MISSOURI HOSPITAL ASSOCIATION

Hospital Self-Report and Complaint Toolkit

A Guide to Self-reporting and Complaint Process

MHA
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Hospital Self-Report and Complaint Toolkit

What is the difference between a self-report and a complaint?

A self-report is when a hospital proactively notifies the Missouri Department of Health and Senior Services Bureau of Hospital Licensure and Standards regarding an event that either is regulatorily required to be reported or is something the hospital would prefer to proactively manage with the department. This may include an event that impacts the patient, has the potential to impact the patient or has the potential to reach the department as a complaint. According to the Centers for Medicare & Medicaid Services, a complaint is described as the following.

> "A 'patient grievance' is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489."

A complaint may be generated by a patient, family or caregiver, staff member, or clinician and reported to the department. Complaints also may be made directly to the CMS Regional Office, which then works with the state agency to investigate and monitor. When a complaint or grievance is made to the hospital, that same complaint or grievance also may be made by the complainant to the department or state agency.

There are protections for staff who bring forward concerns or who might make a complaint, including under Sections 197.152-Protection for reporting infection control concerns; 574.203-Interference with a health care facility (workplace violence); and 197.285-Protections for hospital…facility employees for certain disclosures. Additionally, CMS requires follow-up on complaints or grievances within certain timeframes, according to 42 CFR 482.13(a)(2). While critical access hospital CoPs are not as prescriptive, they must have complaint or grievance procedures.

This explanation is not to confuse the complaint process that hospitals must have in place to address patient, family or caregiver, or staff complaints with that of the department and state agency.

SELF-REPORTS

Self-reporting — outside of abuse and neglect mandated reporting requirements found in Sections 210.115 and 198.070, RSMo — is not required by Missouri law or regulation. There are a limited number of situations where a hospital is required to self-report an event under the CMS CoPs, which is described below.

What Are Potential Incidents To Self-Report?

Below are examples of incidences that the hospital may choose to self-report. This is not an exhaustive list. The below situations also could result in a complaint to the department by the patient, family or health care provider, or they could be discovered and investigated by the department, state agency or CMS Regional Office.

- patient suicide or attempted suicide
- patient elopement or abduction
- surgery incidents, such as wrong patient, wrong body part, wrong procedure/surgery or unintended retention of a foreign object
- patient-to-patient altercations resulting in injury (also encourage patient to file police report)
- patient-to-patient sexual contact in a psychiatric inpatient setting
- events that have the potential to generate media attention
- patient abuse or neglect (sexual, physical, verbal) by another patient, employee, vendor or visitor

What Are The Required Incidents To Self-Report?

- Patient's Rights 42 CFR §482.13(g) requires hospitals to report deaths during and within one week after use of seclusion or restraint. The report should be made to the CMS Regional Office by telephone no later than the close of business on the next business day following knowledge of the patient's death.
- EMTALA-42 CFR §489.20(m) requires hospitals to report to the CMS Regional Office or the state agency promptly when it suspects it may have received an improperly transferred individual. Notification should take place within 72 hours of the occurrence. Failure to report improper transfers may subject the receiving hospital to termination of its provider agreement.
- 19 CSR 30-1.032 Security for Nonpractitioners requires reporting of loss, diversion, abuse or misuse of controlled substances. The registrant shall complete and submit a report of loss, theft, or diversion of controlled substances or regulated chemicals to DHSS no later than seven business days after the discovery of such a loss.

There are many other reportable events/issues that hospitals are subject to, such as communicable disease, outside the purview of this communication.

Are There Benefits Of Self-Reporting?

- demonstrates compliance with regulations prior to, or in lieu of, an on-site investigation by the state agency
- timely communication to ensure the investigation is thorough and patients are protected

- timely investigation of incidents where the alleged perpetrator is an employee and referral for potential inclusion on the Employee Disqualification List may be required; failure of the hospital to self-report employees who have abused/neglected patients allows the employee to change employment and abuse patients in other hospitals or health care settings
- initiates the self-report within 24 hours of a reportable incident when possible

What Is The Process To Self-Report?

When filing a self-report, the hospital should call the concerns/complaint hotline at 800-392-0210. Be advised, this is a general complaint line accepting complaints for a variety of reasons, for a variety of departments and from a variety of individuals. The hospital must specify they are calling to file a "self-report" to the Bureau of Hospital Standards. The hospital could follow up with an email to hospitalcomplaints@health.mo.gov. If transferred to the wrong department, the hospital should hang up and call again until there is a clear understanding for the call. The hospital also may consider a follow-up call to the bureau (573-751-6303) if they are concerned the information was received incorrectly.

The main number for the DHSS Bureau of Hospital Standards is 573-751-6303.

- Press 1 to file a complaint against a hospital.
- Press 2 to file a complaint against a physician or provider.
- Press 0 to speak with a department representative.

The Bureau of Hospital Standards phone line is not designed to be a self-reporting line. The hospital can ask to speak with the bureau chief or one of the assistant bureau chiefs if they would like help determining if they should self-report, if they have a concern about the self-reporting process or if they would like to verify that their information was received.

Hospitals may develop their own or use the example Self-Report Summary Template provided in the toolkit as the record of report.

What Should The Hospital Send To The State Agency?

- copy of all policies and procedures which apply to the issue reported
- copy of the hospital's internal investigation of the event and corrective actions taken to protect the patient(s) involved, including an event timeline, copies of all interviews, written statements, emails, etc., that document witness accounts of the event or were pertinent to the investigation; for all interviews and written statements, have the staff member sign the document
- opportunities for improvement identified as a part of the investigation and event evaluation with a description of plans to implement the opportunities

Keep in mind that the more detailed and comprehensive the information, the more accurate the final triage decision will be. In many cases, the follow-up documentation will be adequate to demonstrate compliance with the regulations, therefore eliminating the need for an on-site visit except for cases when an EDL investigation is warranted. Placement on the EDL only may be done following an on-site investigation by a DHSS staff member.

COMPLAINTS

This section outlines the process and guidance the department follows, and guides surveyors in processing complaints. There may be variations; however, including the following information provides the hospital with an idea of how complaints and self-reports will be evaluated.

DHSS Guidance To Surveyors' Triaging Complaints

The goal of the department, which also is the CMS state agency, is to review and respond to all complaints within three days, which includes sending the acknowledgment letter. Performance standards set by the CMS Regional Office includes taking less than 14 days to decide about a complaint.

Complaint Triage

1. Does the department have authority to investigate (is there a regulation that covers that concern)?
2. Does the complaint potentially reflect a CoP level of noncompliance (potential for harm, or of an egregious nature)? If so, it is sent to the CMS Regional Office for review.
3. If the CMS Regional Office declines, DHSS decides if they can investigate under licensure regulations.
4. If the issue is covered by regulation but is not at CoPs level, a decision for on-site or off-site investigation is made.
5. If it is a nondeemed hospital, an investigation is determined by the state agency. If an investigation is completed, the federal regulations are utilized.
6. Other:
   - If the complaint occurred more than 12 months in the past, the department generally does not investigate. They can investigate events that occurred before their most recent visit if the allegations in the complaint fall under the same condition that was surveyed on the most recent visit.
   - If the complaint is about billing and represents potential fraud, it will be sent to the Missouri Attorney General.
   - When information in the complaint is secondhand, the department will attempt to talk with the person who witnessed what occurred.
   - Suggest the complainant also file a grievance with the hospital.

Calling Complainants For More Information

Per instructions from the CMS Regional Office, complainants <u>must</u> be contacted to obtain additional information if they determine the complaint is regulatory-based and if more information is needed. The department advises to NOT call the complainant if the patient is hospitalized or if the complaint is about billing.

The department will make two attempts to contact the complainant. Once they have tried twice to contact them and have been unsuccessful, they will stop and close the complaint.

After contacting the complainant, the department revises the complaint in ACTS (software system used by the department and CMS).

Next Steps/Decision-Making

- The department opens ACTS to review the past few complaints the facility had.
- The department checks ACO (software system used by the department and CMS) to see if there were any citations in the past six to 12 months. (This is done when the department has difficulty in determining based on allegations alone.)
- The department determines whether it should be investigated on-site or off-site.
- The department determines whether it should be sent to the CMS Regional Office. The direction provided to triage is only to send a complaint to the CMS Regional Office if it is a systemic problem, very egregious or there are a lot of complaints about the same facility in a short time.

Hospital Self-Report Sample Template

Re: Subject
Date of self-report to DHSS: XX/XX/XXXX
Reported to: 1-800-392-0210
Date summary sent to DHSS: XX/XX/XXXX

PATIENT BACKGROUND

- Patient Name:________________________________
  DOB:____
  DOS: XX/XX/XXXX – XX/XX/XXXX
  Medical Record #:____________________________
  Visit #:_____________________________________
- Summary of patient background, medical history, etc.

HOSPITAL COURSE

- timeline of pertinent hospital course leading up to event/situation

SUMMARY OF EVENT

- bullet points of what happened to give a clear picture of the event
- include dates/times, where helpful, to explain how events unfolded

EVALUATION/CONCLUSION

- review of documentation in medical record
- correlate to policies related to the event; explain how policies were followed and if there were any deviations or not
- pertinent points/clarifications based on interviews — who was interviewed, by whom, related learnings
- patient status at time of report

ACTIONS TAKEN

- address each deviation and what was done to mitigate future risk
- be as detailed as possible; this is the most critical section to explain all actions taken (education, audits, presentations, emails, etc.)
- address how to ensure sustainment
- explain any modifications or updates to policies and provide copies

ATTACHMENTS

- patient face sheet
- any education documents or presentations developed
- any communication sent to staff/physicians
- policies related to the event that is reported, whether revised or not
- medical records — any portion of the medical record prior to, during or immediately following that may be directly related to the event that is reported (i.e., a fall would need the fall risk score before, during and after)

REPORT CONTACT

Name:____
Title:____
Phone:____
Email:____