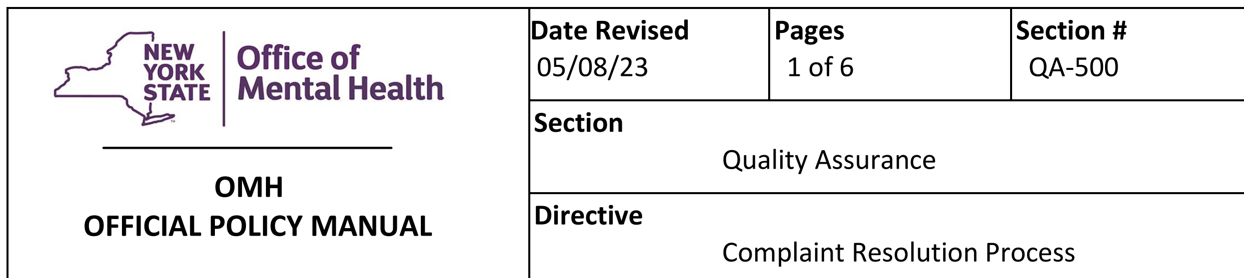

OMH OFFICIAL POLICY MANUAL	Date Revised	Pages	Section #
	05/08/23	1 of 6	QA-500
	Section: Quality Assurance		
	Directive: Complaint Resolution Process		

A. <u>Policy Statement:</u>

It is the policy of the Office of Mental Health to fully respect an individual's right to register complaints about any aspect of his or her care or treatment, and to ensure that such complaints are addressed by the treating facility in a timely manner.

The issues an individual may raise about their care and environment can range from fairly minor concerns that can be quickly and easily resolved in the course of a facility's normal daily operations to more serious matters that need to be addressed through a formal complaint resolution process. While many times it is preferable for complaints to routinely be resolved informally on a day-to-day basis with the primary therapist or other staff member, in some cases, it is not possible to immediately resolve the issues raised and the registering of a more formal complaint is desirable or necessary.

This policy directive sets forth the principles for the development of a responsive review process to facilitate prompt and fair resolution of complaints. While individual facilities may tailor their own complaint resolution policies to best meet their unique needs, this policy directive sets forth basic requirements that must be included in all such individual facility policies and is not intended to inhibit the use of additional helpful approaches in handling grievances. In this regard, facilities may wish to supplement this policy with the use of additional tools to resolve complaints, such as meeting with the individual and their family, or other methods the facility finds effective.

This policy directive is effective immediately and is applicable to all state-operated forensic and civil psychiatric facilities and programs.

B. <u>Relevant Statutes, Standards and Requirements:</u>

14 NYCRR Part 524
42 C.F.R. §482.13
42 C.F.R. §489.27
Mental Hygiene Law §33.02
CMS State Operations Manual: Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
The Joint Commission Comprehensive Accreditation Manual
The Joint Commission Behavioral Health Care and Human Services Manual

C. **<u>Definitions:</u>** For purposes of this policy directive:

1. ***Informal complaint*** means an individual's complaint, usually raised to direct care staff or an individual's clinician, which can be promptly resolved to the individual's satisfaction.

2. ***Formal complaint*** means a written or verbal complaint raised by an individual or their representative that cannot be promptly resolved to their satisfaction. An individual may raise a formal complaint after being unsatisfied with the result of their informal complaint or they may raise a formal complaint without having previously raised their concern as an informal complaint.

3. ***Minor*** means an individual under eighteen years of age.

4. ***Patient*** means and includes:
   a. for adults: each individual for whom a clinical record is maintained or possessed by a facility or program and, if applicable, his or her legally appointed guardian; and
   b. for minors: each individual for whom a clinical record is maintained or possessed by a facility or program and his or her parent, unless clinically contraindicated, or legal guardian.

5. ***Individual*** means a patient at a hospital or resident at a facility, such as Secure Treatment and Rehabilitation Center (STARC), for whom a clinical record is maintained.
6. ***Facility*** refers to a State Operated hospital inpatient or outpatient program, or Secured Treatment Facility.

D. Body of the Directive:

1. Each facility must establish a process for prompt resolution of all individual related complaints and must ensure that each individual is informed as to whom to contact to file a complaint and appeal a complaint determination.

2. Each facility must attempt to resolve all grievances as soon as possible.

3. The Facility Director must review and approve, and shall be responsible for, the effective operation of the complaint resolution process.

4. Governing principles:

   At a minimum, the following governing principles must be included in a facility's complaint resolution process:

   a. Individuals must be made aware of the reasonable expectations related to their care and services, and facilities must address these expectations in a timely, reasonable, and consistent manner.

   b. Individuals have the right to make complaints about any aspect of their care and treatment.

   c. The right to make complaints must not be limited by facility staff as a means of punishment or for the convenience of staff.

   d. The complaint resolution process shall assure confidentiality.

e. Whenever possible, complaints should be resolved by beginning with direct care staff. If staff present cannot resolve a complaint at the time it is made, each facility shall establish a process to ensure referral to other designated staff for later resolution, investigation, and/or required further actions.

5. Formal Complaint Resolution Process:

The following provisions must be included in a facility's complaint resolution process:

a. Notification procedures:

   I. The process shall include provisions designed to assure that each individual receives written information about the complaint resolution process upon admission to a program and again upon their request. This information must include whom to contact to file and how to file a complaint. With the individual's consent, such information shall also be provided to the individual's family member or to whomever they designate. In addition to information on how to file a complaint, this written information must include the following:

      i. The individual has the right to file a complaint with the Office of Mental Health Customer Relations in Central Office, (1- 800-597-8481) regardless of whether or not they choose to use the facility complaint resolution process.[1]
      ii. For inpatients who are Medicare beneficiaries, they must be advised of their right to file complaints with the Quality Improvement Organization (QIO) about quality of care, disagreement with a coverage decision, or if they wish to appeal a premature discharge. [2]
      iii. How to contact facility management and the Joint Commission to report concerns about safety and quality of care.

   II. For hospitals that use Joint Commission accreditation for deemed status purposes, written notification of the compliant process to the individual shall clearly explain the facility's complaint resolution procedure and identify who an individual should contact if they wish to access the complaint resolution process and file a complaint. This notice shall contain:

      i. the name of the facility contact person,
      ii. a summary of the steps taken on behalf of the individual to investigate the complaint,
      iii. the results of the complaint process, and
      iv. the date of completion.

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[1] Each facility must establish a process by which they respond to complaints or concerns assigned to them by the Office of Mental Health Customer Relations.

[2] A hospital is not required to automatically refer each Medicare beneficiary's complaint to the QIO; however, the facility must inform the beneficiary of this right and comply with his or her request if the beneficiary asks for the QIO review. Quality Improvement Organizations are CMS contractors charged with reviewing the appropriateness and quality of care rendered to Medicare beneficiaries in the hospital setting. The QIOs are also tasked with reviewing utilization decisions. Part of this duty includes reviewing discontinuation of stay determinations based upon a beneficiary's request.
Note: the hospital must provide a hospital-issued notice of non-coverage (HINN) to any fee-for-service beneficiary that expresses dissatisfaction with an impending hospital discharge.

The hospital must maintain evidence of its compliance with these requirements for formal complaints.

III. Each individual should also be advised of their ability to appeal the facility's determination with regard to a complaint and shall be informed how to do so in accordance with Section D7 of this policy directive.

IV. As required by Section 33.02 of the Mental Hygiene Law, a notice of rights shall be posted in each ward or living area of each facility, which shall include the address and telephone number of the facility director, a designee responsible for receiving questions or complaints, the Board of Visitors[3], and Mental Hygiene Legal Services.

b. Procedures must permit and address the processing of complaints made in either verbal or written form. Each facility policy must:
   I. clearly explain how to submit either a verbal or written complaint.
   II. specify time frames for review of the complaint and the provision of a response.
   III. describe how and when the individual or complainant is provided notice of its decision

c. Time frames: The complaint resolution process must specify that, upon receipt of a formal complaint by an individual, the facility's decision regarding the complaint shall be provided in writing. If however, the complaint relates to the safety of individuals or others, the facility shall take immediate action.[4] For hospitals that use Joint Commission accreditation for deemed status purposes, the timeframe for providing the written response shall be within seven days of receiving the complaint.[5] In circumstances where an investigation requires more than seven days to complete, the facility shall advise the individual in writing that the decision will be forthcoming. This notification will be made within seven days of receiving the complaint.

d. In the event that a formal complaint is resolved without a written response, the individual shall be notified of the resolution verbally. A formalized process should be in place to ensure that each compliant raised receives the appropriate level of communication back to the complainant.

6. <u>Written Decision for Formal Complaints</u>:

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[3] BOV as applicable

[4] For example, complaints about situations that endanger the individual, such as neglect or abuse, must be reviewed immediately, given the seriousness of the allegations and the potential for harm. Furthermore, cases in which the safety of individuals or others is at issue qualify as incidents and must be processed as such in accordance with OMH Policy QA-510 and incidents that qualify must be also reported to the New York State Justice Center for the Protection of People with Special Needs, as applicable.

For all complaints, the Facility Director, or designee,[6] must review and timely render a determination in a written decision that shall be communicated to the individual or complainant in a language and manner the individual understands.[7]

Each facility which provides treatment services must establish a process for prompt resolution of all **formal** complaints and must ensure that each individual is informed as to whom to contact to file a complaint and to whom to appeal a **formal** complaint determination. See Section 5.a.II of this policy for a description of what to include in the written decision.

7. Appeal of Formal Complaint Decisions:

    a. Each facility shall develop a process to be followed if an individual wishes to appeal a formal complaint determination. This process may include a second level of review within the facility. Appeals shall be processed in a timely fashion and decisions shall be provided in written form.

    b. If an individual's complaint resolution attempts are unsuccessful at the facility level, the individual shall be informed in writing that they may contact the Office of Quality Improvement in Central Office or Division of Forensic Service (DFS) for further review. In addition, the facility may remind an individual of the availability of Peer Advocates or other appropriate resources for additional assistance in resolving complaints.
    c. The Office of Quality Improvement or DFS shall conduct a review of complaints that may not have been successfully resolved at the facility level. This review shall include:
        a. Review of documentation from the facility, and
        b. Communication with the facility as to the determination.

    d. The OMH Office of Quality Improvement or DFS will respond to the complainant and facility in writing with the response to the review. This may include supporting the facility findings or a statement that recommendations were made to the facility about the complaint resolution.

    e. The Office of Quality Improvement or DFS will notify the facility Executive Director or designee of any recommendations or observations made during the appeal review and may request a plan of corrective action or additional response from the facility.

8. Recordkeeping and Reporting for Formal Complaints:

    a. Each facility must establish a process for recording and monitoring all formal complaints received. This process shall include a description of how, and the date upon which, each complaint was resolved. The process shall also identify if the individual was satisfied with the outcome of the process, whenever possible.

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[6] The Facility Director may elect to establish a Complaint or Grievance Committee, to whom it may delegate the responsibility of reviewing and resolving complaints.

[7] While facility determinations of filed complaints must always be provided to an individual in writing, prefacing or supplementing the written response with a verbal, face-to-face contact, may also be utilized whenever feasible to facilitate meaningful resolution of complaints. All relevant communications regarding complaints should be documented.

b. Each facility must aggregate its complaint data and analyze it as part of its performance improvement program, identifying systemic trends or patterns.

c. Each facility must include an analysis of its aggregate complaint data in its annual report to the Governing Body. The facility's governing body must approve and be responsible for the effective operation of the complaint process, and must review and resolve complaints, unless it delegates the responsibility in writing to a compliant committee.

9. Staff Education and Training:

   a. Each facility will provide education and training relating to the implementation of this policy directive to all staff.