# OMH Guidance for Complaint Resolution Process Issued July 2025

**A. Statement:**

The Office of Mental Health fully respects an Individual's right to register complaints about any aspect of their care or treatment. The issues an Individual may raise can range from minor complaints that can be quickly and easily resolved during a Provider's normal daily operations, to more serious matters that need to be addressed through a complaint resolution process. While many times it is preferable for complaints to routinely be resolved informally with the primary therapist or other staff member on a day-today basis, 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 guidance document delineates best practices for the development of a responsive review process that facilities prompt and fair resolution of complaints. While Providers should tailor their own complaint resolution policies to best meet their unique needs and to satisfy regulatory requirements, this guidance document sets forth basic requirements that should be included in all such Provider policies and is not intended to inhibit the use of additional helpful approaches in handling complaints. In this regard, Providers may wish to supplement this guidance document with the use of additional tools to resolve complaints, such as meeting with the Individual and their family, or other methods the Provider finds effective.

This guidance document is effective immediately and is applicable to all OMH licensed, OMH designated, and OMH funded facilities and programs.

**B. Relevant Statutes, Standards and Requirements:**

14 NYCRR Part 524-Incident Management Programs
14 NYCRR Part 527-Rights of Patients
42 C.F.R. §482.13-Condition of Participation: Patient's Rights
42 C.F.R. §489.27-Beneficiary Notice of Discharge or Change in Status Rights
Mental Hygiene Law §33.02- Notice of Rights of Individuals with Mental Disabilities
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. Definitions:** For purposes of this guidance document:

1. ***Complaint*** means a written or verbal complaint, concern, or grievance, raised by an Individual, their representative, or other Third Party, that cannot be promptly resolved to their satisfaction.

2. ***Minor*** means an Individual under eighteen years of age.

3. ***Individual*** means and includes:
   a. for adults: each Individual for whom a clinical record is maintained or possessed by a Provider and, if applicable, their legally appointed guardian; and
   b. for minors: each Individual for whom a clinical record is maintained or possessed by a Provider, and the minor's parent, unless clinically contraindicated, or legal guardian.

4. ***Third Party*** means a person, other than an Individual, who expresses or registers a complaint.

5. ***Provider*** means the operator of an OMH licensed, OMH designated, or OMH funded program.

**D. Complaint Standards:**

1. Each Provider should establish a process for prompt resolution of all complaints and should ensure that every Individual is informed as to whom to contact to file a complaint and to appeal a complaint determination.
2. Each Provider should establish a process for reporting retaliation and should ensure every Individual is informed as to whom to contact to report retaliation.
3. Each Provider should attempt to resolve all complaints as soon as possible.
   The Facility or Program Director should review and approve, and be responsible for, the effective operation of the complaint resolution process.

**DI. Governing Principles:**

1. Individuals should be made aware of the reasonable expectations related to their care and services. The Provider should address these expectations in a timely, reasonable, and consistent manner.
2. Individuals have the right to make complaints about any aspect of their care and treatment.
3. The right to make complaints should not be limited by Provider's staff as a means of punishment or for the convenience of staff.
4. The complaint resolution process should assure confidentiality.
5. Whenever possible, complaints should be resolved beginning with staff who work directly with the Individual. If staff present cannot resolve a complaint at the time it is made, each Provider should establish a process to ensure referral to other designated staff for later resolution, investigation, and/or required further actions.

**DII. Notification Procedures:**

The following provisions should be included in a Provider's complaint resolution process:

1. The complaint resolution process should include provisions designed to assure that every Individual and legal guardian receives written information about the complaint resolution process upon admission to a Provider and again upon their request.

2. This information must include whom to contact to file and how to file a complaint.

3. In addition to information on how to file a complaint, this written information must include the following:
    a. That the Individual has the right to file a complaint with the Office of Mental Health Customer Relations (1-800-597-8481) in Central Office, regardless of whether they choose to use the Provider's complaint resolution process or not.[1]
    b. 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]
    c. How to contact Provider management to report complaints about safety and quality of care.
    d. For Providers that use Joint Commission or other accrediting agencies for deemed status purposes, written notification must clearly explain the facility's complaint resolution procedure and contact information for the accrediting agency.
4. Every Individual should also be advised of their ability to appeal the Provider's complaint determination and should be informed how to do so in accordance with Section I of this guidance document.
5. The Provider should maintain evidence of its compliance with these requirements.
6. A notice of rights must be posted in each ward or living area of each facility or program, which must include the address and telephone number of the Facility or Program Director, a designee responsible for receiving questions or complaints, and for such covered settings, the contact information for Mental Hygiene Legal Services.
7. The complaint resolution process should permit and address the processing of complaints made in either verbal or written form. Each Provider policy should:
    a. Clearly explain how to submit either a verbal or written complaint.
    b. Specify time frames for review of the complaint and the provision of a response.
    c. Describe how and when the Individual or Third Party will be provided notice of its determination.
    d. Include response with supporting documentation to the OMH Field Office for all complaints reported to OMH.

**G. Timeframes**

1. The complaint resolution process should specify that, upon receipt of a complaint by an Individual, the Provider's determination regarding the complaint should be provided in writing.

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[1] Each Provider should establish a process by which they respond to complaints assigned to them by the Office of Mental Health Customer Relations or OMH Field Office.

[2] A Provider is not required to automatically refer each Medicare beneficiary's complaint to the QIO; however, the provider must inform the beneficiary of this right and comply with their request if the beneficiary asks for the QIO review. QIOs 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 provider must provide a provider-issued notice of non-coverage (HINN) to any fee-for-service beneficiary that expresses dissatisfaction with an impending provider discharge.

2. The timeframe for providing the written response should be within seven days of receiving the complaint.
3. If, however, the complaint relates to the safety of Individuals or others, the Provider should take immediate actions[3].
4. In circumstances where follow up requires more than seven days to complete, the Provider should advise the Individual in writing that the determination will be forthcoming. This notification will be made within seven days of receiving the complaint.

**H. Complaint Resolution**

1. Complaint resolution should be conducted verbally, followed by a written determination.
2. If verbal resolution cannot occur, there should be sufficient documentation supporting attempts made and/or the rationale for the lack of verbal follow up.
3. A formalized process should be in place to ensure that each complaint raised receives the appropriate level of communication back to the complainant.
4. Written Determination for Complaints:
    a. For all complaints, the Facility or Program Director, or designee,[4] should review and timely render a written determination that should be communicated to the Individual or Third Party in a language and manner they understand.[5]
    b. In its resolution of complaints, the Provider provides the Individual with a written notice of the determination, which contains the following:
        i. The name of the Provider contact person.
        ii. The steps taken on behalf of the Individual to investigate the complaint.
        iii. The results of the complaint process.
        iv. The date of completion of the complaint process.
    c. Each Provider should ensure that every Individual is informed as to whom to appeal a complaint determination.

**I. Appeal of Complaint Determination:**

1. Each Provider should develop a process to be followed if an Individual wishes to appeal a complaint determination.
    a. The first step should be to appeal the complaint determination to the Facility or Program Executive Director or designee.
    b. If the Individual wishes to appeal the Facility or Program Executive Director's determination they should be advised of their right to appeal to the regional OMH Field Office.
2. Appeals should be processed in a timely fashion and decisions should be provided in written form.

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[3] 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. Incidents that qualify must also be reported to the New York State Justice Center for the Protection of People with Special Needs, as applicable.

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

[5] While Provider determinations of filed complaints should 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.

3. The Provider may remind an Individual of the availability of Peer Advocates or other appropriate resources for additional assistance in resolving complaints.
4. The OMH Field Office should review complaints that may not have been successfully resolved at the Provider level per written request by the Individual. This review should include:
    I. Review of documentation from the Provider and
    II. Communication with the Provider as to the determination.
5. The OMH Field Office will respond to the complainant and Provider's Executive Director or designee in writing with the response to the review. This may include supporting the Provider's findings or a statement that recommendations were made to the Provider about the complaint resolution.
6. The OMH Field Office will notify the Provider's 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 Provider.

**J. Record Keeping and Reporting for Complaints:**

a. Each Provider should establish a process for recording and monitoring all complaints received. This process should include a description of how, and the date upon which, each complaint was resolved. The process should also identify if the Individual was satisfied with the outcome of the process, whenever possible.
b. When a complaint originated through OMH Customer Relations or the Field Office, a copy of the written determination, details of specific complaint resolution process, if the Individual is satisfied with the outcome and all supporting documentation should be forwarded to the OMH staff who notified the Provider of the complaint.
c. Each Provider should aggregate its complaint data and analyze it as part of its performance improvement program, identifying systemic trends or patterns.
d. Each Provider should include an analysis of its aggregate complaint data in its annual report to the Governing Body. The Provider's Governing Body should approve and be responsible for the effective operation of the complaint process, and should review and resolve complaints, unless it delegates the responsibility in writing to a complaint committee.

**K. Staff Education and Training:**

Each Provider should provide complaint policy education and training to all staff.

A recorded training for this guidance can be found at

https://omh.ny.gov/omhweb/dqm/bqi/clinical_risk_man.html