Rimrock Trails Treatment Services
Policies and Procedures

Policy Title:	**Complaints, Grievances and Appeals**	**Date Initiated:**	11/10/2009
Program Focus:	All	**Date(s) Revised:**	05/24/2019
Approver:	Executive Director	**Last Reviewed Date:**	05/24/2019

Policy:	Rimrock Trails Treatment Services (Rimrock Trails) will have a process for documenting complaints, will provide clients a copy of this process and will post it in a conspicuous location at each facility where services are provided.

Goal/Purpose of Policy:	To provide clients and their representatives with an avenue to express their dissatisfaction, to ensure that each complaint is investigated and to ensure that the client or representative receives a response in a timely manner.

Reference(s):	OAR 309-019-0215; OAR 309-018-0210; OAR 413-215-0046

Definitions:

Appeal A Grievance that involves the dissatisfaction with a decision made by the provider to deny, reduce or terminate services (such as entry or transfer); or an appeal of a grievance decision.

Complaint An informal expression of dissatisfaction with services offered or provided by a provider, including decisions made by a provider regarding services.

Grievance A formal complaint submitted to a provider verbally or in writing by an individual or the individual's chosen representative, pertaining to the denial or delivery of services and supports.
Representative Guardian; custodial parent; foster parent; medical, dental, vision or behavioral health provider; pharmacist; parole officer; teacher; or any other party providing care to the client.

Procedure:

1) Clients and guardians will be notified of their right to file grievances and will be given information on how to file a grievance.

a) The right to file a grievance will be communicated in the Individual Bill of Rights document.
    i) The Individual Bill of Rights will be given to all new clients during the Intake process.
    ii) The Individual's Rights will be posted in a conspicuous location in each facility where services are provided.
        (1) In Outpatient facilities it will be posted in the waiting room.
        (2) In Residential facilities it will be posted in a common area that all residents have access to.
b) The process for filing a grievance will be provided to all clients and guardians.
    i) The grievance process will be given to all new clients during the Intake process.
    ii) The grievance process will be posted in a conspicuous location in each facility where services are provided.
        (1) In Outpatient facilities it will be posted in the waiting room.
        (2) In Residential facilities it will be posted in a common area that all residents have access to.
    iii) The grievance process document will include:
        (1) The method(s) in which a grievance may be filed;
        (2) The contact information at Rimrock Trails Treatment Services for filing a grievance;
        (3) The telephone numbers of
            (a) The Division;
            (b) Disability Rights Oregon;
            (c) Any applicable coordinated care organization; and
            (d) The Governor's Advocacy Office.
c) Both the Individual Bill of Rights will inform the client that a grievant may not be subject to retaliation by a provider for making a report. Prohibited retaliation includes, but is not limited to, dismissal, harassment, intimidation, reduction in services or benefits or basing service on the action.

2) Rimrock Trails Treatment Services will assist clients and guardians in understanding and completing the grievance process as follows:
a) Grievances may be submitted orally or in writing. No specific form is required, however Rimrock as a Complaint form that can be provided to the individual.
b) Complaints that involve the following will be reported as grievances:
    i) Complaint that Rimrock Trails or their staff failed to do something that Rimrock Trails should have done per regulations and/or policies. Examples include:
        (1) Failing to provide required or requested information.
        (2) Failing to provide individuals their rights – see Individual Rights document.
        (3) Failing to provide services as required or agreed.
    ii) Complaint that Rimrock Trails or their staff did something that Rimrock Trails should not have done per regulations and/or policies such as:
        (1) Causing harm or injury to a client whether negligently or on purpose.
        (2) Threatening a client with harm.
        (3) Rude or inappropriate behavior towards a client.
        (4) Retaliation, discrimination or intimidation of a client.
    iii) Decisions made by Rimrock Trails or their staff regarding the provision of behavioral health services that the client or their representatives disagrees with such as:
        (1) Decision to discontinue treatment.
        (2) Decision to not provide requested services.
c) Staff will assume that any complaint received from a client or their representative is to be reported as a grievance unless the individual specifically states the do not want it reported.

i) Representatives include guardians; custodial parents; foster parents; medical, dental, vision and behavioral health providers; pharmacists; parole officers; teachers; and any other party providing care to the client.
ii) Complaints received from other parties not representing the client may also be reported, but will not be considered grievances for purposes of reports to the Oregon Health Authority or a Coordinated Care Organization.

d) Staff will not discourage or intimidate a client or their representative from reporting a grievance. This includes asking such questions as "Are you sure you want to file a grievance?"
e) The client or their representative may request that the grievance be expedited if the circumstances could likely cause harm to the individual.

3) Rimrock Trails Treatment Services will process and resolve grievances and notify clients and guardians of the results in a timely manner.
a) All grievances will be reported to the Quality and Compliance Manager within one business day of receipt, including those that are already resolved.
i) Some grievances may be immediately resolved with the client or the representative. Examples include:
(1) Complaint that information previously requested was not received.
(2) Return call not received.
(3) Misunderstanding that is able to be resolved in one conversation.
ii) These "one call resolution" grievances are documented along with the resolution.
b) The Quality and Compliance Manager will begin investigation of the grievance within 24 hours of receipt of the report from staff. This investigation will include:
i) Determining if the grievance will be processed as an expedited or standard request.
(1) If the client or their representative requested an expedited review and it is determined that the circumstances do not qualify for an expedited review, the Quality and Compliance Manager will notify the individual or their representative within 48 hours for their submission of the grievance that the grievance does not qualify and it will be processed within the standard timeframes. This notification will include the appeal process.
ii) Interviewing staff members involved in the incident and/or decision resulting in the complaint;
iii) Interviewing individuals who witnessed the incident, if any;
iv) Determining the category of the grievance; and
v) Discussing options for resolution with management.
c) The Quality and Compliance Manager will notify the client or their representative of the resolution or the reason for the delay of resolution:
i) Within 48 hours for expedited grievances.
ii) Within five (5) working days for standard grievances.
iii) All grievances resolutions that are delayed will be completed and the notification delivered within 30 days.
iv) This notification will be:
(1) Delivered in writing for all grievances submitted in writing or for quality of care grievances.
(2) Delivered orally or in writing for all other grievances.

4) The notification to the client or the representative will include:
a) The name of the client who is the subject of the grievance.
b) The date the grievance was submitted by the client or their representative.
c) A summary of the grievance.
d) The resolution of the grievance.
e) Appeal rights and contact information for:
i) The Governor's Advocacy Office for all notices
ii) Oregon Health Authority (OHA) Health Systems Division (Division), if a Medicaid client

iii) Coordinated Care Organization, if a member of a Coordinated Care Organization
iv) Disability Rights Oregon, as applicable

5) Grievance categories are listed below and in Appendix 1 for full description. Any grievance that falls into more than one category should be listed in each of the applicable categories and will be counted in each category (i.e. if the grievance falls into two (2) different categories, it will be counted as two (2) grievances).
   a) Access
   b) Interaction with provider
   c) Consumer rights
   d) Quality of Care
   e) Quality of Service
   f) Client Billing
   g) Miscellaneous
6) If the client or their representative appeals the grievance decision to the Division:
   a) The appeal must be submitted to the Division in writing within ten (10) working days of the date of the grievance notification.
   b) Rimrock Trails Treatment Services staff will be available to assist the client or their representative with the appeal.
   c) The Division will respond in writing within ten (ten) working days. This decision can also be appealed within ten (10) working days.
7) All grievances, their investigations, actions, resolutions and notifications will be documented by the Quality and Compliance Manager and records will be maintained for seven (7) years.
8) Rimrock Trails Treatment Services will not retaliate against any client, their representative, staff member, provider or other individual who reports, is interviewed regarding or is a witness to a grievance.
   a) Prohibited retaliation includes, but is not limited to, dismissal, harassment, intimidation, reduction in services, wages or benefits or basing service or a performance review on the action.
   b) The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.
9) Grievances will be reported to OHA and/or the Coordinated Care Organization within timeframes required by contract, if applicable.
10) Grievance reports will be compiled by the Quality and Compliance Manager and reviewed quarterly by management and the Quality and Compliance Committee for the purposes of quality improvement.

Appendix 1

ACCESS - "A"
A.a) Provider's office unresponsive, not available, difficult to contact for appointment or information.
A.b) Plan unresponsive, not available, difficult to contact for appointment or information.
A.c) Provider's office too far away, not convenient
A.d) Unable to schedule appointment in a timely manner.
A.e) Unable to be seen in a timely manner for urgent/emergent care
A.f) Provider's office closed to new patients.
A.g) Referral or 2nd opinion denied/refused by provider.
A.h) Referral or 2nd opinion denied/refused by plan.
A.i) Provider not available to give necessary care
A.j) Eligibility issues
A.k) Female or male provider preferred, but not available
A.l) NEMT not provided, late pick up w/missed appointment, no coordination of services
A.m) Dismissed by provider as a result of past due billing issues
A.n) Dismissed by clinic as a result of past due billing issues
INTERACTION WITH PROVIDER OR PLAN - "IP"
IP.a) Wants to change providers; provider not a good fit.
IP.b) Provider rude or inappropriate comments or behavior
IP.c) Plan rude or inappropriate comments or behavior
IP.d) Provider explanation/instruction inadequate/incomplete
IP.e) Plan explanation/instruction inadequate/incomplete
IP.f) Wait too long in office before receiving care
IP.g) Member not treated with respect and due consideration for his/her dignity and privacy
IP.h) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.
IP.i) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity
IP.j) Member has difficulty understanding provider due to language or cultural barriers.
IP.k) Lack of communication and coordination among providers
IP.l) Dismissed by provider (member misbehavior, missed appts. etc.)
IP.m) Dismissed by clinic (member misbehavior, missed appts. Etc.)
CONSUMER RIGHTS - "CR"
CR.a) Provider's office has a physical barrier/not ADA compliant, prevents access to office, lavatory, examination room, etc.
CR.b) Concern over confidentiality.
CR.c) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group, treatment options not discussed)
CR.d) No choice of clinical or clinician choice not available
CR.e) Fraud and financial abuse
CR.f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health, marital status, Medicare/Medicaid)
CR.g) Complaint/appeal process not explained, lack of adequate or understandable NOA

CR.h) Not informed of consumer (Member) rights
CR.i) Member denied access to medical records (other than as restricted by law)
CR.j) Did not respond to members request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)
CR.k) Advanced or Mental Health Directive not discussed, offered or followed.
CR.l) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Restraint or seclusion used other than to assure members immediate safety.
Quality-of-Care - (QC) **A concern that the care provided did not meet a professionally recognized standard of health care and a Member may have been exposed to serious harm as a result or may potentially be exposed to imminent future harm as a result of the quality of care provided.**
QC.a) Received appropriate care, but experienced an adverse outcome, complications, misdiagnosis or concern related to provider care.
QC.b) Testing / assessment insufficient, inadequate or omitted
QC.c) Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider or Plan)
QC.d) Member neglect or physical, mental or psychological abuse
QC.e) Provider office unsafe/unsanitary environment or equipment
QC.f) Lack of appropriate individualized setting in treatment.
QUALITY OF SERVICE - "QS"
QS.a) Delay in receiving or concern regarding quality of materials and supplies (DME) or dental
QS.b) Lack of access to medical records or unable to make changes
QS.c) Benefits not covered
CLIENT BILLING ISSUES - "CB"
CB.a) Co-pays
CB.b) Premiums
CB.c) Billing OHP clients without a waiver