Policy Title: Patient Complaints, Grievances & Appeal Policy			
Department Responsible: Operations	**Policy Number:** OP-104	**THN's Effective Date:** January 1, 2022	**Next Review/Revision Date:** September 30, 2024
Title of Person Responsible: Operations Manager	**THN Approval Council:** THN Operations Committee	**Date Approved:** June 8, 2023	

DEFINITIONS:

Patient: An ACO Beneficiary, Commercial Health Plan member or Medicare Advantage member.
Complaint: Patient issues that can be resolved promptly or within 24 hours and involve a THN department who is the source of the complaint. Complaints typically involve minor issues, such as communication, mailings, lack of courtesy by THN staff, etc.
Grievance: A formal or informal written or verbal complaint that is made 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.

I. **PURPOSE.** The purpose of OP-104 is to provide (1) a statement of Triad HealthCare Network's (THN's) policy regarding patient's Complaints, Grievances and Appeals and, (2) procedures to ensure that THN's practices are consistent with its stated policies.

II. **POLICY.**

A. Service recovery and complaint resolution is a practice that demonstrates our commitment to caring for patients or Patients' families whose expectations have not been met. The goal is for a THN employee to promptly turn an unmet expectation into a positive experience. We intend to restore our relationship with the Patient and/or family member and address all concerns in a member and family-centered approach. Our intent is to identify and recognize situations that may cause concern or complaint. This commitment to proactively address a member's needs increase the likelihood that we will create positive experiences.

B. THN recognizes that patients have the right to voice concerns without fear of discrimination or reprisal and to have these concerns reviewed and addressed in a timely manner. THN seeks to provide prompt review and timely resolution of patient complaints and grievances. The THN

Board of Managers shall delegate resolution of complaints and grievances to THN management, THN Operations staff, and/or the THN Director of Compliance & Privacy.

C. As it pertains to THN-aligned patients, THN shall require its Participant Providers and Preferred Providers to make Medically Necessary Covered Services available to patients in accordance with applicable laws, regulations, and guidance.

D. All Patient complaints made to THN regarding denied claims will be reported to patient's billing entity and/or the patient's commercial or Medicare Advantage health plan for adjudication under the claim's appeals process at 42 CFR Part 405, Subpart I.

E. Any change in State or Federal requirements will take precedence over this policy.

III. PROCEDURE.

A. **Patients Informed of Procedure.** Patients and/or their representatives are informed of their rights regarding complaints and grievances by the THN representatives receiving the complaint. If a patient or their representative thinks their privacy has been violated or wants to complain to the Compliance and Privacy Officer, they may make a report to the Compliance Hotline: 1(866) 683-9709.

B. **Receipt and Response to a Complaint or Concern.**

1. Patient complaints or concerns are received directly via THN Now, THN Concierge, which is the 24-hour nurse line, and/or the Compliance Hotline. Once received and documented, all complaints are directed to the appropriate THN department for mitigation.
2. If the complaint involves allegations of abuse and/or neglect, THN staff should notify the appropriate authorities (e.g., APS, CPS, and police) immediately. The Social Services Department is available to assist staff if needed.
3. Responsibility for resolving complaints lie with the department in which the complaint originates
4. All THN staff seeks to provide prompt resolution of all member complaints by the "Take the LEAD Service Recovery Process" (**L** - Listen to concerns with **E** – Empathy, **A** – Apologize and acknowledge the concern, and **D** – Do something yourself or direct the concern to someone who can follow up).
5. The THN department employee receiving the complaint will immediately attempt to resolve the complaint through direct communication with the patient. The THN department employee will notify his/her supervisor and other appropriate leadership of any patient complaint or concern that cannot be resolved. The "Take

the LEAD Service Recovery Process" is used by the next level leader.

6. The Department employee may consult with their immediate supervisor concerning resolution of the complaint.
7. All quality-of-care concerns should be directed to the patient's provider or medical facility for mitigation.
8. If the complaint alleges inappropriate release of restricted personal health information, the ACO Compliance & Privacy Officer will be notified,
10. Upon receiving a complaint, the recipient of the complaint will document the complaint using the Complaint and Grievance Intake Form (Appendix A). and notify the department employee in which the complaint originates to mitigate the complaint. The department employee will contact the patient and take appropriate corrective actions to resolve the complaint immediately. Acknowledging receipt of the complaint should occur within 24 hours, but no more than 72 hours. A resolution should occur promptly within seven days from receipt with the requirement that it takes no longer than 30 days for completion.
11. The Department employee receiving the complaint is responsible to document the complaint, the corrective actions, and the outcome.
12. If the complaint cannot be resolved within the seven-day time span, the complaint should be escalated to a THN Medical Director or Chief Clinical Officer.

C. **Grievances.**

1. All written complaints (received via fax, e-mail, US mail, interoffice mail, social media, or attached to a survey) regarding member care, abuse, and neglect or Conditions of Participation (COP) compliance.
2. A verbal complaint from the Patient or their representative regarding quality of care that cannot be resolved and is either delayed, referred, requires more investigation, or requires further action for resolution.
3. All verbal allegations of abuse, neglect, member harm, release of restricted information, or noncompliance with the COP.
4. A complaint that was unresolved during a facility inpatient stay that is identified during a transition of care call.
5. A completed member satisfaction survey (on which the member specifically requests resolution in the comments). If a written complaint is attached to a survey, it must be treated as a grievance.
6. All post-visit complaints made to the THN website, social media platforms, or THN leadership.

D. **Receipt and Response to a Grievance.**

1. Patient grievances received by mail or via THN Now, THN Concierge and/or the Compliance Hotline. Once received and documented, all complaints are directed to the appropriate THN department for mitigation.
2. A THN department employee will follow the same procedures as outlined in responding to patient complaints in III.B
3. All grievances will be resolved as soon as possible, with a goal of resolution within seven calendar days and the requirement that it takes no longer than 30 days for completion.
4. If the grievance alleges release of restricted personal health information (PHI), the THN Compliance and Privacy Officer is notified, and is responsible to handle the investigation.
5. The grievance is considered resolved when the member or representative is satisfied with the actions taken. If the member or representative is dissatisfied, the grievance is considered resolved when THN department employee has taken all appropriate and reasonable actions on behalf of the member.
6. All documents and/or electronic copies of complaint intake records, member letters, and resolution actions will be maintained in a THN complaint/grievance log, which provided to Compliance monthly.

E. **Appeals.**

1. If the patient or patient's representative is not satisfied with the response to the grievance, the Compliance Department Representative will notify him or her of the appeals process.
2. The member or representative is required to provide a written statement requesting an appeal of the grievance that includes why he/she is not satisfied.
3. The appeal is reviewed by the Director of Compliance.
4. A letter is sent to the patient or patient's representative within thirty (30) business days indicating whether the grievance resolution is supported or overturned. If the appeal is upheld the patient will be directed to call 1-800-Medicare for further guidance.

Date	Reviewed	Revised	Notes
January 1, 2022			Original Publication
August 2022	X		No changes
May 2023		X	Converted to REACH and changes to workflow and processes