Grievance and Access To Care Policy and Procedures

2017

Table of Revisions

The contents of this document are subject to change based upon current CMS guidance. When revisions become necessary, the person revising the document shall complete the table below.

Revision #	Reason	Date
1	Initial Release	January 2005
2	Annual Review	February 2006
3	Annual Review- March 2008	March 2008
4	Network Council Review	October 2008
5	Annual Review- October 2009	October 2009
6	Internal Process Updates	March 2010
7	Internal Process Updates	March 2011
8	Internal Process Updates	August 2011
9	Internal Process Updates	March 2012
10	Addendum from Medical Review Board	January 2013
11	Complete revision based upon the Medicare ESRD Network Organizations Manual, Chapter 9 – *Grievances and Patient-Appropriate Access to Care,* draft provided July 2, 2013. MRB review. Approval pending finalized NOM.	October 17, 2013
12	Revision based on 2-20-14 ESRD NW Organizations Manual Chapter 9. MRB review- approval pending final NOM draft.	April 2, 2014
13	Revision based upon ESRD Network Organizations Manual, Chapter 9 final draft June 10, 2014.	July 2014
14	Review and revision based upon ESRD Network Program Scope of Work, Attachment J-11, December 11, 2014.	January 2015
15	Review and revision based upon 2016 ESRD Program Scope of Work, November 26, 2015.	January 2016
16	Review and revision based upon 2016 ESRD Program Scope of Work, Attachment J-8, February 25, 2016.	March 2016
17	Review and revision based upon OY1 SOW[MOD02] CMS-2016-ESRD-Networks, October 13, 2016	December 2016

Contents

BACKGROUND

The purpose of this document is to protect patient rights and to communicate guidelines and procedures to evaluate and resolve patient grievances as required by §§1881(c) (2) (D) and (E) of the Social Security Act and CMS regulations at 42 CFR §405.2112(g) which specifies "evaluating and resolving patient grievances" as one of the Network's functions. Additionally, this document will include procedures for addressing access to care issues. The Heartland Kidney Network (Network) processes grievances from patients diagnosed with End-Stage Renal Disease (ESRD), their representatives, family members and patient advocates related to the quality of care in a Medicare certified ESRD facility.

The End Stage Renal Disease (ESRD) Networks are critical to achieving bold CMS goals for health care transformation. The successful Networks will be patient care advocates and educators, and will lead transformation by serving as partners with ESRD patients, their family members and other caregivers, dialysis facilities and transplant centers, physicians and other practitioners, and other stakeholders. The Network's role in resolving grievances and improving patient-appropriate access to care is facilitated by securing commitments to create collaborative relationships between patients and providers through patient and family engagement.

Federal regulations at 42 CFR §494.180(i) require a dialysis facility to "cooperate with the ESRD Network designated for its geographic area, in fulfilling the terms of the Network's current Statement of Work" and to "participate in ESRD Network activities and pursue Network goals."

Additionally, the End-Stage Renal Disease Conditions for Coverage (ESRD CfCs) for Dialysis Facilities address facility responsibilities with respect to "Patients' rights" at 42 CFR §494.70(a). These include the rights to:

> *"... (14) Be informed of the facility's internal grievance process; (15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State Survey Agency (SA); (16) Be informed of his or her right to file internal grievances or external grievances or both without reprisal or denial of services; and (17) Be informed that he or she may file internal or external grievances, personally, anonymously or through a representative of the patient's choosing*."

Federal regulations at 42 CFR §405.2112(g) specify "evaluating and resolving patient grievances" as one of the Network's functions. The Network will implement procedures for evaluating and resolving patient grievances as required by §§1881(c) (2) (D) and (E) of the Social Security Act and CMS regulations at 42 CFR §405.2112(g). The Network's activities' in response to grievances and non-grievance access to care issues will be consistent with a patient-centered orientation. Network staff will convey openness, acceptance, and empathy in communicating with patients and non-patient grievants as well as when assisting them in communicating with facility managers, physicians, and other health professionals.

Role of the Network

The Network's case review responsibilities include investigating and resolving grievances filed with the Network and addressing non-grievance access to care cases. CMS views the investigation and resolution of grievances and non-grievance access to care cases as an opportunity to focus on meeting the needs of ESRD patients as well as an opportunity to create change by listening to and learning from the patient's and/or caregiver's perspective. Change occurs when dialysis facilities understand the root cause(s) of the grievance issue and implement steps to resolve the issue(s). The steps that lead to resolution may be simple and specific to the grievant or there may be a need for a systemic change to correct the issue for the benefit of all patients within a dialysis facility.

Depending on the details of a case, the Network may assume one or more of the following roles in addressing (1) a grievance filed by an ESRD patient, an individual representing an ESRD patient, or another party and (2) addressing non-grievance access to care cases:

- **Facilitator:** When communication is problematic between a patient and a provider or practitioner, the Network's role is to support and advocate for the patient, to facilitate communication, and to provide for a fair and impartial resolution of differences. The Network will also serve as facilitator to help the patient understand his or her rights as an ESRD patient and to help the patient navigate the ESRD care delivery system.

- **Expert Investigator:** The Network may assume the role of an expert investigator with respect to issues related to quality of care. The investigation will focus on the issues identified in the specific grievance, the overall pattern of care related to the grievance, and/or other issues that may arise during the course of the investigation.

- **Educator:** Depending on the results of the investigation, the Network may need to provide education to the dialysis facility. Grievances provide unique teachable moments where the Network can assist dialysis facilities to use the patient's perspective as well as the Network's expertise to improve processes.

- **Quality Improvement Specialist:** The Network will often need to request the dialysis facility develop and implement a Performance Improvement plan. This affords the dialysis facility the opportunity to take advantage of an unbiased review of the issue and institute improvements through the facility's quality improvement process to make sustainable changes to improve patient care.

- **Advocate:** Networks advocate for individual rights and/or the rights of all patients at a facility, depending on the situation. A Network acts for the greater good when the situation involves a threatening or violent patient.

- **Referral Source:** When the Network determines that another agency or organization could more effectively address a grievance, the Network will make the referral and provide the referral information to the grievant. The Network will also conduct appropriate follow-up after referring a case to a State Survey Agency or the Office for Civil Rights.

The Network may also take on other roles as required by the case, based on an understanding that the Network's primary objective is to resolve the case as successfully as possible for the grievant.

Authority

The authority establishing the scope of responsibility for the ESRD Networks is provided in Section 1881 of the Social Security Act and the Omnibus Budget Reconciliation Act of 1986. Section 1881(c)(2)(D) of the Social Security Act requires the Network to implement "a procedure for evaluating and resolving patient grievances." Additionally, under §1881(c) (2) (E), the Network is responsible for "conducting on-site reviews of facilities and providers as necessary (as determined by [the Network's Medical Review Board] or the Secretary [of Health and Human Services]) utilizing standards of care established by the [Network] to assure proper medical care." Under §1881(c) (2) (G), the Network is responsible for identifying ESRD providers that are "not cooperating toward meeting [N]etwork goals and assisting [them] in developing appropriate plans for correction...."

Federal regulations at 42 CFR §405.2112(g) specify "evaluating and resolving patient grievances" as one of the Network's functions.

The Omnibus Budget Reconciliation Act of 1989 amended the Social Security Act to provide for confidentiality in the medical review process (see §1160 of the Social Security Act) and established a limitation on the Network's liability (see §1157 of the Social Security Act).

Providing Information to ESRD Patients on Network, Provider, and State Survey Agency (SA) Grievance Processes

The Network will provide ESRD patients in its jurisdiction with information on:

- The Network's role in the grievance process
- The right to file a grievance with the Network using the CMS-directed grievance process
- The right to file an anonymous grievance
- The right to file a grievance with the Network and to have their information remain confidential and not be released to the provider and/or practitioner(s)
- The right to file a grievance with the SA

This will be accomplished by:

- Distribution of Network posters to every dialysis facility in the Network's service area for posting in an area visible and accessible to patients including "Patients' Concerns", addressing grievances, "Patients Rights' & Responsibilities" and a general Network poster.
- Distribution through the "My Life, My Choices: Knowledge is Power", MY KIDNEY KIT- "MY NETWORK: Grievances" page available to all patients in each ESRD facility and online at www.mykidneykit.org.
- Posting of information on the Network website www.heartlandkidney.org.
- Inclusion in the Heartland Headlines: Patient Newsletter articles
- All Network correspondence to patients and all materials sent to providers for distribution to patients will contain the following language: "To file a grievance, please contact the Heartland Kidney Network at 920 Main St., Suite 801, Kansas City, MO 64105, Toll-free Patient Line (800)444-9965, net12@nw12.esrd.net, www.heartlandkidney.org."
- The Network will ensure every Medicare-certified dialysis facility in the Network's service area is aware of its responsibility to inform its patients of the patient's right to directly file a grievance with the Network without first using the facility's grievance procedures.
- The grievant has the right to decide whether to begin the grievance process at either the Network or the facility level. The Network will review a facility's grievance procedures as part of the investigation of a grievance.

Providing Updated Information to Providers on the Network Grievance Process

As directed by CMS and/or when substantive changes are made to the Network grievance process, the Network will provide updated information on the Network's grievance process to Medicare-certified dialysis facilities in the Network's service area with a directive that each facility should make the information available to its patients or inform its patients on how to contact the Network to obtain the information. See 42 CFR §494.70(c): "Standard: Posting of rights."

Conflict of Interest

Any member of the Network staff, Medical Review Board (MRB), or Board of Directors who has direct or indirect financial, professional or personal involvement with a grievant or with a provider or practitioner who is the subject of a grievance, will not participate in the investigation and resolution of the grievance. See 42 CFR § 405.2113(b): "Restrictions on medical review board members."

Confidentiality and Disclosure

A grievant's identity is confidential information. The Network shall not reveal the identity of the grievant to any other party unless the grievant specifically authorizes release of her/his name either orally or in writing. The Network shall follow all confidentiality requirements as described in 42 CFR, Part 480.

The Network will maintain all hard copies of grievance-related correspondence and documentation in a confidential file in a locked cabinet. The Network will adhere to CMS security guidelines regarding storage of confidential electronic and hard copy information.

DEFINITIONS

- **Anonymous grievance:** A grievance in which (a) the grievant's identity is not known to the Network. This may be any type of grievance.
- **Appointed representative:** An appointed representative is an individual appointed by a court of competent jurisdiction to act on a patient's behalf or an individual who is otherwise authorized under applicable law to act on a patient's behalf, or an individual appointed by a competent patient who provides authorization to act on their behalf either verbally or in writing. The Network shall request a written authorization using J-8A-1; and will file it with the records for the case if received. An Appointed representative does not usurp the grievant's rights, unless the grievant is cognitively unable to interact with the Network.
- **At Risk for Involuntary Discharge:** A situation in which the Network is notified that a patient is in danger of being discharged from a facility in accordance with the ESRD CfCs but no involuntary discharge process has been initiated and no 30-day discharge letter has been given to the patient. This includes all facility consultations with the Network regarding a specific patient's disruptive behavior. A Network shall not accept anonymous patients as "at risk."
- **Averted Discharge:** Aversion occurs in a situation in which an "At Risk", IVD or IVT patients previous circumstances have been resolved, and the patient will stay in its current facility.
- **Confidential grievance:** A grievance in which the grievant's identity is known to the Network but the grievant does not give permission for his/her identity to be disclosed to the provider and/or practitioner(s) involved in the grievance.
- **ESRD patient:** An individual receiving ESRD services from a Medicare-certified dialysis facility or transplant center. ESRD patients who are not Medicare beneficiaries have the same rights as Medicare beneficiaries in all processes related to grievances and patient-appropriate access to care.
- **Facility Concern:** specific or general circumstance(s) about a patient or the facility brought to the Network's attention by a facility staff member, for which there is insufficient information to consider the case a grievance.
- **Failure to Place:** A situation in which no outpatient dialysis facility can be located that will accept an ESRD patient for routine dialysis treatment. This may include situations in which a transient patient has been refused admission to a dialysis facility for a reason that violates the ESRD CfCs. An involuntary discharge may, but does not necessarily, lead to a failure to place.
- **Grievance:** A written or oral communication from an ESRD patient, and/or an individual representing an ESRD patient, and/or another party, alleging that an ESRD service received from a Medicare-certified provider did not meet the grievant's expectations with respect to safety, civility, patient rights, and/or clinical standards of care. The grievant is not required to explicitly state that the care did not meet professionally recognized standards.

- **Grievant:** An ESRD patient or other individual who files a grievance with a Medicare-certified ESRD provider or the ESRD Network.
- **Involuntary Discharge:** A situation in which, consistent with 42 CFR §494.180(f), a patient is informed in writing that treatment at a dialysis facility will terminate in 30 days or the dialysis facility notifies the Network and SA that it is following an abbreviated termination procedure for a patient who has made an immediate severe threat of physical harm.
- **Involuntary Transfer:** A situation in which a patient who is registered to receive dialysis treatment at one dialysis facility is being transferred to another dialysis facility not by their own choosing, for any reason. This will include a patient who was provided a 30 day notice of discharge but was transferred before the last day of service to another dialysis provider.
- **Medicare beneficiary:** An individual who is enrolled in fee-for-service Medicare or a Medicare health plan to receive benefits under Medicare Part A and/or B.
- **Practitioner:** An individual credentialed in a recognized health care discipline who provides the services of that discipline to patients.
- **Provider**: A health care facility, organization, or agency that provides ESRD services covered in whole or part by Medicare.

PROCEDURES

These procedures have been developed utilizing the guidelines provided in the CMS End Stage Renal Disease Network Organization Scope of Work, including Attachment J-8, Grievance and Patient-Appropriate Access to Care, October 13, 2016.

The Network will address all access to care and grievances regarding a Medicare-certified dialysis facility made by a patient and/or individual representing a patient, an/or another party regarding failure to provide care and services. The Network will act upon grievances and access to care cases that could affect patients' health or safety immediately, and/or refers case to State Survey Agencies (SA) or other appropriate authorities.

Receipt of Grievance

A grievance can be submitted to the Network by telephone, mail, email, or fax. The Network has a voicemail system that notes the date and time of calls as a mechanism to accept grievances outside of normal business hours. Messages captured outside of Network business hours by voicemail, email or fax will be responded to on the **next business day**.

The Network may be directed to investigate certain cases by the CMS Contracting Officer Representative (COR) or CMS Central Office. Other sources, such as the media, may also make the Network aware of issues that could prompt an investigation.

If at any point the grievant alleges that she/he or another person is in imminent danger of serious harm, or the Network has reason to believe that one or more individuals may be in imminent danger of serious harm based on events described by the grievant, the Network shall refer the case to the SA and notify the COR **immediately**.

If at any point the Network suspects that patient care is being compromised or denied due to discrimination on the basis of race/ethnicity, religion, national origin, age, sex, familial status, sexual orientation, gender identity, disability, or veteran status, the Network will notify the COR and inform the grievant that they can assist them in referring the case to the Office for Civil Rights (OCR) for investigation.

Initial Telephone Contact with Grievant

1. Intake. The Network will attempt to collect the following information during the initial phone call with the grievant:
   - A detailed description of the grievance
   - The grievant's status, e.g., ESRD patient, appointed representative of an ESRD patient, family member or friend, social worker or other facility staff member, agency representative.
     - If the grievant is an appointed or authorized representative of an ESRD patient, the Network will ask for documentation of the grievants status, obtain verbal confirmation, with documentation in the PCU or other CMS-designated system, and request that the grievant complete Exhibit 1.
     - If an ESRD patient does not already have an appointed or authorized representative and wishes to do so, the Network will mail or fax a copy of the Appointment of Personal Representative Form, (Exhibit 1) to be completed by the patient.
   - If the grievant is **not** an ESRD patient: the grievant' s address, telephone number(s), and e-mail address
   - The grievant's name and date of birth
   - The name of the provider involved in the grievance
   - The name(s) of any involved practitioner(s)
   - The date(s) of the event(s) in question
   - The state or other jurisdiction in which the care was provided

2. Clarification. Network staff will use their judgment to ask additional questions for clarification. If specific information is not readily available, the Network will follow up as needed to obtain the information.
3. Grievance Process Review. After collecting the information:
    - The Network will review the information with the grievant for accuracy and ask if s/he has any additional information to provide.
    - The Network will request permission to disclose the grievant's name to the involved provider/practitioner(s).
        - If a patient grievant does not provide their identifying information to the Network or asks the Network to keep their identify confidential from the provider/practitioner(s), or if a non-patient grievant does not provide the patient's identifying information to the Network or asks the Network to keep the patient's identity confidential, the Network will explain that it may not be able to act on the grievance without the patient's name and/or that it may not be possible to guarantee the patient's anonymity because of specific details of the grievance, the census of the dialysis unit, or other information related to the care of the patient. **Note**: that only an individual with legal authority to act on behalf of the patient can give permission for the patient's identity to be released to another party.
        - The Network will ask the grievant to report any facility action that the patient considers retribution and will assure the grievant that any acts of retribution will be reported to the COR and the SA.
    - If the Network determines the grievance meets the definition and can be resolved through Immediate Advocacy, the option of Immediate Advocacy shall be explained and discussed with the grievant. The grievant wishes, the Network will initiate the case as an Immediate Advocacy.
    - If the case will be referred to another agency or organization, the Network will explain the reason for the referral, indicate that the Network will make the referral, and provide a contact name and contact information for the agency/organization. The Network will follow-up with the grievant to ensure the receiving agency has made contact.
    - The Network will explain the steps of the Network's grievance procedures and ask the grievant whether she/he has any questions regarding these procedures.
    - Ask the grievant, if they are not a staff member of a dialysis facility, if they are willing to participate in a Grievance Satisfaction Survey.
4. Documentation. The Network will enter all information collected into the PCU, or CMS-designated case review system as directed by CMS. If the CMS-designated case review system does not include a specific field for any information collected at this stage, the Network will use the available "comments" and/or "miscellaneous" fields to enter the information.
5. Network will utilize a Grievance Checklist (Exhibit 9) to ensure that all requirements are met for each grievance received.

Identification of Imminent Danger of Serious Harm or a Situation that Appears to Pose Substantial Risk to Public Health

If, in gathering information about a grievance, the Network becomes aware of a situation that appears to pose a risk to safety, patient health, and/or public health, not related to the grievance, the Network will refer the case to the State Survey Agency and notify the COR.

Timeline

1. The Network shall complete all activities related to a grievance (except an Immediate Advocacy) within **60 calendar days** of receipt of the grievance.
    - This includes the completion of an Improvement Plan if the Network has requested the dialysis facility to initiate one.
2. For an Immediate Advocacy, the Network has **7 calendar days**, with no extensions permitted.
3. If additional time is required for the grievance, the Network shall obtain COR approval to extend the deadline by providing a synopsis of the case, a summary of the Networks actions in addressing the case, and a rationale for the

request for additional time. If additional time for the grievance is granted by the COR, the Network shall notify all parties of the reason for the delay and the new anticipated completion date.

4. The grievant has the option to withdraw a grievance at any time. If a grievant requests that the grievance process be discontinued, the Network shall consult with the COR to determine, based on the available information whether to proceed with the investigation. If the COR and Network concur to proceed with the case, the Network shall document the reasons for proceeding in the PCU, or other CMS-designated system. Regardless of whether the case is continued or not, the Network shall provide the patient with a summary letter (Exhibit 4) within **3 business days**, describing the case and Network actions up to the point when the patient withdrew their grievance.

Following Up on Grievance Received by Mail, E-mail, Voicemail or Fax

1. When a grievance is received by mail, e-mail, voicemail, or fax, the Network shall documents its attempts to contact the grievant no later than the Network's **close of business the following day** after a member of the Network staff initially receives the written grievance or voicemail message.
2. When an attempt is unsuccessful, the Network will leave a message giving the name of a Network contact person and his/her telephone number.
3. If the Network does not reach the grievant by the Network's **close of business on the 3rd day** after the Network receives the grievance the Network will proceed with the information available if it is sufficient to identify one or more potential quality issues and if the information is sufficient to identify the involved provider/practitioner(s).
4. If there is enough information to identify the grievant, but not enough information to identify the provider/practitioner(s), the Network will attempt to locate the patient's provider/practitioner in CROWNWeb.
5. If the Network is unable to locate the patient and provider/practitioner information in the CROWNWeb system, the Network shall contact the grievant advising them that no further action can be taken unless the provider and/or practitioner(s)is identified.

CASE REVIEW PROCESSES

Case review of grievances will fall under five (5) categories, with three (3) being related to the grievances and two (2) being related to Access to care cases. In addition, Networks shall document appropriate Facility Concerns within the PCU. The three Grievance categories are Immediate Advocacy, General Grievance and Quality of Care Grievance and the two Access to Care case types are At-Risk for Access to Care issues and Access to Care.

Immediate Advocacy (IA)

These are cases of a simple, generally non-Quality of Care nature that can be completed in **7 calendar days** or less. In some IA cases, the grievant may be anonymous or confidential. If the Network determines that the case cannot be processed without the grievant's name being provided to the Network, the grievance cannot be anonymous. If the grievant provides their name, the Network will ascertain the grievant's willingness to have their name revealed to the provider/practitioner(s). If the grievant is not the patient, the Network will also ascertain the grievant's willingness to have their name revealed to the patient as well as their willingness to have the patient's name revealed to the provider/practitioner(s). Only an individual with legal authority to act on behalf of the patient can give permission for the patient's identity to be released to another party.

Steps for processing an Immediate Advocacy (IA) are as follows:

1. Obtain the intake information and determine if this meets the definition of an Immediate Advocacy grievance and can reasonably be accomplished within the **7 calendar day** timeframe.
2. Determine if the grievant is willing to provide their identity and whether their name may be shared with the facility.
   - The patient may be anonymous, confidential or express a willingness to have their identity shared.
   - The Network shall determine if the case can be processed if the grievant is unwilling to provide their identity. If not, the Network shall inform the grievant that the case will be closed and close the case.
3. The Network shall complete the activities related to the case, and document the information in the PCU, or other CMS-designated system.
4. All cases, including those the Networks determines cannot be processed, shall be documented in the PCU, or other CMS-designated system, with the appropriate information, to include the reason why the case was closed, and/or why the case could not be processed.
5. There are no extensions for IAs. If an IA cannot be completed within **7 calendar days** the case will be opened as a General Grievance case, and an acknowledgement letter will provided within **2 business days** of opening the General Grievance.
6. IAs do not normally require any letters, with the exception that if a referral is provided as part of the IA process, a summary letter will be provided to the grievant within **3 business days** of closing the case, which includes a summary of the Network actions, and the referral information previously provided.
7. IAs may include multiple minor issues, so long as they meet the criteria; each of which will be documented in the PCU, or other CMS-designated system. However, if the grievant has an issue which does not meet the IA criteria, the appropriate grievance type process must be followed.

General Grievances (GG):

These are cases of a more complex matter, that do not contain clinical Quality of Care issues, and that cannot be resolved within 7 calendar days. IA cases which cannot be completed in the allotted time will have their category changed to that of a General Grievance. Similarly, General Grievances can be either anonymous or confidential unless the Network determines that the case cannot be process without the grievant's identification to the Network, though they may remain confidential. Issues of professional conduct are considered to be General Grievances and not Clinical Quality of Care grievances. If the grievant provides their name, the Network will ascertain the grievant's willingness to have their name revealed to the other parties. General Grievances shall be closed within **60 calendar days**, unless an extension is requested by the **50th calendar day** of the case and is granted by the COR.

Steps for processing a General Grievance are as follows:

1. Obtain the intake information and Network determines if the issues presented are appropriate for this grievance type.
2. Determine if the grievant is willing to provide their identity and whether their name may be shared with the facility.
   - The patient may be anonymous, confidential or express a willingness to have their identity shared.
   - The Network shall determine if the case can be processed if the grievant is unwilling to provide their identity. If not, the Network shall inform the grievant, and close the case.
3. The Network shall provide an acknowledgement letter to the grievant within **2 business days** of opening the grievance.
4. The Network shall complete the activities related to the case, and document the information in the PCU, or other CMS-designated system.
5. All cases, including those the Networks determines cannot be processed, shall be documented in the PCU, or other CMS-designated system, with the appropriate information, to include the reason why the case was closed, and/or why the case could not be processed.
6. The Network shall request any documentation from the dialysis facility or transplant center in a timely manner, and the facility shall provide such document within **5 calendar days** of the Networks request.
7. The Network shall implement Improvement Plans (IPs) as necessary based on identified process change needs of the investigation of the case. All IPs shall be completed within the **60 calendar days** of the grievance process.
8. If a Network will not be able to complete the grievance within **60 calendar days**, the Network shall provide documentation of a brief summary of the case (1-2 paragraphs), a timeline of action taken by the network, and a rationale for the need for the extend period by the **50th calendar day** of the case to the COR. Failure to receive an extension from the COR will be discussed with the Contracting Officer for contract action.
9. A summary letter of the initial issues presented, Networks actions, and which issues have been resolved and how, will be provided to the grievant within **3 business days** of the closing of the case.
10. If a referral is a component of a grievance the referral information will be included in the acknowledgement letter and/or summary letter, whichever is more appropriate.

Clinical Quality of Care cases (QoC):

These are circumstances in which the grievant alleges that an ESRD service received from a Medicare-certified provider did not meet professionally-recognized standards of clinical care. Clinical QoC cases may be either 1) patient-specific nature, in which the care impacted a specific patient, or 2) a general Clinical QoC case, in which two or more patients at a facility were impacted. Grievants may be anonymous or confidential, and depending on the nature of the circumstances presented. The Network shall determine whether the identity of the grievant, or the individual patient that was impacted, must be revealed to the Network for the case to proceed.

Steps for processing a Clinical Quality of Care (QoC) Grievance are as follows:

1. Obtain the intake information and Network determines if the issues presented are appropriate for this Grievance type.
2. Determine if the grievant is willing to provide their identity and whether their name may be shared with the facility.
   - The grievant may be anonymous, confidential or express a willingness to have their identity shared.
   - The Network shall determine if the case can be processed if the grievant is unwilling to provide their identity. If not, the Network shall inform the grievant, and close the case.
3. The Network shall provide an acknowledgement letter to the grievant within **2 business days** of opening the grievance.
4. The Network shall complete the activities related to the case, and document the information in the PCU, or other CMS-designated system.

5. All cases, including those the Networks determines cannot be processed, shall be documented in the PCU, or other CMS-designated system, with the appropriate information, to include the reason why the case was closed, and/or why the case could not be processed.
6. The Network shall request any documentation from the dialysis facility or transplant center in a timely manner, and the facility shall provide such document within **5 calendar days** of the Networks request.
7. The Network shall implement Improvement Plans (IPs) as necessary based on identified process change needs of the investigation of the case. All IPs shall be completed within the **60 calendar days** of the grievance process.
8. If a Network cannot complete the grievance within **60 calendar days**, the Network shall provide documentation of a brief summary of the case (1-2 paragraphs), a timeline of action taken by the network, and a rationale for the need for the extend period by the **50th calendar day** of the case to the COR. Failure to receive an extension from the COR will be discussed with the Contracting Officer for contract action.
9. A summary letter of the initial issues presented, Networks actions, and which issues have been resolved and how, will be provided to the grievant within **3 business days** of the closing of the case.

"At Risk" Access to Care cases ("At Risk" for IVD or IVT):

These are cases in which the Network learns from any source of a patient who is in danger of losing their admission status at a facility. Patients may be either in-center or home dialysis patients. This shall include any cases involving concerns with difficult patient behavior, but may include any patient for whom the Network Patient Services staff member in their professional judgment determines that the patient is at risk for an involuntary discharge or transfer. The Network shall continue to follow and document these cases until they have 'evidence' that the patient has been averted, and will work to facilitate as successful an event as possible. Evidence is defined as the Patients Services staff members' professional judgment that the patient is no longer at risk and/or that patient has been averted. When the Network is able to identify that they are able to remove the patient from "at risk" status the Network will indicate that the patient was "averted", and will detail such information in the PCU or other CMS-designated system.

Steps for processing an At Risk Access to Care Grievance are as follows:

1. Obtain the intake information and Network determines if the issues presented are appropriate for this Grievance type.
2. "At Risk for Access to Care issues" Grievances may not be anonymous.
3. The Network shall complete the activities related to the case, and document the information in the PCU, or other CMS-designated system.
4. If the case is "averted", either by actions of the Network, the dialysis facility, or the patient, the actions taken and the averted status shall be documented in the PCU, or other CMS-designated system.
5. The Network shall follow all CfC required elements of processing a case of this type.
6. These grievance types do not have a time limit. However, the Network shall provide at least monthly updates within the PCU of actions taken by all parties to maintain this case as an "at risk". "At-risk" cases will continue to be monitored and reported in the COR Monthly Report, until they are averted, have become an actual IVD or IVT, or the patient is lost-to-follow-up (LTFU). If a patient has a change in status (that is, proceeds to an Access to Care issue, is averted, or is Lost to Follow-Up), the Network shall take the appropriate action as described in this document.
7. "At-Risk" for access to care cases may or may not involve a summary letter, depending on whether they are received from a grievant or dialysis facility, if they are received from a grievant (i.e., not from a facility staff member), the case shall follow provision of letters as that of a General Grievance, to include an acknowledgement letter, written request for any medical records, and summary letter. If the "At-risk" case is identified by someone other than the patient him/herself, then an appointed representative status shall be documented and an attempt to receive a written authorization will occur.

Access to Care Grievances (IVD/IVT/F2P):

These are cases involving involuntarily discharges, involuntary transfers, or failures to place the patient in an appropriate dialysis facility. The Network shall conduct a thorough and proper investigation in order to facilitate as successful an outcome as possible. All relevant activities of this investigation shall be documented in the PCU. Dialysis facilities who give patients a 30 day notice or an immediate discharge must notify the Network and State Survey Agency (SA) according to the CfCs (42 CFR 494.180(f)(4)). The Networks shall ascertain and reinforce the dialysis facility's responsibilities for IVDs, IVTs, and F2Ps per the Conditions for Coverage. This shall include contacting the SA to ascertain whether the facility provided appropriate discharge information, and otherwise informing the SA of the event.

A referral to another agency or organization may occur as any part of the grievance process and is not a grievance case type in itself, but the occurrence and details of the referral shall be documented in the PCU, or other CMS-designated system. All referrals may be provided orally to the grievant, but shall be included in writing to the grievant, either in the acknowledgment letter or case summary letter.

Steps for processing an "Access to Care" Grievance are as follows:

1. Obtain the intake information and Network determines if the issues presented are appropriate for this Grievance type.
2. "Access to Care" Grievances may not be anonymous.
3. The Network shall complete the activities related to the case, and document the information in the PCU, or other CMS-designated system.
4. If the case is "averted", either by actions of the Network, the dialysis facility, or the patient, the actions taken and the averted status shall be documented in the PCU, or other CMS-designated system.
5. The Network shall follow all CfC required elements of processing a case of this type.
6. These grievance types do not have a time limit. However, the Network shall provide at least monthly updates within the PCU of actions taken by all parties to maintain this case as an "access to care" Grievance. If a patient has a change in status (that is, the issue is averted, or the patient is Lost to Follow-Up), the Network shall take the appropriate action as described in this document. The Network shall report all Access to Care occurrences within the Monthly report based on the date of occurrence.
7. IVD or IVT access to care cases may or may not involve a summary letter, depending on whether they are received from a grievant or dialysis facility, if they are received from a grievant (i.e., not from a facility staff member), the case shall follow the provision of letters as that of a General Grievance, to include an acknowledgement letter, written request for any medical records, and summary letter. If the IVD or IVT case is identified by someone other than the patient him/herself, then an appointed representative status shall be documented and an attempt to receive a written authorization will occur.
8. The Network shall conduct a **30 day** follow-up of the patient's status/location to determine if the patient was admitted to another outpatient dialysis facility or if that patient is a Failure to Place. This will be noted in the IVD tab of the PCU or other CMS-designated system under "Follow-up Disposition".
9. For Access to Care cases, including F2P's, while it is not the Network's responsibility to place patients in dialysis facilities, the Network is responsible for assistance with the placement of patients by advocating for the patient, and providing resources or information to anyone involved in coordinating the placement of a patient in dialysis treatment, including home treatment modalities. Additional Network interventions may include direct communication with a physician, social worker, or other facility staff at the facilities contacted as potential treatment facilities.

Facility Concerns

Facility concerns are not a Grievance or Access to Care case type, and shall not be reported on the COR Monthly Report. A facility concern is a contact from a facility staff member who wishes to discuss either a specific or general circumstance(s) about a patient or a facility, but for which there is insufficient information to declare an actual grievance or access to care case. Facility concerns shall be documented in the PCU, or other CMS-designated system. The Facility Concern category is reserved only for those items which are directly related to grievance or Access to Care

related issues, and is not intended for other purposes. Facility Concerns shall be linked within the PCU to a Grievance and/or Access to Care case when the Facility Concern escalates into either of these types of cases.

Referrals to Other Agencies or Organizations

At any time during the grievance process, the Network will refer a grievance to another agency or organization, and/or provide referral information to the grievant, when the grievance involves a concern that falls under that agency's or organization's authority. If there is a question about whether to refer a case, the Network will seek direction from the COR.

Referrals may be made to any of the following:

1. **Medicare payment contractors and CMS Regional Office:** If the grievance involves payment for services or denial of services, the Network will refer the grievance to the Medicare payment contractor and the appropriate Regional Office component.
2. **State Survey Agency (SA):** The Network will refer to the SAs for the states of Iowa, Kansas, Missouri, and Nebraska. Current contact information will be kept on file and available to all Network staff.
    - The Network will make a referral to the appropriate SA and notify the COR when the Network has reason to believe that:
        - One or more individuals may be in imminent danger of serious harm.
        - A dialysis facility may have failed to comply with the ESRD Conditions for Coverage (CfCs) or has demonstrated a repeated pattern of not complying with the ESRD CfCs.
        - An ESRD provider is not providing appropriate medical care.
        - A dialysis facility has inappropriately discharged a patient for non-compliance, for filing a grievance, or for any reason other than those listed at 42 CFR §494.180(f).
        - A dialysis facility has inappropriately transferred a patient for non-compliance, for filing a grievance, or for any reason other than those listed at 42 CFR §494.180(f).
        - An ESRD provider has violated the rights of one or more ESRD patients.
    - When a grievance meets the criteria for referral to the SA the Network will:
        - Report life threatening situations are referred immediately to the appropriate SA and notify the COR.
        - Contact the appropriate SA within **2 days** via phone and/or letter.
        - Request a case number from the SA representative and/or another form of verification of the contact.
        - If sent by mail, the letter will detail the concerns and with a request for written acknowledgement. See Exhibits 7 and 8: Referral letter(s) to State Survey Agency.
        - Document the case in the PCU or other CMS-designated case review system.
        - Referrals may be discussed during bi-monthly NW/SA/CMS conference calls.
    - When the Network refers a case to the SA, the Network will coordinate communication, problem-solving, and resolution to avoid duplication of effort with the SA. The Network may provide quality improvement assistance or require an Improvement Plan even when a case has been referred to the SA.
    - When a case meets CMS-specified criteria for a sanction/alternative sanction recommendation to CMS, the Network will follow CMS-specified procedures for making the sanction/alternative sanction recommendation. These may include:
        - Identification of a pattern of grievances and involuntary discharges.
        - Identification of failure to comply with Network activities.
        - Identification of failure to meet Network goals.
        - The facility refuses to work with the Network to correct an identified problem(s).
        - Quality Improvement Plan (QIP) noncompliance. If it has been determined that the facility has not complied with the QIP after timely Network reviews, a decision will be made by the Network and MRB chair or assigned reviewer as to whether to amend the existing QIP, recommend a sanction to the COR and/or refer the situation to the SA.
3. **Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)** The Network will refer grievances involving hospital inpatient stays, nursing home stays, home health services, services provided by ambulatory surgical centers, and any other medical service that is outside of the Network's scope of authority to

the BFCC-QIO responsible for the state or other jurisdiction in which the service provider is located whether or not the grievance is specifically related to ESRD treatment or services. **EXAMPLE**: An ESRD patient states that he failed to receive diabetic foot care while in the hospital and that the lack of care resulted in a gangrenous heel ulcer.

4. **Accreditation or Licensing Agency:** The Network will refer grievances about care furnished by a physician or other practitioner to the relevant accreditation or licensing agency when there is a question about the practitioner's credentials or when there is a concern about clinician abandonment of a patient. **EXAMPLES**: The Network receives information that a facility staff person is working on a suspended or revoked license or the Network receives information that the relationship between a treating physician and patient was severed with no attempt by the physician to help the patient find another treating physician.
5. **Office of Civil Rights**: The Network will refer grievances of suspected discrimination.
6. **Other State or Federal Agency:** If a grievance raises an alleged or potential fraud or abuse issue, the Network will refer the grievance to the state or federal agency responsible for the investigation of fraud or abuse in the Medicaid or Medicare Program. See 42 CFR §480.137(b). **EXAMPLE:** A patient states that his physician repeatedly billed Medicare for services that he did not receive and that the physician's billing office refused to make any adjustments.
7. **Managed Care Plan:** If a patient is enrolled in a managed care plan and has a concern about a service furnished under the plan, the Network will advise the grievant to follow the plan's grievance process. If the grievance is about the managed care plan, the Network will refer the grievance to the CMS Regional Office component responsible for the managed care plan.
8. **Law Enforcement:** If the Network has reason to believe that a law has been broken, the Network will refer the case to the appropriate law enforcement agency(ies).

If a referral is a component of an Immediate Advocacy the Network shall provide the information pertaining to the referral within a Summary letter to be provided to the grievant within **3 business days** of the closing of the case. If the referral is a component of a grievance the referral information will be included in the acknowledgement letter and/or summary letter, whichever is more appropriate. The Network will contact the patient to follow-up with the grievant to ensure the receiving agency has made contact.

Medical Review Board (MRB) Involvement

In conducting a Quality of Care Review the Network may ask its MRB, or the Grievance Sub-committee, to review the case.

1. The Network may ask the MRB/Grievance Sub-committee to:
   - Review the medical aspects of care to make sure patients received the professionally recognized standard of care
   - Assess whether the involved patient(s) were treated with civility and respect, whether any patient's rights were violated, and whether there is evidence of any disparities in the quality of or provision of care
2. The Network will redact the names of all individuals and/or facilities to protect the confidentiality of involved parties when grievance-related information is provided to MRB members.
3. The deliberations of the MRB are considered pre-decisional and confidential and are not to be released.

Sending Grievance Summary to Grievant

When the Network has conducted a Grievance, or has included a referral as part of any type of case review, the Network shall report the findings of the Review to the grievant in a summary letter (using Exhibit 4: Grievance Summary Letter), consistent with confidentiality requirements.

The letter shall include:

- A brief description of the grievance
- If a General Grievance was conducted, a brief overview of the results of the review, including if any records were reviewed, and a brief overview of any subsequent actions taken by the Network

- If a Clinical Quality of Care Review was conducted: notification that the patient's medical record was reviewed, a brief overview of the results of the review, and a brief overview of any subsequent actions taken by the Network
- A statement encouraging the grievant to contact the Network if the problem is not resolved or if it occurs again. (Note: The Network may re-open the case or start a new case, as the Network deems appropriate, if new information is received related to the case.)
- A detailed explanation of other options that the grievant may pursue if she/he is not satisfied with the results of the Network grievance process, including the options of contacting the SA, or contacting the Network's COR. The Network will provide the grievant with contact information for each of these options.
- The Network shall send a copy (cc) of the letter to any practitioners mentioned in the letter, whether mentioned by name or title.
- All letters shall be signed by the individual processing the case, with the exception if it is a clinical QoC case and an RN, who is not the PSC/PSD, was the primary reviewer. In that circumstance, the RN will summarize the clinical aspect of the review, but the letter should be sent under the signature of the Patient Service staff processing the case.
- The PSD will review all case review correspondence, as they have responsibility for all case review correspondence that is provided to grievants, regardless of the author.

Lost-to-Follow-up (LTFU)

Any grievant for which there is an active grievance or access to care case, for which there has not been contact by either the Network or dialysis facility for at least **30 days**, may be closed as LTFU, unless the concerns identified in the grievance are related to systemic issues within the dialysis facility that could affect patients other than the grievant. If the grievance has systemic issues, the grievance related to the patient LTFU will be closed and a general grievance will be initiated for the initial concern. Contact is defined as a meaningful reply which provides sufficient indication that the active case may continue. If the case is an active grievance, then the Network shall provide a summary letter to the last known address within **3 business days** of closing the case as LTFU. If the case is an active "at risk" or actual IVD/IVT then the case would be identified as having been averted. Proper documentation of the LTFU and why the case was closed as such shall be entered into the PCU.

QUALITY IMPROVEMENT ACTIVITIES

Performance Improvement Plans

The Network shall implement Improvement Plans (IPs) as necessary based on identified process change needs of the investigation of a grievance case.

1. The Network will request an Improvement Plan in writing from facility staff. The facility may utilize a facility developed form or a form supplied by the Network.
2. Timeframes for completion of the Improvement Plan will be determined in order to comply with CMS guidelines for completion of the grievance process. All IPs shall be completed within the **60 calendar days** of the grievance process.
3. The Network may request specific actions to be completed and provide resource recommendations to assist with staff training. These may include but are not exclusive to:
    - Staff review and re-training on identified policy and procedures
    - Quality Assurance and Performance Improvement (QAPI) team review
    - Decreasing Dialysis Provider-Provider Conflict Training modules
    - 5 Diamond Patient Safety modules

Education to Dialysis Facilities

Network shall provide education to dialysis facilities as appropriate to facilitate the grievance processes within the dialysis facilities. Grievances provide the opportunity to education both facilities and patients in a distinct manner to influence learning and change in facilities that may not otherwise be connected with a Network project. This could include, but is not limited to, education on the use of grievance logs, effective communication, formulating effective grievance processes, or being alert for and managing retaliation. Networks shall make dialysis facilities aware that while CMS encourages an active and robust internal grievance process, the grievant may always choose to initiate a grievance with the Network without first initiating a grievance with the dialysis facility.

1. The Network will complete an audit of grievances reported to the Network in for the first and third quarters of the year to identify trends.
2. Based upon the issues identified the Network will provide educational resources.

CONCLUSION

Heartland Kidney Network (ESRD Network 12) has been designated by CMS to evaluate and resolve grievances from patients diagnosed with End Stage Renal Disease, their representatives, family members and patient advocates related to the quality of care in a Medicare certified ESRD facility. Additionally, the Network is responsible for facilitating patient-appropriate access to care. The policy and procedures as described assist the Network to meet the responsibilities assigned through the ESRD Scope of Work and reflect the guidance provided in the Attachment J-08 – *Grievances and Patient-Appropriate Access to Care*. As per the Scope of Work, the Network will utilize the current guidance as provided and update the policies and procedures as necessary.

920 Main Street, Suite 801
Kansas City, MO 64105

Main Telephone Number: 816/880-9990
Patient Only Toll-Free Telephone Number: 800/444-9965
Fax: 816/880-9088

facebook.com/heartlandkidney

Appointment of Representative Form

Part 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.)

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Date

Name
Address
City, State Zip

Subject: Acknowledgement of Grievance Received

Dear Ms./Mr. Last Name:

Heartland Kidney Network (ESRD Network 12) is authorized by the Medicare Program to receive, investigate and when possible resolve grievances made by or on behalf of ESRD patients in the Iowa, Kansas, Missouri and Nebraska. The Network responsibilities include collecting the available information to determine the nature and extent of a problem and/or whether the services you received met medically acceptable standards. When a quality of care concerns is identified, we either request the facility to correct the problem or we ask the State Survey Agency to look into the problem and take appropriate action.

This letter is to notify you that we have received the grievance concerning your (**involved party**) care, (**patient's name***),* at (**facility name***).* The grievance described the following concern(s):

-
-

You have already indicated that your willingness to disclose your identity is _____. If your disclosure status changes, or you would like to change your disclosure status, please inform the Network immediately.

A member of the Patient Services Department will contact you within the next several weeks for further clarification/information, if necessary. We will also be contacting the facility to gather their information on the incident. As a team we will start our review of your concern(s).

When the review has been completed, the findings may be submitted to the Medical Review Board (MRB) or the MRB Grievance Sub-Committee for review and recommendations. Be assured that your grievance is of concern to ESRD Network 12. We will appropriately follow the necessary steps to resolve your grievance to the best of our ability.

We would like to encourage all patients to visit www.medicare.gov/dialysis to compare dialysis facilities in your area. This site will provide you with quality measures data, facilities characteristics, and demographic information for Medicare certified facilities. If you have any questions or need further assistance, please call me at 816-880-9990 or toll free 800-444-9965.

Sincerely,
Network Patient Services Name, MSW

920 Main Street, Suite 801
Kansas City, MO 64105

Main Telephone Number: 816/880-9990
Patient Only Toll-Free Telephone Number: 800/444-9965
Fax: 816/880-9088

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Date

Facility Administrator
Facility Name
Street Address
City, State, Zip

RE: Filing of Grievance

Dear Mr./Mrs. Last Name:

Heartland Kidney Network is the End Stage Renal Disease Network Organization authorized by the Medicare Program to receive and to the extent possible, resolve grievances filed by or on behalf of ESRD patients in Iowa, Kansas, Missouri and Nebraska. We review grievances related to the quality of dialysis and transplant services given to patients as well as the care provided to them in Medicare certified facilities.

On **Date** a grievance was filed with Heartland Kidney Network by **Grievant**. The grievance states the following concerns:

-
-

To review the grievance appropriately, please send us copies of the documents being requested on the Medical Records Request form attached by **(within 5 working days)**. The facility has the option to submit a letter or any additional documentation supporting its position on this complaint in addition to the requested documents.

Thank you for your cooperation in this case. If you have any questions or need further clarification, please contact me at 816-880-9990.

Sincerely,

Name
Patient Services Manager

cc:

Patient Name(s): _____

Provider Name: _____

Attn: _____

The Information Requested:

❑	Dialysis Treatment Sheets	Date(s): _____ -	_____
❑	Patient's Plan of Care	Date(s): _____ -	_____
❑	Social Services Notes	Date(s): _____ -	_____
❑	Multi-disciplinary Progress Notes	Date(s): _____ -	_____
❑	Comprehensive Assessment	Date(s): _____ -	_____
❑	Medication Records	Date(s): _____ -	_____
❑	Vascular Access Tracking Form	Date(s): _____ -	_____
❑	Laboratory Results	Date(s): _____ -	_____
❑	History & Physical	Date(s): _____ -	_____
❑	Discharge Summary	Date(s): _____ -	_____
❑	Physician Orders	Date(s): _____ -	_____
❑	Grievance Log	Date(s): _____ -	_____
❑	Policy/procedure regarding: _____ _____ _____	Date(s): _____ -	_____
❑	Other: _____ _____ _____	Date(s): _____ -	_____

The information is to be sent to:

Organization: Heartland Kidney Network

Attention: Patient Services

Address: 920 Main St., Suite 801
Kansas City, MO 64105

Phone: 816-880-9990

Fax: 816-880-9088

**Please do not fax if records number over 20 pages.*

*As specified in 42 CRF 405.2139 (b), the ESRD facility must make all records available for inspection by the Network as required to carry out the Network's statutory responsibility. This request will expire on the date the Network investigation is complete. The investigation is complete and the case is considered closed once the administrator and/or facility representative assisting with the investigation has been notified in writing.

920 Main Street, Suite 801
Kansas City, MO 64105

Main Telephone Number: 816/880-9990
Patient Only Toll-Free Telephone Number: 800/444-9965
Fax: 816/880-9088

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Date

Name
Address
City, State Zip

Subject: Outcome of Filed Grievance

Dear Ms./Mr. Last Name:

Heartland Kidney Network is the End Stage Renal Disease (ESRD) Network organization authorized by the Medicare Program to receive and to the extent possible, resolve grievances filed by or on behalf of ESRD patients in Iowa, Kansas, Missouri and Nebraska. We look into grievances relating to the quality of dialysis and transplant services and care provided to Medicare patients or in Medicare certified facilities. In some situations we may collaborate or refer the complaint to the State Survey Agency, which assures the care that dialysis facilities provide meet Medicare standards.

On *(Date Grievance Received)*, ESRD Network 12- Heartland Kidney Network received a grievance outlining the concerns you had regarding the care received by, (you or **patient's name**), at (**facility name**). The concerns you reported were the following:

-
-
-

We have carefully examined your concerns and conducted a thorough review of the relevant medical records and facility policies and procedures pertaining to the grievance raised. We were able to determine that…. Education and quality improvement efforts have been undertaken with the dialysis facility as appropriate.

We therefore, have the following recommendations for you:

-
-
-

Thank you for bringing this concern to our attention. We are committed to providing a service that meets the needs of the ESRD population in Iowa, Kansas, Missouri and Nebraska. If you have concerns about how the Network processes your issues, please contact:

Lisa Rees, CMS ESRD COR/Project Officer
Centers for Medicare & Medicaid Services Region VII
New Federal Office Building
601 E. 12th St.

Kansas City, MO 64106
816-426-6353

You may also contact your State Survey Agency, which is responsible for making sure that the care provided at dialysis and transplant facilities is safe and complies with Medicare requirements or you may contact the Centers for Medicare & Medicaid Service. They can be reached at:

Department:
Street Address
City, State, Zip Code
Phone:

We would like to encourage all patients to visit www.medicare.gov/dialysis to compare dialysis facilities in your area. This site will provide you with quality measures data, facilities characteristics, and demographic information for Medicare certified facilities. If you have any questions of need further assistance, please call me at 816-880-9990 or toll free at 800-444-9965.

Sincerely,

Name
Title

cc: [Practitioner/Facility staff if mentioned in letter by name or title]
[Other individuals as appropriate]

920 Main Street, Suite 801
Kansas City, MO 64105

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Fax: 816/880-9088

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FACSIMILE MEMORANDUM – SENSITIVE INFORMATION

Date: Number of Pages (including cover):

To: Facility Administrator
Facility Name
Fax Number:
From: Patient Services Representative
816-880-9990/ 816-880-9088 fax

RE: Involuntary Discharge

Dear Mr/Mrs Last Name:

Heartland Kidney Network is the End Stage Renal Disease Network Organization authorized by the Medicare Program to receive and to the extent possible facilitate a successful outcome in cases in which a patient experiences an access to care issue in any facility in Iowa, Kansas, Missouri and Nebraska. We review access to care concerns related to the quality of dialysis and transplant services given to patients as well as the care provided to them in Medicare certified facilities.

On **Date,** Heartland Kidney Network was notified of an involuntary discharge by **staff name/title.**

To review the involuntary discharge appropriately, please send us copies of the documents being requested on the Medical Records Request form attached by **(within 5 working days)**. The facility has the option to submit any additional documentation supporting its position on this discharge with the requested documents.

In addition, please notify the State Survey Agency of the involuntary discharge. The contact information is as listed below:

[Name of State Survey Agency]
[Street address]
[City, state, ZIP Code]
[Telephone number and/or toll-free number]

Thank you for your cooperation in this case. If you have any questions or need further clarification, please contact me at 816-880-9990.

Patient Name(s): _____

Provider Name: _____

Attn: _____

The Information Requested:

❑	Dialysis Treatment Sheets	Date(s):	_____ - _____
❑	Patient's Plan of Care	Date(s):	_____ - _____
❑	Social Services Notes	Date(s):	_____ - _____
❑	Multi-disciplinary Progress Notes	Date(s):	_____ - _____
❑	Comprehensive Assessment	Date(s):	_____ - _____
❑	30 day notice of discharge letter	Date(s):	_____ - _____
❑	Physician Orders (signed by Medical Director and Attending Nephrologist)	Date(s):	_____ - _____
❑	Acknowledgement of receipt of patients' rights and responsibilities	Date(s):	_____ - _____
❑	Acknowledgement of receipt of facility discharge and transfer policy/procedure	Date(s):	_____ - _____
❑	Policy/procedure regarding: Patients' Rights and Responsibilities;_____ Patient Discharge and Transfer_____	Date(s):	_____ - _____
❑	Other: Documentation of efforts to relocate the patient;_____ Documentation of notification of State__ Survey Agency;_____ Police Report(if Severe Immediate Threat) _____	Date(s):	_____ - _____

The information is to be sent to:

Organization: Heartland Kidney Network

Attention: Name, Title
Patient Services

Address: 920 Main St., Suite 801
Kansas City, MO 64105

Phone: 816-880-9990

Fax: 816-880-9088

Please do not fax if documents total over 20 pages.

*As specified in 42 CRF 405.2139 (b), the ESRD facility must make all records available for inspection by the Network as required to carry out the Network's statutory responsibility. This request will expire on the date the Network investigation is complete. The investigation is complete and the case is considered closed once the administrator and/or facility representative assisting with the investigation has been notified in writing.

Exhibit 6: Involuntary Discharge (IVD) Information Form

920 Main Street ♦ Suite 801 ♦ Kansas City, MO 64105
816.880.9990 ♦ Fax: 816.880.9088 ♦ heartlandkidney.org

Provider # : _____ Representative Name: _____

Patient Name: _____ Crown Web ID#: _____

DOB: _____ Gender: ☐ Male ☐ Female Date of First Dialysis: _____

Race:
☐ African American/Black ☐ American Indian/Alaska Native ☐Asian ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Date of Notice of Discharge to the Patient: _____ Date of Last Treatment: _____

Date of Anticipated discharge: _____

Reason for Discharge:
- ☐ Non-Payment
- ☐ Facility Closure
- ☐ Facility Unable to Meet Medical Needs
- ☐ Ongoing disruptive and abusive behavior
- ☐ Immediate Severe Threat
- ☐ Termination by Physician (invalid under CfC)

Prior Involuntary Discharge: Yes/No
Mental Health Diagnosis: Yes/No
Chemical Dependency/Abuse: Yes/No
Cognitive Deficit: Yes/No

Date State Survey Agency Notified: _____ SA Contact Name: _____

Employment Status at time of Discharge:
- ☐ Employed- Full-time
- ☐ Employed- Part-time
- ☐ Homemaker
- ☐ Medical Leave of Absence
- ☐ Retired due to age/preference
- ☐ Retired due to disability
- ☐ Student
- ☐ Unemployed

Intervention Strategies Prior to Discharge:
- ☐ Reviewed Conditions for Coverage
- ☐ Reviewed facility Policy & Procedures
- ☐ Interdisciplinary Team Meeting to complete a Re-Assessment)
- ☐ Patient involvement in IDT meetings and re-assessment POC
- ☐ Root Cause identified as: _____
- ☐ Care Agreement/Behavior Contract
- ☐ Involvement of the family (if appropriate)
- ☐ Provided patient with assistance, counseling and/or other appropriate referrals to address behavior
- ☐ Staff training: _____
- ☐ Contacted the Network prior to discharge in an effort to prevent an IVD
- ☐ Other: _____

Heartland Kidney Network
We're Here For You.

920 Main Street, Suite 801
Kansas City, MO 64105

Main Telephone Number: 816/880-9990
Patient Only Toll-Free Telephone Number: 800/444-9965
Fax: 816/880-9088

facebook.com/heartlandkidney

Date

Name of Regional Office
Address
City, State Zip

Dear Mr./Ms.:

The Heartland Kidney Network has received a grievance from **patient** on **date** regarding **his/her** care at **facility name (Medicare #)**. The patient was concerned with _____and reported it to the Network. After carefully reviewing the case, we felt that this issue will have an immediate negative impact and is a potential risk to the health and safety of other patients. The following list details the specific issues of concern:
If you have any questions regarding this case, please contact me at 816-880-9990 or via email at . Please confirm your receipt of this referral via phone or email. Thank you.

Sincerely,

Patient Services
Heartland Kidney Network

cc: Executive Director
COR, CMS

Heartland Kidney Network
We're Here For You.

920 Main Street, Suite 801
Kansas City, MO 64105

Main Telephone Number: 816/880-9990
Patient Only Toll-Free Telephone Number: 800/444-9965
Fax: 816/880-9088

facebook.com/heartlandkidney

Date

Name of Regional Office
Address
City, State

Dear Ms./Mr.:

Heartland Kidney Network has verified the Involuntary Discharge based _____ of **patient** on **date** from **facility name** (**Medicare #**). After reviewing the documentation provided to the Network by the facility, and/or due to the nature of the reason for discharge we are referring this case to the State for your review.

If you have any questions regarding this case, please contact me at 816-880-9990 or via email at nw12.esrd.net . Please confirm your receipt of this referral via phone or email. Thank you.

Sincerely,

Patient Services
Heartland Kidney Network

cc: Executive Director
COR, CMS

GRIEVANCE CHECKLIST

Date Initiated: _____

Deadline for Completion: _____ Extension Request: _____ Date Closed: _____

IA= 7 days Extension=by day 50 Closed=60 days

Grievant	☐ Patient ☐ Anonymous ☐ Appointed Rep ☐ Other _____
	Name
	☐ Patient Demographics Entered

Facility	Facility/CCN:
	Contact Name/Position

Completed	Initial Contact
	If grievance received by Voice Mail or Email, return all grievance calls by **COB next business day**
	Unable to get in touch with grievant? After **5 business days** of initial contact, send letter to grievant advising that no further action will be taken unless they contact the NW (if patient provided mailing or email address)
	Verbal consent to disclose identity received ☐ No Determine if the Network can proceed as anonymous ☐ If filed by a person other than the patient, attempt to verify the grievance with the patient.
☐ Yes ☐ No	Is the grievant an appointed representative of the patient? ☐ Send the Appointment of Personal Representative form. (*Exhibit 1*) Sent by ☐ fax ☐ email ☐ mail ☐ Received copy of documentation on _____
	Reviewed role of Network, grievance process and options
	Reviewed patient right to no reprisal
	Provided info about the Patient Satisfaction Survey
☐ Yes ☐ No	Willingness to participate in the Patient Satisfaction Survey
	Entered into PCU within **1 business day**
	☐ Immediate Advocacy ☐ General (complex, non-QOC issues, or IA unable to complete in 7 days) ☐ Quality of Care (QOC issues only- patient specific or general) ☐ Access to Care reported by patient (treated as General grievance no timelines ☐ Referral _____ (Agency)
	Suspicion of imminent danger, <u>immediately</u> contact the SA and notify the COR. ☐ SA ☐ COR ☐ Contact/Follow up with SA within **2 business days** via phone and/or letter. Request case # and verification of receipt. (Exhibit 7)
	Sent Acknowledgement letter within **2 business days** (Exhibit 2) *(General/QOC)*
	Requested medical records? Records are due in **5 business days**: _____ ☐ Sent Medical Records request form (Exhibit 3)

	☐ Received copy of documentation on: _____
	NW RN *(Required for Clinical QoC)* ☐ Provided to RN for review on _____ ☐ Review completed and documented in PCU
	MRB Review Required? *(General/QoC)* ☐ Discuss with Grievance Committee (GC) Chair. ☐ Full Committee/Physician Review? ☐ Blind Records ☐ Draft Network Summary of Findings ☐ Distribute Records to GC (provide **5 business days** for review) ☐ Grievance Committee Conference Call
	Network Summary of Findings and Recommendations letter *(General/QoC)*
	Performance Improvement Plan Needed? ☐ PIP Start Date: _____ End Date: _____ ☐ PIP Restarted: _____ ☐ Reported failure to State _____
	Referral to State? ☐ Facility failed to follow the Conditions for Coverage(within **1 business day**) ☐ SA ☐ COR ☐ Follow up with SA within **2 business days** via phone and/or letter. Request case # and verification of receipt. (Exhibit 7) ☐ If case is referred out, notify the grievant of referral with a summary letter within **3 business day** (Exhibit 4)
	Provided a grievant summary letter (Exhibits 4) with a cc: to facility/practitioners. *(Gen/QoC)*
	Patient requests to discontinue a Quality Of Care review ☐ Consulted with COR ☐ Sent a summary letter within **3 business days**, describing the case and NW actions up to that point.
	Lost to Follow Up? Patient/grievant stops responding/unreachable the Network.
	All PCU case notes reviewed and tabs complete
	Case File Includes: ☐ PCU Case Summary ☐ Medical Records ☐ Letters ☐ Performance Improvement Plan

PSC:_____ Date: _____

PSD:_____Date: _____