

**Council of Community Clinics Health Network  
Policy and Procedure**

<b>Clinic/Health Center:</b> CCHN Participating Clinic Sites	<b>Subject:</b> Complaint Reporting	<b>Page:</b> 1 of 1 <b>Section:</b> Initiative Description
<b>Committee:</b> CCHN Physician Council - Health Network BOD -	<b>Date:</b> 3/4/03 <b>Physician Council</b>	
<b>Re-review Date:</b> 03/04/03	<b>Signature(s):</b>	

<p><b>Action Requested:</b>    <input checked="" type="checkbox"/> Approve        <input type="checkbox"/> Implement        <input type="checkbox"/> Create</p>
<p><b>Description:</b> Revising the Unusual Occurrence Policy by the establishment of two separate policies: one for Unusual Occurrences and one for Complaints.</p> <p><b>Policy:</b> Complaints are documented as soon as possible after the event to assure accuracy of the facts. Complaints may be submitted by a point person, staff, or outside agency. A staff member will describe the event in writing on the Complaint Worksheet and submit the worksheet to the Clinic Manager (Director or designee) for follow-up.</p> <p><b>Purpose:</b> To establish a uniform process to obtain accurate, detailed information for all complaints. To analyze the data obtained from reports, to minimize risk potential and maintain and improve the quality of healthcare provided. To develop systems to reduce the recurrence of similar events. To monitor patient complaint ratios within the CCHN Network in order to establish benchmarks on complaints per thousand visits.</p>
<p><b>Estimated Resource Needs:</b> Designated Point Person to coordinate the tracking and trending Executive Director review of potential risk Medical Director for peer review of cases with a priority of 2a-3a Clinic Quality Management Committee</p>
<p><b>Notes on BOD Modifications to Resource Needs:</b></p>

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**Goal:**

To establish a uniform process to obtain accurate, detailed information for all complaints. To analyze the data obtained from reports, to minimize risk potential and maintain and improve the quality of healthcare provided. To develop systems to reduce the recurrence of similar events.

**Policy:**

Complaints can be submitted by patients, staff or outside agencies. A Complaint Worksheet is completed either by a patient or a staff member.

*The threshold for reporting a complaint is defined as any dissatisfaction with clinic services that cannot be resolved at the time when it occurred or when there is substantial disruption generated by the issue. All complaints that reach the second level of management must be reported.*

**Staff Member:** Any individual performing job related functions for the Clinic. This includes off site health promotion/education, fundraisers, volunteers and transportation drivers.

**Complaint:** A complaint is either a verbal or written perceived quality of care or service issue such as waiting time, provider behavior (may include specialists), adequacy of facilities, access and other similar issues. Patients are encouraged to first resolve issues with the Clinic, but are also informed of their right to voice their issue to their health plan if they are a member of a managed care plan. Copies of health plan complaint forms are maintained by the clinic for patients to report directly to their health plan if requested.

Complaints can be differentiated from appeals, which are problems with denial of services or payment for services.

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**Procedure:**

1. Complaint Worksheets are available at each front desk for patients to complete.
2. If the complaint is immediately resolved and the patient is satisfied, the complaint is not reported.
3. All unresolved complaints brought to the supervisor's attention will be reported and trended.
4. The Worksheet is completed by the staff member at the time of the complaint and submitted to the supervisor of the unit.
5. The supervisor completes the follow up box and notes the date received.
6. All complaint worksheets are forwarded to (Clinic Specific Individual) who assigns a priority and enters the complaint into the Complaint Tracking Access database
7. (Clinic Specific Individual) runs regular (quarterly recommended) reports and submits to the Clinic Quality Management Committee
8. Annual complaint reports are submitted to the CCHN Quality Management staff for Network reporting.

**Types Defined**

Complaints are reported by type. The (Clinic specific individual) assigns the type of complaint that best describes the general category. Complaint types include:

- Access (time to get an appointment, response to telephone calls)
- Appeal (denial of service or payment by a health plan)
- Billing (refers to billing issues: billed for service, late submission)
- Communication (no call backs, not informed of abnormal tests)
- Housekeeping (dirty bathrooms, waiting rooms etc)
- Insurance (limited coverage, lack of specialists)
- Laboratory (off site, drawing techniques)
- Medical Care (not addressing all medical questions)
- Medical Staff (issues with a particular provider: rude, hurried)
- Personnel (issues with staff: uncaring, rude)
- Pharmacy (medication refill issues)
- Policies (not willing to comply with clinic policies, no show)
- Security/Safety (stealing, threat, forging prescription)
- Radiology (pertaining to radiology services)
- Waiting Time (long wait, flow issues)

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**Priority Levels:**

1. The following are priority levels for classifying Complaints:
  - A. **Level 0:** No quality of care issues
  - B. **Level 1:** Pertains primarily to the art of caring and communication issues.
  - C. **Level 1a:** Surgical complications-Untoward surgical or post-surgical events which are not determined to be due to negligence or poor technical ability.
  - D. **Level 1b:** Pertains to minor systems problems, including documentation issues.
  - E. **Level 2a:** Pertains to systems problems with potential for an adverse Outcome to the patient.
   
**Level 2b:** Pertains primarily to clinical issues and/or clinical judgment directly impacting patient care with the potential for a mild to moderate adverse effect on the patient.
  - F. **Level 2c:** Clinical issues which reflect the potential for significant to serious adverse effect on the patient or for those cases that demonstrate moderate adverse effect on the patient.
   
**Level 3:** Death with no medical mismanagement. Clinical intervention would not have effected the outcome.
   
**Level 3a:** Medical mismanagement with significant adverse effect on the patient. "Significant Adverse Effect" is defined as:
    1. Unnecessarily prolonged treatment, complications, or readmission; or
    2. Patient management which results in anatomical or physiological impairment, disability or death.
   
**(Sentinel Event)**

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**Receipt of External Complaint:**

1. When complaints are received from external sources (health plan inquiries) the request is immediately forwarded to the (Clinic Specific Individual).
2. The turnaround time to submit all supporting documentation to the health plan is ten (10) working days or as otherwise specified by the health plan. (Some instances may require an expedited process).
3. The (Clinic Specific Individual) will identify the nature of the complaint and prepare the response to the health plan. The response may include additional documentation and clarifying information.
4. Upon receipt of Clinic response, the health plan will process the complaint and is responsible for notifying the patient.
5. The (Clinic Specific Individual) will log the complaint in the Access database indicating health plan source for reporting purposes. (A report on complaints by health plan is in the Report section of the Access database)

**Unacceptable Patient Behavior:**

Unacceptable patient behavior is trended in the complaint Access database. The reason for the patient to become angry and/or dissatisfied may show trends that should be addressed by the clinic Quality Management Committee. The type of complaint defines the reason that the patient became upset. ( waiting time, access, policy such as medication refills, etc).

Interventions such as changes in policy or patient flow may be indicated.

Unlike complaints and unusual occurrences, all patient discussions/counseling should be documented in the patient’s medical record in the progress section.

Clinics cannot refuse to continue to see managed care plan patients unless there has been compliance with the managed care policy for disenrollment. There must be a record that the patient has been counseled and warned before action can be taken to refuse to continue to see the managed care patient. The managed care plan (CHG, Sharp Advantage, UCSD etc) must be sent copies of all letters to the patient regarding patient unacceptable behavior.

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1. There are three levels of unacceptable patient behavior:
  - A. **Level I:** Minor disruptive behavior such as demanding non-emergent care within an unreasonable time frame, or demanding appointments at a particular time. (Please note – there is a subtle difference between demanding and requesting). Other examples are: Three (3) missed appointments within two (2) consecutive months; harassing staff; shouting; verbal abuse. Threats to pursue legal action (as opposed to the written notification from a lawyer) and refusal to comply with clinic policy are included in this level.
  - B. **Level II:** Refusing to follow recommended medical treatment physician believes there is no alternative treatment or procedure. Such refusal would have to, in the physician’s opinion, endanger the health of the patient or aggravate a condition, resulting in more extensive treatment in the future. Examples include: refusing ER transfer, continued drug-seeking behavior, non-compliance with prescribed medications.
  - C. **Level III:** Dangerous behavior such as threatened or attempted abuse of personnel or other patients. Receipt of a notice of a patient’s intent to pursue legal action, damage or theft of clinic property, and falsification or alteration of prescriptions are also included in this category. Only one instance of this type of behavior may be reason to refuse to continue to see the patient. Termination letter can be issued. For managed care patients, notify the health plan so that they can transfer the patient to another physician.

