvement Plan must be finalized and implemented within 60 calendar days of the initial notification (15 calendar days after the Network’s approval of the plan).

**Improvement Plan Tracking System-** The Network will maintain a tracking system in a database and will check with the facility at least monthly on the status of improvement plan activities.

### **Improvement Plan Timetable**

<b>Submission</b>	<b>Network Approval</b>	<b>Implementation</b>	<b>IP Completion and Evaluation</b>	<b>Follow-up</b>
15 calendar days from determination of need	Up to 30 calendar days	Within 15 calendar days of approval	30 calendar days after implementation	1-3 months as appropriate

### **Example:**

<b>Submission</b>	<b>Network Approval</b>	<b>Implementation</b>	<b>IP Completion and Evaluation</b>	<b>Follow-up</b>
Grievance opened May 1. Network determined need for Improvement Plan on May 5. Facility submits Improvement Plan by May 20.	The Network approves the Improvement Plan by May 31.	The facility implements the Improvement Plan by June 15.	The facility completes and evaluates the Improvement Plan by July 15.	The Network will follow up with the facility by July 31.

**Conclusion of Improvement Plan-** At the conclusion of the approved time period for completion of the Improvement Plan (30 days if possible), the Network will determine whether the facility has complied with the plan and if the problem was adequately addressed. The determination may be made by either onsite inspection or offsite review of material provided by the facility or a conference call with involved parties. The Network will follow-up at least once to confirm that the improvement plan was carried out, the complaint or grievance was resolved and the problem did not recur.

**Non-Compliance With Improvement Plan-** If the Medical Review Board determines that the facility has not complied with the Improvement Plan, the Medical Review Board, with timely concurrence from the Board of Directors, will decide whether to amend the Improvement Plan and correspond with the facility’s Medical Director or designee as necessary. Further, the

Medical Review Board will determine whether a facility site visit is necessary. The Network may refer to the State Survey Agency or recommend a sanction to the CMS Regional Office.

### **Personal Representative**

A personal representative is an individual designated by a court of competent jurisdiction or by the beneficiary, as evidenced by a document signed by such beneficiary, to act on his/her behalf. An individual may designate whomever he/she chooses as a personal representative. An individual may designate a representative by executing Power of Attorney, a Durable Power of Attorney, or a signed and dated proxy statement. The personal representative may act for the person they represent in any capacity that the person authorizes (for example, financial actions, health care decisions or advocacy that may be limited to a single transaction or ongoing responsibility). The court may appoint a guardian of the individual or a representative if the person is deemed incompetent. The appointment may be for a single action/transaction or it may last for the life of the individual. The names of the involved parties, the duration of the appointment and the extent of the power would be stated in the court document. Whenever a third party acts as a representative of an adult patient in the filing of a complaint or grievance, the Network will have a copy of the document appointing them as a representative before releasing any confidential information or the results of Network activities. A third party can, however, file a complaint or grievance on behalf of a patient without being a lawfully appointed patient representative.

### **Conflict of Interest**

The Network will ensure that a conflict of interest or potential conflict of interest does not exist among members of the Medical Review Board, or Board of Directors handling complaints and grievances. Any individual who has direct involvement with the complainant or the provider under investigation, whether it is a financial, professional or personal relationship, is excluded from participation in the investigation and resolution of the complaint or grievance.

### **Definitions**

Closed - The complaint or grievance has been referred, investigated and acted on by another agency or when no further action can be taken by or required of the Network.

Complaint – A written, verbal, or electronic request for assistance regarding care, treatment or provider issues initiated by or on behalf of an ESRD patient(s).

Complainant – An individual who expresses a concern by filing a complaint or grievance.

Grievance – A request for a formal investigation or a serious complaint involving a facility, physician, or other provider.

Grievance Determination – Initial report of findings.

Inquiry – A written, verbal, or electronic request for information, referral or educational materials that does not require problem resolution.

Medicare Beneficiary – An individual who, due to age, disability or ESRD is entitled to receive benefits under Medicare.

Personal Representative – An individual designated to represent another individual for a designated reason and a specific length of time.

Referred – The complaint or grievance has been sent to the agency or individual that can most appropriately respond to the complaint or grievance. Or the complainant has been given the appropriate contact information for the best agency or individual to assist him or her with their concern and will make the contact himself/herself.

Reopened – The complaint or grievance that had been previously resolved or closed has reoccurred.

Resolved – The complaint or grievance has been explained, corrected, or settled by the Network so that the complainant is satisfied with the determination or outcome.

### **Time Tables**

<b>Contact Type</b>	<b>Acknowledge</b>	<b>Investigation</b>	<b>Final Report</b>	<b>Total Days</b>
Complaint	Acknowledge during first contact	Gather information for resolution	Follow-up by phone or letter	90
Grievance	Acknowledgement letter sent within 5 days of receipt of grievance	Up to 50 calendar days for intake and resolution	30 days prior to letter of response to grievant	90

## **State Survey Agencies**

North Carolina Department of Health and Human Services  
Division of Facility Services  
Acute and Home Care Branch  
2712 Mail Service Center  
Raleigh, NC 27699-2712  
(919) 855-4560  
(800) 624-3004 toll-free

GA Department of Community Health  
Healthcare Facility Regulation Division  
Suite 31.447  
2 Peachtree Street, NW  
Atlanta, GA 30303-3142  
(404) 657-5728  
(800) 878-6442

South Carolina Department of Health and Environmental Control  
Bureau of Certification/Health Regulations  
2600 Bull St.  
Columbia, SC 29201  
(803) 545-4293

Statement of Opportunity for Improvement:	Facility Name:  Person completing report:  Date:
Goal for Improvement:	
Data Required-Needed Resources:	
Root Causes-Barriers:	
Actions Already in Place:	

<b>Action Plan Implementation Steps</b>	<b>Team Members (Note responsible member)</b>	<b>Start Date</b>	<b>Estimated Completion Date</b>	<b>Checkpoint Dates</b>	<b>Date Completed</b>	<b>Comments</b> (Status, outcomes, disposition, etc)

