GRANTEE GRIEVANCE POLICIES

FY 2008

BEHAVIORAL HEALTH TREATMENT & RECOVERY

GRIEVANCE
POLICIES AND PROCEDURES
BEHAVIORAL HEALTH

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF BEHAVIORAL HEALTH

SARAH PALIN, GOVERNOR

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June 27, 2007

DHSS-Behavioral Health
Grantee Organization

RE: Agency Grievance Policy & Procedure

Dear Grantee,

In a continuing effort to maintain complete and updated grantee records Behavioral Health needs to receive a copy of your agency's Grievance Policy and Procedure. Alaska Administrative Code, 7 AAC 71.220, states that "a center must establish a grievance procedure by which a client may seek redress of grievances. A copy of the center's grievance procedure must be filed with the department and posted at the center."

As you know, the mission of Behavioral Health is to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships. Confirming that consumer complaints are properly handled is an important element in Behavioral Health's management of the behavioral health system. As a partner in providing effective consumer care we need to know and understand your agency's grievance procedure.

Attached to this letter is a copy of DHSS Behavioral Health policy and procedure: "Requirements for Grantee Grievance Procedures". This policy is based upon the Standards adopted by both Behavioral Health and the Alaska Mental Health Board in 2002 which were subsequently included as Conditions of Grant Award for 2002- 2004.

Please submit a copy of your grievance P&P to your BH Regional Specialist by July 31, 2007.

We appreciate your dedication and service to the peoples of Alaska.

Respectfully,

Melissa Witzler Stone,
Director Behavioral Health

State of Alaska
Department of Health and Social Services
Behavioral Health

Policy & Procedure

Topic: State Behavioral Health Requirements for Grantee Grievance Procedures

Policy: All Behavioral Health (BH) grantee treatment organizations are required to develop grievance procedures by which all clients, without regard to services used or funding source, including those clients denied services, may seek redress of grievances. The procedures, written in plain language, should be developed with meaningful consumer participation utilizing the general guidelines established by State Behavioral Health. A copy of the procedures must be filed with BH and should also be posted at the grantee organization's facility(s).[1]

Intent: The Department of Health and Social Services (DHSS) by law is required to adopt regulations to assure patient rights[2], to establish standards for treatment facilities and to keep related records[3], and to investigate complaints made by a patient[4]. This policy outlines the DHSS BH guidelines for grantee grievance procedures, explains BH's role in response to grievances, and lists relevant policy clarifications and all related references of the Alaska Statutes and the Alaska Administrative Code.

Grievance Procedure Guidelines: Grantee consumer grievance procedures must, at a minimum, meet the following criteria:

1. Provision(s) that ensure the right of consumers to file a grievance without intimidation
2. Provision(s) that ensure there is NO retaliation perpetrated against consumers who have filed a grievance
3. Provision(s) that outline a process by which consumers may easily file a grievance, to include:

[1] 7 AAC 13.135 Grievance procedures; 7 AAC 71.220 Grievance procedures
[2] AS 47.30.590 Comprehensive services
[3] AS 47.37.030 Powers of Department; AS 47.37.140 Public and Private Treatment Facilities
[4] AS 47.30.660 (b) (12) Powers and duties of department

   a. A simple form written in plain language that also provides for an optional waiver of confidentiality which consumers may complete and submit,
   b. Procedure(s) that allow consumers to submit a grievance orally
   c. Procedure(s) that allow consumers to submit a grievance over the phone or via email
4. Explanation of agency's grievance procedure / policy provided to ALL consumers upon entry to services, to include the following:
   a. Copy of agency procedure / policy
   b. A form for consumers to sign, which shall be maintained in the consumer's clinical record, that declares their receipt and understanding of the agency procedure / policy
5. Provision(s) for consumers to designate a representative or advocate to assist them with all steps of the grievance process
6. Procedure(s) for the agency, upon consumers request, to assist the consumer with filing a grievance, which should include either:
   a. Identifying specific agency staff to provide assistance
   b. Written referral to other consumer advocacy resources such as the Disability Law Center and NAMI-Alaska
7. Step-wise procedures, limited to the following, for resolving ALL grievances:
   a. Resource and means for commonly resolving consumer disputes to minimize the need to invoke the grievance process
   b. Communication with consumer upon receipt of grievance that the agency has begun the process to resolve the grievance
   c. Direct resolution through dialogue with the agency staff member involved or with the staff member's supervisor, or with both as consumer requests
   d. Resolution through the agency Executive Director
   e. Resolution through the agency Governing or Advisory Board
   f. Referral of grievances unresolved at the agency's highest level to DHSS Behavioral Health for technical assistance
8. Established time frames to include the following that ensure prompt hearing of grievances:
   a. Initiation of resolution (according to the procedures noted in # 7 above) within 5 days of receiving a grievance
   b. If agency is unable to adequately initiate resolution within 5 days, a written notification shall be sent to the consumer by the end of 5 days from receipt of grievance explaining why and identifying when the grievance process will initiate
   c. Satisfactory resolution to grievances within 30 days of receipt of grievance
   d. Referral to BH, within 5 business days, for technical assistance with grievances that remain unresolved after 30 days.
9. Provision(s) for immediately elevating to the Governing or Advisory Board level any grievances that involve abuse, neglect or unnecessary seclusion or restraint.
10. Procedure(s) that provide for the creation, maintenance and storage of files for each individual grievance which shall contain all related documents, records, actions and communications.

11. Provision(s) that address maintenance of consumer confidentiality throughout the grievance process

BH Role & Responsibility:

DHSS BH shall initially represent the Department of Health and Social Services for any grievance referred for technical assistance involving BH grantee treatment organizations. BH shall take the following steps to assist with these grievances:

1. **Exercise the primary responsibility of DHSS BH to orient consumers, or other individuals calling on behalf of consumers, to the grievance process and procedures available thru the involved grantee organization**
2. For questions regarding grievances which have been heard according to the involved grantee organization's grievance procedures, BH may:
   a. Review any written response from the involved grantee organization regarding their findings and resolution to the grievance.
   b. Investigate whether the involved grantee organization complied with the following, as indicated, in regards to processing the consumer grievance:
      i. Alaska Statute / Behavioral Health Regulations
      ii. Medicaid Regulations
      iii. Special Conditions of Grant Award
   c. Determine if resolution of the grievance is reasonable based on resources available to the grantee organization
   d. Share BH findings with both the consumer and the involved grantee organization
3. In the course of providing technical assistance for any consumer grievance BH may:
   a. Communicate with any involved party to seek clarification of information, or to obtain access to supporting documents
   b. Consult with other Department or division resource
   c. Refer case to other Department or division resource for continued technical assistance or action
   d. Take any other action deemed prudent or necessary to assist consumer and / or grantee organization

Policy Clarifications:

1) The Department of Health and Social Services is authorized to review, obtain, and copy confidential and other records and information about clients, including services requested or furnished, to evaluate a grantee organization's compliance with statutes (AS 47.30.520 – 47.30.620)[5]

2) For substance abuse treatment facilities and programs, DHSS has adopted by reference the standards contained in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) *Standards for*

[5] AS 47.30.590 (b) Patient rights and the confidential nature of records and information

Behavioral Health Care, 2004 – 2005.[6] The Department also provides for exemption from the provisions regarding substance abuse facilities or programs established by the State of Alaska Administrative Code for those private and public treatment facilities currently certified by JCAHO or the Commission on Accreditation of Rehabilitation Facilities (CARF).[7] Therefore:

a. All substance abuse grantee organizations are also obligated to comply with JCAHO standards regarding client Ethics, Rights, and Responsibilities (RI.2.120 – RI.2.130)[8] OR
b. If certified by CARF are obligated to also comply with the CARF standards for rights of persons served (Section 1. Business Practices: Criterion D. Rights of Persons Served)[9]

References:

Alaska Statutes (Authority)

Title 47. Welfare, Social Services and Institutions
Chapter 30. Mental Health
Section 520 - 620. Community Mental Health Services Act
Chapter 37, Uniform Alcoholism and Intoxication Treatment Act
Section 30, Powers of Department
Section 140, Public and Private Treatment Facilities

Alaska Administrative Code

Title 7. Health and Social Services
Chapter 13, Assistance for Community Health Facilities
Section 135. Grievance procedures
Chapter 29, Uniform Substance Abuse Treatment
Section 10. Application of standards
Section 30. Adoption of standards by reference
Chapter 71, Community Mental Health Services
Section 220. Grievance procedures

[6] 7 AAC 29.030 Adoption of standards by reference
[7] 7 AAC 29.010 Application of standards
[8] Comprehensive Accreditation Manual for Behavioral Health Care, 2004 – 2005
[9] 2007 Behavioral Health Standards Manual, CARF International

NORTHERN REGION

FAIRBANKS COMMUNITY BEHAVIORAL HEALTH CENTER

Main Office
3830 South Cushman St.
Fairbanks, Alaska 99701
Phone: (907) 452-1575
Fax: (907) 456-9761

FAIRBANKS COMMUNITY BEHAVIORAL HEALTH CENTER
A REGIONAL MENTAL HEALTH PROVIDER
"Building strong roots in the Interior."

Delta Junction Office
2855 Alcan Highway
Jarvis West Ste. 2A & 2C
Delta Junction, Alaska 99737
Phone: (907) 895-4077

CLIENT GRIEVANCES

POLICY:

The Fairbanks Community Behavioral Health Center shall accept written grievances from FCBHC clients or other interested parties. Center staff shall not discriminate in providing services or take reprisal on any person filing a complaint in good faith or the consumer on whose behalf the complaint was filed.

PROCEDURES:

1. Preferably, the first step in the grievance procedure would be for the client to discuss the grievance with the primary clinician/case manager.

2. If a mutually acceptable solution cannot be reached, the client should submit a written complaint to the Executive Director. Assistance in writing and filing the complaint will be granted by any member of FCBHC staff.

3. The written complaint must include the following: client's name, date and time of incident, name of staff involved and witnesses (if any). The Executive Director may dismiss the complaint, resolve the complaint, or appoint an impartial investigator within 7 days of receiving the complaint. If an impartial investigator is appointed, the investigator will have 30 days to investigate the complaint and file a report with the Executive Director.

4. If the client or other interested party is not satisfied with the decision an/or action, he/she may request, in writing, a reconsideration by the Board of Directors within 7 days of issuance of the written decision.

POLICY:

To protect the rights of consumers and improve the quality of services and programs, Fairbanks Community Mental Health Center shall establish a systematic process for receiving, investigating, and disposing of complaints concerning possible violation of rights, unethical behavior, abuse of consumers, non-accidental injury to consumer while participating in a program, negligence resulting in loss or damage to the personal property of a consumer, failure to provide treatment, or other serious issue involving client care.

Any person including clients, families, friends, staff, or other interested party may file a complaint if they have reason to believe that one of the events noted above has or is occurring. Any member of the Fairbanks Community Mental Health Center staff who has knowledge of a violation of rights, abuse of a consumer, or unethical behavior will be expected to file a complaint. All staff are expected to inform consumers of the complaint process and assist them as necessary in filing a complaint if necessary.

Complaints shall be in writing and submitted to the Executive Director. Complaints should state the facts of the situation as accurately as possible including the nature of the offense(s), date(s) and time(s) of occurrences, names of clients involved, names of staff involved, others involved, and witnesses (if any). The complaint must be dated and signed by the person originating the complaint. The complaint shall be confidential except to the Impartial Investigator if appointed. All parties shall be notified that a complaint has been received, if an Impartial Investigator has been appointed, and the proposed disposition of the complaint before it becomes final. Parties may review the Impartial Investigator's report once it has been accepted and they sign a statement to keep it confidential. Neither the complaint nor the Impartial Investigator's report shall be included in part or in whole in any client or personnel record. Parties to a complaint include the consumer(s) alleged to have suffered a wrong, the staff named as responsible, the consumer's advocate on request of the consumer, and the consumer's guardian if applicable. State and federal law provides designated legal advocacy organizations access to the process in which cases that organization would automatically be a party to the complaint.

All consumers shall receive a plain language statement of this policy and the procedure for submitting a complaint when entering service. Copies of it also shall be posted in all Center facilities.

Center staff shall not discriminate in providing services or take reprisal on any person filing a complaint in good faith or the consumer on whose behalf the complaint was filed.

The Executive Director shall provide the Board with an annual report of the number and summarizing the nature and findings for complaints received during the previous 12 months.

PROCEDURE:

A. Complainant	1.	Submits written complaint to the Executive Director. Assistance in filing the report will be granted by any member of the Center staff.
B. Executive Director	1.	Logs complaint and takes initial action within 7 days of receipt.
	2.	Takes one of the following initial actions within 7 days: (a), dismisses complaint as frivolous; (b), dismisses complaint if event occurred over twelve months prior to receipt; (c), proposes immediate disposition when the issues are self evident; or (d), appoints an Impartial Investigator.
	3.	Notifies complainant if complaint has been dismissed or accepted within 7 days. May suggest alternative remedies if complaint is dismissed.
	4.	Notifies parties within 7 days of complaint and initial action unless dismissed.
	5.	Reviews Impartial Investigator's report within 7 days and either accepts it or requests additional

considerations be addressed by the Investigator.

6. Based on report of Impartial Investigator, proposes disposition of complaint and sends copies to parties within 7 days after accepting report.

7. Makes final disposition of complaint 14 days after accepting report of the Impartial Investigator. May consider issues raised by parties for review.

C. Impartial Investigator

1. Notifies Executive Director within 5 days if unable to serve as Impartial Investigator.

2. Completes investigation and submits report of findings and recommendations to Executive Director within 30 days. May request extension if unable to complete report in allotted time.

D. Appeals

1. Any party may request reconsideration of the Executive Director's disposition within 7 days after proposed disposition is issued. Request should state specific reasons for contesting either findings or disposition. The Executive Director shall respond to the request within 7 days.

2. A party who is not an employee may request an appeal to the final disposition by filing a written request within 7 days after it becomes final. Request

should be submitted to the President of the Board of Directors. The Board may elect to review the Complaint, findings, and disposition if it believes doing so to be in the best interests of the Center. The Board's determination shall be final.

Douglas R. Pomeroy, Ph.D.
Douglas R. Pomeroy, Ph.D.
Executive Director

FCMHC - Reviewed 11/95 - Policy and Procedure Manual

Fairbanks Native ASSOCIATION
(F N A)

FAIRBANKS NATIVE ASSOCIATION
Policy

TITLE: Consumer Complaint Policy		Policy # BHS RR 2
Authorization:	FNA Executive Director 9/19/06 Date	Review Date & Initials
Supersedes:	Client Complaint Policy, March 2002	Page 1 of 3

POLICY

All Consumers have a right to be treated in a respectful manner that promotes dignity and self-worth. If a Consumer believes their human, civil, or legal rights have been infringed upon, or that he or she has been mistreated in any manner, the Consumer has the right to file a formal complaint.

All Consumers have the right to assistance by the FNA/BHS Consumer Advocate in filing such a complaint. The Consumer Advocate is responsible for ensuring that the Consumer's concerns are appropriately addressed and is available to the Consumer throughout the complaint process.

PROCEDURES

1. Communication of Complaint Procedures to Persons served

All program Consumers are informed of the Consumer Complaint Policy and procedures during their orientation process. Consumers must sign that they have read and understand the policy and this must be documented in the Consumer's individual case file. A copy of the policy and Consumer Complaint Form is also included in the *Consumer Handbook* and is posted in a highly visible place in the treatment facility.

2. Assistance in Filing a Complaint and Understanding the Results.

The Primary Counselor, Clinical Coordinator, or any other staff member will assist any Consumer in initiating the complaint process, following attempts to resolve the complaint verbally. Further, the decisions made at each level of the process will be explained to the Consumer in a manner in which the Consumer can understand.

3. Steps in Complaint Procedure

All responses to complaints must be documented, and a copy of that response must be provided to the Consumer at each level of response.

A. **Verbal Complaints** - If a Consumer believes his/her rights have been violated, the Consumer will advise his/her counselor and request a meeting with the staff involved. In the event the complaint is against his/her counselor, the Consumer will inform the Program

Coordinator (or Program Director for Graf and WCCIH) to request a meeting. The staff will set up a meeting no longer than 24 hours after the request is made. Persons not involved may be present only with the consent of both parties. Both parties will be afforded an opportunity to explain their perceptions of what led to the complaint in a manner respectful to each other. Both parties should attempt to reach an understanding and consensus that will avoid future similar situations. No further action is needed if the Consumer is satisfied that resolution has been achieved. If the Consumer verbalizes fear of meeting with staff, he/she will be advised of the right to contact the FNA Consumer Advocate and provided with contact information. The resolution of the complaint must be documented by program staff, and a copy is to be provided to the Consumer.

If the Consumer is not satisfied with the resolution, the referring Clinical Coordinator or Program Director is notified that the Consumer wishes to make a formal written complaint. The Clinical Coordinator or Program Director is responsible for the following:

- Providing the Consumer with a copy of the Consumer Complaint Policy and appropriate forms for filing a complaint
- Providing Consumer with contact information to the FNA Consumer Advocate
- Notification of the parents, if the Consumer is an adolescent
- Assigning staff to conduct an investigation
- Notifying the Human Resources Department, should the complaint involve a violation of the FNA Personnel Policies and Procedures Manual by a staff member

B. **Written Complaints** - All written complaints are submitted to the Clinical Coordinator or Program Director within 3 days (72 hours) following the verbal meeting outlined above. The written complaint must contain:

- The Consumer's name, date and signature on the complaint
- The nature of the complaint and all parties involved
- All actions taken by Consumer and staff in seeking resolution of the complaint
- What the Consumer would consider a satisfactory resolution

C. **Investigative Process** –If it is necessary, Clinical Coordinator or Program Director will carry out, or assign a BHS staff person to carry out, an investigation of the complaint. This may include interviews with staff and Consumers, record reviews, etc. A report of the investigative process completed and findings and recommendations is submitted to the Consumer Advocate. If the complaint is of a clinical nature, a clinical review team will be selected by the Consumer Advocate to review the complaint jointly.

D. **Final Decision** - The Consumer Advocate makes a final decision which is provided to the Consumer within five (5) working days after receipt of the written complaint. The decision must be provided in writing to the Consumer and may include an extension of time for further investigation if deemed prudent.

E. **BHS Director** - If the resolution recommended by the Consumer Advocate is not satisfactory to the Consumer, the Consumer may notify the Director of Behavioral Health Services in writing and include copies of all documents. The final documented decision of the BHS Director is provided to the Consumer within five (5) working days after receipt of the written complaint. The BHS Director may extend the time for further investigation if the BHS Director believes such course to be prudent.

4. Appeal Procedures

If the resolution recommended by the BHS Director is not satisfactory to the Consumer, the Consumer must notify the BHS Director in writing within five (5) working days after receiving the BHS Director's final decision. The Consumer must provide the reasons for the appeal. The BHS Director will notify the Consumer of the appeal decision within five (5) working days of receipt of the Consumer's written appeal. The final decision on the appeal may include:

1) rejecting any further inquiry into the complaint,
2) selecting a committee to investigate and recommend a final decision,
3) referring the complaint to an attorney, or
4) some other method for seeking Consumer satisfaction with the resolution.

A. **Further Appeals** - If the Consumer is still not satisfied with the resolution, the Consumer will be advised by the BHS Director that the Consumer has the right to appeal to the State of Alaska, Division of Behavioral Health. The State of Alaska, Division of Behavioral Health Northern Region Representative can be contacted at (907) 451-5042.

B. **Documentation** - Copies of the Investigative Report and recommendations will be submitted to the Consumer Advocate and to the Human Resources Department.

C. **No retaliation against Consumer** - It is understood that the Consumer will not be retaliated against as a result of filing a complaint.

D. **Failure to meet stated time frame** - If the Consumer fails to meet the policy time frame, the complaint will be considered waived. If the staff fails to meet the policy time frame, the complaint will proceed to the next level of the procedure.

The complaint form is attached.

FAIRBANKS NATIVE ASSOCIATION, INC.

CONSUMER COMPLAINT FORM

Consumer Name: _____

Date of Complaint: _____

FNA Program Name: _____

Type of Complaint (please check the box)

- ☐ Health & Safety
- ☐ Legal
- ☐ Staff Attitude
- ☐ Treatment Issues
- ☐ Other_____

Please explain your complaint in your own words. State the time, place and date of the event.

_____
_____
_____
_____
_____
_____
_____
_____
_____

How would you like to see this resolved?

_____
_____
_____

I, _____, hereby authorize release of the above Consumer Complaint Form, related information, and any related attachments, to individuals within the Fairbanks Native Association, Inc. assigned to investigate or carry out a response to my complaint.

_____ _____

Signature Date

FAMILY CENTERED SERVICES
Of
ALASKA

CLIENT GRIEVANCE

PURPOSE:
The purpose of this policy is to establish a procedure by which the complaints of FCSA clients and families may be expressed and resolved.

RESPONSIBILITY:
It will be the responsibility of FCSA staff to ensure proper implementation of this policy and procedure regarding client grievances.

If for any reason the client has difficulty documenting a complaint in written form, the Coordinator will be responsible for reasonably accommodating the client by assisting him/her in placing an oral complaint in written form. If needed, the next supervisory level will assist the client.

It is the responsibility of all staff to ensure that any grievance filed will not result in retaliation or barriers to services for the person submitting the grievance.

Clients or their legal guardian may designate a representative (advocate) to assist them.

It is the responsibility of FCSA staff to ensure confidentiality is maintained in accordance with QA Policy #105.

PROCEDURE:
At any time during the grievance process The Executive Director, Director of Behavioral Health Services, Program Director, Financial Officer, Quality Assurance Director, or Human Resource Director may initiate a request to conduct an investigation into the complaint per Administrative Policy #602 Internal Investigations.

Grievances involving abuse or neglect of any description, or unnecessary seclusion or restraint will be investigated and reported immediately to the governing body and DMHDD.

1. All clients and client' s families will be given a copy of this policy upon admission into services.

2. Routing of a client's complaints.

1. Written complaints go to the assigned Coordinator/Case Manager. The Coordinator/Case Manager will notify the client that the grievance has been received and the process to resolve if has begun. The Coordinator/Case Manager will respond to the client in writing within two working days. (If not resolved, go to step two).

2. Client provides written appeal to the Program Director. The Program Director will review the client's an d Coordinator/Case Manager's documentation, interview both persons and then provide the client and Coordinator/Case Manager with their conclusion in writing within three working days. (If not resolved, go to step three).

3. Client provides written appeal to the FCSA Executive Director. Procedure is the same as step two. The Board of Directors will be informed of any grievances that are forwarded to the Executive Director.

4. In the event the grievance is specifically against the Coordinator/Case Manager, the grievance will be forwarded directly to the Program Director.

5. In the event the grievance is specifically against the Program Director, the grievance will be forwarded directly to the FCSA Executive Director.

3. The client will be given a written response at each step of the grievance.

4. All client complaints and corresponding documentation will be placed in the client's file.

5. The decision of the FCSA Executive Director will be final.

6. This is an internal agency procedure. The public has a right to contact the Division of Behavioral Health office at anytime to express concerns about FCSA at this address and phone number:

   Division of Behavioral Health Office
   751 Old Richardson Hwy., Suite 123
   Fairbanks, Alaska 99701
   (907) 451-5045

FORMS REQUIRED:
Client Grievance Notification

GALENA

Edgar Nollner Health Center Policy and Procedures Manual	Policy Number 12.4
Section: Governance Policy Title: ENHC Grievance Procedures	Page 1 of 2
Reviewed On: Approved By: Date Approved:	Revised On: 25 July 2007

POLICY:
Clients have the right to lodge a complaint if they feel ENHC staff did not treat them appropriately. Both clients and staff have the right to a fair and careful investigation of the complaint before any action is taken. Every attempt will be made to develop a corrective plan that addresses the problem that led to the client complaint.

All client complaints will remain confidential (unless the client chooses to waive this right) and will not interfere with the quality of care and service the client or their family receives at the Edgar Nollner Health Center or any facility where ENHC employees provide services.

1) Copies of ENHC's *Grievance Policy* will be posted in plain view in the ENHC waiting area.

2) A Copy of this policy and an *Acknowledgement* of having read and understood this policy will be given to all new and updating clients. A copy of the signed *Acknowledgement* will be kept in the client's medical and behavioral health files.

POCEDURES:

1. Clients are encouraged to bring any question or complaint to the provider, clinician or staff person that the client is interacting with at the time the problem occurs; if there is no satisfactory resolution or the client is unable to do this the client may lodge a grievance in the following manners:
    a. submit a written complaint in the form of a letter, an email or submit a completed *ENHC Grievance Form* to the staff member's supervisor or the Executive Director of the facility
    b. Lodge a verbal complaint, in person or via telephone, with the staff member's supervisor or the Executive Director of the facility.

2. The client may appoint a designated person to represent them during the grievance process. If the client wants to delegate a person but does not have anyone available to them the Executive Director will appoint an impartial staff member to represent and assist the client throughout the process (the client must agree to the appointed staff member).

3. If a designated representative cannot be agreed upon from ENHC staff members, ENHC will be provided the client with contact information for the **Disability Law Center** for their advocacy services (phone: 1-800-478-1234). If the client is a **Tanana Chiefs Conference** beneficiary, the client will also be offered the contact information for Virginia Sweetsir, TCC Client Advocate (phone: 1-800-478-6822).

Edgar Nollner Health Center Policy and Procedures Manual	Policy Number 12.4
Section: Governance Policy Title: ENHC Grievance Procedures	Page 2 of 2
Reviewed On: Approved By: Date Approved:	Revised On: 25 July 2007

4. The client will be asked to sign a waiver allowing ENHC staff to discuss the complaint with the client's chosen representative. Without a signed waiver ENHC staff may not discuss the complaint with outside entities that may be representing the client (per HIPAA § 164.510).

5. Within five days of receiving a complaint or a grievance, the Supervisor or the Executive Director will contact the client to acknowledge the complaint and to initiate the grievance procedure. The supervisor or Executive Director will confirm that the client has a signed Acknowledgement of understanding of the grievance policy in his or her file. The client will be asked if they wish to waive their right to confidentiality* during the grievance process.

6. Plan on resolution of a grievance within 30 days of said acknowledgement. If the person responsible is unable to initiate the resolution process within 5 days of receiving the complaint, a written notification will be sent to the client explaining why and will identify the date the resolution process will begin.

7. The grievance resolution process will include interviewing all parties involved and examination of any and all pertinent medical or behavioral health files relevant to the complaint. ENHC Policies and Procedures and evidence-based standards of practice will be used as measures of provider competency regarding the grievance.

8. If the Supervisor or the Executive Director is unable to resolve the conflict, the matter will be turned over to the ENHC Governing Board at their next scheduled meeting. The client will be informed of the next meeting of the ENHC Governing Board. All parties will be invited to the Board meeting.

9. Grievances unresolved within 30 days of initiation of the grievance process and/or unresolved by this facility's highest level, within the same time-frame, will be referred to the DHSS Behavioral Health for technical assistance.

10. Grievances involving abuse, neglect or unnecessary seclusion or restraint will immediately be referred to the State authority responsible for such complaints. The ENHC Governing Board will be notified of such a report at their next scheduled meeting.

11. A file will be created for each individual grievance in the Executive Director's office. This file will contain all related documents, records, actions and communications significant to the case. These files will remain confidential.

Edgar Nollner Health Center
Grievance/ Complaint Form

This form is to be filled out, as completely as possible, by the person lodging a complaint or a grievance (or their designated representative) against (a) staff member(s) of the Edgar Nollner Health Center medical or behavioral health clinics. Enclose the form in the accompanying envelope addressed to the Executive Director and hand in at the front desk or mail to ENHC at PO Box 77 Galena, AK 99741.

Your complaint will remain confidential (unless you choose to waive this right) and will not interfere with the quality of care and service you or your family receives at the Edgar Nollner Health Center or any clinic where our employees provide services.

Name of consumer(s)/patient(s)/client(s) involved:

Name of staff member(s) involved:

Name of consumer designated representative or advocate who will assist the consumer in all steps of the grievance procedure:

Name of person(s) incident was witnessed by:

Time and place incident occurred:

Nature of the complaint: Describe what happened (use additional sheets as needed)

Consumer Signature: **Date:**

Designated Representative: **Date:**

EDGAR NOLLNER HEALTH CENTER

ACKNOWLEDGMENT

I,_____, state that I have been given a copy of the *ENHC Grievance Policy*. I have read and understand said policy and agree to abide by all the terms and conditions provided therein.

Signature: Date:

_____

Witness Signature: Date:

_____

EDGAR NOLLNER HEALTH CENTER

(Serving the Surrounding Villages)
Huslia, Kaltag, Koyukuk, Nulato, Ruby

WAIVER

I,_____, **do / do not** (circle one) waive my right to confidentiality during this grievance process (per HIPAA §164.520). By waiving my right to confidentiality I understand that my grievances will, in no way, interfere with the quality of care and service I or my family receives at the Edgar Nollner Health Center or any clinic where ENHC employees provide services

Signature: _____

Date: _____

Witness Signature: _____

Date: _____

INTERIOR AIDS ASSOCIATION

XI. GRIEVANCE PROCEDURES

A. Denial or Termination of Treatment Services

Participants in the PSD program have the right to appeal a decision to deny or terminate services if they believe that the services have been denied or terminated unfairly or that he/she is being discriminated against in a manner prohibited by these policies. Appeal procedures are described below. Participants will receive clear explanation of these procedures and will sign a copy to be placed in their files.

1. Filing a Grievance

An individual who believes that services have been denied or terminated unfairly or that he/she is being discriminated against in a manner prohibited by PSD policies should submit a written request for re-consideration to the Executive Director at the address shown below OR submit a request for reconsideration (orally or in writing) at a scheduled appointment with the Executive Director (call 452-4222).

A form is available, that also provides an optional waiver of confidentiality. The grievance does not have to be on the form to be considered. Grievances received orally shall be written by the individual receiving the information, and confirmed by the patient in writing or verbally (if by phone).

Interior AIDS Association – PSD Director
P.O. Box 71248
Fairbanks, AK 99707
Or by email: anna@interioraids.org

2. Review Process and Timelines

a) Grievances will be reviewed by the Executive Director within 5 days of receipt and then at the next PSD Treatment Team meeting. If the review process will not be initiated within 5 days, a written notice will be given to the participant.
b) A decision will be made within 30 days of receipt of the grievance.
c) If the request is denied and the participant wishes to appeal further, the grievance may be submitted to IAA's Board of Directors at the address above, and then to the State, at the address below.
d) Any grievances relating to abuse or neglect of consumers, or relating to the Executive Director will be taken immediately to the Board of Directors.
e) The IAA Board will consider unresolved grievances in regard to administrative issues. They will advance unresolved grievances of clinical decisions to the Division of Behavioral Health. All grievances unresolved at the Governing Board level, or unresolved after 30 days, will be forwarded to:

State of Alaska
Division of Behavioral Health
Attn: Viki Wells, Behavioral Health Specialist
3601 'C' Street, Suite 878
Anchorage, AK 99503
(907)269-3794
1-800-770-3930

B. Denial or Termination of Program Privileges

Program privileges include, but are not limited to take-home dosing. Decisions to deny or terminate privileges are the responsibility of the PSD Treatment Team and finally the Medical Director and/or the Program Director (depending on the issue).

Appeal of Treatment Team Decisions regarding privileges can be made in writing on the grievance form, by email, or letter; orally to their counselor or the program director (who will write down the grievance for the consumer and have them sign).

Since PSD consumers are in frequent contact with the program for counseling and methadone dispensing, it is expected that all grievances will be signed in a timely manner by the participant – whether received orally in person or by phone.

The appeal will be reviewed by the Program Director within 5 days. If not, the consumer will be notified in writing. The Treatment Team will make a decision within 30 days, though usually this is done at the next treatment team meeting.

Consumers have the right to contact the Division of Behavioral Health with grievances or complaints at the address noted above. Program privileges are "clinical decisions," and as such they will not be considered by IAA's Board of Directors; they will be forwarded to the Division of Behavioral Health if submitted to the Board.

C. Complaints

Complaints and suggestions are welcomed by the program. A form is provided for this purpose that is accessible to all participants.

This process is intended as a means for resolving consumer and program problems and to minimize the need to invoke the formal grievance process. The Executive Director reviews all complaints and notifies the consumer (if identified) that the complaint is being reviewed.

Complaints that have implications for the quality of the program are taken to the Consumer Advisory Council (without identification) and to the PSD Treatment Team after review by the Executive Director.

Solutions and resolutions are discussed with the person who complained, if identified, and implemented.

Complaints that involve abuse or neglect shall be directed to the Board of Directors, with the same attention as a "grievance."

Complaints that involve a single consumer's issue, that are not potentially program-wide are discussed with the consumer's counselor and the treatment team. The Executive Director provides a response to the complaint. If the complaint is not resolved to the consumer's satisfaction, they have the right to elevate it to the grievance level.

D. Additional Rights and Responsibilities

1. Participants have the right to have an advocate or representative to assist them with the process. A member of the Consumer Advisory Council often provides this assistance.

2. Upon request, a PSD counselor will assist the participant in completing a grievance. The participant may request their own counselor's assistance, or another counselor.
3. Participants will be provided with a written referral to the Disability Law Center or Alaska Legal Services when they request it or when a counselor believes that the participant will be better served by outside assistance to prepare the grievance or respond to the decision.
4. Grievances will be filed individually, with all documents and records relating to the grievance. Files will be secured in the Executive Director's office until each issue is resolved. After the grievance is resolved, all original documents will be included in the participant's file. Files are retained for 7 years after discharge or last contact.
5. All grievances and complaints are logged and analyzed, then summarized in the Annual Management Report.
6. Participants (consumers and applicants) have the right to **confidentiality** throughout the grievance process. They have the option to waive confidentiality for review at the governing board and State level.

Acknowledgement

- I have been provided with a copy of these grievance procedures and have had them explained to me.

- I understand my right to submit grievances and complaints.

- I understand that I have the right to file grievances and complaints without retribution or intimidation of any kind.

- I also understand that it is my responsibility to inform (complain to) program personnel when I know there is a problem that impacts the quality of my treatment or other consumers.

_____ _____
Consumer Signature Date

_____ _____
PSD Staff Signature Date

Project Special Delivery
Consumer Rights and Responsibilities

RIGHTS	RESPONSIBILITIES
1. You have the RIGHT to confidentiality protections. Your name will not be disclosed to anyone outside the PSD program without your written permission.	You have the RESPONSIBILITY to respect the confidentiality of other consumers and staff and to supply written releases when necessary to obtain services you desire.
2. You have the RIGHT to privacy in your interactions with PSD staff. Information will not be available, either intentionally or inadvertently, to staff who do not need to know.	You have the RESPONSIBILITY to request a private space to discuss matters you want to remain private; and to respect the privacy of others.
3. You have the RIGHT to be treated with consideration and respect by all members of the PSD staff and the Consumer Advisory Council, INCLUDING Freedom from 1) Abuse; 2) Financial or other exploitation; 3) Retaliation; 4) Humiliation; and 5) Neglect.	You have the RESPONSIBILITY to treat staff, Council members and other consumers with consideration and respect, INCLUDING not taking part in abuse, exploitation, retaliation or humiliation of PSD Consumers or Staff.
4. You have the RIGHT not to be discriminated against based on race, ethnicity, religion, gender, age sexual orientation or disability.	You have the RESPONSIBILITY not to discriminate against staff and other consumers based on race, ethnicity, religion, gender, age sexual orientation or disability.
5. You have the RIGHT to receive accurate and easily understood information.	You have the RESPONSIBILITY to allow adequate time for copying and to reimburse the program for the cost of photocopy services.
6. You have the RIGHT to see your treatment file during a scheduled appointment. The file is the property of the IAA's Project Special Delivery, but you may request a copy of the file.	You have the RESPONSIBILITY to let staff know about your concerns and questions.
7. You have the RIGHT to informed consent or refusal or expression of choice regarding: Service Delivery, release of information, concurrent services, composition of the treatment team, and involvement in research projects.	You have the RESPONSIBILITY to express your choices clearly and in writing when required.
8. You have the RIGHT to receive PSD services when you have verified your eligibility for treatment and been admitted to the program.	You have the RESPONSIBILITY to provide necessary verification documents (proof of addiction history).

RIGHTS	RESPONSIBILITIES
9. You have the RIGHT to refuse services at PSD and/or to receive a complete and understandable explanation of why PSD services may not be appropriate to your needs. In such instances, PSD will make every effort to refer you to an alternative program/agency for assessment and care services.	You have the RESPONSIBILITY to share with staff your drug use history, treatment expectations and preferences so that the best possible plan can be developed for you.
10. You have the RIGHT to participate in all treatment decisions and to be supported in the decision-making process by staff.	You have the RESPONSIBILITY to actively pursue and provide for your needs as much as you are able.
11. You have a RIGHT to request appointments with PSD staff or Council members and to be seen within a reasonable period of time following that request (72 hours).	You have the RESPONSIBILITY to keep your appointments or to cancel with reasonable notice. You also have the responsibility to respect the scheduled hours and availability of staff or Council members and to give sufficient notice whenever possible.
12. You have the RIGHT to make suggestions and have your opinion heard regarding PSD services and policies.	You have the RESPONSIBILITY to use appropriate channels when you wish to voice your concerns, including talking to or participating in the Consumer Advisory Council and/or making an appointment to discuss an issue with staff.
13. You have the RIGHT to an investigation and resolution when you believe your rights have been violated.	You have the RESPONSIBILITY to make your complaint in writing (including e-mail) or orally (including by phone) to the program director or IAA's Board of Directors.
14. You have the RIGHT to appeal decisions regarding your treatment, and/or privileges without intimidation of any kind if you believe the decision is wrong or unfair.	You have the RESPONSIBILITY to follow the appeal process and to participate in scheduled meetings about your appeal.
15. You have the RIGHT to receive HIV education and risk reduction counseling and testing.	You have the RESPONSIBILITY to participate in the development of an individual HIV risk reduction plan.
16. You have the RIGHT to referral to legal assistance for appropriate representation (Alaska Legal Services, Public Defenders, etc.)	You have the RESPONSIBILITY to request further assistance if the referral information provided to you is not adequate.
17. You have the RIGHT to access self-help and advocacy support services.	You have the responsibility to request assistance and referral, and to understand that services available in Fairbanks may be limited (e.g. Methadone Anonymous, etc.)
18. You have the RIGHT to expect that research guidelines and ethics will be adhered to if you agree to participate in any research projects at PSD.	You have the RESPONSIBILITY to express your concerns during any research project.

Consumer Signature _____ Date _____ Staff Signature _____ Date _____

PROJECT SPECIAL DELIVERY

Form for

Complaints or Suggestions

If you have a complaint about the program or a suggestion to make it better, complete this form and give it to a staff member, a Consumer Advisory Council Member, or put it in the Executive Director's mail box (on the door).

You do not need to identify yourself, but it is encouraged so that we can respond to your concern or get more information.

Describe your complaint or suggestion, and what ideas you have that may solve the problem (if applicable):

Submitted by (optional):_____

Interior AIDS Association
Project Special Delivery
NOTICE OF APPEAL
Grievance Form

Name _____ Date _____

Mailing Address _____

I am appealing a decision to (check one)

_____ deny my application for services or earned privileges
_____ terminate my existing services
_____ other, please explain _____

_____

The PSD has given me the following reason for this denial or termination (check those that apply)

_____ failure to participate in other required program activities
_____ engaging in violent, fraudulent, or illegal activity
_____ I do not know, or understand, the reason for denial
_____ other, please explain _____

_____

In your own words, please give the reasons why you believe that this action is wrong or unfair.

_____

_____

_____

_____

In your own words, please explain what you believe should be done to correct this problem.

_____

_____

_____

Have you been given the opportunity to read the PSD Policy and Procedure Manual?
_____ yes _____ no

The PSD Policy and Procedure Manual states:

Applicants have the right to appeal a decision to deny services if they believe that the service has been denied unfairly or that she/he is being discriminated against in a manner prohibited by these policies.

Appeal Procedure to follow:

1. Submit a written request for re-consideration to:
   Executive Director
   Interior AIDS Association
   PO Box 71248
   Fairbanks, AK 99707

   OR

   Submit request for re-consideration at a scheduled appointment with the Executive Director, please call 452.4222.

If request is denied and further appeal is appropriate:

2. Submit a written request for re-consideration to:
   State of Alaska
   Division of Behavioral Health
   3601 C St.
   Anchorage, AK 99503
   Attn: Viki Wells

Please attach copies of all correspondence or other forms that you think should be considered by the individual(s) considering your appeal. Use the space below for any additional comments you wish to make.

_____

_____

_____

_____

_____

I understand that I have the right to appeal decisions to deny and/or terminate PSD services and that my appeal will be considered by the individuals named above. I also

understand that I am responsible for following the process as described and to provide accurate and true information on this form and at any meetings where my appeal is being heard.

Signature Date

OPTIONAL Waiver of Confidentiality

I waive my right to confidentiality regarding this grievance. Information about this grievance, including my identity, may be disclosed to:

_____

_____

_____ _____

Signature Date Witness Date

MANILLAQ ASSOCIATION
BEHAVIORAL HEALTH SERVICES

Maniilaq Association
Behavioral Health Services

Client Grievance Policy and Procedure

Policy:

It is the policy of Maniilaq Association's Behavioral Health Services to employ and maintain a Client Grievance Policy and Procedure that will assure a client's right to file a grievance. This policy and procedure establishes standards for the client to follow if he/she believes that they have a grievance regarding any aspect of services/treatment, including those clients denied services.

Procedure:

A copy of the Client's Grievance Policy and Procedure will be maintained at each program in Behavioral Health Services. Client handbooks will also contain a copy of the Client's Grievance Policy and Procedure.

1) All clients receiving services from Behavioral Health Services will be provided a copy of the Client's Grievance Policy and Procedure. The client will be given a form so that they may provide their signature indicating that they have received a copy of the Client Grievance Policy and Procedure and that they understand the policy. This form will be maintained in the client's record.
2) The client maintains the right to file a grievance without fear from intimidation, retaliation, and/or retribution. Most importantly, clients will not be denied services for employing their client right to file a legitimate grievance.

Informal grievance: Clients are asked to make a good-faith attempt to resolve problems at the lowest level possible without resorting to the formal grievance procedure. An informal grievance is to be submitted in writing and/or verbally to staff within three (3) working days from the date of the dispute or concern. Staff is expected to determine as promptly as possible the cause for the concern while making every effort to resolve said complaint informally. Staff shall conduct any necessary and/or appropriate investigation and inform the grievant of a decision based upon a fair consideration of all the facts within five (5) working days after the receipt of said grievance. The staff will issue a written memo to the grievant stating how the complaint was processed and resolved. If the grievant is dissatisfied after making a good faith effort to resolve the problem with the informal process, the grievant may next qualify to have the concern addressed through a formal process.

Formal Grievance: A formal grievance may be submitted in writing after an informal grievance failed to resolve the client's concern.

Step One

The grievant has three (3) working days from the date that the informal decision was made to submit a written request for a formal grievance to the staff supervisor. The supervisor or designee will issue a written decision regarding the grievance within five (5) working days of receipt. Copies of the decision will be forwarded to the aggrieved, the staff, the Clinical Compliance Officer.

Step Two

If the aggrieved is dissatisfied with the decision at step one, they may submit a written appeal to the Clinical Compliance Officer. The appeal must be filed within five (5) working days after the receipt of the decision in Step One. The next level of management will conduct an investigation as they deem appropriate. In addition, if determined necessary, a conference will be scheduled with the aggrieved and any other necessary parties within five (5) working days after receipt of the written request for an appeal. A decision will be submitted in writing to the aggrieved within five (5) working days from receipt of the appeal or five (5) working days after conclusion of the conference. The decision will be forwarded to the aggrieved, the staff, and the Deputy Director.

Step Three

If the aggrieved is dissatisfied with the decision at Step Two (2), they may submit a written appeal to the Deputy Director. The appeal must be filed in writing within five (5) working days after receipt of the decision from Step Two. The Deputy Director will conduct such investigation as he/she deems appropriate. In addition, the Deputy Director will schedule and hold a conference with the aggrieved and any other necessary parties within five (5) working days after receipt of the appeal to Step Three. The Deputy Director will issue a written decision after five (5) working days from the conclusion of the conference. A copy of said decision will be forwarded to the aggrieved, the staff, the program supervisor, Clinical Compliance Officer, and to the Director.

Step Four

If the aggrieved continues to feel dissatisfied, after Step Three (3), they may request in writing a Step Four (4) hearing with the Director. An appeal must be submitted in writing by five (5) working days after receipt of the decision from Step Three. Within five (5) working days from receipt of the written request for a Step Four (4), the Director and will schedule a hearing.

Within five (5) working days after the hearing, a written decision will be submitted to all concerned parties. This decision shall be final and binding. If the aggrieved client continues to maintain their dissatisfaction with the entire grievance process they have a right to contact The State of Alaska Department of Health and Social Services: Behavioral Health Unit (DHSS BH) for technical assistance and/or for review of the aforementioned grievance process. At this level, the (DHSS BH) will take any action deemed prudent or necessary to assist the client and/or the agency.

Exception to the Steps Process

If the aggrieved client's grievance involves abuse, neglect, unnecessary seclusion, illicit restraint, sexual assault/abuse, bodily injury and/or life threatening behaviors, the aggrieved maintains the right to have said grievance immediately addressed by the BHS Director or designee.

NORTH SLOPE BOROUGH

North Slope Borough Behavioral Health			
Subject:	**Consumer Grievance Procedure**		Section: 3.2.1
Created:	5-1-2005	Revised:	Page: 1 of 1
Approved:			

Policy:
All consumers have the right to file a formal grievance if they believe that their civil and/or human rights have been violated. All formal grievances will be filed in writing.

Procedure:
Consumer grievances will be addressed as follows:

- Any consumer who believes that his/her civil and/or human rights have been violated will first discuss the incident with the North Slope Borough Behavioral Health employee(s) involved. The meeting will take place within five working days of the violation. Another person will be selected by both parties to be present at this meeting. This person will act as mediator. The meeting will take place in private and remain confidential.
- If the problem is not resolved, or the consumer chooses not to meet with the employee(s), the consumer can file a written grievance and submit it to the Clinical Director of North Slope Borough Behavioral Health. The Clinical Director will respond within seven days of being notified of the violation.
- If the complaint is against the Clinical Director of North Slope Borough Behavioral Health, the written grievance should be sent to the North Slope Borough Behavioral Health Program Administrator.
- If the complaint is against the Program Administrator of North Slope Borough Behavioral Health, the written grievance should be sent to the North Slope Borough Department of Health and Social Services Director.
- If the problem is not resolved within 21 days of the grievance, the North Slope Borough Department of Health and Social Services Director may appoint a grievance committee.
- If the problem is still unresolved, the consumer has the right to take their grievance to the Division of Behavioral Health. The address and contact individual will be presented to the consumer upon request.
- A copy of the letter of grievance, the results of the investigation(s) and the action(s) ultimately taken will be placed in a confidential file in the North Slope Borough Department of Health and Social Services Director's office.

CHAPTER 2.08 - GRIEVANCE PROCEDURE

§2.08.1 EMPLOYEE GRIEVANCES. Employees in the classified service who have a non-disciplinary grievance related to their employment may utilize the procedures outlined in this chapter.

§2.08.2 LIMITATION ON THE SUBJECT MATTER OF EMPLOYEE GRIEVANCES. Grievances may address problems related to an employee's position, working conditions or other aspects of employment. They may not be used to grieve or otherwise dispute disciplinary actions, or the contents of employee performance appraisals, or compensation issues.

§2.08.3 EMPLOYEES GRIEVANCE PROCEDURE. (A) The employee shall first submit grievances in writing and seek to resolve the grievable matter with his or her immediate supervisor. Every effort to resolve the issues shall be made by both parties at this stage. The participants in a meeting to discuss the grievance shall be limited to the grievant and his or her immediate supervisor. There shall be no audio or video taping of the meeting. The supervisor and grievant may write confirming memoranda to be placed in the grievant's supervisory file.

(B) If the matter cannot be satisfactorily resolved by the employee's immediate supervisor, the employee may submit the matter in writing to the next level in the chain of command within the department.

(C) When the subject of a grievance is the conduct of the employee's immediate supervisor, at the request of the employee the department director shall assign consideration of the grievance to a supervisor of equivalent rank. When the subject of the grievance is the conduct of the department director, or there is a basis to believe that consideration of a grievance by the director would be inappropriate, at the request of the employee the Mayor shall consider the grievance.

(D) The department shall investigate and issue a response in a timely manner, but no later than sixty (60) calendar days from the filing of the grievance.

(E) An employee who believes he or she has been or is about to be constructively discharged may file a written grievance before resigning but no later than ten (10) days after his or her last day of work. If a written decision is issued within twenty (20) days of the filing, the grievance shall be deemed to have been rejected. If the employee is not satisfied with the decision or if the written decision is not issued within the time prescribed, a written appeal to the Personnel Board may be filed with the Director of Personnel within five (5) working days of receipt of the decision or the date it was due, whichever is later.

(F) Upon receipt of a grievance, any necessary investigation shall be conducted and a written response shall be communicated to the employee within twenty (20) working days.

§2.08.4 INTERDEPARTMENTAL GRIEVANCE PROCEDURE. Grievances involving another department within the Borough shall be filed in writing with the employee's department director who will endeavor to resolve the complaint by meeting with the director of the involved department. A written resolution shall be reached in a timely manner, but no later than sixty (60) calendar days from the filing of the grievance. If a satisfactory resolution is not possible, or a timely response is not made by the department, the employee may forward the grievance to the Mayor.

NORTON SOUND
HEALTH CORPORATION

NORTON SOUND HEALTH CORPORATION
BEHAVIORAL HEALTH SERVICES
Policy and Procedure

Policy Name: Client Grievance Procedure

Policy Number: BH08.04

Date Reviewed:
Date Approved:

Policy:
Behavioral Health Outpatient Services clients have the right to be treated in a manner that is both humane and dignified. All clients have the right to file a formal grievance if s/he believes that any BHS employee or any other individual in the BHS program has mistreated them. All grievances will be filed with the Outpatient Manager and/or designee, unless the grievance is against the Outpatient Manager. In this case, the grievance will be filed with the Behavioral Health Services Director.

Procedure:

1. Each client shall be informed of the client grievance policy and procedures at the time of Intake. The client will read and sign a grievance form, which will be placed inside the client's chart. BHS believes every client should have full knowledge of their rights and the grievance process.

2. A form is available to any client for the purpose of filing a formal grievance against any BHS employee.

3. All grievance shall be filed in writing on the proper form unless a client is unable to prepare a written statement. In this case, a client will submit an oral complaint to the designated staff member. Copies of the grievance will be forwarded to the NHSC Compliance Officer.

4. All grievances must specify the nature of the complaint, the time and day it occurred and the identity of the staff member for which the complaint is being lodged against.

5. The Outpatient Manager, and /or the designee, of BHS shall take steps to resolve the complaint within seventy-two (72) hours after the receipt of the complaint.

A. S/He can reject the complaint if s/he deems it to be petty, made in bad faith or insubstantial, provided that the person or committee may not reject the complaint without having made further inquiry when the complaint alleges violation of a client's rights.

B. The complaint can be resolved with the client and staff member that the complaint is lodged against. An advocate can be appointed to speak on the behalf of a client if it appears to be in the best interest of the client.

6. Once the Outpatient Manager, and/or the designee, adjudicates the complaint, a written statement will be prepared indicating results of the investigation and disposition of the complaint. This statement will be prepared and given to the client within forty-eight (48) hours of the resolution.

7. If the Outpatient Manager and/or the designee, is not able to resolve the complaint as stated in paragraph (6), subsection A or B, s/he will prepare a summary of the complaint with a description of his/her attempted resolution. The summary will then be submitted to the BHS Director and NSHC Compliance Officer.

By my signature below, I indicate that I have read this document or have had it read to me, and I fully understand it's meaning, and that I consent to it's terms knowingly and voluntarily, that I have not been under any undue duress or influence, nor under the influence of alcohol or drugs in making this agreement.

_____ _____

Client Signature Date

Witness Statement

I,_____ have witnessed the above named
BHS Staff Name

Client's signature on this document and thereby certify that the above named client has either read or had read to him/her this agreement, that s/he has indicated she/he fully understands it's meaning, had has executed this agreement knowingly and voluntarily, was not under any undue duress or influence, nor under the influence of alcohol or drugs, and that s/he has been given a copy of this form.

_____ _____

Staff Signature Date

cc: client

Behavioral Health Services – NSHC
Notice of Clients Grievance

TO: _____ DATE: _____

I hereby file a grievance against _____
for the following (specify act or condition), time and day of occurrence and person accused of action.

_____
_____
_____
_____
_____
_____
_____.

_____ _____
Client Signature Date

STEP I - OUTPATIENT DIRECTOR'S RESPONSE

I find as follows:

_____
_____
_____
_____
_____.

STEP II – CLIENT'S RESPONSE

I find the response: _____SATISFACTORY _____UNSATISFACTORY
_____RECEIVED NO RESPONSE

_____ _____
Client Signature Date

STEP III (If Necessary) BHS DIRECTOR'S RESPONSE (if necessary)

I find as follows:_____

_____

_____

_____

_____

_____.

_____ _____

BHS Director Date

STEP IV – CLIENT'S RESPONSE

I find the response: _____Satisfactory _____Unsatisfactory_____Received no response.

STEP V (If Necessary) – NSHC EXECUTIVE DIRECTOR RESPONSE

I find as follows:_____

_____

_____

_____.

_____ _____

Executive Director Date

STEP VI (If Necessary) CLIENT RESPONSE

I find the response: ____Satisfactory ____Unsatisfactory ____Received no response.

STEP VII (If Necessary) – NSHC BOARD OF DIRECTORS RESPONSE

We find as follows:

_____
_____
_____
_____
_____.

_____ _____

Chairman Of The Board Date

RAILBELT
MENTAL HEALTH & ADDICITIONS

Railbelt Mental Health & Addictions
PO Box 159
Nenana, AK 99760

CLIENT GRIEVANCE PROCEDURE

1. Any client who feels that he or she has been treated improperly by a RMHA employee should immediately report the incident to the Director. If the Director is the employee against whom the complaint is made, the incident should be reported to the President of the Board of Directors.

2. At the time of the verbal report, the Director or Board President shall request the client to put his or her complaint in writing within five working days of receiving the verbal report. A simple form for consumer grievances is available, which includes an optional waiver of confidentiality. RMHA will also accept grievances submitted in other formats, including grievances submitted orally, in person, or over the telephone, but will request that the grievance will be placed in writing within five days of the initial report. RMHA will also inform in writing to those filing grievances or expressing interest in filing grievances that advocates such as the Disability Law Center, the Alaska Mental Health Consumer Web, and MAMI-Alaska may be available to assist them in the grievance process. During the time between the written and verbal notification, the Director or Board President will take appropriate measures to avoid further allegations of mistreatment by the client.

3. Upon receipt of the written report from the client, the Director or Board President shall take appropriate steps to limit contact between the employee and the client while the complaint is being investigated, including but not limited to suspending the employee with pay for the duration of the investigation.

4. If no written report is received, RMHA may, but is not required to, investigate. Upon receipt of the written report, the Director or the Board President shall investigate the complaint. The investigation shall include, but may not be limited to, interviews with the employee and client, interviews with others that the Director or Board President determines have information relevant to the complaint and review of any documentary evidence relevant to the complaint. The investigation shall be conducted in a timely fashion. The length of the investigation shall be dependent on the circumstances, and be determined solely and exclusively by the Director or the Board President. The Director or the Board President shall attempt to complete the investigation within ten days of receipt of the written report, and to prepare a written report summarizing the investigation and his or her findings within two working days of completing his or her investigation. A copy of the Director's or the Board President's report will be provided to the employee and the client, who may comment on and meet with the Director or the Board President regarding the report. Any such comment or meeting must be requested within two working days of receipt of the report. If no such request is made, the opportunity to comment or meet shall be waived.

5. The Director or the Board President shall take appropriate action to resolve the grievance after preparation of the written report. Such action may include taking no action; discipline of

Railbelt Mental Health & Addictions
PO Box 159
Nenana, AK 99760

the employee, up to and including termination; or taking any other action deemed appropriate by the Director or the Board President. Discipline shall comply with RMHA personnel policies and procedures.

CONSUMER GRIEVANCE REDRESS STANDARDS

1. Each consumer and family member will be given a document called "Consent to Treatment". This document, stated in plain language, will outline procedures, rights, and responsibilities for both RMHA and the consumer in order for treatment to take place at this agency. All consumers and family members will sign the form to confirm that they have received this document. The original document will be placed in the client file, and a copy will be given to the consumer and family members.

2. The grievance procedure will be available to the public through the Policy and Procedure manual. It will also be posted in RMHA waiting rooms, and published in the agency newsletter once per year.

3. A simple form for consumer grievances is available, which includes an optional waiver of confidentiality. RMHA will also accept grievances submitted in other formats, including grievances submitted orally, in person, or over the telephone.

4. RMHA will maintain grievance files separate from client treatment files.

5. All grievances will be reported to the RMHA Board of Directors. All reports will maintain consumer confidentiality.

6. All grievances that are unresolved to the consumers satisfaction within 30 days shall be reported to the DMHDD Regional Coordinator (AS 47.30.660(b)(12)).

7. Grievances involving abuse or neglect of any description, or unnecessary seclusion or restraint will be investigated and reported immediately to the RMHA Board and DMHDD.

8. All consumers have the right to grieve without intimidation to prevent the filing of a grievance, or retaliation if they do. To ensure this, RMHA will take appropriate steps to provide interim clinical support to the consumer by another clinician or another agency.

9. All consumers and family members may have advocates present during all steps of a grievance. Upon request, RMHA will provide assistance to those who wish to file grievances. RMHA may identify staff to provide assistance, but consumers and family members may choose their own advocate, whether from the RMHA staff or elsewhere.

TANANA CHIEFS CONFERENCE
BEHAVIORAL HEALTH

Tanana Chiefs Conference Behavioral Health Department
Policies and Procedures

Subject: Client Complaints and Resolution
Section: Rights and Responsibilities
Authorization: Behavioral Health Director
Signature:
Date:
Supersedes P&P Mental Health Program, Dated 4/16/99

POLICIES:

The Tanana Chiefs Conference seeks to provide high quality behavioral health care. If clients believe they were denied those services to which they should have access, or if clients believe there is a problem with the care they have received, it is our responsibility to investigate their concerns in order to determine the just outcome of their individual situation as well as to adjust our service delivery system as needed so that others do not experience the same response or outcome.

The Behavioral Health Department pledges that:

1. It is open to client challenges on service quality and service delivery and expects all staff to accept client concerns and act on them or refer the concern to someone who can act. This is a function of customer services with which we will aim for rapid response to concerns, thus diminishing the need for clients to resort to the grievance process.
2. All clients or would-be clients have the right to file a complaint.
3. Anyone filing a complaint will be treated with respect and fairness such that neither intimidation nor retaliation occurs.
4. That the procedure for filing such a complaint, provided below, will be posted where clients receive Behavioral Health care, provided at the time of admission and followed by Behavioral Health staff.
5. All clients may be assisted in the complaint process by a guardian, advocate, parent or other representative.
6. Any client filing a complaint will be informed by Behavioral Health staff of the supports available to aid in the complaint process.
7. That the procedures for filing such a complaint include a description of the means of resolution as well as the timeline for those steps.
8. That complaints will be reviewed in an objective, fair and timely fashion and with the goal of resolution.
9. That any complaints of abuse, neglect or unnecessary seclusion or restraint will be heard directly by the Health Board.
10. That confidentiality will be maintained throughout the grievance process and its conclusion.

PROCEDURES:

1. Complaints regarding Behavioral Health services may be given verbally, in person or by telephone, or in writing, including email, to any staff member at any TCC location. Contact information should be included if any response is requested. If an individual desires a written response, the complaint must be made in writing.
2. Anyone receiving such a complaint will communicate it to the TCC Patient Advocate, the Quality Assurance Manager for Behavioral Health or the Behavioral Health Director and notify the client that the complaint has been received and to whom it has been referred.
3. The information requested will be the name and client identifier, the date and location of the incident, the staff member involved, a description of the incident and the action requested.
4. The person filing the complaint will be informed of the complaint process including the accessibility of advocacy or other assistance including the Disability Law Center, NAMI or similar resource.
5. An investigation of the allegations will be initiated within 5 days of receipt and will be conducted by the TCC Patient Advocate, Human Resources, the Quality Assurance Manager for Behavioral Health, the Behavioral Health Director or an appropriate supervisor. Should circumstances delay the initiation of the investigation, a written explanation and time line will be provided.
6. A response will be provided within 30 days. Should resolution not occur, notification is to be provided to the State Division of Behavioral Health and technical assistance requested as appropriate.
7. Should the client be dissatisfied with the response, an appeal may be filed with the Health Services Director.
8. The appeal will be reviewed and a response provided within 10 working days.
9. Should the client continue to be dissatisfied by the outcome, a written appeal may be submitted to the President of TCC.
10. The President will respond in a timely manner.
11. Should the client continue to be dissatisfied with the outcome, the client may write to the Director of the Alaska Area Native Health Service for an appeal within the federal system.
12. Confidential files of all proceedings will be afforded all possible safeguards and will ultimately reside with the Quality Management Director. All documents related to the grievance are to be marked confidential and so marked and sealed when moving between offices. Those involved in the investigation will receive notification of confidentiality. There will be consequences for any breach of confidentiality as per TCC Personnel Policy 801, Personal Conduct.
13. The TCC Quality Management Council may review any or all complaints due to their oversight function.

IMPLEMENTATION:

Please note: This draft policy is subject to the review of the TCC Health Board for final approval.

1. A form will be developed for use in filing written complaints no later than 8/1/07. Upon approval, a signed receipt of this form will be included in each client file.
2. Upon approval, a copy of this policy and procedure will be posted in all service delivery areas.
3. Upon approval, all clients entering any Behavioral Health Department service will be provided a copy of this policy and the above referenced form.
4. Upon approval, all currently active clients will be provided with a copy of this policy and the above referenced form.

YUKON KUSKOKWIM
MENTAL HEALTH DIVISION

PATIENT INFORMATION

Please answer all questions. This information will remain confidential.

NOTICE OF NON-DISCRIMINATION **File Copy**

The Yukon Kuskokwim Health Corporation, Mental Health Department, wants every Alaskan to know that all of it's human service programs, whether administered by the Department or it's service agents, are conducted without regard to any person's race, color, national origin or handicap. The Department is firmly committed to full and positive compliance with the provisions of the Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitative Act of 1973.

For the information of all handicapped Alaskans, the Department does not discriminate against you, or if you know of any act of discrimination on account of race, color, national origin or handicap, please report the facts and circumstances to:

V.L. Iverson, Administrative Service Director
& Civil Rights Coordinator
Alaska Office Building, Room 304
Pouch H-02
Juneau, Alaska 99811

Or

U.S. Department of Health, Education & Welfare
Office for Civil Rights
Arcade Plaza Building – MS/508
1321 Second Avenue
Seattle, Washington 8101

GRIEVANCE POLICY:

In the event that a patient has a grievance with another patient or staff, it is recommended that the patient first talk to the person he/she has the grievance with. If the patient still feels dissatisfied, or is uncomfortable with this, he/she has the right to complete a grievance form that must be turned in to the Behavioral Health Administrator:

Laura Baez
Behavioral Health Administrator
Yukon-Kuskokwim Health Corporation
P.O. Box 528
Bethel, AK 99559

The Behavioral Health Administrator must respond to this written grievance within 3 working days. If the patient is still not satisfied with the Behavioral Health Administrator's decision, he/she may file another grievance form with the Yukon-Kuskokwim Health Corporation (YKHC) Administration:

Gene Peltola
Chief Executive Officer
Yukon-Kuskokwim Health Corporation
P.O. Box 528
Bethel, AK 99559

YKHC Administration will respond to this written grievance within 5 working days. This decision is final.

Immunity. Under AS 47.33.510 a person who files a complaint concerning a suspected victim of this chapter or of a regulation adopted under this chapter, or who testifies in an administrative or judicial proceeding arising from a complaint concerning a suspected violation of this chapter or of a regulation adopted under this chapter, is immune from civil liability for the filing or testifying unless the person acted in bad faith or with malicious purpose

ANCHORAGE REGION

ACCESS ALASKA
INDEPENDENT WELLNESS PROGRAM

ACCESS ALASKA INDEPENDENT WELLNESS PROGRAM
CONSUMER GRIEVANCE PROCEDURE

Policy

To provide a clear and accessible procedure for the effective resolution of consumer complaints or dissatisfaction with any aspect of treatment or services provided by Access Alaska.

Procedure

1. Consumers who express grievances (and/or their designated representative) will be encouraged to meet with the person(s) named in the grievance as the first attempt to resolve the problem. If a solution is reached which is satisfactory to the consumer, not further action is needed.
2. If the grievance is not resolved in the first step of the procedure, the consumer (and/or their designated representative) may request a meeting with the supervisor of the program or an appropriate designated representative. The meeting will be held within five (5) business days of receiving the consumer's request for the meeting. Prior to the meeting, the supervisor will consult with the person(s) named in the grievance to gather information about the first meeting and any solutions, if any, that were presented at that time. The consumer and supervisor will discuss the grievance and will attempt to reach a resolution satisfactory to all parties. Documentation of this meeting and any agreed corrective action will be completed and a copy given to the consumer. Information will be shared with the person(s) named in the grievance so that they may offer a response and are aware of the solution that was reached.
3. If the grievance is not resolved in the first two steps of the procedure, the consumer (and/or their designated representative) may request a private meeting with the Executive Director (or their designated representative). The meeting will be held within five (5) business days of receiving the consumer's request for the meeting. The Executive Director will be provided with notes from the previous meetings. Documentation of this meeting and any agreed corrective action will be completed and a copy given to the consumer. Information will be shared with the person(s) named in the grievance so that they may offer a response and are aware of the solution that was reached.
4. If the grievance is not resolved in the first three steps of the procedure, the consumer (and/or their designated representative) may request a meeting with the Board of Directors in an open or executive session to seek resolution of the grievance. All information and documentation from the previous meetings will be made available to the Board and diligent efforts will be made to resolve the situation to the satisfaction of all parties. Documentation of this meeting and any agreed corrective action will be completed and a copy given to the consumer. Information will be shared with the person(s) named in the grievance so that they may offer a response and are aware of the solution that was reached. The decision of the Board will be final with respect to Access Alaska.
5. If the grievance is not resolved in all of the above steps, the consumer (and/or their designated representative) may contact the Alaska Division of Behavioral Health. A copy of the formal grievance documentation will be forwarded to the Division of Behavioral Health. The phone number is 1-800-465-4828 or in Anchorage 907-269-3600.

(Please give this page to consumer)

(Please keep this page in consumer's file)

I understand and have received a copy of Access Alaska's Grievance Policy and Procedure.

_____ _____

Consumer Signature Date

_____ _____

Witness Signature Date

1-07 CLIENT GRIEVANCE PROCEDURE **AKEELA**

Effective Date: 1/1/2000
Revision Date: 06/20/2007

All clients have the right to file a formal grievance if they believe that their civil and/or human rights have been violated by Akeela, Inc. A staff person of Akeela, Inc. will help any client access the resources required to file a formal grievance. All formal grievances must be filed in writing.

Procedures for Grievance:
Any client who believes s/he has a grievance is encouraged to seek resolution through discussion with the appropriate program staff. If the client chooses this less formal process, a meeting will be scheduled within two (2) working days of the request. An agreed upon mediator will be selected to facilitate the discussion. The meeting will be held in private and will remain confidential.

If the grievance cannot be resolved in the meeting, the client may file the compliant in a written statement to the Program Manager or his/her designee. This written statement must be filed in five (5) working days following the initial meeting. If the complaint involves the Program Manager, the appropriate Director will conduct the investigation.

The Program Manager or designee shall meet with the client no later than five working days after receiving the written statement. If the grievance is resolved during this meeting, the client will be provided with a written report of the meeting and a copy will be given to the Human Resources Manager.

If the client does not feel that the issue has been resolved, s/he may appeal in writing to the appropriate Director within five days. That director has five days to review the findings and inform the client in writing of the final decision. If the issue involves the Director, the Deputy Director will review the matter using all of the same required timelines. Regardless of which of the clinical staff is involved in the grievance, the client may appeal any finding including the "final" finding to the Deputy Director. He/she has 30 days to review the matter and render a finding either supporting or overturning the Director's finding within 14 days of receiving the grievance.

The client will be informed in writing of the results of the grievance procedure. No client filing a grievance will be discriminated against or harassed. Grievance procedure time limits may be extended by mutual consent of the parties. An explanation of the grievance procedures will be given to the client prior to the beginning of the formal grievance process.

A client may, at any time, notify the Division of Behavioral Health of his/her grievance.

ALASKA CHILDREN'S SERVICES

ALASKA CHILDREN'S SERVICES
CONSUMER PROBLEM RESOLUTION

1. If you have a problem with the way in which you, your son/daughter or someone you care for is being treated at Alaska Children's Services, we encourage you to speak directly with the staff involved. We believe in communication and we want to hear from you. If your matter was not resolved at that level, you may contact the supervisor listed below:

_____	_____
Name of Supervisor	*Phone Number of Supervisor*

2. If the matter has not been addressed to your satisfaction, we encourage you to contact the Program Director listed below:

_____	_____
Name of Program Director	*Phone Number of Program Director*

3. At any time, you may request the assistance of a staff member at ACS or the assistance of an advocacy group to help you resolve the problem. The Director of Admissions can help you with this process.

_____	_____
Name of Director of Admissions	*Phone Number of Director of Admissions*

4. If problems persist following this, you may file a grievance with the Chief Executive Officer. Please contact the Compliance Officer to set up a time to discuss the matter. You can phone, email or use the form on the reverse side to set up this time.

Kristie Nelsen	**(907) 348-9271**	**knelsen@akchild.org**
Name of Compliance Officer	*Phone Number of Compliance Officer*	*E-mail of Compliance Officer*

Jim Maley	**(907) 348-9270**
Name of Chief Executive Officer	*Phone Number of Chief Executive Officer*

5. If you feel the issue has not been resolved, you may request a meeting with a member of the Board of Directors. Please contact the Compliance Officer again, this time to set up a time to discuss the matter with a Board Member.

6. If this does not work or it has been more than 30 days since you first brought the issue to our attention, we will contact the Division of Behavioral Health for assistance. The Compliance Officer will keep you informed.

7. If the processes listed above have not been effective, you have the right to contact the agencies listed below.

Office of Children's Services (Community Programs)..... 1-907-269-4000 (Anchorage)
Division of Public Health (Residential Services)..... 1-907-334-2493 (Anchorage)
The Joint Commission ..... 1-800-994-6610 or complaint@jcaho.org

By signing below, you are acknowledging receipt and understanding of the Grievance Procedure.

_____	_____
Signature	*Date*

_____	_____
Signature	*Date*

Original in Medical Record; Copy to Consumer

Student Name	Student #	DOB

ALASKA CHILDREN'S SERVICES
WRITTEN CONSUMER GRIEVANCE

At Alaska Children's Services, we believe in open communication and we encourage direct discussion before filing a formal grievance. If we can help you resolve the problem before filing a grievance, please contact the Compliance Officer, contact information on the reverse of this page.

Name: _____

Name of student currently in treatment: _____

Program student enrolled in (check one): ☐ **Residential** ☐ **CP**

Grievance: _____

_____

_____

_____

_____

_____

List ways in which you have tried to resolve the problem: _____

_____

_____

_____

_____

_____

Is there anyone that you would like to have help you with this grievance, such as an ACS staff member or an advocacy group such as OPA? If yes, you need to give us permission to release information to them. Our Intake Coordinator can help you find a good advocacy group if you don't know any.

The Compliance Officer will contact you within 24 business hours of receiving this form. Remember, you may also file a grievance by phone or by email.

_____ _____

Signature *Date*

Student Name	Student #	DOB

Alaska Children's Services

CONSUMER PROBLEM RESOLUTION AND GRIEVANCE PROCEDURES

POLICY

Alaska Children's Services (ACS) is committed to and fosters open communication among all of our stakeholders. Consumers who have a complaint or a disagreement involving any aspect of care or treatment are encouraged to seek immediate resolution.

DEFINITION

For purposes of this document, a consumer is the youth directly receiving services/treatment and his/her family/guardian. Clients denied services, placing workers and any third party with a legitimate interest will also be considered consumers and are entitled to initiate any procedure detailed in this document.

PROCEDURE

I. Consumers of any program or service at ACS, irrespective of funding source, or any third party with legitimate interest have the right to seek problem resolution without intimidation or fear of retaliation.

II. Consumers will be notified of their right to problem resolution or grievance procedure through the following:

A. At the time of admission, each youth, their family and placing worker (if appropriate) will be given a copy of the Consumer Problem Resolution and Grievance Procedure. The admitting staff member will also fill out a form summarizing the process and listing the names and contact information of all staff involved. On the reverse side of this form is a template that can be used to file a written grievance.

B. Admitting staff will review these documents and provide a verbal summary to the youth and other adults at admission. Procedures will be explained in a language understandable to all present. Staff will also be available to answer any questions.

C. The youth and adults will sign a form, to be filed in the medical record, documenting the receipt and their understanding of the policy and procedure.

D. If a consumer is denied services, the Director of Admissions has the responsibility to inform the consumer of their rights to problem resolution and grievance procedures.

III. All consumers are encouraged to begin the problem resolution procedures informally prior to the initiation of a formal grievance.

A. The consumer is encouraged to first discuss their complaint directly with the staff member. If the issue cannot be resolved at that level, the staff member or the consumer may request a discussion with the immediate supervisor.

B. If the consumer feels that the matter remains unresolved, he/she may contact the director of the program to request a problem resolution meeting. This meeting will be conducted within 5 business days of the request being made and can be conducted either in person or by telephone, consumer's preference.

IV. If the matter still remains unresolved following discussions with the respective program director, the consumer may file a grievance with the Chief Executive Officer (CEO).

A. A grievance may be filed in several ways including:

1. Use of the written form given to the consumer at admission

2. Conveying verbally the request for a grievance procedure either in person with the CEO, by phone or by email.

B. A consumer may designate through written consent and release of information, a representative or advocate to assist in all steps of the grievance process.

1. A consumer can request a specific ACS staff member to provide assistance, or

2. A written request will be made to an advocacy resource such as the Disability Law Center or NAMI-Alaska. The Director of Admissions maintains a current list of advocacy organizations and will provide them upon the request of the consumer. The consumer may use these resources at this or any stage of the grievance procedure.

C. The consumer will be notified by phone, email or by writing within 24 business hours of receipt of the grievance that resolution process has been initiated.

D. All effort will be made to conduct a meeting with the CEO within 5 business days from receipt of the grievance in the method preferred by the consumer, e.g. telephonic or in person. The consumer will be notified by phone or email and in writing of any need to extend these timelines.

V. If the matter remains unresolved following a meeting with the CEO, the consumer may request resolution through the President of the Board of Directors.

A. This level of grievance may be filed with the Compliance Officer in several ways including:

1. Use of the written form given to the consumer at admission

2. Conveying by phone or email the request for a grievance meeting.

B. The consumer will be notified within 24 business hours of receipt of the grievance that resolution process at this level has been initiated.

C. All effort will be made to conduct a meeting with the Board President or his/her designee within 5 business days from receipt of the grievance in the method preferred by the consumer, e.g. telephonic or in person. The consumer will be notified by phone or email and in writing of any need to extend these timelines.

VI. If the matter remains unresolved following either a meeting with the President of the Board of Directors or his/her designee or if 30 days have expired from the filing of the first level of the grievance procedure, the Compliance Officer will contact the Department of Health and Social Services, Division of Behavioral Health for technical assistance. The consumer will be immediately notified of this request.

VII. Should the complaint involve an allegation of abuse, neglect or unnecessary seclusion or restraint, the consumer may request that the grievance be taken immediately to the level of the Board of Directors. This can be done through contact with the Compliance Officer.

VIII. The Compliance Officer will maintain all documentation associated with the communication, filing, actions taken and resolution of the grievance. Following the resolution of the grievance, all documentation will be treated as any other part of the consumer medical record containing protected health information. (The reader is directed to the policies regarding the medical record and protected health information.)

IX. Consumer confidentiality will be maintained throughout the grievance procedure. Only with a signed release from the consumer will information be given to any third party, e.g. request for an advocate.

X. In addition to the procedures described above, any consumer or interested third party may contact the following organizations listed below:

A. State Licensing for Residential Services is the Division of Public Health (Anchorage: 1- 907-334-2493)

B. State Licensing for Community Programs is the Office of Children's Services (Anchorage: 1-907-269-4000)

C. The Joint Commission: by phone (1-800-994-6610) or by email (compliant@jcaho.org).

APPROVED: _____ _____
President and CEO *Date*

Revision implementation date:.....
Origination date: 08/01/07

ANCHORAGE
COMMUNITY MENTAL HEALTH SERVICES

2 July 2007

John Bajowski, MA
Behavioral Health Regional Specialist
Behavioral Health
Alaska Department of Health and Social Services
3601 C Street, Suite 878
Anchorage, AK 99503-5924

Re: Agency Grievance Policy and Procedure Request

Dear Mr. Bajowski:

The purpose of this letter is to forward you a copy of the ACMHS Policy and Procedure "Client Rights and Responsibilities," Policy Number 620-001-1, revised 27 April 2004 and the ACMHS Policy and Procedure "Client Grievances," Policy Number 620-002-1 revised 27 April 2004. These are being forwarded per request of Behavioral Health Director Melissa Witzler Stone on 27 June 2007.

ACMHS Policy and Procedure Number 620-001-1, "Client Rights," paragraph 14 states clients' have "The right to address grievances without fear of reprisal." Further, under "Client Responsibilities," paragraph 7, clients are responsible "To address concerns, complaints or grievances directly to agency staff and to reasonably work toward a satisfactory conclusion."

ACMHS Policy Number 620-002-1, "Client Grievances," formally outlines the grievance process.

We will review the "State Behavioral Health Requirement for Grantee Grievance Procedures," approved 18 June 2007, and make any necessary updates or clarifications. We will also note on referenced policies and procedures to automatically provide you a copy of any revisions. Please advise if additional information or action is needed at this time.

Regards,

Jerry A. Jenkins, M.Ed., MAC
Executive Director

Attachments
Cc: Melissa Witzler Stone, Director, Behavioral Health
Andrea Schmook, Director, Consumer Directed Services, ACMHS
Carol Mikos, Executive Coordinator, ACMHS

Client Rights and Responsibilities

Policy Number #620-001-1

EXECUTIVE DIRECTOR Date

Effective Date: November 15, 2001

Policy:

It is the policy of Anchorage Community Mental Health Services, Inc., to uphold and protect the rights of people receiving services from ACMHS programs.

Procedures

A person receiving services through ACMHS programs has the same legal rights and responsibilities guaranteed to all persons by the constitution and statutes of the United States and the State of Alaska. A form explaining this Policy will be presented for client review and acknowledgement of receipt by signature at his or her first meeting with a provider at ACHMS. The specific rights and responsibilities addressed are intended to be consistent with statutory and regulatory direction.

Client Rights

ACMHS will prepare a "Client Bill of Rights" that informs the public of all the rights recognized in this section. The Client Bill of Rights will be posted prominently in ACMHS service locations. Persons served at ACMHS shall have the following rights:

1. The right to receive appropriate and necessary mental health treatment without regard to race, religion, gender, age, place of origin, sexual orientation, marital status, or physical or mental abilities.

2. The right to be treated with full recognition of personal dignity, individuality, and the need for privacy, respect, and consideration.

3. The right to participate in formulating, evaluating, and periodically reviewing their individualized, written, treatment plan. This includes the right to request specific forms of therapy, and if not provided, to be informed why requested services would not be made available, as well as the right to refuse specific forms of services offered, and the right to be informed of treatment prognosis.

4. The right to examine all records of and plans for their treatment or treatment of their legal dependent within a reasonable time frame, and to ask for copies of any portion of these records (excluding information confidential to other individuals).

5. The right to be informed by the prescribing physician of the name, purpose and possible side effects of any medication prescribed as part of the treatment plan.

6. The right to request a copy of the treatment summary upon discharge, including follow up plans.

7. The right to request restrictions on the use or disclosure of protected health information.

8. The right to request confidential communications from SCC by alternate means or at an alternate location, e.g., e-mailing rather than calling or calling a neighbor or designee rather than calling home or work number.

9. The right to request an amendment of protected health information in client records.

10. The right to an accounting of all disclosures that may have been made of protected health information not relating to treatment, payment, or health care operations.

11. The right to confidentiality of all information pertaining to the client and the right of prior written approval for the release of identifiable information. As defined in HIPAA (Health Insurance Portability and Accountability Act), Protected Health Information may be used and disclosed without consent, authorization, or agreement when required by law to the extent that the use or disclosure complies with, and is limited to, the relevant requirements of such law.

    Records and information about clients shall be safeguarded and kept confidential with the following exceptions:

    a) requests by legal guardian;
    b) disclosures authorized or ordered by subpoena or court order or otherwise required by law (eg. mandatory report of child/elder abuse);
    c) requests by other emergency or health/mental health professionals in the event of an emergency that results in imminent danger to self or others;

d) disclosure to a designated hospital to which a client is involuntarily committed;
e) requests by insurance, medical assistance, or other programs to the extent necessary for clients to make a claim, or for a claim to be made on behalf of the client;
f) requests by the Division of Behavioral Health (DBH) or designated mental health professionals to conduct program analysis or on-site reviews of DBH grant-funded programs (requires signature of ACMHS Confidentiality Statement);
g) requests for agency-approved research or maintenance of health statistics (requires anonymity of data); and
h) disclosures authorized by written consent of the client.

12. The right to decline participation in experimental treatments, nonstandard treatment and participation in education or demonstration programs (eg. use of audio-visual equipment and one-way mirrors). Any participation shall only be allowed with the client's informed, voluntary, written consent and with documentation in the client record.

13. The right, in residential care, to communicate with others privately, to have convenient and reasonable access to the telephone and mails, and to see visitors during regularly scheduled hours.

14. The right to address grievances without fear of reprisal.

Client Responsibilities

Clients of ACMHS have the following responsibilities to ensure appropriate treatment:

1. To provide information about the present problem or complaint, past illnesses, medications, and relevant history.

2. To provide complete and accurate information to insure a current file.

3. To ask questions about any information not understood.

4. To take an active role in treatment (this includes families or guardians in

the case of minor clients) and to follow mutually developed and agreed upon treatment plans.

5. To arrive on time for appointments and to provide at least 24 hours advance notice to cancel an appointment.

6. To act with consideration and respect for others, including respect for the confidentiality of other clients encountered during the course of services.

7. To address concerns, complaints or grievances directly to agency staff and to reasonably work toward a satisfactory conclusion.

8. To immediately report abuse or other unethical or unprofessional staff behavior to the Consumer Advocate, Executive Director, or other appropriate staff.

9. To fulfill financial obligations.

(Revision 11/05/2001)
(Revision 1/4/2001)
(Format revision 07/24/98)
(Revision 06/30/01)
(Revisions presented to Board 11/15/01)
(Revision 04/27/2004)

ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES, INC. CLINICAL POLICIES AND PROCEDURES MANUAL	NO. 620-002-1 Page 1 of 3
SUBJECT: CLIENT GRIEVANCES	
EXECUTIVE DIRECTOR'S APPROVAL:	DATE: 3/27/2004 Rev.

Policy:

It is the policy of Anchorage Community Mental Health Services, Inc., (ACMHS) to treat all of our clients with dignity, respect, individuality, and with consideration for privacy. ACMHS shall provide all of its clients a constructive process for addressing grievances in a respectful, timely, and impartial manner without fear of retribution.

Procedures:

1. Clients are requested to thoroughly review the form entitled *Client Rights and Responsibilities.* This form will be presented for client signature at time of entry to ACMHS services.

2. Clients are encouraged to discuss any concerns or grievances they have about their care and treatment at ACMHS with their primary provider and/or that person's supervisor to seek resolution.

3. If the problem cannot be resolved as described in Procedure #2, the client should document their grievance in writing by briefly describing the grievance and submit it in a sealed envelope to the Consumer Advocate.

4. Clients or family members may designate a representative/advocate to assist them and be present during any/all grievance proceedings.

5. Upon request, ACMHS will provide assistance to clients who wish to file grievances.

6. ACMHS will inform clients interested in filing grievances of advocacy resources including the Disability Law Center, the Alaska Mental Health Consumer Web, NAMI Anchorage and NAMI Alaska, or any other known resource.

7. It is the responsibility of the Director of Care Management to review all client grievances and report findings in writing to the Executive Director and to provide quarterly reports to the ACMHS Board of Directors' Corporate Operations Committee.

8. The Director of Care Management will send a letter of acknowledgment within five (5) working days of receiving the grievance, informing the client that the grievance has been received and that the prescribed internal review procedure is in process and a written response to the grievance will be provided within 20 working days after the investigation begins.

9. The status of findings and proposed resolution will be communicated in writing to the client not later than twenty (20) working days after the investigation begins, or after moving a grievance to the next level. If unable to resolve the grievance in twenty (20) working days, ACMHS will explain the delay in writing to the client.

10. For clients receiving publicly funded services, grievances unresolved to the client's satisfaction within thirty (30) calendar days shall be reported to the Division of Behavioral Health (1-800-465-4828 or 907-465-3370).

11. Individuals may file a complaint with ACMHS and the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated.

12. ACMHS has a "no tolerance" policy regarding abuse or neglect as well as intimidation to prevent the filing of a grievance or retaliation for filing a grievance. Any report of abuse, neglect, intimidation or retaliation shall be investigated and immediately reported to the Executive Director and the ACMHS Board of Directors through the Corporate Operations committee. For clients receiving publicly funded services, the same will be reported to the Division of Behavioral Health.

13. The Client Grievance Redress policy will:
    a. be available to all clients, legal guardians and to those denied services;
    b. be signed and copied to client or legal guardian and client's file; and
    c. be prominently displayed in all ACMHS facilities.

14. The Director of Care Management will utilize client grievance information to track and trend grievances. The Director of Care Management shall incorporate the monitoring of grievances in the ACMHS Quality Management Plan (QMP).

(Format revision 07/24/98)
(Revised 04/27/2004)

ARC
ANCHORAGE

the Arc of anchorage
2211 Arca Drive • Anchorage, Alaska 99508

(907) 277-6677
Fax (907) 272-2161
TTY (907) 258-2232
E-mail: info@arc-anchorage.org
www.arc-anchorage.org

July 19, 2007

John Bajowski
Division of Behavioral Health
3601 C Street, Suite 878
Anchorage, AK 99503

Mr. Bajowski,

We received a letter from Ms. Stone, Director of Behavioral Health with the State of Alaska, requesting that we submit a copy of our grievance P&P to our Regional Specialist by July 31st, 2007. Please find those P&P's enclosed.

Thank you,

Rachel Faralan
Behavioral Health Services Director

Encl.

The Arc of Anchorage Recovery Center (AARC) | Management

Subject	Section #:	Page #:	Replaces:
Consumer/Guardian Grievance Procedures	2.01	1 of 1	All Prior
		Updated: 05/01/07	Effective Date: 12/01/04

Standard:

It is The Arc of Anchorage Recovery Center's (AARC) policy that all consumers of The Arc service have the right to pursue a grievance with regard to their participation in a program.

Procedure:

1. The first step is to bring the grievance to a staff member, except in cases of verbal and physical abuse, in which case the grievance should be reported directly to the Team Leader.

2. If the issue remains unresolved after two working days, after raising it with a staff member, consumers may then bring their grievance, written or verbal, to the Team Leader.

3. If the issue remains unresolved after two more working days, after raising it with the Team Leader, consumers may then bring their grievance, written or verbal, to the Director of Behavioral Health.

4. After all the above steps have been followed, the Associate Director of Individual Services will accept and review an official written grievance.

5. If the grievance reaches the Associate Director, a written response explaining the final decision regarding the consumer's grievance will be returned to the consumer/guardian within two weeks of receiving the grievance.

6. In most cases the decision of the Associate Director is final. Consumer/guardian may appeal the decision to the Executive Director. In all cases the decision of the Executive Director will be final.

7. Consumers have the right to be represented by an advocate and/or Disability Law Center. A signed release of information will be required in order for Arc staff to discuss the grievance with any advocates.

8. Any person making a complaint is immune from civil liability for the filing of the complaint or for testifying unless the person acted in bad faith or with malicious purpose.

CONSUMER/GUARDIAN GRIEVANCE PROCEDURES

The Arc's policy is that all consumers of The Arc services, both primary and secondary;

a. Have the right to pursue a grievance with regard to their participation in a program.
b. Have the right to be notified in writing, within 30 days after the filing of the grievance, of the final decision of The Arc regarding the grievance.
c. Are protected from retaliation if they;
    1. exercise the right to file a grievance.
    2. appear as a witness, or refuse to appear as a witness, in an adjudicatory proceeding regarding The Arc.
    3. file a civil action alleging a violation of assisted living licensing statutes; or
    4. claims a violation of assisted living licensing statutes before a state or federal agency having jurisdiction over the home or its employees.

The procedures for grievances are as follows:

1. The first step is to bring the grievance directly to a staff member, except in cases of verbal and physical abuse, which we ask that you report directly to the Program Director.

2. If the issue remains unresolved after two working days, after raising it with a staff member, consumers may then bring their grievance, written or verbal, to the Program Director.

3. After all the above steps have been followed, the Associate Director of Consumer Services will accept and review the official written grievance.

4. If the grievance reaches the Associate Director, a written response explaining the final decision regarding the consumer's grievance will be returned to the consumer/guardian within two weeks of receiving the grievance.

5. In most cases the decision of the Associate Director is final. Consumers/guardian may appeal the decision to the Executive Director. In all cases the decision of the Executive Director will be final.

6. Consumers have the right to be represented by an advocate and/or Disability Law Center. A signed release of information will be required in order for Arc staff to discuss the grievance with any advocates.

7. Any person making a complaint is immune from civil liability for the filing of the complaint or for testifying unless the person acted in bad faith or with malicious purpose.

_____ _____

Signature of Consumer Witness (Staff of The Arc of Anchorage)

_____ _____

Date Date

_____

Signature of Parent/Legal Guardian

_____

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF BEHAVIORAL HEALTH

SARAH PALIN, GOVERNOR

ANCHORAGE OFFICE
3601 C Street, Suite 878
ANCHORAGE, ALASKA 99503-5924
PHONE: (907) 269-3600
FAX: (907) 269-3623
TOLL FREE: (800) 770-3930

June 27, 2007

ARC of Anchorage
2211 Area Drive
Anchorage AK 99503

RE: Agency Grievance Policy & Procedure

Dear Gwendolyn Lee

In a continuing effort to maintain complete and updated grantee records Behavioral Health needs to receive a copy of your agency's Grievance Policy and Procedure. Alaska Administrative Code, 7 AAC 71.220, states that "a center must establish a grievance procedure by which a client may seek redress of grievances. A copy of the center's grievance procedure must be filed with the department and posted at the center."

As you know, the mission of Behavioral Health is to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships. Confirming that consumer complaints are properly handled is an important element in Behavioral Health's management of the behavioral health system. As a partner in providing effective consumer care we need to know and understand your agency's grievance procedure.

Attached to this letter is a copy of DHSS Behavioral Health policy and procedure: "Requirements for Grantee Grievance Procedures". This policy is based upon the Standards adopted by both Behavioral Health and the Alaska Mental Health Board in 2002 which were subsequently included as Conditions of Grant Award for 2002- 2004.

Please submit a copy of your grievance P&P to your BH Regional Specialist by July 31, 2007.

We appreciate your dedication and service to the peoples of Alaska.

Respectfully,

Melissa Witzler Stone,
Director Behavioral Health

ASSETS

Assets, Inc.

Date: 7/3/07
To: John Bajowski
BH Regional Specialist

From: Matthew J. Jones M.A.
Executive Director

Re: complaint /grievance procedure. As requested by Division

John, our process was developed by a committee of clients several years ago. It was updated after the creation of the service Integrity Position here at Assets.

Please advise if it does not meet the spirit of the division's intent.

thanks

Assets, Inc.

Matthew J. Jones M.A., Executive Director

Service Complaint/Resolution Process

Are you dissatisfied with the services you receive from Assets?

Here is what you can do:

1. Tell the person who is giving you poor service what you want to change about the services you receive.

2. If the change(s) you requested don't happen within one week, ask to meet with the Director of Service Integrity, who will document your complaint and help you resolve your situation. ***Please note:*** ***If you are a client who is also an employee, you may consider consulting with the Director or Human Resources.*** The Department Director will be informed of complaint and consulted for further assistance, if needed, to resolve your complaint. The Director of Service Integrity will provide a written response within one week, or an explanation if more time is required, noting what follow up was done.

3. If your situation is still not resolved, ask to meet with the Executive Director who will attempt to resolve the situation to your satisfaction. The Executive Director will respond in writing within five days or provide an explanation if more time is required.

4. At any time, you may call the Disability Law Center of Alaska (phone number 344-1002) or any other advocacy organization or person to represent you in seeking resolution to your complaint.

This process has been established to ensure that all persons receiving funded services from Assets have a means by which to exercise their right to file a complaint about their services. Assets is committed to hearing and attempting to resolve all complaints in a fair and timely manner. All information related to your complaint will be kept separate from normal client files.

Your right to complain is protected by Assets' company policy, Department of Health and Social Services grant requirements and Alaska State law. No employee of Assets, Inc. may retaliate or try to get you in trouble because you have made a complaint. Your signature below means that you understand this complaint process and have been given a copy of it. Please check the box if you give us permission to share your complaint with those staff who need to be involved in resolving your complaint which may include the specific person with whom you are dissatisfied.

☐ Permission to share

_____ _____

Service Recipient or Representative Date

_____ _____

Assets Representative Date

CHOICES

CHOICES, Inc.
Clinical Policies and Procedures

Grievance Procedure for People Served by CHOICES, Inc.

Policy Number #620-002-1

James Gottstein
Choices, Inc. Board President

Date: 7-27-07

Effective Date:

Policy:

It is the policy of CHOICES, to encourage and support the right of people receiving services from CHOICES, Inc. to file a grievance when dissatisfied with those services.

It is the policy of CHOICES, to treat all people we serve with dignity, respect, individualit, and with consideration for their privacy. CHOICES, will provide all of its clients a practical course of action for addressing grievances in a respectful, timely, and impartial manner without fear of retribution, threat, harassment, intimidation, discontinuation, or withholding of services by any employee of CHOICES,.

Procedures:

1. People receiving services provided by CHOICES, their interested family members, and/or supporters are requested to thoroughly review the policies entitled **Rights and Responsibilities of People Served by CHOICES, Inc.** and **Grievance Procedure for People Served by CHOICES, Inc.** A form will be presented for signature to people establishing services with CHOICES, at the time of their entry into care, acknowledging receipt, and understanding these policies and procedures. This form will provide a provision for the waiving of confidentiality by the person filing the grievance. This form will be maintained as part of the person's clinical record.

2. People receiving services provided by CHOICES, are encouraged to discuss any suggestions, concerns or grievances they have about their care and treatment at CHOICES, with their primary provider and/or that person's supervisor to seek resolution.

3. People receiving services at CHOICES, or family members may designate a representative/advocate to assist them and be present during any/all grievance proceedings.

4. If the problem cannot be resolved as described in Procedure #2, the client should fill out the *Client Grievance Form,* seal it in an envelope, and give it to the receptionist at CHOICES' office. A notice will be issued acknowledging delivery of the grievance and noting the start date of the resolution process.

5. People served by CHOICES wishing to file grievances by email may do so by accessing the Suggestions/Concerns/Grievances link on CHOICES website @ www.CHOICES-AK.org. A notice will be emailed, and sent by postal mail if a physical address is provided, acknowledging receipt of the grievance and noting start date of the resolution process.

6. People served by CHOICES wishing to file a grievance over the phone may do so by dialing (907) 333-4343 and informing the receptionist they wish to file a grievance telephonically. A notice will be mailed acknowledging receipt of the grievance and noting start date of the resolution process.

7. If requested, CHOICES will provide confidential support to clients who need assistance in the filing of a grievance or make referral to a mental health advocacy group that provides such assistance. This assistance includes, but is not limited to, support for individuals with physical or other limitations that need aid in transcribing their oral grievance.

8. CHOICES, will inform clients interested in filing grievances of advocacy resources including the Disability Law Center, the Alaska Mental Health Consumer Web, NAMI Anchorage and NAMI Alaska, or any other known resource.

9. It is the responsibility of the Project Manager to review all client grievances and report findings in writing to the Executive Director and to the CHOICES Board of Directors.

10. The Project Manager will send a letter of acknowledgment within five (5) days of receiving the grievance, informing the client that the grievance has been received and that the prescribed internal review procedure is in process.

11. If CHOICES is unable to adequately initiate resolution of the grievance within five (5) days of receipt of the grievance a written notification shall be sent to the person filing the grievance explaining why and outlining the steps being taken to do so.

12. If CHOICES is unable to adequately initiate satisfactory resolution of the grievance within five (5) days of the receipt of the initial grievance the grievance shall be forwarded to the Executive Director for further investigation and mediation

13. If CHOICES is unable to initiate satisfactory resolution of the grievance, through investigation and mediation by the Executive Director, within fifteen (15) days of the receipt of the grievance, the grievance shall be forwarded to the CHOICES Board of Directors for investigation and mediation.

14. All grievances received by CHOICES will be resolved to the satisfaction of the person filing the grievance within thirty (30) days after the receipt of the grievance. All grievances remaining unresolved at the end of thirty (30) days will be referred to the Division of Behavioral Health (1-800-465-4828 or 907-465-3370) for technical assistance within five (5) business days after the end of the initial thirty (30) day resolution period.

15. All grievances received by CHOICES involving allegations of physical or emotional abuse, neglect or physical restraint shall bypass the above process and be immediately referred to the CHOICES Board of Directors for investigation and resolution.

16. Individuals may file a complaint with CHOICES and the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated.

17. CHOICES has a "no tolerance" policy regarding abuse or neglect, as well as, retribution, threat, harassment, intimidation, discontinuation, or withholding of services by any employee of CHOICES designed to prevent the filing of a grievance. Any report of the above will be immediately investigated and reported to the Executive Director and the CHOICES Board of Directors upon the receipt of the complaint. Allegations of shall result in the immediate suspension of the involved employee(s). Substantiated allegations shall result in the immediate termination of the involved employee(s). For clients receiving publicly funded services, the same will be reported to the Division of Behavioral Health Investigations Unit.

18. The **Rights and Responsibilities of People Served by CHOICES, Inc.** and **Grievance Procedure for People Served by CHOICES, Inc** will:
    a. be available to all clients, legal guardians and to those denied services;
    b. be signed and copied to client or legal guardian and client's file; and
    c. be prominently displayed at CHOICES facilities.

19. The Project Manager will maintain information necessary to track grievances in a manner consistent with existing HIPPA standards and policies

regarding the storage and maintenance of clinical records. The information will be utilized in updating the Quality Management Plan (QMP).

COOK INLET
TRIBAL COUCIL INC

COOK INLET
TRIBAL
COUNCIL, INC.

3600 SAN JERONIMO DRIVE, ANCHORAGE, ALASKA 99508

FAX: (907) 793-3602

PHONE: (907) 793-3600

Cook Inlet Tribal Council, Inc.
CLIENT GRIEVANCE STEPS

If an event occurs that results in a grievance, a CITC Client is to follow the steps outlined below.

Step 1 **INFORMAL DISCUSSION**

a. Contact the CITC Staff with whom issue arose for an informal talk. For HIPAA confidentiality issues, contact the CITC Client Rights and Privacy (CRP) Officer, 3600 San Jeronimo Drive, Anchorage, AK 99508, Tel (907) 793-3404 or (907) 793-3413.

→ Reach agreeable solution for Client and Staff at the earliest possible time.

HIPAA only

b. If complaint is not resolved with Staff, contact the Staff's Supervisor, Program Director, Department Director, or any combination thereof, for informal talk.

→ Reach agreeable solution for Client and Staff at the earliest possible time.

[If the grievance is not resolved in Step 1, go to Step 2.]

Step 2 **FORMAL WRITTEN COMPLAINT**

Prepare and submit a written Formal Complaint to the CRP Officer, 3600 San Jeronimo Dr., Anchorage, AK 99508.

Step 2 Deadline: Must be submitted within 30 calendar days from the date the event occurred.

Step 3 **ADMINISTRATIVE REVIEW**

Contact the CRP Officer (or external independent investigator) who will conduct an Administrative Review, report results to the Client, and develop a written Agreement with the Client.

→ Reach agreeable solution for Client and Staff.

Step 3 Deadline: Step 3 must be completed within 30 calendar days for HIPAA and 45 calendar days for all other complains from the date of receipt of Client Formal Complaint.

[If the grievance is not resolved in Step 3, go to Step 4. Client has the option to skip Step 4 and go directly to Step 5.]

Step 4 **MEDIATION**

Submit a written request for Mediation to CRP Officer. Mediation is conducted. Written MediationAgreement is developed and signed with Client.

→ Reach agreeable solution for Client and Staff.

Step 4 Deadline: Submit Client Request within 30 calendar days from receipt of notice on last grievance step Step 4 completed within 45 calendar days from receipt of Client Request in Step 4.

[If the grievance is not resolved in Step 4, go to Step 5.]

Step 5 **ADMINISTRATIVE HEARING**

Submit a written request for an Administrative Hearing to CRP Officer. Administrative Hearing is conducted and written decision issued. **Decision is final.**

→ Reach agreeable solution for Client and Staff.

Step 5 Deadline: Submit Client Request within 30 calendar days from receipt of notice on last grievance step. Step 5 completed within 45 calendar days from receipt of Client Request for Step 5.

NOTE: A Client who has a grievance, is expected to follow the CITC Grievance policy options before pursuing external resolution of a complaint. This Chart is a summary of the CITC client grievance process. CITC Policy No. 3.100 "Client Grievance," approved by the CITC Board of Directors, February 27, 2004, should be read in its entirety for full information.

POLICY: CLIENT GRIEVANCE

Policy No.:	3.100
Effective Date:	Feb 27, 2004
Supercedes Previous Pol. No.:	630 and all other previous CITC client grievance procedures.
Previous Pol. No. 630 Date:	Oct 12, 2000
Pol No. 4.100 Approved Date:	Feb 27, 2004

I. PURPOSE

Cook Inlet Tribal Council, Inc. (CITC) respects the rights of clients and will assist clients in resolving any complaints arising from a real or perceived violation of client rights through a fair, impartial and orderly process.

II. SCOPE

This policy applies to all CITC clients and supercedes all other client grievance policies and procedures that CITC had at the time this policy was adopted.

III. DEFINITIONS

A. **Client.** A person of any age who is either currently receiving services or has received services from CITC. "Client" also includes a client's designated representative such as family members, care-givers and support persons.

B. **Client Rights and Privacy Officer ("CRP Officer").** A CITC employee, appointed by the CITC President/CEO and is the key compliance officer for all federal and state human rights laws including those that apply to the privacy (confidentiality) of patient/client information pursuant to HIPAA, 42 U.S.C. Par. 290dd-3 implementing regulations and 42 C.F.R. Part 2 and client rights.

C. **Complaint.** Formal charge or accusation made by a client arising from unjust treatment as a result of policies or actions such as but not limited to confidentiality, non-discrimination, staff conduct, client conduct of the department, a department service offered, or lack of access to an offered service.

D. **Grievance.** A circumstance thought to be unjust or injurious and grounds for a complaint.

E. **HIPAA. Health Insurance Portability and Accountability Act of 1996** (federal law) Contains provisions for safeguarding the privacy and confidentiality of patient/clients' protected health information. It applies to CITC's covered programs: Tribal Vocational Rehabilitation; Substance Abuse Services' Residential Treatment Center; First Step Assessment Center; Family Treatment Center; Mobile Treatment Unit; Clare Swan; Recovery Journey; Wisdom Place; Re-entry/Pathways to Sobriety; Family Service Department's Clinical Services; Program Evaluation; Shared Services Accounting Department Billing Unit; and Shared Services Information Technology Services.

IV. POLICY

A. **Policy Statement**. It is the policy of Cook Inlet Tribal Council, Inc. (CITC) that a current or past client who has a real or perceived grievance arising from unjust treatment at CITC as a result of policies or actions such as but not limited to (a) non-discrimination, (b) conduct of staff, (c) conduct of clients of the department, (d) a department service offered or determination, (e) lack of access to a service offered; or (f) confidentiality is entitled to protest the policies or actions and participate in a process to resolve the dissatisfaction through an orderly CITC internal grievance procedure. **All** CITC services and programs are dependent upon grant agency and donor funds, and eligibility for such services and program participation is dependent upon the terms and conditions of the respective funding sources.

The original document will be kept by CITC and a copy issued to the client. The CITC Client Grievance Policy and Procedures will be posted in every building where CITC provides programs and services.

E. **Costs.** CITC will not pay legal fees that may be incurred by a client involved in an informal or formal grievance with CITC. CITC will pay for its mediation expenses but not the costs for client representation.

F. **Disability Accommodation.** The applicable CITC program shall make disability-related accommodation to the extent required under applicable law to assist an individual in the conduct of a client grievance.

G. **Client Services During Complaint Resolution.** Pending a final resolution of a complaint, no service may be reduced or terminated unless the services were obtained through misrepresentation, fraud or collusion or the individual or authorized representative requests suspension, reduction, or termination of services.

H. **Employee Disciplinary Action.** If a CITC employee is determined to be in violation of the CITC's policies, including CITC's HIPAA Use and Disclosure Policy and Procedures (CITC Policy No. 2.100), the employee will be subject to discipline, up to and including termination of employment.

V. TIME LIMITS

The time limits stated in the CITC Client Grievance Policy and Procedures are mandatory.

VI. CONTACT

CITC Client Rights and Privacy Officer (CRP Officer): Cook Inlet Tribal Council, Inc., 670 West Fireweed Lane, Anchorage, AK 99503, telephone: (907) 265-5900.

VII. PROCEDURES

There are several options to assist a client in resolving a complaint arising from a real or perceived violation of client rights during any and all stages of client participation in the delivery of CITC programs and services. Every effort should be made to resolve the client grievance at the earliest possible time. If the complaint is not resolved through Informal Discussion, a client may follow the Formal Complaint Procedures.

Step 1. Informal Discussion

The client, before submitting a Formal Complaint, should attempt to resolve the complaint through Informal Discussion so that no further action is required. The client is to request a meeting with the CITC employee against whom the complaint is aimed or with the person who is most involved in the conditions resulting in the complaint; or, the client may request a meeting with the employee's supervisor or program director or department director.

If a client contacts an employee other than the one against whom the complaint is aimed, the client is to be referred to the CRP Officer. It is the responsibility of the CRP Officer to direct the client to the appropriate employee against whom the complaint is aimed.

Confidentiality Complaints. If the complaint involves a matter of HIPAA confidentiality, it must be directed to the CRP Officer. The CRP Officer will investigate the alleged privacy violations and

Mediation is an alternative dispute resolution method available to clients as another means of resolving a complaint when a CITC Administrative Review has not resolved the dispute to the satisfaction of the aggrieved client.

Mediation discussions are confidential and may not be used as evidence in a subsequent due process hearing, nor may mediation be used to deny or delay the client's right to pursue an impartial hearing, provided that the client has signed a written confidentiality agreement.

Participation in Mediation is voluntary on the part of the client and CITC. Either party may reject Mediation as an alternate dispute resolution method. Either party, once accepting Mediation, may terminate the mediation process with or without cause upon submission of a written notice to the other party.

Mediation Procedure:

1. The aggrieved client must submit (a) a written request for Mediation to the CRP Officer that clearly states the reason for dissatisfaction with the results of the Administrative Review, signed and dated, and (b) a written confidentiality agreement that mediation discussions shall remain confidential. Mediation must be requested by the client within thirty (30) calendar days from the issued Administrative Review notice of results; otherwise, mediation is not an option.

2. The CRP Officer will request the department director or division vice president who is not directly related to the issue that created the client's dissatisfaction to represent CITC in the mediation.

3. The CRP Officer will select randomly a name from an external independent mediator list maintained by CITC.

4. The Mediator will
   a. Arrange and conduct the mediation session with the aggrieved client and the CITC representative. Mediation must be conducted within twelve (12) calendar days from receipt of the client's written request for Mediation or at a time mutually agreed to by the parties involved. The entire review must be completed within forty-five (45) days, unless the parties agree to a specific time extension. If the Mediation is not conducted within thirty (30) calendar days from the submission of the written request due to undue delays by the client, the client's request for Mediation will be declared invalid.

   b. Prepare a written Mediation Agreement, if agreement between the parties is reached, signed and dated by the client, the Mediator and the CITC representative.

   c. Submit a copy of the signed and dated Mediation Agreement to the client, CITC representative and the Department Director.

Step 5. Administrative Hearing

An Administrative Hearing is a procedure whereby the aggrieved client who is dissatisfied with any determination concerning his/her complaint may present testimony and evidence or arguments, including testimony and evidence or arguments to the contrary, and seek a final determination from an impartial CITC Administrative Hearing Committee or Hearing Officer. This step may be selected by the client after a concluded Administrative Review and either before or after the Mediation step in the client grievance procedure.

believe to be in violation of the applicable requirements of HIPAA; and (3) be filed within 180 days of when the client knew or should have known that the act or omission occurred, unless this time limit is waived by the Office for Civil Rights ("OCR") for good cause shown. Complaints to the Secretary may be filed only with respect to alleged violations occurring on or after April 14, 2003.

The Secretary (of "DHHS") has delegated to the "OCR" the authority to receive and investigate complaints as they may relate to HIPAA. A client may file a written complaint with the OCR by mail, fax, or e-mail at the addresses listed below. Clients may, but are not required to, use the OCR's Health Information Privacy Complaint form. To obtain a copy of this form, or for more information about the Privacy Rule or how to file a complaint, contact an OCR office or the internet address: www.hhs.gov/ocr/hipaa/. Address written complaints to: Region X, Office for Civil Rights, U.S. DHHS, 2201 Sixth Avenue, Suite 900, Seattle, WA 98121-1831. TEL (206) 615-2287. FAX (206) 615-2297. TDD (106) 615-2296. For all complaints filed by e-mail, send to: OCRComplaint@hhs.gov. For further information contact Lester Coffer, OCR, DHHS, Mail Stop Room 506F, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. TEL (202) 205-8725.

COOK INLET TRIBAL COUNCIL
Substance Abuse Services
Policy & Procedures Manual

SECTION: 200 SUPPORT SERVICES
200C **PATIENT RIGHTS**

NUMBER: 200.7C **PATIENT GRIEVANCES**

DATE: OCTOBER 2002
Revised August 2004
Review: August 2007
(CARF and CITC board 2008)

POLICY:
SAS shall comply with Cook Inlet Tribal Council, Inc. Corporate Policy No: 3.100 and all outlined Procedures pertaining to Client Grievances.

STANDARDS: CARF

POLICY: CLIENT GRIEVANCE **Policy No.:** **3.100**
Effective Date: Feb 27, 2004
CORPORATE POLICY
Supercedes Previous Pol. No.: 630 and all other previous CITC client grievance procedures. Previous Pol. No. 630 Date: Oct 12, 2000 Pol No. 4.100 Approved Date: Feb 27, 2004

I. PURPOSE

Cook Inlet Tribal Council, Inc. (CITC) respects the rights of clients and will assist clients in resolving any complaints arising from a real or perceived violation of client rights through a fair, impartial and orderly process.

II. SCOPE

This policy applies to all CITC clients and supercedes all other client grievance policies and procedures that CITC had at the time this policy was adopted.

III. DEFINITIONS

A. **Client.** A person of any age who is either currently receiving services or has received services from CITC. "Client" also includes a client's representative such as family members, care-givers and support persons.

B. **Client Rights and Privacy Officer ("CRP Officer").** A CITC employee, appointed by the CITC President/CEO and is the key compliance officer for all federal and state human rights laws including those that apply to the privacy (confidentiality) of patient/client information pursuant to HIPAA, 42 U.S.C. Par. 290dd-3 implementing regulations and 42 C.F.R. Part 2 and client rights.

C. **Complaint.** Formal charge or accusation made by a client arising from unjust treatment as a result of policies or actions such as but not limited to confidentiality, non-discrimination, staff conduct, client conduct of the department, a department service offered, or lack of access to an offered service.

D. **Grievance.** A circumstance thought to be unjust or injurious and grounds for a complaint.

E. **HIPAA. Health Insurance Portability and Accountability Act of 1996** (federal law) Contains provisions for safeguarding the privacy and confidentiality of patient/clients' protected health information. It applies to CITC's covered programs: Tribal Vocational Rehabilitation; Substance Abuse Services' Residential Treatment Center; First Step Assessment Center; Family Treatment Center; Mobile Treatment Unit; Clare Swan; Recovery Journey; Wisdom Place; Re-entry/Pathways to Sobriety; Family Service Department's Clinical Services; Program Evaluation; Shared Services Accounting Department Billing Unit; and Shared Services Information Technology Services.

IV. POLICY

A. **Policy Statement**. It is the policy of Cook Inlet Tribal Council, Inc. (CITC) that a current or past client who has a real or perceived grievance arising from unjust treatment at CITC as a result of policies or actions such as but not limited to (a) non-discrimination, (b) conduct of staff, (c) conduct of clients of the department, (d) a department service offered or determination, (e) lack of access to a service offered; or (f) confidentiality is entitled to protest the policies or actions and participate in a process to resolve the dissatisfaction through an orderly CITC internal grievance procedure. **All** CITC services and programs are dependent upon grant agency and donor funds, and eligibility for such services and program participation is dependent upon the terms and conditions of the respective funding sources.

B. **Client Rights and Responsibilities**

1. Rights. A client has a right to:
   a. be treated with respect;
   b. be treated without regard to race, age, color, sex, religion, national origin, disability, marital status, parental status, changes in marital status pregnancy, socioeconomic status, language or status as a Viet Nam Era or special disabled veteran, or other protected classification under local, state or federal law;
   c. be treated without regard to disability unless treatment being provided by CITC makes treatment hazardous to the individual;
   d. have all personal information treated in a confidential manner; provided, however that only protected health information maintained by covered programs shall be subject to CITC's HIPAA Policies or HIPAA use and Disclosure Procedures;
   e. review his/her file with an appropriate staff present;
   f. be fully informed regarding any and all fees associated with his/her services received from CITC;
   g. be given clear information regarding participation in all program activities, i.e., attendance, completion requirements;
   h. be treated without fear of reprisals;
   i. fair and impartial resolution of issues that may arise in the delivery of CITC programs or services to the client; and
   i. if denied direct assistance or services be provided with a written explanation regarding the reasons for denial and indication as to what issues need to be resolved for re-application or reinstatement.
2. Responsibilities. A client has the responsibility to:

a. treat CITC employees with respect;
b. be accurate and complete as possible when providing information to a CITC employee;
c. submit complaints that are not frivolous (trivial);
d. abide by CITC program/service rules and regulations in which the client is applying to enter;
e. actively participate in decisions and perform those activities made in the decision-making process regarding any services received from CITC;
f. inform the appropriate CITC employee of any changes in client information such as name, address, or income changes, etc.
g. abide by CITC's Client Grievance Policy and Procedure; and
h. ask for clarification regarding any CITC services received but not understood by the client.

C. **Client Complaint Resolution**. All client complaints will be reviewed fairly and impartially. No specific form is necessary to file a grievance; however a complaint must be in writing.

Confidentiality - If the grievance involves breaches of patient/client confidentiality regarding HIPAA requests to amend, for an accounting, for access, for a restriction, and for alternative communications, it shall be processed in accordance with the CITC HIPPA Use and Disclosure Policy and Procedure (Pol. No. 3.100) by the CITC CRP Officer. If any of CITC's grants require CITC to have a client grievance procedure, HIPAA does not preempt their application to complaints arising under HIPAA.

D. **Client Notification**. The CITC Client Grievance Policy and Procedures shall be discussed and distributed to all clients at the time of entry into a CITC program or service. Each client will enter into an agreement with CITC using the *"CITC Client Rights and Responsibilities Agreement"* form. The original document will be kept by CITC and a copy issued to the client. The CITC Client Grievance Policy and Procedures will be posted in every building where CITC provides programs and services.

E. **Costs.** CITC will not pay legal fees that may be incurred by a client involved in an informal or formal grievance with CITC. CITC will pay for its mediation expenses but not the costs for client representation.

F. **Disability Accommodation**. The applicable CITC program shall make disability-related accommodation to the extent required under applicable law to assist an individual in the conduct of a client grievance.

G. **Client Services During Complaint Resolution**. Pending a final resolution of a complaint, no service may be reduced or terminated unless the services were obtained through misrepresentation, fraud or collusion or the individual or authorized representative requests suspension, reduction, or termination of services.

H. **Employee Disciplinary Action**. If a CITC employee is determined to be in violation of the CITC's policies, including CITC's HIPAA Use and Disclosure Policy and Procedures (CITC Policy No. 2.100), the employee will be subject to discipline, up to and including termination of employment.

V. TIME LIMITS

The time limits stated in the CITC Client Grievance Policy and Procedures are mandatory.

VI. CONTACT

CITC Client Rights and Privacy Officer (CRP Officer): Cook Inlet Tribal Council, Inc., 670 West Fireweed Lane, Anchorage, AK 99503, telephone: (907) 265-5900.

VII. PROCEDURES

There are several options to assist a client in resolving a complaint arising from a real or perceived violation of client rights during any and all stages of client participation in the delivery of CITC programs and services. Every effort should be made to resolve the client grievance at the earliest possible time. If the complaint is not resolved through Informal Discussion, a client may follow the Formal Complaint Procedures.

Step 1. Informal Discussion

The client, before submitting a Formal Complaint, should attempt to resolve the complaint through Informal Discussion so that no further action is required. The client is to request a meeting with the CITC employee against whom the complaint is aimed or with the person who is most involved in the conditions resulting in the complaint; or, the client may request a meeting with the employee's supervisor or program director or department director or any combination thereof.

If a client contacts an employee other than the one against whom the complaint is aimed, the client is to be referred to the CRP Officer. It is the responsibility of the CRP Officer to direct the client to the appropriate employee against whom the complaint is aimed.

Confidentiality Complaints- If the complaint involves a matter of HIPAA confidentiality, it must be directed to the CRP Officer. The CRP Officer will investigate the alleged privacy violations and render a written decision to the client within thirty (30) days. A copy of the decision shall be kept on file by the CRP Officer. The CRP Officer's decision is final.

Step 2. Formal Written Complaint

If the complaint is not resolved satisfactorily in Step 1, the client may prepare and submit a written Formal Complaint to the CRP Officer no later than thirty (30) calendar days from the time of the occurrence of the event that resulted in the grievance. The written statement must include: (1) description of the complaint, (2) name of the CITC employee or condition about which the complaint is issued, (3) date when the grievance arose, (4) proposed solution to the complaint, (5) signature of the client submitting the complaint, and (6) date in which the complaint was written and submitted. No form is necessary but it must be submitted in written form. (CRP Officer, 670 W. Fireweed Lane, Anchorage, AK 99503, tel. (907) 265-5900.]

Step 3. Administrative Review

Upon receipt of a Formal Complaint submitted in writing by the client, the CRP Officer will conduct an Administrative Review or select another internal investigator (CITC employee) or an external independent investigator to conduct the Administrative Review in the CRP Officer's sole discretion.

Administrative Review Procedure: The CRP Officer will:

1. Inform the aggrieved client of (a) the Administrative Review procedure and (b) his/her right to have a representative present during the Administrative Review;
2. Review documents pertinent to the issue and identify and conduct interviews of key individuals to the issue;
3. Conduct the Administrative Review within twelve (12) calendar days from receipt of the client's written complaint or at a time mutually agreed to by the parties involved so that the entire review can be completed within forty-five (45) calendar days, unless the parties agree to a specific time extension. If the Administrative Review is not conducted within thirty (30) calendar days from the submission of the written complaint due to undue delays by the client, the client's request for an Administrative Review will be declared invalid.
4. Hold the Administrative Review at a time and place convenient to the client and any other individuals to be interviewed.
5. Attempt to resolve the matter to the satisfaction of the client and develop a written agreement with the client. Submit a copy of the written agreement to the department director, the involved employee(s) and program manager.
6. If there is no resolution to the complaint to the satisfaction of the client, explore options with the client and provide information on the right to Mediation or Administrative Hearing, including timeframes and direct the written request to the CRP Officer.
7. Following the review, brief the employee, program manager and department director on the results of the Administrative Review and be available to clarify the results.
8. The results of the Administrative Review are binding unless the decision of the CRP Officer is not permitted by law.
9. The client may reject the findings of the review and request either Mediation (Step 4) or an Administrative Hearing (Step 5).

Step 4. Mediation

Mediation is an alternative dispute resolution method available to clients as another means of resolving a complaint when a CITC Administrative Review has not resolved the dispute to the satisfaction of the aggrieved client.

Mediation discussions are confidential and may not be used as evidence in a subsequent due process hearing, nor may mediation be used to deny or delay the client's right to pursue an impartial hearing, provided that the client has signed a written confidentiality agreement.

Participation in Mediation is voluntary on the part of the client and CITC. Either party may reject Mediation as an alternate dispute resolution method. Either party, once accepting Mediation, may terminate the mediation process with or without cause upon submission of a written notice to the other party.

Mediation Procedure:

1. The aggrieved client must submit (a) a written request for Mediation to the CRP Officer that clearly states the reason for dissatisfaction with the results of the Administrative Review, signed and dated, and (b) a written confidentiality agreement that mediation discussions shall remain confidential. Mediation must be requested by the client within thirty (30) calendar days from the issued Administrative Review notice of results; otherwise, mediation is not an option.

2. The CRP Officer will request the department director or division vice president who is not directly related to the issue that created the client's dissatisfaction to represent CITC in the mediation.

3. The CRP Officer will select randomly a name from an external independent mediator list maintained by CITC.

4. The Mediator will
   a. Arrange and conduct the mediation session with the aggrieved client and the CITC representative. Mediation must be conducted within twelve (12) calendar days from receipt of the client's written request for Mediation or at a time mutually agreed to by the parties involved. The entire review must be completed within forty-five (45) days, unless the parties agree to a specific time extension. If the Mediation is not conducted within thirty (30) calendar days from the submission of the written request due to undue delays by the client, the client's request for Mediation will be declared invalid.

   b. Prepare a written Mediation Agreement, if agreement between the parties is reached, signed and dated by the client, the Mediator and the CITC representative.

   c. Submit a copy of the signed and dated Mediation Agreement to the client, CITC representative and the Department Director.

Step 5. Administrative Hearing

An Administrative Hearing is a procedure whereby the aggrieved client who is dissatisfied with any determination concerning his/her complaint may present testimony and evidence or arguments, including testimony and evidence or arguments to the contrary, and seek a final determination from an impartial CITC Administrative Hearing Committee or Hearing Officer. This step may be selected by the client after a concluded Administrative Review and either before or after the Mediation step in the client grievance procedure.

Administrative Hearing Committee and Officer- The Committee and Committee Chair shall be appointed by the CRP Officer and include one vice president and two department directors or program managers none of whom has oversight for the program or service from which the complaint arose. As an alternative, the CRP Officer may, in consultation with appropriate CITC staff, select an external and independent Hearing Officer that is particularly knowledgeable about the nature of the grievance from a list maintained by CITC or available to CITC upon request to conduct the Administrative Hearing.

Administrative Hearing Procedure:

1. The client must submit a written request for an Administrative Hearing to the CRP Officer. The client's written request, clearly stating the client's dissatisfaction, must be submitted within thirty (30) calendar days from the date of receipt of notice of results from the CRP Officer pertaining to the last completed grievance procedure; otherwise, the request is voided.

2. An Administrative Hearing shall be conducted within ten (10) calendar days of receipt of the client's written request, unless informal resolution is achieved prior to the forty-five (45) day Administrative Review or the parties agree to a specific extension of time.

3. The Administrative Hearing Committee (or Hearing Officer) shall arrange for the Hearing by issuing notice of date, time and location of the Hearing to the client and other individuals named in the complaint that are to provide information pertinent to the issue. The Committee (or Hearing Officer) shall make all reasonable efforts to determine the facts regarding the allegations in the complaint based on pertinent documents and to allow the client and other individuals, if any, a reasonable opportunity to present evidence or argument.

4. The Administrative Hearing shall be held as scheduled, and the Committee (or Hearing Officer) shall listen to all testimony presented during the Hearing.

5. Upon conclusion of the Administrative Hearing, the Committee (or Hearing Officer) shall review and discuss the complaint, evidence, findings and decision for dismissal or resolution of the complaint. The Committee (or Hearing Officer) shall issue a written report of the findings and decision of the hearing within thirty (30) days from the completion of the hearing to the client, the program director, department director division vice president and president/chief executive officer.

6. The decision of the Administrative Hearing Committee (or Hearing Officer) is final.

7. The reports and related documents to the Administrative Hearing shall be maintained in a confidential file by the CRP Officer.

Step 6. External Complaint Resolution

Clients must exhaust the procedures available under this CITC client grievance policy before pursuing an external resolution of a complaint.

Confidentiality Complaints

A client also may file a complaint with the Secretary of the U.S. Department of Health and Human Services ("DHHS"). Complaints must be (1) filed in writing, either on paper or electronically; (2) name the entity that is the subject of the complaint and specifically describe the acts or omission believe to be in violation of the applicable requirements of HIPAA; and (3) be filed within 180 days of when the client knew or should have known that the act or omission occurred, unless this time limit is waived by the Office for Civil Rights ("OCR") for good cause shown. Complaints to the Secretary may be filed only with respect to alleged violations occurring on or after April 14, 2003.

The Secretary (of "DHHS") has delegated to the "OCR" the authority to receive and investigate complaints as they may relate to HIPAA. A client may file a written complaint with the OCR by mail, fax, or e-mail at the addresses listed below. Clients may, but are not required to, use the OCR's Health Information Privacy Complaint form. To obtain a copy of this form, or for more information about the Privacy Rule or how to file a complaint, contact an OCR office or the internet address: www.hhs.gov/ocr/hipaa/. Address written complaints to: Region X, Office for Civil Rights, U.S. DHHS, 2201 Sixth Avenue, Suite 900, Seattle, WA 98121-1831. TEL. (206) 615-2287. FAX (206) 615-2297. TDD (106) 615-2296. For all complaints filed by e-mail, send to: OCRComplaint@hhs.gov. For further information contact Lester Coffer, OCR, DHHS, Mail Stop Room 506F, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. TEL. (202) 205-8725.

Cook Inlet Tribal Council
RECOVERY SERVICES

PATIENT GRIEVANCE

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
I UNDERSTAND THAT GENERALLY COOK INLET TRIBAL COUNCIL MAY NOT CONDITION MY TREATMENT ON WHETHER I SIGN THIS CONSENT FORM, BUT IN CERTAIN LIMITED CIRCUMSTANCES I MAY BE DENIED TREATMENT IF I DO NOT SIGN THE CONSENT FORM.
REVOCATION OF THIS INFORMED CONSENT OR RELEASE OF INFORMATION MUST BE IN WRITING.

I,_____, the undersigned patient of Cook Inlet Tribal Council, INC.'s Recovery Services, understand that I have the right to be treated with dignity and respect in the course of my treatment. I also understand that it may be therapeutically necessary on the basis of findings during the course of treatment to confront my disease, thus my behavior. However, I realize that I have a right to file a grievance. Should I feel it necessary to file a grievance, I may report this to the clinical supervisor or designee.

1) Grievance must be a signed written statement with date, time, persons involved, and a detailed account of the incident.

If I am not satisfied with the disposition, I may request a meeting with the program director. I understand that I will be informed of the disposition within (5) working days. In the event I am still not satisfied with the disposition, I may request a meeting with the Human Resources director at the Cook Inlet Tribal Council. (907)793-3101.

I hereby certify that I have read and fully understand the above and that it was explained to me by staff and members of the treatment program.

_____ _____/_____/20___
Patient Signature Date

_____ _____/_____/20___
Staff Signature Date

DENALI FAMILY SERVICES

P&P#: 7040	**Page 1 of 1**
Section: Clinical Director	Effective Date: **August 1, 2007**
Subject: Consumer Grievances	
Supersedes P&P#: S1-4	Dated: July 30, 2007

COA Standards: G1.8
AK Regulations: 7 AAC 71.220

POLICY: ***Denali Family Services shall resolve to the maximum extent possible a consumer's complaint or appeal.***

PROCEDURE:

1. All clients have the right to file a grievance without fear or intimidation, or retaliation of any kind.
2. All clients shall be notified in writing of the grievance policy, during the intake process. A signed copy of receipt of the grievance policy shall be maintained in the client record, and updated at least annually.
3. Consumer grievances and feedback can be filed in one of three ways:
    a. any staff person shall provide a feedback form to any consumer upon request. Forms shall be readily available.
    b. a consumer may file a verbal complaint directly or over the phone with the utilization review coordinator who will complete the consumer feedback form.
    c. clients can file a grievance by e-mail to the utilization review coordinator.
4. If clients would like assistance in filing a grievance the client can designate a representative or advocate to assist them with all steps of the grievance process.
5. Upon request a clients case manager or clinician or the utilization review coordinator can assist the client in filing a grievance or provide a written referral to a client organization such as NAMI-Alaska or the Disability Law Center to assist them with a grievance.
6. The utilization review coordinator shall acknowledge positive feedback verbally or in writing to the consumer.
7. If the feedback is negative, the utilization review coordinator shall attempt to resolve the issue with the client in collaboration with the clinical director and treatment team within five (5) days of receiving the initial grievance.
8. If the consumer does not feel that the issue was satisfactorily resolved, s/he must inform the utilization review coordinator within ten (10) days.
9. Within five (5) days of receipt of notice of consumer appeal, the CEO shall review all related documentation and make a determination. The CEO shall send notice of this determination to the consumer and to the utilization review coordinator.
10. If the client wishes to appeal the decision further, they may request verbally or in writing to have the appeal forwarded to the board of directors to be reviewed at the next board meeting.

11. Within 30 days if a satisfactory resolution can not be found a referral to Behavioral Health will be made to provide technical assistance for an unresolved grievance.
12. If the grievance involves abuse, unnecessary seclusion or restraint it will automatically be brought to the board of directors at the next board meeting.
13. The utilization review coordinator shall implement the resolution through collaboration with appropriate personnel, and shall document the resulting plan for grievance resolution.
14. The utilization review coordinator shall maintain a copy of the complaint, the resolution, and the notification.
15. The utilization review coordinator shall maintain a cumulative list regarding the nature and resolution of complaints.
16. The board of directors review a report analysis of consumer complaints at least once per quarter to assess complaint patterns, liability issues, and potential areas for improvement.
17. The continuous quality improvement process shall include review of feedback forms.
18. Client confidentiality shall be maintained throughout the grievance procedures.

HOPE

Hope Community Resources

Grievance Procedure for Individuals Choosing Hope's Support

It is the practice of Hope Community Resources to nurture and protect the rights and dignity of all persons receiving services from our agency. As such, it is Hope's responsibility to assure that recipients of service, and their representatives, are directing the level of support they desire and are satisfied with the services they receive. This grievance policy provides a means for support recipients to make complaints regarding care, treatment, living conditions, or the exercise of rights, and to have those complaints heard and acted upon in a timely manner without retaliation or barriers to services.

If, at any time, a concern is brought forward, it is Hope's responsibility to resolve the issue in a timely manner. Hope has an open door policy for conflict resolution. This policy encourages support recipients and their representatives to utilize any member of their support team to resolve conflicts in as informal and expeditious a manner as possible to achieve resolution. However, should resolution not be achieved, then the following guidelines should be used:

1. If a support recipient, or their representative, has an issue or complaint, it should be discussed in a timely manner after the problem arises with the staff member most involved with the issue. In most cases, this would be the lead direct care professional.

2. If this resolution is unsatisfactory and the individual wishes to pursue the matter further, he/she may file a formal grievance with any member of Hope's supervisory or management team, up to and including the applicable Director of Community Support Services (Director). This may be done orally (either in person or via telephone), via email or by completing and submitting a Grievance Form.

3. A support recipient may designate a representative or advocate to assist them with all steps of the grievance process. Upon request, the recipient's care coordinator or community support supervisor will assist the support recipient with the filing of a grievance.

4. Upon receipt of a grievance, Hope will initiate, within 5 business days, the process to resolve the grievance and will notify the support recipient of such. If Hope is unable to adequately initiate resolution within 5 days, a written notification shall be sent to the support recipient by the end of 5 days from receipt of grievance explaining why and identifying when the grievance process will initiate.

5. Direct resolution will be attempted through dialogue with any Hope staff involved, and/or his/her supervisor depending on the request of the support recipient.

6. If direct resolution is unsatisfactory, the appropriate Director will formally investigate the matter and provide the support recipient with a reply within ten (10) business days thereafter.

7. In cases where a resolution has not been achieved as described above, the support recipient or their representative may request a meeting within ten (10) working days of the Director's reply, attended by the appropriate Director, the support recipient and/or their representative, and the Deputy Director for Community Support Services. Recommendations will be made to the Executive Director and the decision of the Executive Director or his/her designee will be final.

8. Hope will attempt to gain a satisfactory resolution of all grievances within 30 days of receipt of that grievance. If a grievance remains unresolved after 30 days, Hope will, within 5 business days thereafter, refer the issue to the Department of Health and Social Services Behavioral Health for technical assistance.

9. If a grievance involves abuse, neglect, or unnecessary seclusion or restraint, the grievance shall immediately be reviewed by the Executive Director. The Executive Director shall inform the Executive Committee of Hope Board of Director's mittee regarding this matter.

10. Throughout the entirety of the grievance procedure, all matters relating to the situation will be kept confidential to the highest degree possible.

11. No person filing a grievance shall be intimidated, harassed, retaliated against or discriminated against, solely or in part, for having asserted a grievance, or sought advice or inquired about filing a grievance. Support recipients are encouraged to use the available grievance system. Support recipients will not be discouraged from filing a grievance.

12. Upon entry to Hope's services, a support recipient will be provided a copy of this policy and procedure. A form for support recipients to sign will be maintained in their file which declares their receipt and understanding of the agency policy and procedure.

13. Upon resolution of the grievance, a file containing all pertinent documents, records, actions and communications shall be created, maintained and stored by the Deputy Director of Community Support Services or his/her designee separate from the support recipient's master file.

Support Recipient Grievance Form

To file a formal grievance, a support recipient or his/her legal representative should submit the grievance orally (either in person or via telephone), via e-mail or complete and submit this form to a member of Hope Community Resources' supervisory or management team. Please complete all sections. (Attach additional sheets if necessary.)

SUPPORT RECIPIENT INFORMATION

Name_____

Address_____ Telephone_____

STATEMENT OF GRIEVANCE

What is your grievance?

_____

_____

What happened?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

When did it occur?

_____

_____

_____

Where did it happen?

_____

_____

_____

Why did it happen?

D. State the specific resolution being requested:

Support Recipient's Signature _____ Date _____

Legal Representative's Signature (if applicable) _____ Date _____

Hope Community Resources _____ Date _____

Grievance was presented to Hope Staff: ____Orally ____In Writing

Date Received:_____

Optional Waiver of Confidentiality

I hereby give permission to Hope Community Resources and its officers, directors and employees to share pertinent information which I have revealed in the process of this grievance to other parties who may be relevant to the resolution of this grievance.

Support Recipient's Signature	**Date**
Legal Representative's Signature (if applicable)	**Date**

NDTC INC

Center for Drug Problems

PATIENT GRIEVANCE PROCEDURE

If you are not satisfied with progress in treatment, resolve the problem with your counselor. If you cannot resolve it with your counselor, you may submit your grievance to the Clinical Director in writing or verbally. A written response will be made and/or an appointment will be scheduled. The decision may be appealed in writing to the treatment team. A written response will be made and/or an appointment will be scheduled within one week. The treatment team's resolution with you is final for treatment issues.

You have the right to file a grievance without intimidation, retaliation, or barriers to service. Patient confidentiality will be strictly maintained throughout the grievance procedure, unless confidentiality is waived by the patient and is in compliance with 42 C.F.R. and HIPAA regulations.

A full copy of the Grievance Procedure may be obtained from any CDP treatment team member. If assistance is needed in completing the grievance procedure, contact the Clinical Director or the Nursing Supervisor.

Any unresolved Agency complaints may be submitted in writing to:

Corporate Compliance Officer
NDTC, Inc.
520 E. 4th Avenue, Ste. 102,
Anchorage, AK 99501

Any confidentiality or privacy issues, complaints may be submitted in writing to:

HIPPA Compliance Officer
NDTC, Inc.
520 E. 4th Avenue, Ste. 102
Anchorage, AK 99501

After receipt of the complaint, the appropriate officer, will schedule a review of the complaint within 2 (two) weeks.

Additionally, any unresolved complaints may be submitted in writing to the following office:

BEHAVIORAL HEALTH SPECIALIST
State of Alaska
Dept. of Behavioral Health
P.O. Box 240249
Anchorage, Alaska 99524-0249

THIS FORM MUST BE SIGNED AND RETURNED WITH THE FULL GRIEVANCE REPORT.

Patient Number: _____ Date: _____

(2) Documents which must contain patients' names for legal purposes are maintained in the patient files which are kept in fireproof locked file cabinets in a locked room.

(3) All records are maintained in strict accordance with 42CFR, Federal Confidentiality Regulations and HIPAA Regulations.

Notwithstanding the above confidentiality measures, according to policy and procedure established by Behavioral Health (State of Alaska Division of Alcohol and Drug Abuse, Department of Health and Social Services) which, because of its grantee status, affects CDP, certain kinds of demographic information must be provided on the Patient Admission Form to the department's AKaims System. The stated purpose of the collection of this information for AKaims concerns documentation of the number of unique patients participating in Alaska's mental health and drug and alcohol treatment/rehabilitation programs.

b) Patient's Human and Legal Rights

CDP endorses supports and defends the principle of protecting and guaranteeing to each individual patient their respective rights established and provided under the Constitutions of the United States and the State of Alaska. CDP is in full compliance with all laws, municipal, state and federal, concerning the civil and human rights of its patients.

c) Patient Grievance Procedures

CDP has established the following process as a mechanism for addressing and resolving any patient grievances which may occur as a result of interaction with program staff. A patient with a grievance notifies his/her counselor of their particular issue and an attempt is made to resolve it at that level.

If resolution is not possible, or if the patient is dissatisfied, the grievance can be submitted orally, in person or by phone or in writing to the Clinical Director for resolution. The Clinical Director will respond in writing or schedule an appointment within 5 days following the submission of the grievance. If the resolution process cannot begin within 5 days, the patient will be notified with an explanation of the delay and a notification of when the resolution process will be initiated. The patient should keep a copy of the grievance to be filed with the Clinical Director.

All grievances and appeals will be kept in a log maintained by the Clinical Director.

If the patient is still dissatisfied the grievance can be taken to the treatment team with a copy of the original grievance and the Clinical Directors response to the grievance.

The treatment team will respond within one week following the notification of the grievance. The decision of the treatment team is final for all treatment issues.

If a patient remains unsatisfied and there has been no resolution reached, the grievance can be taken to the Executive Director. If the patient does not accept the Executive Director's decision s/he can take an unresolved agency grievance to the Board of Directors.

If the grievance is not resolved within 30 days a referral will be provided to the Behavioral Health Specialist with the state of Alaska.

A patient grievance procedure developed for use by and made available to CDP patients is provided in the clinical operations desk manual. The procedures will be reviewed with the patient at intake. The grievance procedure and sample grievance will be made readily available to patients and copies of the procedure will be posted in the lobby.

A patient's confidentiality will be strictly maintained throughout the grievance procedure unless it is waived by a signature of the patient and is in compliance with 42 C.F.R and the HIPAA regulations.

Any patient filing a grievance will be free of any form of retaliation, intimidation or barriers to service.

If a CDP patient needs assistance in filing a grievance, they may request the assistance the Clinical Director or Nursing Supervisor.

d) Patient Bill of Rights (see clinical operations desk manual) .

e) Abuse and Neglect

Any person who is a patient at this agency has the right to report any staff member to the Executive Director if she/he feels they are being abused or neglected.

Areas of abuse include but are not limited to:

(1) Payment of account
(2) Lack of counseling
(3) Exclusion from group counseling
(4) Sexual harassment
(5) Verbal abuse
(6) Physical abuse

or any other area of service provided.

f) Patient Advocacy Groups

CDP supports the concept of patient advocacy groups and will afford local groups the use of meeting space at the agency facility when scheduling is possible. The agency will be pro active in informing patients of and making referrals to regional or national advocacy groups. When appropriate, CDP will assist patients in organizing local groups and recruit community support for these advocacy groups.

3. Health and Medical Care

a) Policy

CDP's treatment philosophy is predicted upon the significant need of encouraging a healthy emotional and physical existence for its patients. Accordingly, it is a goal of the CDP treatment program to enable each patient to develop and maintain the best possible health. CDP believes that a patient's good health will facilitate their reaping the maximum benefits from its program.

b) Health Evaluation

Each prospective methadone patient applying to the CDP treatment program shall be given a health evaluation prior to admission. Drug-Free candidates may at the recommendation of the treatment team receive the same evaluation within 30 days of admission to the program. The health evaluation shall include:

(1) History: past medical history, family history, review of symptoms.

(2) Laboratory: SMA 12-60, CBC, VDRL, urinalysis (as per physician's request)

(3) Physical examination

(4) Health Surveillance: immunization update, TB screening, appropriate health education

All deviations from normal limits documented from the above health evaluation shall be identified and documented on a health problem list by the Medical Director or his/her staff and filed in the patient's records. Patient's shall be informed regarding problems requiring follow-up treatment or diagnostic evaluation and these shall be managed appropriately or referred.

c. Other Health and Medical Policies and Procedures

PROVIDENCE
CRISIS RECOVERY CENTER
ANCHORAGE

PROVIDENCE CRISIS RECOVERY CENTER

Subject: Client Complaint Management	Number: 900.107 Page: 1 or 3
Approved by: Cindy Gough Date Signed: Effective Date:	Original Effective Date: 7/30/07 Review Date (s): Revision Date (s):

I. POLICY

In keeping with the philosophy and mission of Providence Health and Services, Providence Health System in Alaska provides systems to receive, promptly investigate, respond to and resolve complaints made by clients and their families.

II. PURPOSE/SCOPE

To improve the satisfaction of those we serve and to identify opportunities for improvement of services.

III. DEFINITION(S)

UOR- Unusual Occurrence Report
Complainant- The client, family member or visitor making the complaint

IV. PROCEDURE

A. Complaints can be made in person or over the phone (907-563-5006).

B. Clients will be informed of the Providence Crisis Recovery Center Complaint Management Policy upon admission into the program.

   a. A copy of the Providence Crisis Recovery Center Complaint Management Policy will be in the Client Handbook that the client receives upon admission.
   b. The client will sign a notice stating that they received a copy of the policy. This notice will also summarize the policy and will be kept in the client's chart. (See attachment A)

C. The client (client/family member/visitor) complaints will be documented on the appropriate UOR form if resolution is not reached between the complainant and the involved staff member when the complaint is initially made.

D. UOR forms must be submitted to Clinical Director or Mental Health Specialist Supervisor for investigation.

E. The individual investigating the complaint will promptly speak directly with the complainant involved and work towards a resolution as quickly as possible. The sequential chain of command and listed procedures will be followed to the point a complaint has reached resolution:

   a. Communication with the complainant upon receiving the complaint that the process has begun to reach resolution.
   b. Direct resolution through dialogue with the staff member involved or with the Director/Supervisor of the staff member or with both if the complainant requests.
   c. Resolution through the Providence Area Operations Administrator or their designee.
   d. Resolution through the Community Advisory Board.
   e. Resolution through utilizing the technical assistance of the State of Alaska Department of Health and Social Services, Division of Behavioral Health (DBH).

F. The complainant filing the complaint must receive a written response within 7 (seven) days of filing the complaint to inform them of the resolution of the complaint.

   a. If the Clinical Director or Mental Health Specialist Supervisor is not able to reach a resolution within this time period, the complainant must receive written notification of the progress and be provided a date with which there will be a resolution or when they will be contacted again if the investigation is not yet complete.

G. Satisfactory resolution to complaint should occur within 30 (thirty) days of receiving the complaint.

   a. If satisfactory resolution has not been reached after 30 (thirty) days a referral to DBH will be made for technical assistance.

H. Any complaints that involve abuse, neglect, or unnecessary seclusion or restraint will be immediately elevated to the Providence Area Operations Administrator or designee and then to the Community Advisory Board as necessary.

I. Individual records for complaints that are filed will be kept and maintained at Providence Crisis Recovery Center. Files will be kept in a secure location and be maintained for a ten year period after the resolution of the complaint.

V. JOB TITLE/RESPONSIBILITIES

None.

VI. CROSS REFERENCE

End of Policy

Attachment A

Client Acknowledgement of Complaint Procedures

I, _____, have received and been shown the Providence Crisis Recovery Center's Complaint Management Policy.

- I understand that I can make a complaint at any point during my admission at Providence Crisis Recovery Center.
- Complaints can be made in person or over the phone (907-563-5006).
- All complaints can be made without concern for retribution, intimidation or the early termination of treatment.
- Complaints will be taken seriously and investigated by the appropriate level of command.
- Complainants will receive a written response within 7 (seven) days regarding the status and/or outcome of the complaint.

_____ _____

Client Signature Date

_____

Witness Signature

SALVATION ARMY
CLITHEROE

SALVATION ARMY CLITHEROE CENTER

Client Grievance Procedures

Every Salvation Army Clitheroe Center (SACC) client has the right to express a grievance or complaint that they may have relating to treatment. Every effort will be made to resolve complaints with the person with whom they occur. Initially, the complaint may be submitted orally or in writing, in person, over the phone, or via e-mail. In no instance will the expression of a complaint or filing of a grievance result in retaliation or barriers to service.

If a client has a grievance with the SACC program, the first step is to thoroughly discuss it with his or her Counselor (or the Head Nurse, for Detox clients). If no resolution is forthcoming from this meeting, the client may put the complaint in writing to the Unit Supervisor. A response will be made within 5 working days of the receipt of the complaint. If the matter is still not resolved, the client may submit the written complaint to the SACC Assistant Director. Again, a response will be made within 5 working days of the receipt of the complaint. If the issue still remains unresolved, the client may direct their written grievance to the Executive Director. A response will be made within 5 working days of the receipt of the complaint. If resolution is still outstanding, the client may appeal to the Divisional Social Services Coordinator of The Salvation Army by calling 276-2515 to find out where to forward their written grievance. A response by the Social Services Coordinator will be given within 7 days of receipt of the complaint. Grievances that are unresolved at this level and/or remain unresolved after 30 days from the time they were submitted, will be referred to DHSS Behavioral Health for technical assistance.

Clients may request a representative or advocate to assist them with all steps of the grievance process. The client should document their complaint(s) on the ***Client Grievance Form.*** If they choose to be represented by a third party, they should sign the optional waiver of confidentiality on that form, to the individual and/or agency that they would like to represent them. If desired, SACC staff will provide them with a referral to Disability law Center (DLC), National Alliance for the Mentally Ill (NAMI), or other appropriate organization in order to secure qualified representation.

Should a grievance involve possible neglect or abuse of a client, the initial recipient of the grievance should immediately contact a member of the SACC Executive Staff, who will investigate the incident within 2 working days and review it with the Ex. Director and with the Human Resources Director to:

- Determine whether the alleged incident is factual, and does indeed constitute a case of client abuse or neglect;
- Provide necessary therapeutic intervention to the client.

In the case of incidents which are determined to constitute valid cases of abuse or neglect, the Supervisor of the Unit in which the incident occurred will:

- Submit a Class I Incident Report
- Conduct a Supervision with the employee(s) involved, file a disciplinary report, and
- Recommend a final disposition of the case.

All correspondence/documents/notes related to each individual grievance shall be maintained by the SACC Assistant Director until final resolution has been reached. At such time as the grievance is resolved, the documentation shall be transferred to the SACC Records Department to be maintained along with the individual's treatment file(s). Strict adherence to Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164 shall be maintained throughout the grievance process.

SOUTHCENTRAL FOUNDATION

CUSTOMER COMPLAINT, CONCERNS AND COMPLIMENTS PROCEDURE

I. PURPOSE

To provide a process for employees to receive, address and resolve patients'/Customers' and others' concerns, complaints and compliments.

II. SCOPE

This applies to all direct hire employees, volunteers, and Civil Service and Commissioned Corps Officers working under contractual agreements with Southcentral Foundation (SCF). Contractual agreements are exempt unless otherwise stated in their contracts.

III. DEFINITIONS

A. Customer: Patients, customers, residents, students who seek and receive services at SCF programs.

B. Potentially Compensable Event (PCE): Any adverse event related to illness, accidents or injuries that have a potential for litigation.

IV. PROCEDURE

A. SCF customers may express a complaint, concern, or compliment in any of the following formats:

1. Verbal: to include face-to-face or phone communication.

2. Written: to include email and fax communication in addition to a Customer Comment Form, a report to the Customer Reporting Hotline (877-837-4251) and/or any other written communication.

B. SCF customers will be assured that:

1. they may file a complaint or concern without threat of intimidation as a result of filing the complaint and/or concern.

2. they will not be retaliated against or encounter barriers to service as a result of filing a complaint and/or concern.

3. their confidentiality will be protected to the extent possible to allow proper resolution of the concern.

4. they will receive information on how to express a complaint, concern, or compliment.

5. they may designate a representative or advocate to assist them during all phases of the complaint and/or concern process.

6. If they are receiving Behavioral Health Services under the Community Mental Health grant, that SCF will handle all complaints and/or concerns according to the State of Alaska, Department of Health and Social Services, Division of Behavioral Health (DHSS) requirements (see Section G)

C. Customer Comment Form/Computer Reporting System:

1. The employee who the Customer initially contacts should document the conversation and either enters the information into the computer reporting system or assist the Customer in filling out the comment form. The employee may fill out the form for the Customer.

   a. Complete all customer information.

   b. Briefly, describe the issue.

   c. Note any other persons who were involved or present at the time of the occurrence.

   d. Ask the customer what, if any, resolution they would like to see as an outcome.

   e. Document, in appropriate detail, the circumstances that generated the communication.

   f. It may be necessary to check the record of the customer involved. If the person submitting the communication is a family member, customer/patient permission is necessary prior to access of the record.

   g. No disclosure of information in a customer's record will be made to third parties without written authorization/consent from the Customer.

2. Notify the affected program manager and Quality Resources (QA) of all customer concerns and complaints.

C. Investigation:

1. The employee who receives the concern will acknowledge, investigate and resolve the concern at the time of receipt, if possible.

   a. This employee will be responsible for the resolution of the concern and will contact the customer when the issue is resolved, no matter which step the concern is resolved at. Responsibility may be transferred to another employee in the resolution process if both employees agree to the transfer.

i. If the concern cannot be resolved at the time of receipt, the customer will be contacted within one (1) business day of receipt of the concern to confirm receipt of the concern and request more information if needed.

b. If the employee cannot resolve the issue, the employee will notify their Supervisor who will investigate and resolve the concern, if possible.

i. If a Supervisor is unable to resolve the issue, they will notify the the Program/Department Manager.

c. If the Program/Department Manager cannot resolve the issue, the Supervisor will notify the appropriate Division Administrator (DA) who will investigate and resolve the concern, if possible.

d. If the DA cannot resolve the issue, the DA will notify the Division Vice-President who will investigate and resolve the concern, if possible.

e. If the Division Vice-President cannot resolve the concern, they will notify the President/CEO who will investigate, resolve and respond to the Customer.

2. Follow-up contact will be made within three (3) business days of receipt of the concern, even if responsibility is being transferred. Regular contact with the customer will be maintained during the investigation.

3. Any investigation or review of the facts and circumstances of a situation should occur on a timely basis.

4. The employee who is doing the investigation should gather information about the facts and circumstances of the situation.

5. Additional information gathered through the investigation should be documented in the "Staff Perspective" section of the Customer Comment Form or computer reporting system.

6. In the event that the issue is identified as a Potentially Compensable Event (PCE), the Risk Manager will be notified.

D. Resolution:

1. Resolution of the concern must have customer input and agreement, if possible.

2. When resolution of the issue is achieved, it will be documented and the Customer notified.

a. The lack of documented resolution responses may be considered during the responsible employee's performance cycle.

3. Quality Assurance (QA) must review all written correspondence to customers regarding a concern before the correspondence is sent out.

    a. Any department using a typical response letter must have the letter approved by QA prior to implementation.

4. If the resolution differs from that originally requested by the customer, an explanation for the difference will be given to the customer at the time of notification.

5. The type of notification will be documented on the Customer Comment Form or computer reporting system.

6. Disposition of concerns will be conveyed on a timely basis to QA. Cases will receive appropriate review and follow-up as needed. QA must be provided with a copy of the type of resolution achieved.

7. If the Customer is unsatisfied with the ultimate resolution, the customer may appeal to the Program Manager or QA for further action.

8. QA will, in their discretion, notify the Vice President of the Program or the President/CEO as the situation warrants.

E. Assistance is available, if needed, however primary responsibility for taking and resolving customer concerns resides with the affected program.

    1. The Advocates, where available, and the QA Department will assist in taking suggestions, comments and concerns if the situation warrants and will refer them to the affected department supervisors, Program Manager or Vice-President.

F. File/Maintenance/Tracking/Trending:

    1. All information regarding customer complaints, concerns, and compliments are entered into an electronic database (Feedback Monitor Pro).

    2. In order to improve the quality of care and services, all customer complaints and/or concerns will be tracked and trended to aid in identification of systems improvement opportunities.

        a. The Quality Assurance Department is responsible for oversight of the tracking and trending of customer complaints and/or concerns.

    3. QA will make available reports on investigations, resolutions, tracking and trending to appropriate managers, vice-presidents and to the President/CEO and any outside agencies/entities in accordance with applicable laws and regulations.

G. Behavioral Health Complaints/Concerns – DHSS requirements

1. DHSS Timeframes for resolving customer complaints and/or concerns are as follows:

    a. Resolution of a customer complaint and/or concern will be initiated within five (5) days of receipt of the complaint and/or concern.

    b. If resolution is not initiated within five (5) days, the consumer will be sent written notification at the end of the five day period. The notice will inform the customer of:

        i. the reason why resolution of the complaint and/or concern has not been initiated.

        ii. providing a date when resolution will begin.

    c. Customer complaints and/or concerns should be satisfactorily resolved within thirty (30) days after the complaint and/or concern was raised.

    d. Any customer complaints and/or concerns not resolved within thirty (30) days will be referred to the DHHS Division of Behavioral Health for technical assistance.

    e. SCF Behavioral Health Customers will sign a Patient's Rights and Responsibilities form that will be filed in the clinical record to verify that they:

        i. receive a copy of the complaint, concern, compliment process.

        ii. understand the process.

    f. SCF will provide written referral to other consumer advocacy resources in accordance with DHSS requirements.

H. QA has the option of discussing any issue with the President/CEO if they determine that the situation warrants the President/CEO's direct knowledge and involvement.

Here is the updated Corporate Procedure. It is posted on the intranet.

Danna Teicheira

Compliance Specialist & Privacy Officer

907-729-5457

HIPAA: IT'S NOT JUST A LAW -

IT'S A WHOLE NEW WAY OF DOING BUSINESS

VOLUNTEERS of AMERICA
(V O A)

VOLUNTEERS OF AMERICA OF ALASKA
CLIENT GRIEVANCE POLICY & PROCEDURE

Policy:
It is the policy of Volunteers of America Alaska to address all client grievances in a timely and uniform manner. Clients and their families will be encouraged to file grievances at any time without any intimidation or discouragement on the part of staff. Client grievances are a mechanism to ensure consumer satisfaction and program improvement and are to be treated as such. When a problem arises which a client and/or family member feels is unacceptable the following grievance process is available:

Procedure:
1. The Grievance Policy will be reviewed with the client and his/her parents at intake in a manner that is understandable.

2. Clients and their parents are encouraged to talk to their primary counselor about any concerns they may have. It is possible that a misunderstanding has taken place and can be cleared up if the persons involved are aware that a problem exists.

3. If an agreement cannot be achieved then a client can submit the grievance verbally, in writing, and via email at anytime. The client and their family will be encouraged to submit the grievance in a timely manner to ensure swift resolution.

4. The Treatment Services Director, President CEO and Board of Directors will be notified immediately of any grievances involving abuse, neglect, or unnecessary seclusion or restraint.

5. The client Grievance Form is to be used however does not necessarily need to be completed by the client. A staff member can take down the compliant, or attach the email. Grievance forms and envelopes are available at the reception area of the facility upon request and are posted in areas that are accessible by clients at anytime.

6. If a client or family member appears to need assistance with the grievance or grievance process the primary counselor will consult with their supervisor in order to assign an impartial person to assist. Resources include agency employees outside of the Treatment Services Department, the Disability Law Center and other advocacy groups.

7. The grievance will be forwarded to the Clinical Director (Assist) and the Clinical Supervisor (ARCH).

8. The Clinical Supervisor or the Clinical Director will respond in writing to the client/parent with a decision within five days of receipt of client's written complaint.

9. If an agreement cannot be achieved, the client may contact the Treatment Services Director within 5 days and ask for a case review. At that time, parents, appropriate caseworkers, probation officers and VOA staff will schedule a meeting with the resident

to resolve the situation. Every effort will be made to have this meeting within 72 hours dependent upon the availability of caseworkers, client, parents and probation officer.

10. If the situation remains unresolved, the issue will be forwarded immediately to the CEO/President for consideration.

11. If the situation remains unresolved, the issue will be forwarded to the Board of Directors for consideration.

12. If a resolution is not reached, The Division of Behavioral Health will be contacted with a request to mediate the situation.

13. Grievances will not go unresolved for over 30 days of receipt.

14. Grievances will be reviewed quarterly at the Quality Assurance Committee meeting to assess for trends and areas needing performance improvement. All grievances will be kept on file at the agency.

15. Clients are guaranteed no retaliation, barriers to service, or consequences as a result of filing a grievance.

SOUTHCENTRAL REGION

ALASKA ADDICTIONS REHABILITATION SERVICES (NUGEN'S RANCH)

NUGEN'S RANCH

July 19, 2007

Viki Wells
Department of Health and Social Services
Division of Behavioral Health
3601 C Street, Suite 878
Anchorage, AK 99503

RE: Agency Grievance Policy & Procedure

Dear Viki:

Attached you will find Alaska Addiction Rehabilitation Services, Inc./ Nugen's Ranch Grievance policies and procedures for both staff and clients. Please let me know if you need any further information regarding Nugen's Ranch Grievance policy and procedures.

Sincerely,

Karen Nugen-Logan
Executive Director

Alaska Addiction Rehabilitation Services, Inc.
P. O. Box 871545 · 3701 Palmer-Wasilla Highway · Wasilla, Alaska 99687 · (907) 376 4534 · Fax: 376 2348 · 1-800-376-4535

ALASKA ADDICTION REHABILITATION SERVICE, INC. - OPERATION MANUAL	
MANUAL SECTION: TREATMENT	**POLICY NO: T - 23**
TITLE: CLIENT GRIEVANCE PROCEDURE	
PROGRAM APPLICATION:	DESCRIBE PROCEDURES FOR CLIENT AND STAFF TO FOLLOW WHEN THERE IS A GRIEVANCE
DATE ADOPTED:	DATE REVIEWED: 6/88, 5/91, 7/91, 8/93, 1/94, 9/96, 7/98 1/02 , 11/06
AMENDED/REPLACES: T-15 8/7/82 2/85 3/87 10/91, 7/07	

POLICY

All clients, at the time of their admission to treatment, shall be advised how to make a complaint, either regarding the fee charged the client, or the quality or manner of any form of treatment received from any member of the staff.

PROCEDURE

1) Complaints shall be made in writing and signed by the client on a form (#8373) provided by the program to the client and shall be submitted to the Clinical Supervisor of the program. Complaints will be accepted via e-mail and forward to the Clinical Supervisior. If a client is unable to prepare or submit a written complaint, s/he may submit an oral complaint to his/her counselor or other member of the treatment staff who shall draft a written complaint for the client's signature.

2) The complaint shall specify the act complained of, the time and day on which the act occurred, and identify the individual or staff member to whom the complaint is directed.

3) Upon receipt of any client complaint, the Clinical Supervisor of the program shall, as soon as practicable, provide a copy of the compliant to the individual or staff member to whom the complaint is directed. The Clinical Supervisor shall request a response by the individual or staff member either orally or in writing within three working days. Within 72 hours of the receipt of the response by the individual or staff member, the Clinical Supervisor shall take action to resolve the complaint and may:

   a) reject and dismiss the complaint if s/he deems the complaint petty, insubstantial, or made in bad faith, provided, however, that the Clinical Supervisor may not reject without further inquiry any complaint alleging a violation of client rights.

   b) resolve the complaint with the client and the affected counselor or other member of the staff. The Clinical Supervisor may, at his/her discretion, appoint an advocate to speak on behalf of the client if the Clinical Supervisor feels that said appointment is in the client's interest or the client may request an adovcate to assistance with the grievances process. The Clinical Supervior will provide a written referral to other consumer advancy resources if needed.

4) The results of the disposition of a client complaint pursuant to paragraphs a) and b) above shall be reduced to writing in a response to be delivered to the client within forty-eight (48) hours of the resolution of the grievance.

5) If the Clinical Supervisor is unable to resolve the complaint pursuant to paragraphs a) and b) above, s/he shall prepare a summary of the complaint which includes the complaint as well as the response by the affected staff member or individual, with a statement of his/her attempted resolution for submission to the program's Executive Director. The Executive Director shall take action on the complaint within one week after its submission by the Clinical Supervisor. Upon the request of the client, the Clinical Supervisor will prepare a brief written statement on behalf of the client for inclusion in the complaint file. The Executive Director will thereupon review the file and recommend appropriate disposition of the grievance, and submit to the client a written response to the client's complaint which shall state the disposition of the grievance and which shall be delivered to the client within forty-eight (48) hours of the resolution of the complaint. In the preparation of any summary of the grievance for the Executive Director, the confidentiality of the client shall be preserved in all respects.

6) If the client complaint is directed at the Executive Director of the program; or abuse, neglacet or unnecessary seclution or restraint, the complaint shall be immediately forwarded to the Treatment Committee for resolution within one week after receipt of the client grievance. In such event, the confidentiality of the client shall be preserved and the Clinical Supervisor shall prepare the statement of grievance on behalf of the client. A written response to the client grievance shall be prepared by the Treatment Committee for submission to the client in the same manner as provided above.

7) A client who has filed a grievance will in no way have his/her treatment or participation in the program affected as a result of such filing.

8) If a grievances is unresolved at Board level, after 30 days, they agency will notified DHSS Behavioral Helath for technical assistance.

9) Form #8373 is attached and considered a part of this policy.

Signature_____ Date _____

Witness _____ Date _____

AARS #8373
T - 22, T - 23
REV. 11/06

CLIENT NOTICE OF GRIEVANCE

TO:_____ DATE ___/___/___

I hereby file a grievance against _____
for the following (specify act or condition, time and day of occurrence and accused person's action): use another sheet if need more room.

_____

_____

_____

_____

Signature _____

STEP I - - - - - - CLINICAL SUPERVISOR

I find as follows: _____

_____

_____

Signature _____ Date ___/___/___

STEP II - - - - - - - - CLIENT'S RESPONSE

I find the response: satisfactory _____ unsatisfactory _____ received no response _____

Signature _____ Date ___/___/___

STEP III (as necessary) --EXECUTIVE DIRECTOR/TREATMENT COMMITTEE

Recommendation: _____

_____

_____

Signature _____ Date ___/___/___

TREATMENT COMMITTEE MEMBERS

_____

ALASKA ADDICTION REHABILITATION SERVICES, INC. - OPERATION MANUAL	
MANUAL SECTION: PERSONNEL	**POLICY NO: P - 13**
TITLE: GRIEVANCE PROCEDURE	
PROGRAM APPLICATION: PROCEDURES AVAILABLE FOR EMPLOYEE GRIEVANCE	
DATE ADOPTED:	DATE REVIEWED: 6/88, 7/90, 7/91, 4/93, 8/95, 7/98 8/01,11/04
AMENDED/REPLACES: 3/86 3/87 10/91 8/92 11/93 3/02	

POLICY

AARS provides all staff with administrative processes for staff to file a complaint regarding treatment of staff or clients by other staff or supervisors. AARS believes that each staff member is to be treated with dignity and equity.

Introductory probationary employees; casual and temporary employees are employees at will, serve at the satisfaction of the employer, and may be terminated for any reason and without cause. The grievance procedures outlined below does not apply to Introductory probationary employees; casual and temporary employees.

PROCEDURE

1) Any Regular employee, subject to the limitations specified below, may file a grievance regarding any personnel action taken in regard to him/her, including, but not limited to:

   a. Verbal warnings;
   b. Disciplinary probation;
   c. Termination;
   d. Change in job assignment;
   e. Change in salary;
   f. Failure to promote;
   g. Failure to transfer;
   h. Suspension without pay;
   i. Prohibited discriminatory action;
   j. Harassment (sexual or nonsexual)

   Additionally, any Regular employee may file a grievance about working conditions, client abuse, or the actions of a fellow employee, which may adversely affect working conditions, client treatment, or the ability of a fellow employee to adequately perform tasks assigned.

2) A grievance must be made in writing and must be submitted within five working days of the action or decision which is grieved, except that grievances concerning working conditions or fellow employee actions shall be made within five working days after the employee's supervisor fails to take any action regarding a verbal complaint lodged by the employee.

   The grievance shall state in reasonable detail the act complained of, the date on which the act occurred, the policy or procedure violated, reasons why the employee feels he/she is entitled to relief, and the relief requested.

3) Grievances concerning working conditions, client abuse, or the actions of other employees shall be first filed with the employee's immediate supervisor. In the event the grievance directly involves the employee's immediate supervisor, the grievance may be filed with the Executive Director. The supervisor shall, upon receipt, provide a copy of the grievance to the staff member, employee, or other individual at whom the complaint is directed, and shall ask the staff member, employee, or individual to respond to the grievance either orally or in writing within five working days. The employee's immediate supervisor shall attempt to informally resolve the grievance to the satisfaction of the employee or dismiss the grievance. A grievance may be dismissed if it is not substantiated, frivolous or if in the opinion of the supervisor, the employee or staff member acted correctly under the circumstances. This action shall be taken within fifteen days of the filing of the grievance, and the action shall be recorded in writing on the grievance filed by the employee.

   An employee may appeal the disposition of a grievance heard by his immediate supervisor by filing an appeal with the Executive Director. The appeal must be filed within five working days of the decision of the immediate supervisor. The Executive Director shall have ten days within which to resolve the appeal informally with the employee and the employee's supervisor, to uphold the decision of the supervisor, or to dismiss the appeal. The disposition by the Executive Director shall be final, except that grievances regarding client abuse shall be reported by the Executive Director to the AARS Board of Directors at the next regularly scheduled board meeting. The Board of Directors, at its option, may elect to re-open a grievance regarding client abuse.

4) An employee may file a grievance regarding personnel action to the Executive Director. The grievance shall be submitted within five working days of the action taken, and shall be considered an appeal of the personnel action taken by the employee's immediate supervisor. The Executive Director shall, upon receipt of the grievance, provide a copy to the employee's immediate supervisor and request an explanation of the personnel action either orally or in writing within five working days. The Executive Director shall attempt to resolve the grievance informally with the employee and the employee's supervisor, and uphold or reverse the action of the employee's supervisor, or dismiss the appeal. The action of the Executive Director shall be noted in writing on the grievance filed by the employee and returned to the employee within fifteen days after the filing of the appeal.

   Disposition by the Executive Director concerning verbal warnings, disciplinary probation, performance probation, changes in job assignment, changes in salary, and promotion shall be deemed final. The disposition of all employee grievances in these categories shall be reported quarterly to the AARS Board of Directors by the Executive Director, or more frequently at the discretion of the Executive Director.

   An employee shall have the right to appeal any involuntary termination or personnel action which is alleged to be prohibited discrimination to the AARS Board of Directors, following disposition by the Executive Director. The appeal shall be in writing and shall be mailed to the president of the AARS Board of Directors within five working days of the decision taken by the Executive Director. The employee may request a hearing before the treatment committee, and shall so designate his request in the appeal.

   Within ten days of receipt of the appeal, the president of the AARS Board of Directors shall notify each member of the treatment committee of the AARS Board of Directors of the receipt of the appeal. At his discretion, the president of the AARS Board of Directors may appoint members of the Board to serve on the treatment committee as alternates in lieu of any members of the treatment committee who are unable to serve on the committee. If requested by the employee, the treatment committee shall convene a hearing within 20 days of receipt of the appeal filed by the employee. If no hearing is requested, the treatment committee shall meet within 20 days of receipt of the appeal filed by the employee and dispose of the appeal as it deems appropriate.

5) At any grievance hearing convened by the treatment committee of the Board of Directors, the employee shall have the right to designate a representative to advocate on his behalf in the hearing, to present evidence and witnesses on his own behalf, and to hear charges, evidence and witnesses against him.

The hearing shall be informal and shall be presided over by the chairman of the treatment committee. The chairman of the treatment committee shall have the authority to limit the length of the hearing, to limit the presentations of either party, to request that additional materials be presented in writing, and to limit or exclude the attendance or participation of witnesses at the hearing. The chairman of the committee may designate a member of the Board or other employee of the Board to make a record of the hearing. All of the Board shall be excluded from the hearing, except by agreement between the employee and the treatment committee, and except to the extent necessary for any witness to present testimony.

When an appeal is filed with the AARS Board of Directors, the Executive Director shall prepare a complete copy of the employee's personnel file. Prior to the convening of any hearing by the AARS Board of Directors, the employee shall have the right to review his file, provided, however, that the Executive Director or his/her designee shall be present at such time as the employee reviews his file. Copies of any and all documents in the employee's file shall be made available to the employee, at the employee's expense.

The decision of the treatment committee regarding any appeal or grievance shall be final. The chairman of the treatment committee of the Board of Directors shall prepare a record of the disposition of the employee's grievance or appeal in writing, for submission to the employee within ten working days after the conclusion of the hearing.

6) No employee or board member of Alaska Addiction Rehabilitation Services may interfere with, threaten, coerce, restrain, or discriminate against any employee or other person because he has filed a complaint, given testimony, or appeared before the Board or its treatment committee in connection with a grievance or appeal. Any employee whose conduct is deemed to be violative of this policy may be subject to discipline. The giving of false testimony by an employee during any grievance proceedings subject to this policy shall be grounds for summary dismissal of the employee.

ALASKA FAMILY SERVICES

ALASKA FAMILY SERVICES
291 East Swanson Ave. Wasilla, AK 99654
Phone: 907-376-4000 Fax: 907-373-1135

CONSUMER GRIEVANCE PROCEDURE

PROCEDURE

GENERAL

1. Consumers have a right to file a grievance without intimidation and there will be no retaliation against a consumer that files a grievance.
2. Consumers will be informed of the Alaska Family Services "Consumer Grievance Procedure" upon entry to services. A copy of this form will be signed and included in the consumer's clinical record.
3. Consumers may designate a representative or an advocate to assist with all steps of the grievance process.
4. Consumers may request assistance from an Alaska Family Services office administrative staff member in filing a grievance.
5. Grievances may be submitted in writing (attachment), orally/in person, through email or over the telephone. Grievances submitted orally will be documented (attachment) in writing by the staff member receiving the report from the consumer.
6. Grievances that are not resolved by Alaska Family Services within 30 days will be referred to the Division of Behavioral Health within five (5) working days.
7. Grievances involving abuse, neglect or unnecessary seclusion or restraint will immediately be elevated to Level Four: Board of Directors.
8. All Federal, State, and local laws regarding confidentiality will be followed. Appropriate releases of information (ROI) forms will be obtained as necessary for investigation and retained in the consumer's clinical record.
9. Documentation of the grievance process, including decisions will be included in the consumer's clinical record and Alaska Family Services' administrative files.
10. Decisions made to resolve the grievance will be carried out and documented by the appropriate Alaska Family Services staff.

LEVEL ONE: INFORMAL

A consumer should attempt to resolve her/his complaint on an informal basis with the counselor or staff person before entering the formal grievance process.

LEVEL TWO: FORMAL

If the grievance is not resolved at Level One, the consumer shall submit the grievance for review by the Alaska Family Services Clinical Director. The grievance shall outline the nature of the grievance, the circumstances from which it arose, and the remedy or correction desired. Within five (5) working days after the grievance is received, the Clinical Director shall render her/his decision in writing with copies to the consumer and the Chief Executive Officer. If a decision can not be made within five (5) working days the Clinical Director will notify the consumer and Chief Executive Officer explaining why and identifying when the grievance process will be completed at this level.

LEVEL THREE: CHIEF EXECUTIVE OFFICER

If the grievance is not resolved at Level Two, the consumer shall submit the grievance to the Chief Executive Officer. The Chief Executive Officer will render her/his decision within five (5) working days of receiving the grievance.

LEVEL FOUR: BOARD OF DIRECTORS (GOVERNING BOARD)

If the grievance is not resolved at Level Three, the consumer shall submit the grievance to the Board of Directors within five (5) working days after receipt of a response at Level Three. The Board, or its Executive committee shall meet with all parties involved, at the next regularly scheduled Board meeting. The Board shall make their decision known in writing within five (5) working days following the meeting.

LEVEL FIVE: DIVISION OF BEHAVIORAL HEALTH

If the grievance is not resolved at Level Four, the consumer shall submit the grievance to the State of Alaska, Division of Behavioral Health within five (5) working days after receipt of a response at Level Four. The Division shall designate a State employee to investigate the complaint and provide the consumer a decision in writing. The decision of the Division of Behavioral Health is final

I have read and understand the Consumer Grievance Procedures.

_____

Printed name

_____ _____

Consumer Signature Date

_____ _____

Agency Representative Signature Date

ALASKA FAMILY SERVICES
291 East Swanson Ave. Wasilla, AK 99654
Phone: 907-376-4000 Fax: 907-373-1135

CONSUMER GRIEVANCE FORM

Consumer Name _____ Date of Report _____

Consumer Representative or Advocate _____

Name of AFS Staff accepting the grievance _____

Does the complaint involve physical/sexual abuse, neglect, or seclusion/restraint?

STATEMENT OF GRIEVANCE – What is your complaint?

DESIRED RESOLUTION - What do you want to happen?

Consumer Signature or verbal report _____ Date _____

ALASKA FAMILY SERVICES
291 East Swanson Ave. Wasilla, AK 99654
Phone: 907-376-4000 Fax: 907-373-1135

RESPONSE TO CONSUMER GRIEVANCE FORM

Consumer Name _____ Date of Grievance Report _____

Process Level – Name of Respondent _____ Decision Date _____

DECISION - RECOMMENDED ACTION

Signature of Respondent _____ Date _____

Position of Respondent _____

The original of this form is submitted to the consumer filing the grievance; a copy goes in the consumer's clinical record; and a copy is retained in the Alaska Family Services administrative files.

ALEUTIAN PRIILOF ISLANDS ASSOCIATION INC

ALEUTIAN/PRIBILOF ISLANDS ASSOCATION, INC.
Behavioral Health Program

CLIENT RIGHTS

(CLIENT MUST READ BEFORE BEING ACCEPTED FOR COUNSELING)

Below are listed the client's rights. A copy of this form will be provided if requested by the client at intake and the client signs receipt acknowledgement that they have been informed of their rights, which are then placed in the client file.

The APIA's Substance Abuse Program holds the following rights for each client:

1. To be treated with dignity and respect.
2. To have an individualized treatment plan following admission.
3. To request and receive a discharge plan recommending specific self-help procedures and other steps suggested benefiting his/her mental health and well being.
4. To ask name and titles of all personnel directly involved in his/her treatment and to consult with treatment team members.
5. To have all information concerning him/her protected by confidentiality.
6. To refuse participation or interviews related to research purposes.
7. To appeal specific treatment decisions to higher authorities for review.
8. To participate as far as is practical and desirable in treatment within the clinic and community.
9. To be informed of his/her rights to leave the treatment program.
10. The client has the right not to be subjected by staff to physical abuse, corporal punishment, or other forms of abuse administered against his/her will.

_____ _____

Client's Signature/Legal Guardian Date

BRISTOL BAY AREA HEALTH CORPORATION

POLICY NO. _____
GRIEVANCE POLICY

MISSION
BBAHC's mission is to promote health with competence, a caring attitude and cultural sensitivity.

PURPOSE: To establish consistent policy and procedures to administer a fair and equitable grievance process related to the relationship between employees and Bristol Bay Area Health Corporation.

POLICY: Bristol Bay Area Health Corporation seeks to resolve employee disputes in a fair, equitable and expedient manner through a grievance process. BBAHC intends this grievance process to be the final step in resolving disputes between employees and BBAHC arising out of the employment relationship.

APPLICATION: This policy applies to all regular employees of BBAHC and recently terminated regular employees of BBAHC for qualifying employee disputes arising during the term of employment. Not all disputes are subject to the grievance procedure. In general, only those disputes concerning the terms and conditions of an employee's job, discipline, promotion, and/or termination are covered by the grievance procedure. BBAHC reserves the right to determine on an individual basis which employee claims are subject to this grievance policy.

GENERAL PROVISIONS AND LIMITATIONS: BBAHC's grievance policy is subject to certain limitations and restrictions as follows:

- Grievances are limited to complaints arising under the terms and conditions of an individual employee's employment by BBAHC. Accordingly, employees may not bring a grievance on behalf of another employee or on behalf of a group of employees.
- Grievances may not be used to change policies set by the Board of Directors or procedures adopted by BBAHC management to implement those policies.
- Grievances may not request as a remedy a change in supervision or reassignment.
- Grievances may not be used to adjust pay scales under the Pay Plan adopted by BBAHC.
- Grievances may not be used to adjust eligibility for benefits of certain classifications or to change classifications.
- Grievances may not be used to effect organizational changes.
- Punitive damages may not be awarded; compensatory damages for lost wages are all that may be considered in the grievance process. No future damages may be awarded.
- The grievance process does not entitle employees to reimbursement for legal expenses. Employees are encouraged to represent themselves in grievance proceedings, provided; however, an employee may use an outside attorney provided adequate written notice is provided to the Human Resources Department, but such attorney fees will not be reimbursed.

- Grievances seeking exemption or changes to statutes, regulations, policies and requirements imposed by agencies or third parties such as insurance carriers will not be accepted.

PROCEDURAL STEPS: The goal of the grievance process is to reach a mutually satisfactory resolution of employee disputes, if possible, as quickly as possible. In accordance with that objective, the grievance process shall follow the following steps:

Step 1. The employee shall meet with his or her immediate supervisor to discuss the grievance within seven (7) calendar days of the occurrence of the incident giving rise to the grievance. Failure to assert a grievance within seven (7) calendar days of the incident will result in the grievance being dismissed and barred from further consideration. If the grievance is not resolved at this step, the employee may proceed to Step 2.

Step 2. The employee shall meet with his or her division manager to discuss the grievance within seven (7) calendar days. If the grievance is not resolved, the employee may proceed to Step 3.

Step 3. The employee shall meet with a representative of the Human Resources Department to discuss the grievance. The HR representative will advise the grievant about whether the claim asserted is subject to the grievance procedure and provide procedural information to the grievant regarding the processing of grievances under this policy. The Human Resources Director may consult with the Chief Operating Officer, the Chief Executive Officer and/or other management personnel in order to attempt the resolve the grievance informally. The meeting between the employee and the Human Resources representative must be scheduled within seven (7) days following the employee's meeting with the division manager. The Human Resources representative shall be afforded two (2) work days in which to resolve the situation. If the matter cannot be resolved after two (2) work days, the grievant may proceed to Step 4.

Step 4. The employee shall reduce his or her grievance to writing and shall submit the grievance to the Director of Human Resources within two (2) working days following Step 3. The written statement of grievance shall contain at least the following information:

- A complete statement of the grievance;
- A complete statement of the facts pertinent to the grievance;

- A reference to the BBAHC policy or procedure alleged to have been violated;
- A suggested remedy or solution to the grievance;
- The date on which the employee became aware of the grievance; and
- The written grievance shall be signed and dated by the grievant.

A sample grievance form is attached to this policy. The Human Resources representative will review the grievance and inform the grievant of any deficiencies. This review process shall be completed within two (2) working days. If the written grievance meets requirements after necessary modification, the grievance will proceed to Step 5.

Step 5. The Human Resources Director shall refer the grievance to the Grievance Committee and certify that all steps have been timely completed and the matter is ready for hearing. If the grievance is deficient, the grievance asks for relief that cannot be granted, the grievance is untimely, or contains new or different allegations, the HR Director will reject the grievance in writing and the matter will not be further considered until all steps have been followed for all allegations. If the grievance is complete, the Grievance Committee shall accept the grievance for processing under the following procedures. Step 5 must be completed in less than five (5) working days.

Formation of the Grievance Committee. The Grievance Committee shall consist of three individuals including two non-exempt employees and one manager. The non-exempt employee members of the Grievance Committee will be selected from a pool of non-management, regular employees of BBAHC who have been appointed by the CEO or COO on an annual basis to serve on the grievance committee. Employees interested in serving on the Grievance Committee shall annually file applications in a format designed by the Human Resources Department to the CEO. In the absence of an adequate number of applicants, CEO may appoint individuals to serve on that committee.

The Grievance Committee shall convene a hearing on the grievance referred by the Human Resources Director under Step 5 of the grievance process no later than fourteen (14) calendar days following the completion of Step 5. The Grievance Committee shall select one of its members to serve as a chairperson who will then be primarily responsible for conducting the hearing. The management representative on the Grievance Committee may not chair the Grievance Committee. The chair of the Grievance Committee shall give written notice to the employee and BBAHC management of a reasonable advance notice of the date, time and location of the hearing within the allowed timeframe. The Committee will discuss and adopt any rules for the hearing including the number of witnesses, the time for opening and closing statements, and how evidence will be introduced.

Conflict of Interest.

No member of the Grievance Committee may participate if he or she has a conflict of interest regarding the people or issues involved in the grievance; provided however, a member will not be excused based on friendship or status as co-worker alone. A conflict of interest will be presumed for immediate family members, business partners, by those individuals who directly or indirectly supervise the grievant, or for those individuals who are witnesses or otherwise have first hand knowledge of the facts in dispute.

Hearing Procedure

1. The use of outside counsel is discouraged and the employee may not have his or her case presented by another individual. In the event an employee elects to be represented by an attorney, he or she must provide written notice to the Corporation in sufficient time for the Corporation to schedule an attorney to represent its interests. The management

representative selected after consultation between the manager(s) affected and the Human Resources Department shall investigate the facts, identify witnesses and be the advocate for management. This management advocate is not the management member serving on the Committee.

2. The Committee members may only consider that evidence presented by the grievant and the management advocate at the hearing. The Committee may not investigate the facts outside the hearing and should disregard any incidental knowledge they may have about the facts underlying the grievance.

3. The hearing process will be informal and the formal rules of evidence do not apply except as may be adopted by the Committee. All parties are expected to treat other people involved with respect.

4. The Committee may only consider those claims contained in the grievance and previously discussed in prior steps. In addition, the Committee may not consider documentary evidence not made available to both parties in the preceding steps.

5. The order of the hearing in general shall be as follows:

   a. The Chair shall introduce the other members and discuss procedural rules, time limits and other restrictions adopted by the Committee in its pre-hearing meeting.

   b. The grievant may make a brief opening statement outlining his or her grievance.

   c. The management advocate may make an opening statement setting forth management's position.

   d. The grievant presents his case through submission of documents and witness testimony. Each witness may be examined by the grievant before the management advocate cross-examines the witness. No other witness may be present during witness testimony.

   e. The management advocate puts on its case through submission of documents and witness testimony. Each witness shall be examined by the management advocate and then the grievant may cross-examine the witness.

   f. After each witness has been examined and cross-examined, the Committee members, acting with permission of the Chair, may ask direct questions of the witness, grievant or management advocate.

   g. The grievant may make a brief closing statement.

   h The management advocate may make a brief closing statement.

6. No witness may be present in the hearing room except to offer testimony and stand for cross-examination. <u>The entire Committee, the grievant and the management advocate must be present for the hearing to proceed and the Committee may receive no evidence if any of the parties are absent</u>.

7. The witness testimony and the arguments of management and the grievant shall be

recorded and the tapes preserved as a part of the official record of the proceedings. The Committee Chair shall be responsible for creating and preserving the record which shall include the recorded tapes and any documents produced during the hearing. Such official record shall be securely stored within the Human Resources Department at the conclusion of the hearing and may be made available for review by the CEO.

8. The Committee may not discuss the evidence or findings with any of the parties outside the hearing; provided however, the Committee may ask for clarification about the grievance policy through an inquiry to the Director of Human Resources.

Grievance Committee Deliberations.

After the grievance hearing is closed, the Grievance Committee shall retire and deliberate privately on the case. The grievance shall be decided by a majority vote of the Grievance Committee. The Grievance Committee will prepare a memorandum of decision which must include a concise statement of the issue or issues to be resolved, its finding regarding disputed facts, its findings regarding the application of facts to the applicable policy or procedure, its determination (to sustain or reject the grievance) and its remedy, if any. Copies of the memorandum of decision shall be furnished to the grievant, to the BBAHC management advocate, and to the CEO. Where the urgency of the case requires immediate action, the Grievance Committee may announce its decision orally and follow up within three days with its memorandum of decision. The decision of the Grievance Committee shall be final unless overruled by the CEO.

Actions by Chief Executive Officer.

1. The CEO shall have five (5) working days from receipt of the Grievance Committee's memorandum of decision to accept or reject its decision. If the CEO is absent when the memorandum of decision is presented, the COO shall act in the CEO's place. If both officers are absent, the five (5) working day time limit shall be tolled and shall not begin to run until one or the other officer returns to his office. The CEO or COO may review the official record of the hearing including the tapes of testimony and documents submitted in reaching his/her decision.

2. If the CEO (or the COO acting in his absence) does not reject the decision of the Grievance Committee within five (5) working days, the decision shall be considered accepted and shall be final. If the decision is rejected, the CEO (or the COO acting in his absence) shall state in writing the reason for rejection and shall specify what remedy, if any, will be afforded the grievant.

3. Copies of the CEO's written decision shall be furnished to the grievant, to the Grievance Committee and to the management advocate involved in the grievance.

Confidential Information.

1. The Record. As a general rule, records and testimony presented to the Grievance Committee and to the Chief Executive Officer upon review of the decision of the Grievance Committee shall be considered confidential and will be made available for review only by the parties to the grievance, the Grievance Committee, the COO and the CEO. If, upon request of any BBAHC supervisor or regular employee, the Grievance Committee finds that any testimony or records can be shared with the requesting party without unduly embarrassing or infringing the privacy of the parties to the grievance, the Grievance Committee may release such records and testimony as it deems appropriate in the circumstances.

2. The Decision. As a general rule, the written decisions of the Grievance Committee and the CEO are not confidential and may be disclosed to other BBAHC supervisors and employees. If any party believes that the decision contains information that should not be disclosed, that party may request that the relevant portions of the decision be deleted before the decision is released to others, or that the decision not be released at all. The Grievance Committee shall, in its discretion, decide what action to take in response to such requests, bearing in mind the importance of openness in the grievance process, the precedential effect of the decision and the parties' privacy interests.

Type of Policy: Personnel
Department: Personnel
Policy Location: Personnel Policies and Procedures

Approvals:

Director of Human Resources

President and CEO or Designee

Chairman of the Board of Directors
(or designee)

Replaces Policy:
Reference/Standard:
Issued: 07/01/05
Reviewed/Revised:

CENTRAL PENNINSULA
COUNSELING SERVICES

Central Peninsula Counseling Services
CLINICAL POLICIES AND PROCEDURES
General Clinical Policies

Client Rights **Policy #700.001**

Ronald D. Howes, PsyD — 25 May 02
Ronald D. Howes — Date
Clinical Director

Effective Date: May 01, 2002

Policy:

Every person admitted to Central Peninsula Counseling Services (CPCS) programs or services for mental health care shall be entitled to the following:

1. The right to appropriate treatment and related services in a setting and under conditions that:
   A. are the most supportive of the person's personal liberty; and
   B. restrict such liberty only to the extent necessary, consistent with such person's treatment needs, applicable requirements of law, and applicable judicial orders.

2. The right to an individualized, written, treatment or service plan (such plan to be developed promptly after admission of such person), the right to treatment based on such plan, the right to periodic review and reassessment of treatment and related service needs, and the right to appropriate revision of such plan, including any revision to provide a description of mental health services that may be needed after the person is discharged from such program or facility.

3. The right to ongoing participation, in a manner appropriate to such person's capabilities, in the planning of mental health services to be provided such person (including the right to participate in the development and periodic revision of the plan described in subparagraph (2), and, in connection with such participation, the right to be provided with a reasonable explanation, in terms of language appropriate to such person's condition and ability to understand, of:
   A. such person's general mental condition and, if such program or facility has provided a physical examination, such person's general physical condition;
   B. the objectives of treatment;
   C. the nature and significant possible adverse effects of recommended treatments;
   D. the reasons why a particular treatment is considered appropriate;
   E. the reasons why access to certain visitors may not be appropriate; and
   F. any appropriate and alternative treatments, services, and types of providers of mental health services.

4. The right not to receive a mode or course of treatment, established pursuant to the treatment plan, in the absence of the person's informed, voluntary, written consent to such mode or course of treatment, except treatment:
   A. during an emergency situation if such treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or

B. as permitted under applicable law in the cases of a person committed by a court to a treatment program or facility.

5. The right not to participate in experimentation in the absence of such person's informed, voluntary, written consent; the right to appropriate protections in connection with such participation, including the right to a reasonable explanation of the procedure to be followed, the benefits to be expected, the relative advantage of alternative treatments, and the potential discomfort and risks; and the right and opportunity to revoke such consent.

6. The right to freedom from restraint or seclusion, other than a mode or course of treatment or restraint or seclusion during an emergency situation is such restraint or seclusion is pursuant to or documented contemporaneously by the written order of a responsible mental health professional.

7. The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy to such person with regard to personal needs.

8. The right to confidentiality of such person's records. Such right shall exist after the person's discharge from the program facility.

9. The right to access, upon request, to such person's mental health care records, except such person may be refused access to:
   A. information in such records provided by a third party under assurance that such information shall remain confidential; and
   B. specific information in such records if the health professional responsible for the mental health services concerned has made a determination that such access would be detrimental to such person's health, except that such material may be made available to a similarly licensed professional selected by such person and such health professional may, in the exercise of professional judgment, provide such person with access to any or all parts of such material or otherwise discuss the information contained in such material to such person.

10. The right, in the case of a person admitted on a residential or inpatient care basis, to converse with others privately, to have convenient and reasonable access to the telephone and mails, and to see visitors during regularly scheduled hours, except that if a mental health professional treating such person determines that denial of access to a particular visitor is necessary for treatment purposes, such mental health professional may, for a specific, limited, and reasonable period of time, deny such access if such

mental health professional has ordered such denial in writing and such order has been incorporated in the treatment plan for such person. An order denying such access should include the reasons for such denial.

11. The right to be informed promptly at the time of admission and periodically thereafter, in language and terms appropriate to such person's condition and ability to understand, of the rights described here.

12. The right to assert grievances with respect to infringement of rights described in this section, including the right to have such grievance considered in a fair, timely, and impartial grievance procedure provided for or by the program or facility.

13. Notwithstanding paragraph (10), the right of access to (including the opportunities and facilities for private communication with) any available:
    A. rights protection service within the program or facility;
    B. rights protection service within the State mental health system designed to be available to such person; and
    C. qualified advocate; for the purpose of receiving assistance to understand, exercise, and protect the rights described in this section and in other provisions of law.

14. The right to exercise the rights described herein without reprisal, including reprisal in the form of denial of any appropriate, available treatment.

15. The right to referral as appropriate to other providers of mental health services upon discharge.

The rights described herein should be in addition to and not in derogation of any other statutory or constitutional rights.

Nothing herein should:

1. obligate an individual mental health or health professional to administer treatment contrary to such professional's clinical judgment.

2. prevent any program or facility from discharging any person for whom the provision of appropriate treatment, consistent with the clinical judgment of the mental health professional primary responsible for such person's treatment, is or has become impossible as a result of such person's refusal to consent to such treatment.

3. require a program or facility to admit any person who, while admitted on prior occasions to such program or facility, has repeatedly frustrated the purposes of such admissions by withholding consent to proposed treatment, or

4. obligate a program or facility to provide treatment services to any person who is admitted to such program or facility solely for diagnostic or evaluative purposes.

Procedures:

The statement of Client Rights and Responsibilities and the Grievance Procedure shall be given to each new client at the time of intake.

Central Peninsula Counseling Services
CLINICAL POLICIES AND PROCEDURES
General Clinical Policies

Client Grievances

Policy #700.002

Ronald D. Howes
Clinical Director

Date

Effective Date: May 01, 2002
Page 1 of 3

Policy:

Central Peninsula Counseling Services (CPCS) shall provide its clients with a way in which they can assert grievances and complaints without fear of retribution and expect them to be reviewed by the organization in a respectful, timely, and impartial manner.

Definition(s):

Advocate:

A person or organization designed by the customer to act on his or her behalf. Also an organization formally designed by the state or federal government to represent a class of people with disabilities.

Complaint:

Any issue determined by the customer or advocate involving a staff member's failure to perform a required service or duty toward a person in care, performing a service or duty in a manner below generally accepted standards of care, acting in an unprofessional manner, using the patient-therapist relationship to take advantage of the customer for material gain or which adversely affects the customer's welfare, or other matters of dissatisfaction.

Day:

For purposes of this policy, a day shall be considered a scheduled work day.

Frivolous:

A complaint or grievance which clearly fails to meet the specified criteria, an allegation which is without merit and lacking factual information supporting the claim, or an obvious attempt to embarrass or harass a staff member.

Grievance:

Any issue determined by the customer or advocate involving the organization's or program's failure to provide a necessary service which the customer had a right to receive discrimination in service provision except for reason mandated by statute, provision of a service below generally accepted standards of care, abandonment, failure to keep confidentiality as required by statue or other acts of omission, or commission by the organization or by a staff member following its policies.

Impartial Investigator:
CPCS employee who has no direct involvement with any customer or staff member who is a party to the complaint or grievance. Investigator may also be a person or persons from outside the organization invited by the Clinical Director to conduct an investigation.

Procedures:

Client Grievances and Complaints

1. Clients are encouraged to discuss any concerns they have about their care and treatment at CPCS with their primary clinician/provider or that person's supervisor. Attempts to seek informal resolution shall not affect their ability to seek formal redress through the Grievance/Complaint process described below. CPCS staff and supervisors are expected to respond to requests for informal resolutions of concerns in a timely manner.

2. If a client is not satisfied with the outcome of the informal resolution or elects to enter a formal complaint or grievance, then s/he shall specify the nature of his or her complaint or grievance in writing and submit it to the Clinical Director.

3. Upon receiving the complaint or grievance and determining that it is not frivolous, the Clinical Director shall either decide the issue on its merits or assign an impartial investigator to investigate the allegation(s), make a report on his or her findings, and make recommendations. The impartial investigator shall have 20 days to submit the investigation report. The impartial investigator may request additional time to complete the report. Such request shall be in writing to the Clinical Director and state specific reasons for requiring an extension of the time limit. The Clinical Director may grant the request based on the merits when s/he believes that the additional time necessary to improve the substance of the investigation outweighs this policy's timeliness principle for dispute resolution.

4. **Grievances**
The impartial investigator's report of a grievance shall be sent to the QARB, which shall review the report within 15 days. The QARB shall make recommendations for action, including taking no action, and submit these to the Clinical Director. The Clinical Director shall distribute copies of the report to the parties involved, take appropriate actions, and report to the Committee on disposition of case.

Client Grievances

Policy #700.002

Ronald D. Howes
Clinical Director

Date

Effective Date: May 01, 2002

5. **Complaints**
   A. A report involving a complaint shall be submitted to the Clinical Director who shall accept the report or ask the impartial investigator to submit further information within 5 days. When accepted, the Clinical Director will provide parties directly involved with a copy of the report.
   B. The parties shall have 5 days to respond to the complaint report. After the response period is ended, the Clinical Director shall take appropriate actions regarding the findings. Such actions may include disciplinary actions, if necessary, in accord with CPCS Personnel Policies and Practices. The Clinical Director's decision shall be final.

6. Employees involved as parties may appeal using the grievance and appeal procedures available to them through the CPCS Personnel Policies and Practices.

7. The Client Right and Responsibilities notice shall include information about the grievance process.

8. For clients' requests to inspect or receive a copy of their own clinical records, see the relevant section in Clinical Records policy. For the procedure for client to place a correction or dissenting note in their clinical records, see the relevant section in Clinical Records policy.

CENTRAL PENNINSULA
HOSPITAL
SERENITY HOUSE

central peninsula hospital

RECEIVED
JUL 16 2007
SOA/DH&SS/DBH

July 9, 2007

Dear Ms. Wells:

Attached is our grievance P & P (OP – 110) requested by Director Stone in a recent letter (copy attached). This policy is a hospital-wide Operational policy; it does not appear to adequately address all 11 points included in the State Grantee Grievance Procedures. If I am correct and you support modifying this policy, I can present this at our next Serenity House Advisory Committee meeting.

As a JCAHO certified facility, we are also obligated to comply with JCAHO standards regarding client Ethics, Rights, and Responsibilities. We anticipate a possible JCAHO review very soon, possibly even this month.

Please feel free to contact me if you need any additional documentation.

Sincerely,

Matt Dammeyer, Ph.D.

Matt Dammeyer, Ph.D.

Central Peninsula General Hospital, Inc, d/b/a

Central Peninsula Hospital

Heritage Place

Serenity House Treatment Center

250 Hospital Place, Soldotna, AK 99669 • (907) 714-4722 • www.cpgh.org

PURPOSE: To provide a resolution process for patients, visitors, and employees to register complaints or express concerns regarding the services provided by Central Peninsula Hospital and its satellite clinics and to provide guidance for these individuals about this process.

POLICY: Central Peninsula Hospital informs patients, families and staff about the complaint resolution process. Notices are placed in various locations in the hospital that notify patients of the mechanism for registering a "grievance" or complaint.

Central Peninsula Hospital receives, reviews, and, when possible, resolves complaints form patients and their families. The hospital responds to individuals making a significant or recurrent complaint.

Patients, visitors, and employees can freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services. Complaints and concerns are documented and investigated, and the findings tracked and trended.

The hospital informs patient about their right to file a complaint with the state authority.

The Complaint/Concern Form will be used by employees to document dissatisfaction or disagreement with another employee or department. Complaints/Concerns of this nature will be forwarded to the Department Director for resolution.

DEFINITIONS: COMPLAINT: An expression of dissatisfaction, pain or resentment.
CONCERN: A matter that relates to or affects one, or causes worry or anxiety.

RESPONSIBILITY: All Central Peninsula Hospital employees are responsible for documenting complaint/concerns and forwarding these to the appropriate individual(s).

The Clinical Resource Director or his/her designee, Department Directors, Supervisors, and House Supervisors are responsible for ensuring that timely investigation and resolution of complaints /concerns occurs. They will ensure that all complaint/concerns found to have a quality of care issue will be documented on an

incident report, and follow the policy and procedure for incident reports.

PROCEDURE:

1. An employee who receives or becomes aware of a complaint/concern will initiate a complaint/concern form with as much information as possible, sign and date the form. Employees will forward the Complaint/Concern form to the Director of Clinical Resource Management, Department Director, Supervisor, or the House Supervisor after regular business hours.

2. The Director of Clinical Resource Management and his/her designee is responsible to conduct an initial review of complaints/concerns from customers treated in that department, to resolve complaints/concerns when possible, and to review complaint/concern and outcomes with the Department Director. Department Directors, Supervisors, or House Supervisors can also conduct initial review of complaint or concern from customers treated in patient care areas and resolve complaints and concerns when possible. The Complaint form will be sent to the Director of Clinical Resource Management. Collaboration will occur with the Department Director, Supervisor, Director of Clinical Resource Management and Administration in the investigation and resolution process.

3. A call from the Director of Clinical Resource Management or his/her designee will be made to an individual who expresses a complaint/concern within 24 hours after complaint is received. Communication with complainant will continue until resolution is achieved, and a written response will be offered and sent to complainant if requested. The complaint/concern form and any supporting documentation (including written response to complainant) will be forwarded to the Director of Clinical Resource Management.

4. A monthly report aggregating and analyzing complaint data for review is compiled by Clinical Resource Management and reviewed by the Quality Board. When aggregate data relates to a specific department, this information will be given to the Department Director.

   NOTE: Customer complaints/concerns regarding quality of care and complaints made by a Medical Staff member or Allied Health Professional will result in documentation on the complaint/concern form and also on an incident report. The Complaint/Concern form will be forwarded to the Director of Clinical Resource Management, and the incident report will be forwarded to the Department Director/Supervisor for resolution.

   NOTE: If a customer asks to whom he/she may direct a complaint about the hospital or a physician, this individual will be provided with the following information:

   Health Facilities Licensing & Certification
   619 E. Ship Creek Ave, Suite 230
   Anchorage, Alaska 99501

(907)334-2483 phone
(907)561-3011 fax

After-Hours Complaint Hotline:

1-888-387-9387 (outside Anchorage)
or 563-0037 (within Anchorage area

Complaints regarding mammography require the following additional actions:

1. Facility must maintain documentation of serious complaints for three years.
2. CPH must provide the individual who submitted the complaint with information on how to contact the accrediting body for mammograms if we are unable to resolve their concern.
3. CPH must report unresolved serious complaints to the accreditation body as mandated by the accreditation body.

_____ _____

Chief Executive Officer Date

Review Date:

Original Date of Policy: 1989

Revision Date: 7/90, 9/92, 9/94, 4/95, 7/95, 2/98, 6/99, 6/00, 9/01, 8/02, 05/03, 4/07

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF BEHAVIORAL HEALTH

SARAH PALIN, GOVERNOR

ANCHORAGE OFFICE
3601 C Street, Suite 878
ANCHORAGE, ALASKA 99503-5924
PHONE: (907) 269-3600
FAX: (907) 269-3623
TOLL FREE: (800) 770-3930

June 27, 2007

Central Peninsula General Hospital
250 Hospital Place
Soldotna AK 99669

RE: Agency Grievance Policy & Procedure

Dear Matthew Dammeyer

In a continuing effort to maintain complete and updated grantee records Behavioral Health needs to receive a copy of your agency's Grievance Policy and Procedure. Alaska Administrative Code, 7 AAC 71.220, states that "a center must establish a grievance procedure by which a client may seek redress of grievances. A copy of the center's grievance procedure must be filed with the department and posted at the center."

As you know, the mission of Behavioral Health is to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships. Confirming that consumer complaints are properly handled is an important element in Behavioral Health's management of the behavioral health system. As a partner in providing effective consumer care we need to know and understand your agency's grievance procedure.

Attached to this letter is a copy of DHSS Behavioral Health policy and procedure: "Requirements for Grantee Grievance Procedures". This policy is based upon the Standards adopted by both Behavioral Health and the Alaska Mental Health Board in 2002 which were subsequently included as Conditions of Grant Award for 2002- 2004.

Please submit a copy of your grievance P&P to your BH Regional Specialist by July 31, 2007.

We appreciate your dedication and service to the peoples of Alaska.

Respectfully,

Melissa Witzler Stone,
Director Behavioral Health

COOK INLET COUNCIL
On
ALCOHOL & DRUG ABUSE
(CICADA)

COOK INLET COUNCIL ON ALCOHOL & DRUG ABUSE

CLINICAL POLICIES AND PROCEDURES

II. B.) POLICY FOR THE GRIEVANCE PROCESS

It is the policy of CICADA to insure the rights of persons served and in so doing provide for them a comprehensive means to appeal decisions about their treatment and for them to voice complaints about staff treatment that is neglectful, abusive or discriminatory. The persons served need to be fully informed of the grievance procedure, and need to feel free to file grievances without fear of recrimination or disruption of their treatment.

PROCEDURE FOR THE GRIEVANCE PROCESS

1. There are three levels of the grievance process which are activated by the person served depending on the nature of the complaint or the lack of resolution at a lower level.
   A. Level I is used for a disagreement with the treatment team or counselor. At this level the person served can file a complaint verbally or in writing with the clinical supervisor. The clinical supervisor will meet with the person served within five working days of the complaint. This meeting may include only the person served or may also include the involved staff. The person served also has the right to meet with the full treatment team to resolve a conflict regarding treatment issues. Results of this investigation will be reported to the person served verbally.
   B. Level II will be used if resolution is not reached at Level I or if the person served is reporting an occurrence of discrimination, abuse, or neglect. At this level the person served contacts the executive director either in writing or verbally. The executive director has five (5) working days to resolve the complaint with the staff and the person served. If that is not successful by the sixth (6) day, a written complaint can be filed with the President of the Board of Directors. The President of the Board has five (5) working days to begin an investigation of the complaint The executive committee has five (5) working days to decide if the complaint can be resolved at that level or if full board involvement is required. If the full board is required, they have an additional ten (10) working days to hear the complaint and either vote on a resolution or call in outside mediation. The person served will be notified in writing by the President of the Board of Directors of the decision of the board within five (5) working days of their decision.
   C. Level III will be used when resolution has not been reached at Level II or if the complaint is about the administrative staff or against the agency as a whole. The process at this level requires the person served to contact the Division of Alcohol and Drug Abuse where they will need to file a written complaint.

2. Every person served will be given a copy of the grievance procedure in the CICADA Handbook at the time of the evaluation. The counselor will review the process with the person served and have them sign a consent for treatment and receipt of the handbook that will become of the clinical file. Counselors will insure that the person served understands the process before the form is signed.
3. The person served has the right to have an advocate of their choosing present during any stage of the grievance process. Staff will assist the person served in locating an agency to provide advocacy services if the person served wants such an advocate.
4. There will be no retaliation or barriers to services to the person served during or after the grievance process. Whenever possible, information from the complaint will be processed to assist in making program improvements.
5. All grievances and complaints will be kept in a special file that will be reviewed by the executive director and the clinical supervisor to implement changes that will reduce future complaints and to identify performance improvements. All complaints and grievances will be logged into the file in chronological order.
6. CICADA does not support the restriction or restraint of any person served. In the case of an emergency situation involving a medical or violent crisis, staff will contact 911.
7. When the complaint or grievance involves the serious violation of professional ethics, it is cause for the termination of that employee. During the investigation of such a grievance, the employee will be placed on leave with pay until the investigation is completed.
8. Neglect or abuse of a person served is defined as any behavior on the part of a staff member that is physically or emotionally damaging to the person served, or to the treatment process. Such behaviors may include, but are not limited to:
   A. Sexual harassment or contact with the person served
   B. Physically striking or harming the person served
   C. Verbally degrading or ridiculing the person served
   D. Neglecting to respond to the medical needs of the person served
   E. Neglecting to respond to a suicide threat of a person served

COPPER RIVER
NATIVE ASSOCIATION

COPPER RIVER NATIVE ASSOCIATION

GRIEVANCE PROCEDURE POLICY

All CRNA Clients have the right to be treated in a manner that is both humane and dignified. All clients have the right to file a formal grievance if he/she believes that any Employee or any other individual in the program has mistreated them. All grievances will be filed with the Behavioral Health Sciences Director unless the grievance is against the Director. In this case, the grievance will be filed with the President/CEO.

1. Each client shall be informed of the policy and following procedures so that they have full know ledge of their rights in the grievance process.

2. A form (Client Notice of Grievance) is available to any client for filing a formal grievance against any CRNA Employee.

3. All grievances shall be filed in writing on the proper form unless a client is unable to prepare a written statement. In this case, a client will submit an oral complaint to the designated staff member. The staff member will draft the complaint and review it with the client. When both client and staff agree that it properly states the clients concern, the client will sign it.

4. All grievances must specify the nature of the complaint, the time, the day it occurred, and the staff member for which the complaint is lodged against.

5. The Behavioral Health Sciences Director shall take steps to resolve the complaint within seventy-two (72) hours after receipt of the complaint.

   A. (S) He can reject the complaint if (s) he deems it petty, made in bad faith or insubstantial, provided that (s) he may not reject the complaint without having made further inquiry what the complaint alleges violation of clients right.

   B. (S) He can resolve the complaint with the client and the staff member the complaint is lodged against. The Director can appoint an advocate to speak on the behalf of a client if it appears to be the best interest o the client.

6. Once the Director adjudicates the complaint, a written statement will be prepared indicating the results of the investigation and disposition of the complaint. This statement will be prepared and given to the client within forty-eight (48) hours of the resolution.

7. If the Director is not able to resolve the complaint as stated in paragraph 6, subsections A or B above, (s) he will prepare a summary of the complaint with description of his/her attempt at resolution. The summary will then be submitted to the President/CEO.

8. The President/CEO, CRNA, is to act within five (5) working days after receipt of the complaint.

9. A client may request that a designated staff member prepare a statement on the client's behalf to be placed in the complaint file.

10. Once the President/CEO, CRNA, reviews the complaint file, they will recommend an appropriate disposition of the complaint. The written response will be given to the client within Forty-eight (48) hours after the complaint is resolved.

11 During this process, a client's confidentiality must be preserved.

12. No client who has filed a complaint shall have his/her treatment or program participation affected by the taking of such action.

13. Form "Client Notification of Grievance" is considered part of this policy.

14. All clients will receive a copy of Grievance Procedures.

By my signature below, I indicate that I have read this form or had it read to me, that I fully understand its meaning. That I consent to its terms knowingly and voluntarily, and that I have not been under any undue duress or influence, nor under the influence of any alcohol or drugs.

Client Signature: _____ Date: _____

I, have witnessed the above-named clients signature on this form and certify that the above-named client has read or had this form read to him/her, that (s) he was not under the influence of any alcohol or drug, and that (s) he has been given a true copy of this form.

Staff Signature: _____ Date: _____

08/22/01

COPPER RIVER NATIVE ASSOCIATION

CLIENT NOTICE OF GRIEVANCE

TO: _____ DATE: _____

I hereby file a grievance against _____
for the following (specify act or condition, time, day of occurrence, and person accused of action):

_____

_____

_____

Signature: _____ Date: _____

****

STEP I: PROGRAM DIRECTOR'S RESPONSE

I find as follows:

_____

_____

_____

Signature: _____ Date: _____

****

STEP II: CLIENT'S RESPONSE

I find the response:

Satisfactory _____ Unsatisfactory _____ Received No Response_____

Signature: _____ Date: _____

****

STEP III: (As Necessary) TREATMENT COMMITTEE

Recommendation:

_____

_____

_____

Grievance Committee Members:

Signatures: _____ Date: _____

_____ Date:

_____

_____ Date: _____

_____ Date: _____

08/22/01

CORDOVA

Cordova Community Medical Center
Policies and Procedures

DEPARTMENT: Sound Alternatives Behavioral Health/Substance Abuse Treatment Services SUBJECT: Client Grievance Procedure Page 1 of 1	POLICY # EFFECTIVE DATE: May 01, 2007

Policy:

All consumers and/or their parent(s) or legal guardian have the right to file a formal grievance if they believe that their rights as consumers have been violated by Sound Alternatives/CCMC. Staff will help any consumer and/or their parent(s) or legal guardian understand the grievance procedure.

Note: the term 'consumer' as used below includes the parent(s) and legal guardian.

Procedure:

Client grievances will be addressed as follows:

- A consumer who believes that their legal rights have been violated may discuss the incident with the Sound Alternatives employee(s) involved, or with the Executive Director if unable/unwilling to meet with the involved staff. The Executive Director or their designee will investigate the complaint as thoroughly and respectfully as possible, and shall attempt to resolve the issue (where appropriate) while endeavoring to maintain the dignity of the consumer.
- If the problem is not resolved, the consumer can file a written grievance and submit it to the Director of Sound Alternatives. The Director will respond to the consumer in writing within seven days of being notified of the grievance.
- If the grievance is against the Director of Sound Alternatives, it should be forwarded to the Cordova Community Medical Center Administrator.
- If the problem is not resolved within 14 days of the grievance being received, the Cordova Community Medical Center Administrator may appoint a grievance committee.
- If the problem remains unresolved, the consumer has the right to take their grievance to the Division of Behavioral Health; contact information will be provided the consumer upon request.
- A copy of the letter of grievance, the results of the investigation(s) and the action(s) ultimately taken will be placed in a confidential file in the Cordova Community Medical Center Administrator's office.

DAYBREAK

Daybreak Mental Health Service Coordinators
Consumer Grievance Procedure

Policy

To provide a clear and accessible procedure for the effective resolution of consumer complaints or dissatisfaction with any aspect of treatment or services provided by Daybreak Incorporated.

Procedure

1. The consumer with the grievance (and/or designated representative is encouraged to meet with the person(s) involved in the grievance to attempt direct resolution to the problem. If a solution is reached which is satisfactory to the consumer, no further action is needed.
2. If the grievance is not resolved, the consumer (and/or designated representative) may request a meeting with the supervisor of the program (or designated representative in which the grievance originated). The meeting will be held within five (5) business days of receipt of the grievance. The consumer and the supervisor will discuss the problem and attempt to reach a solution satisfactory to all parties. A written report of this meting with corrective action will be completed and a copy given to the consumer.
3. If a solution cannot be reached, a private meeting between the consumer (and/or designated representative) and the Chief Executive Officer (or designated representative) will be arranged. The meeting with the Chief Executive Officer will be scheduled within five (5) business days of the meeting with the supervisor. The Chief Executive Officer will be provided with notes from the previous meeting. A written summary of the formal grievance heard by the Chief Executive Officer will be recorded including the corrective action.
4. If a solution is not reached, the consumer (and/or representative) may met with the Board of Directors in open or Executive session and seek resolution of the grievance. All information from earlier attempts to resolve the grievance will be made available to the Board and diligent efforts will be made to resolve the situation to the satisfaction of all parties. The decision of the Board is final with respect to Daybreak, Incorporated.
5. If a resolution has not yet been accomplished, the consumer (and/or representative) is directed to contact the Division of Mental Health and Developmental Disabilities. A copy of the formal grievance will be forwarded to the Division of Mental Health and Developmental Disabilities. The phone number is Toll Free 1-800-465-4828 or (907) 352-6301.

Daybreak Incorporated will subject no consumer who has submitted a grievance or has participated in a grievance procedure to any kind of retribution, retaliation or discrimination.

_____ _____ _____ _____

Client Signature Date Witness Signature Date

EASTERN ALEUTIAN TRIBES

Patient Satisfaction/Grievances:

Purpose:

To define for all consumers of services from the Eastern Aleutian Tribes (EAT) Clinics the process for giving feedback about the quality of services provided by our clinics and perceived need for improvements.

Procedure:

1. Patient satisfaction surveys are available in the waiting room of each clinic. These may be completed and sent in anonymously to Alaska Health Care Management Associates which will prepare a periodic report for the EAT management team and the board.

2. Annually a community needs assessment will be conducted in each village where there is an Eastern Aleutian Tribes clinic.

3. Clinic staff, to plan improvements in services, will use information from the above sources.

4. A patient with a specific complaint or grievance is encouraged to speak first with the clinic staff involved and if the issue cannot be informally resolved the patient is encouraged to take the matter to the Director of Medical Services or Medical Director either by phone or in writing.

5. If the grievance remains unresolved the patient may submit a signed and dated grievance to the Executive Director.

6. All grievances will be addressed in a timely manner ad the entire process should be completed in two weeks. If this time frame cannot be met the person who submitted the grievance must be informed in writing of the reasons for the delay and when the process will be completed.

1/96, 8/99, 12/00 Revised NoN
1/01, 3/02 Revised NoN
1/06, 01/07 Revised

FRONTIER
COMMUNITY SERVICES

POLICY AND PROCEDURE MANUAL

Frontier Community Services Red Diamond Center Soldotna, Alaska 99669	P & P No:	Date: 04-29-97
	Effective Date:	05-12-94
Subject: **Grievance Policy**	Approved By:	P & P Comm.
Department:	Section:	

Purpose

The purpose of this policy is to offer an avenue for individuals to voice any grievances they may have concerning services/treatment received from Frontier Community Services.

Policy

Individuals not satisfied with the services/treatment provided by the staff of Frontier Community Services and Early Intervention may bring complaints to the agency for resolution. These complaints may be brought by the individual or his/her representative (parent, guardian, or advocate). Outside resources for assistance may be utilized if necessary, i.e., Advocacy Services of Alaska or State Granting Agency.

Upon entry into a program and at least every six months thereafter, an individual and/or family member must be advised by his/her Care Coordinator of the right to present grievances. The Care Coordinator shall assist individuals, as may be necessary, in utilizing the Grievance Procedure.

Procedures

1. Upon entry into a program each consumer will be provided with a copy of the FCS Grievance Policy and asked to sign as statement indicating that s/he has been provided with such policy.

2. The FCS Grievance Policy will be explained to every consumer annually by Supervisor and/or Care Coordinator. Each individual or legal guardian will indicate by signature or mark that this policy has been explained to him or her.

3. Individuals displeased with actions or non-actions of any Frontier Community Services and Early Intervention employee on their behalf should attempt to resolve those dissatisfactions directly with the staff person involved by means of informal communication or discussion. Formal complaints must be made known within thirty (30) days of an action or event.

4. If the complaint is about any staff member other than the Executive Director:

a. The complaint shall be directed to the Executive Director;
b. The Executive Director will, within ten (10) working days, make a determination, after an investigation, of the validity of the complaint;
c. If the complaint is found to be valid, remedial action will be taken by the Executive Director and the action taken will be communicated to the person with the complaint if appropriate;
d. If the complaint is found not to be valid, this determination will be communicated to the person with the complaint, along with his/her right to appeal;
e. The employee shall receive copies of any written materials relating to the resolution of a complaint against him/her.

5. If the client is not satisfied with the outcome of the procedure by the Executive Director, s/he may appeal, in writing, to the Board of Directors. The Board will follow the same procedure for dealing with the complaint as above, in a hearing either a full Board at its next regularly scheduled meeting or through a committee or Hearing Officer appointed by the Board. In any event, the hearing will be conducted within thirty (30) days of the date of appeal, and a decision will be reached within thirty (30) days of the date of the hearing. The decision will be communicated in writing to the individual presenting the complaint and his/her representative, if appropriate, and the staff person involved.

6. If the complaint concerns the Executive Director, the complaint shall be directed, in writing, to the President of the Board of Directors. The same procedure as in Item #3 will be followed by the Board of Directors.

7. Copies of complaint, all investigation reports, minutes of any meetings, and resolution will be maintained in the individual's file, the personnel file of the staff person involved, and FCS permanent files.

8. The decision of the Board of Directors is final and binding on all parties.

9. If the grievance is a programmatic issue, appeal can be made to the Division of Senior and Disabilities Services, Division of Behavioral Health Division and the Office of Children's Services of the Department of Health and Social Services or the Division of Vocational Rehabilitation of the Department of Labor & Workforce Development, depending on the individual's fee sponsorship.

10. The consumer/family will also be referred to Advocacy Services of Alaska (phone: (800) 478-1234)

revised 7/18/07 cdl

Signature Page

I have reviewed the FCS Grievance Policy and agree to comply with it.

_____	_____
Date	Signature of Individual/Guardian
	_____
	Printed Name of Individual/Guardian
_____	_____
Date	Witness

revised 7/18/07 cdl

KENAI PENNINSULA
COMMUNITY CARE CENTER

KENAI PENINSULA COMMUNITY CARE CENTER
A Community of Caring for Alaska's Youth and Families
320 S. Spruce St., Kenai AK 99611
(907) 283-7635 Fax (907) 283-9575 Email care@gci.net

July 11, 2007

State of Alaska
Department of Health and Social Services
Division of Behavioral Health
3601 C Street, Suite 878
Anchorage, AK 99503-5924

Re: Agency Grievance Policy & Procedure

Dear Melissa Witzler Stone, Viki

Here is the copy of our current grievance policy and procedure. We will be updating and revising the policy to make sure that it meets the procedural guidelines that have been laid out. We will submit the updated policy and procedure as soon as it has been completed and approved by our board of directors. Thank you.

Sincerely,

Tammy Bidwell
Executive Director KPCCC

Kenai Peninsula Community Care Center

CLIENT GRIEVANCE PROCEDURE

As a client of the Kenai Peninsula Community Care Center, you have the right to initiate the grievance procedure if you feel you have been abused or discriminated against. The grievance procedure is as follows:

a. If appropriate, the client shall make all efforts to resolve the issue with the staff person involved. If the issue is not resolved then:

b. The client shall submit a written account of the grievance to the Program Manager. An investigation will take place within 5 working days and the program manager will meet with the client (and with the staff person involved when appropriate) within the five day period. If the issue is still unresolved then:

c. The client may submit a written grievance to the Executive Director. An investigation will take place within five (5) working days of receipt of the grievance. If a resolution is not reached by the sixth (6th) day then:

d. The client may file a written notice of complaint to the President of the Board of Directors. An investigation will take place within ten (10) working days and three of the four members of the Executive Committee will have another five (5) working days to determine if the complaint can be resolved or if the full Board of Directors should be informed. If the latter occurs, the full Board will meet within ten (10) days to hear the complaint and either vote on a resolution to the complaint, or call in outside mediation.

_____ _____

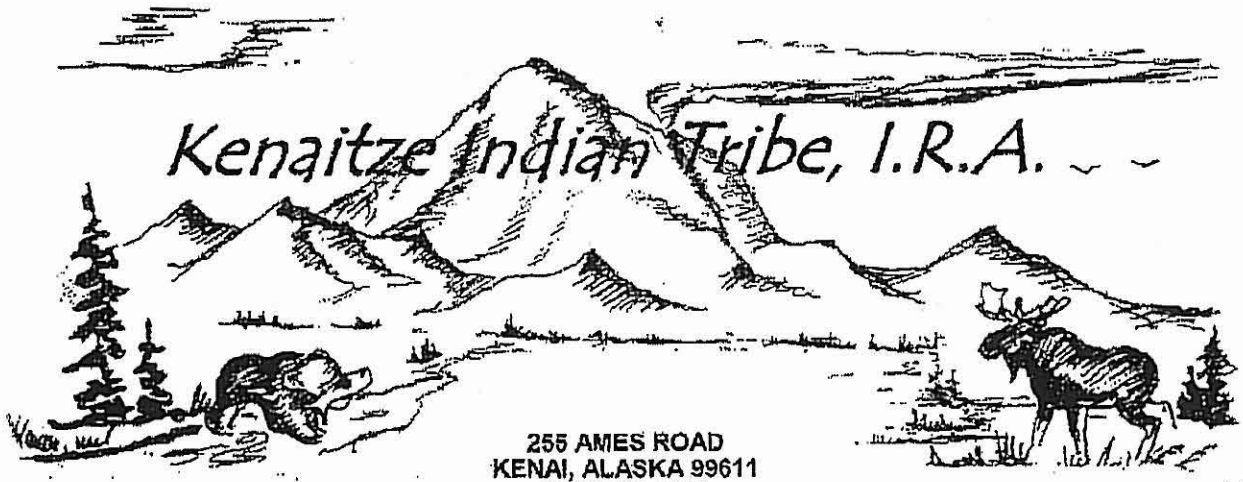
Date Client Signature

_____ _____

Date Witness

320 South Spruce St., Kenai, AK 99611/ (907) 283-7635 fax (907) 283-9575

KENAITZE INDIAN TRIBE, IRA



255 AMES ROAD
KENAI, ALASKA 99611
(907) 283-3633
Fax (907) 283-3052

Welcome

On behalf of your colleagues, I welcome you to Kenaitze Indian Tribe and wish you every success here.

We believe that each employee contributes directly to Kenaitze Indian Tribe's growth and success, and we hope you will take pride in being a member of our team.

This handbook was developed to describe some of the expectations of our employees and to outline the policies, programs, and benefits available to eligible employees. Employees should familiarize themselves with the contents of the employee handbook as soon as possible, for it will answer many questions about employment with Kenaitze Indian Tribe.

We hope that your experience here will be challenging, enjoyable, and rewarding. Again, welcome!

Sincerely,

Connie Wirz
Executive Director

Rosalee Tepp
Tribal Chair

Employees with questions on this policy or issues related to drug or alcohol use in the workplace should raise their concerns with their supervisor or the Human Resources Office without fear of reprisal.

Each employee, at the time of employment, shall read and sign a "Drug and Alcohol Free Work Place Statement", one copy of which shall be provided to the employee and one copy shall be placed in the employee's personnel file.

Client Grievance
Policy Number: 82

***** Denial of Emergency Room Claims will be referred to the Health Committee through the Health Clinic Manager.**

Client Rights
Any client of the Kenaitze Indian Tribe has the following rights:

1. To be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and personal care and respect for personal property, and including being informed of the name, licensure status (as applicable), and staff position and employer of all persons with whom the client has contact.
2. To receive appropriate and professional care without discrimination based on race, color, national origin, religion, sex, disability, age, socioeconomic status, language, reading ability, or any other condition protected under state or federal law; nor shall any such care be denied on account of the person's sexual orientation or marital status.
3. To receive services without regard to disability unless treatment by KIT would be hazardous to the individual.
4. To be fully informed of all fees associated with services received from KIT.
5. To be given clear information regarding participation regarding all program activities (i.e., attendance, program completion, etc.).
6. If in a program that provides individualized services, the right to participate in the development and periodic revision of his/her treatment plan or plan of care and to be informed in advance of any changes to the plan.
7. To refuse services within the confines of the law and to be informed of the consequences of such action, and to be involved in experimental research only upon the client's voluntary written consent.
8. To voice grievances and suggest changes in service or assigned staff without fear of restraint, discrimination, or reprisal.
9. To be free from emotional, psychological, sexual, and physical abuse and from exploitation by KIT providers.
10. To be ensured of confidential treatment of all information contained in the client's personal and clinical record, including the requirement of the client's written consent to release such information to anyone not otherwise authorized by law to receive it. Medical information contained in the client's record shall be deemed to be the client's property and the client has the right to a copy of such records upon request and at a reasonable cost.

11. To be informed in writing of reasons for the denial of services and any conditions to be met prior to re-application or reinstatement in a program.
12. To fair and impartial resolution of issues that may arise while receiving services from KIT.
13. To be informed of any other rights and responsibilities specific to the program or services the individual is receiving, and to receive a copy of client rights and responsibilities at the time of entry into services.

Client Responsibilities

1. To treat KIT employees with respect.
2. To be as accurate and complete as possible when providing information to KIT service providers.
3. To refrain from submitting frivolous complaints.
4. To abide by KIT service or program rules for the program in which he/she is involved.
5. To actively participate in decisions regarding any plan of care or services and to follow through with agreed upon actions in his/her individual plan.
6. To inform the program of any changes in personal information or status including address, name, income, etc.
7. To abide by any confidentiality rules required by his/her program.
8. To ask for clarification about any aspect of programs or services received which are not understood by the client.
9. To abide by client grievance procedures.

Complaint Resolution

Each recipient of KIT services has the right to initiate a complaint as needed. The program's written grievance procedures shall be used. Where these are unavailable, the following process shall be used for the resolution of client grievance:

Step 1: Informal Discussion

The client may request a meeting with the employee against whom the complaint is aimed or with the person most involved with the conditions resulting in the complaint; or the individual may request a meeting with the employee's supervisor or program/department director to attempt to resolve the problem at the earliest possible time. This step is to be completed prior to a written grievance.

Step 2: Formal Written Complaint

In this step, a written grievance statement must be presented to the Executive Director no more than 30 days from the time of the even that caused the complaint. The written complaint must include: 1) A description of the complaint; 2) the name of the KIT employee or condition about which the compliant is made; 3) the date when the problem arose; 4) proposed solution to the complaint; 5) signature of the client submitting the complaint; 6) date the complaint was submitted.

The Executive Director will conduct an administrative review within ten (10) working days of the presentation of the grievance statement, unless another timeline is mutually agreed upon by the client and the Executive Director. This step includes a meeting

between the Executive Director and the grievant(s) to discuss the grievance and attempt to resolve the matter, including developing a written agreement with the client. If no further appeal is made by the grievant within five days after the grievant receives the executive director's response, the executive director's decision is final.

If a client is not satisfied with the Executive Director's resolution of the grievance the client may submit an appeal to the Tribal Council who serve as the Tribe's Grievance Committee, thus initiating step three of the grievance process. Presentation to the Grievance Committee through the office of the Tribal Operations Director must occur within five (5) working days after the date the written decision was presented to the client.

Step 3: Appeal to Grievance Committee

- The Committee shall consider whether the grievance and appeal should be dismissed or investigated further. This need not require a hearing or other oral presentation. The Committee shall make all reasonable efforts to determine the facts regarding the allegations made in the grievance and to allow the Grievant and the employee against whom the grievance is directed a reasonable opportunity to present evidence or argument. If the Committee requests, legal counsel and or other assistance may be provided as necessary. Either a decision shall be rendered or a hearing shall be scheduled within 15 working days of the grievance appeal.
- If a hearing is decided upon the client and the involved personnel shall be given an opportunity to present in the Hearing any additional information not in their written statement, before the Grievance Committee. The Committee may request additional hearings, hear witnesses, or take any other action it deems appropriate to resolve the grievance. The Grievance shall render a written decision of the grievance within three working days of the final hearing session on the grievance.
- The procedures outlined in this policy and procedure manual under "Grievance Committee" shall apply to client grievances.

No grievance procedure exists beyond the final decision of the KIT Grievance Committee.

Tuberculosis Testing
Policy Number: 83

Tuberculosis continues to be a highly infectious, potentially life threatening disease. Because of the increase in tuberculosis worldwide, and in response to the Centers for Disease Control and Prevention's (CDC) recommendations regarding strategies for TB control, Kenaitze Indian Tribe will provide TB skin testing for its employees on annual basis.

All initial and follow-up TB skin tests shall be administered and interpreted by a Dena'ina Health Clinic health care provider or other licensed medical professional if the employee chooses to have the test done by his/her own provider. No one may interpret his/her own test. Tests shall be interpreted according to current Centers for Disease

KENAITZE INDIAN TRIBE
NAKENU FAMILY CENTER
110 N. WILLOW DRIVE
KENAI, AK 99611
(907) 283-6693
Fax (907) 283-7088

JENNIFER SHOWALTER-YEOMAN	Ext. 246	SASHA LINDGREN	Ext. 245
RAMSEY NASSAR/DAVID WILCOX	Ext. 235	JULIE HADDEN	Ext. 240
PAT TRUESDELL	Ext. 280	VIDE VAN VELZOR	Ext. 229
MICHAEL BERNARD	Ext. 242	MANDI HANSEN	Ext. 275
DANA VERRENGIA	Ext. 276	YVETTE TAPPANA	Ext. 227
TIA HOLLEY	Ext. 281	JACQUELYN CANOOSE	Ext. 268
MARTINA GEORGES	Ext. 224	TIM GILLIS	Ext. 248
CURT SHUEY	Ext. 277	PHILLIP LAZENBY	Ext. 251

FACSIMILE TRANSMITTAL SHEET

TO: Viki Wells
FROM: Jennifer
COMPANY:
DATE: 7/6/07
FAX NUMBER: 269-3623
TOTAL NO. OF PAGES INCLUDING COVER: 5
PHONE NUMBER:
SENDER'S REFERENCE NUMBER: (907) 283-7088
RE:
YOUR REFERENCE NUMBER: (907) 283-7088

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

MAT-SU HEALTH SERVICES INC

Mat-Su Health Services, Inc.

July 2, 2007

DHSS/DBH
Diana Weber
PO Box 110650
Juneau, AK 99811-0650

Dear Diana,

I am sending you a copy of our *Client Grievance Policy and Procedure* and related documents *Complaint Form*, and *How to File a Grievance* in response to Melissa Witzler Stone's request dated June 27, 2007 to comply with Administrative Code 7 AAC 71.220.

Please contact me at 352-3201 if you have questions in this matter.

Sincerely,

Angela Stein
Executive Assistant

RECEIVED
JUL 10 2007
SOA/DH&SS/DBH

Enclosures:
Client Grievance Policy and Procedure
Complaint Form
How To File A Grievance

1868 W. Spruce Avenue · Wasilla, AK 99654 · PH: 907-376-2411 · FAX: 907-352-3363
Member Agency United Way

Mat-Su Health Services, Inc.
Comprehensive Mental Health Services

Client Grievance Policy and Procedure

Policy

It is the policy of Mat-Su Health Services, Inc. that our clients be treated with dignity, respect, individuality and with consideration for your privacy. If you are dissatisfied with services or feel your rights have ben infringed upon, you may report your concerns to a Program Director or to the Chief Executive Officer.

Procedure

1. Thoroughly review the form entitled *Client Rights and Responsibilities*. This form is given to you and signed when you become a client.

2. Briefly describe in writing what right has been violated and submit your concern in a sealed envelope to either the Children's Services or Adult Services Program Director. Any staff member can assist you in identifying who the Program Director is.

3. In the event your concern is with a Program Director, please submit your statement to the Chief Executive Officer.

4. The envelope will be routed to the appropriate individual for review and follow-up. Follow-up contact with you will occur within 48 hours.

5. It is the responsibility of the Program Director to review all client grievances, meet with the client, meet with any other staff involved, investigate the grievance and report findings in writing to the Chief Executive Officer.

6. Findings, resolutions/actions and/or recommendations will be communicated with you, the client in a timely manner.

Mat-Su Health Services, Inc.

Complaint
(Under Grievance Procedure)

Please complete this form and submit it to the supervisor of the person whose actions are being grieved.

Today's Date: __/__/__

Date Incident Occurred or Complaint Originated: __/__/__

Who are the persons involved in the situation?

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

Statement of Complaint: _____

Steps Already Taken to Resolve the Complaint: _____

Remedy Expected: _____

Signed _____ Date _____

Mat-Su Health Services, Inc.
How to File a Grievance

Rights

If you are dissatisfied with services, or feel your rights have been violated you have the right to file a grievance. You can file a grievance for yourself or for a family member.

You may have someone help you fill out your complaint. You can have that person with you whenever you discuss your grievance with Mat-Su Health Services. You may contact the Disability Law Center, Alaska Consumer Mental Health Web, and/or NAMI-Alaska to assist you.

You can expect to be informed within five days of filing the grievance or of the grievance being moved to the next level. You will be informed in writing. If we cannot respond within five days we will tell you in writing why we cannot respond that quickly.

You may file your grievance in writing or verbally either in person, or over the telephone.

You have the right to be free from intimidation or retaliation for filing a grievance.

Please provide as much detailed information as possible about your grievance when you file it.

Please tell us what actions you think will fix the problem for you.

Process

Step 1: Please file your grievance with the program's supervisor. That person will investigate your complaint. He or she will work with you to resolve your grievance.

Step 2: If you are dissatisfied with the results of Step 1, you may appeal in writing to the Grievance Officer. The Grievance Officer will review Step 1, collect any additional information needed and work with you to resolve your grievance.

Step 3: If you are dissatisfied with the results of Step 2 you may appeal in writing to the Chief Executive Officer. The Chief Executive Officer will review the findings of Steps 1 and 2, collect any additional information needed and work with you to resolve your grievance.

PROVIDENCE
KODIAK

Providence | Kodiak Island Counseling Center

717 East Rezanof Drive
Kodiak, Alaska
99615

Tel 907.481.2400
Fax 907.481.2419
Safe Harbor
Fax 907.481.2416

To whom it may concern,

This is a copy of our grievance policy, in progress. We are going to update it to be in compliance with the state requirements. I will get a copy to you as soon as this is complete.

Thank you,

Melanie Nelson, Director
Providence Kodiak Island Counseling Center

PROVIDENCE HEALTH SYSTEM - ALASKA REGION

Subject: Patient Complaint Management	Number: R300.002 Page: 1 of 4
Date Signed: 7/29/2006 Approved by: Effective Date: 8/3/2006 /s/ Al Parrish, Vice President/Chief Executive Providence Health System – Alaska Region	Original Effective Date: 9/30/2006 Review Dates: 6/06, 4/05, 5/04 Revision Dates: 6/06, 4/05
Policy Author: Val Tobin /s/ Service Excellence Manager	Note: Current revisions are in blue Italics.

I. PURPOSE/SCOPE

To improve the satisfaction of those we serve, and to identify opportunities for improvement.

II. POLICY

In keeping with the philosophy and mission of Providence Health System, Providence Health System in Alaska provides systems to receive, promptly investigate, respond to, and resolve complaints made by patients/residents and their families.

III. DEFINITIONS

Respond: *Electronic UOR*

IV. SPECIAL CONSIDERATIONS

A. Patient (resident/client/visitor) complaints must be documented through the appropriate facility complaint or UOR form. (Facilities that have access to the electronic UOR (Respond) are encouraged to submit electronic reports.)

B. Allegations of damage, loss, or theft of personal property will be referred immediately to the Department Supervisor, *or Security Department if appropriate*, and entered on an electronic or paper UOR for investigation and reporting. The Department Manager is responsible for the

investigation of allegations of damage or loss involving teeth, eyeglasses, hearing aids, prescriptions, prosthesis, clothing, or other personal belongings. If the investigation reveals that Providence has liability for the loss, contact Risk Management for a resolution. The department responsible for the loss will be billed for the replacement of the lost item.

IV. GENERAL INSTRUCTIONS

A. *Upon receipt of the complaint,* document in the electronic UOR (RESPOND Software) or the appropriate format for the facility.

1. If the complaint is regarding a current patient or resident, transfer responsibility for resolution of the complaint to the Manager of the appropriate area.

2. If the *Customer* would rather not speak with *involved* staff, contact the Supervisor, Manager or the designated person at the facility. Any patient may also call the complaint line 1-800-510-3375 *or 907-261-3615.*

3. *Concerns being called into the facility will be forwarded to the appropriate person in the facility (I.e. PAMC calls will be forwarded to the Customer Service line 3615). See attachment listing appropriate contact information at all facilities (Attachment A).*

B. The person investigating the complaint will *promptly* speak directly with *the concerned individual if possible, and work towards resolution as quickly as possible.* Usually, complaints that are easily and immediately addressed and are not of an unusual or significant nature should not be recorded *as an unusual occurrence* unless there appears to be a trend in these types of complaints. *Initiate service recovery in these situations.*

C. If the complaint concerns the medical practice or behavior of a treating practitioner regarding care at a Providence site, the complaint will be referred to the *appropriate person consistent with the Bylaws and Practices of the facility.*

D. *Customer Service or facility designee will review all complaints, assign department investigator, and generate the acknowledgement letter to be sent to the Customer.*

E. The person filing the complaint must receive a written response within a time frame of seven days. If a resolution has not been reached in this time period the person investigating the complaint must contact the

complainant in writing to let them know of the progress and provide them with another date in which they will provide a resolution or be in contact again if the investigation is not yet complete.

F. *If the complaint concerns the medical practice or behavior of a treating practitioner at Providence Alaska Medical Center, the complaint will be referred to the Clinical Manager and if necessary to the Chief Medical Officer for handling as a peer review function*

G. Letters written in response to complaints about the medical practice of a physician for patients not cared for at a Providence site will include a statement that the State Medical Board of Alaska is the authority that investigates complaints regarding a physician's private practice. As a professional courtesy, the responding Manager will notify the subject of the complaint of the issue received.

H. If the complaint concerns allegations of privacy or information security violations, *file an unusual occurrence report, the Region Privacy Officer or facility Privacy Liaison will be assigned to investigate* to ensure the appropriate investigative process is completed.

I. All resolutions to complaints must include written notice of the facilities decision, which contain the name, and contact information of a facility contact person, the steps taken on behalf of the patient to investigate the complaint and the date of completion.

J. If the patient is not satisfied with the initial resolution offered, and wants to speak with another management or medical staff representative, that will be facilitated by *Customer Service/*Risk Management staff. In these situations the Unusual Occurrence form must be initiated. *The Administrator responsible for the area will review unresolved issues.*

K. Risk Management staff *or designated staff* will review all complaints to identify patterns or trends that may represent opportunities for improvement activities with the appropriate Quality Councils at the facilities.

L. The Providence Health System Alaska Region Board has delegated the responsibility oversight of complaints to the Event Triage Committee (ETC) *or the appropriate facility quality council.*

V. CROSS REFERENCES

Attachment A – Contacts for Patient Complaints
Form #8611-009 – Patient Complaint Management form (form is on PHSA Intranet)
HIPAA Privacy Regulations
JCAHO Standards
Medicare Conditions of Participation

End of Policy

This policy replaces previous policy:
R300.002, effective date 9/30/2002, and reviewed 5/6/2005.

Attachment A
Contacts – All Facilities

PAMC Charlotte Sey or Val Tobin Customer Service 3200 Providence Dr. Anchorage, AK 99519-6604 261-3615 Complaint line 24/7 743-2647- Charlotte Sey 261-6088- Val Tobin	**Providence Mental Health Unit** Cindy Gough, Director Providence Acute Care Behavioral Health/Psych ED 3200 Providence Drive Anchorage, AK 99508 Phone: (907) 261-3007
Psych Emergency Department Marc D. Pellicciaro, M.D. Medical Director, Psychiatric Emergency Room Providence Alaska Medical Center 3200 Providence Drive Anchorage, AK 99508 Phone: (907) 273-7851 Fax: (907) 261-2807	**Providence Family Medicine Clinic** Carol Lang Practice Manager 1201 E 36th Ave Anchorage, AK 99508 Main number 562-9229 Direct line 273-9313
PBMG-Langdon Wendy Bills (out on maternity leave mid-May to August) Practice Manager PBMG Langdon Clinic 4001 Dale St Ste 101 Anchorage, AK 99508 907-550-2311	**PBMG-North Wasilla** Sandy Hobbs Operations Supervisor 1700 E Bogard Suite 201 Wasilla, AK 99654 Main phone: 373-8080 Direct line: 352-5812
Breakthrough Laura Pierce Administrative Coordinator 2401 East 42nd suite 103 Anchorage Alaska 99508 907-273-0438	**Tiffanie Gerkman** (during Wendy's absence) Billing Lead PBMG Langdon Clinic 4001 Dale St Ste 101 Anchorage, AK 99508 907-550-2332
Providence Imaging Center Paulette Compton Clinical Manager, PIC 3340 Providence Drive Anchorage, AK 99508 907 261 5699	**Providence Mat-Su Health Clinic** Debra Brannon Practice Administrator 1700 E Bogard Rd BLDG A Ste. 100 Wasilla, AK 99654 907-352-6216
Mary Conrad Center Jody Howorth Administrator - Mary Conrad Center 9100 Centennial Drive Anchorage, Alaska 99504 Direct Line: 907-269-3201 Fax: 907-338-6789	**Providence Extended Care Center** Penny Meador, Director 4900 Eagle Street Anchorage, AK 99503 Phone: (907) 762-0250 David Hribar, Resident Services Director 4900 Eagle Street Anchorage, AK 99503

Attachment A
Contacts – All Facilities

	Phone (907) 762-0239
Providence Home Health Care Debbie Seidl, Director 3546 La Touche Street, Suite 101 Anchorage, AK 99508 907-563-0130	**Providence Horizon House** Sue Samet, Director Phone: (907) 261-4143 Theresa Gleason, Resident Services Coordinator Phone (907) 261-4167
Providence Valdez Medical Center Pauline Doucet Director of Patient Care Services PO Box 550, Valdez 99686 Direct Line: 907-834-1844	**Providence Adolescent Residential Treatment Program** Renee Rafferty Clinical Director 3400 E 20th Anchorage, AK 99508 272-2148
Providence Seward Medical Center Kathleen R. Kloster Administrator P.O. Box 365 Seward, AK 99664 (907) 224 2874	**Providence Kodiak Island Medical Center** Linda J. Lance Medical Staff /Risk Services Providence Kodiak Island Medical Center 1915 E. Rezanof Drive Kodiak, AK 99615 907-481-2458 (phone) 481-2491 (fax)

PROVIDENCE KODIAK MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL POLICY # 500.04

CLIENT GRIEVANCES

Policy: The Providence Kodiak Mental Health Center shall provide its clients with a way in which they can assert grievances and complaints without fear of retribution and expect them to be reviewed by the organization in a respectful, timely, and impartial manner.

Definition(s):

Advocate: a person or organization designated by the client to act on his or her behalf. Also an organization formally designated by the state or federal government to represent a class of people with disabilities.

Complaint: any issue determined by the client or advocate involving a staff member's failure to perform a required service or duty toward a person in care, performing a service or duty in a manner below generally accepted standards of care, acting in an unprofessional manner, using the patient-therapist relationship to take advantage of the client for material gain or which adversely affects the customer's welfare, or other matters of dissatisfaction.

Day: for purposes of this policy, a day shall be considered a calendar day which, for counting purposes, includes weekends and holidays.

Frivolous: a complaint or grievance which clearly fails to meet the specified criteria, an allegation which is clearly and patently absurd and without merit on its face, an obvious attempt to embarrass or harass a staff member.

Grievance: any issue determined by the client or advocate involving the organization or program's failure to provide a necessary service which the client had a right to receive, discrimination in service provision except for reason mandated by statute, provision of a service below generally accepted standards of care, abandonment, failure to keep confidentiality as required by statute, and other act of omission or commission by the organization or by a staff member following its policy.

Impartial Investigator: a PKMHC employee who has no direct involvement with any client or staff member who is a party to the complaint or grievance. The investigator may also be a person or persons from outside the organization invited by the Director to conduct an investigation.

Procedures:

Client Grievances and Complaints

1. Clients are encouraged to discuss any concerns they may have about their care and treatment at PKMHC with their primary clinician/provider or that person's supervisor. Attempts to seek informal resolution shall not affect their ability to seek formal redress through the Grievance/Complaint process described below. PKMHC staff are expected to respond to requests for informal resolutions of concerns in a ~~timely manner~~. 7 days + record. Complaint + response documents in client
2. If a client is not satisfied with the outcome of the informal resolution or elects to enter a formal complaint or grievance, then ~~s/he~~ shall specify the nature of ~~his or her~~ complaint or grievance in writing and submit it to the Director. The client will be provided with the names and contact information about advocacy groups who may be able to provide assistance. PKMHC staff shall provide the client with information about these organizations, but shall not assist in drafting the complaint because of the inherent conflict of interest. 30 days
3. Upon receiving the complaint or grievance and determining that it is not frivolous, the Director shall either decide the issue on its merits or assign an impartial investigator to investigate the allegation(s), make a report on ~~his or her~~ findings, and make recommendations. The impartial investigator shall have 30 days to submit the investigation report. The impartial investigator may request additional time to complete the report. Such request shall be in writing to the Director and state specific reasons for requiring an extension of the time limit. The Director may grant the request based on the merits when ~~s/he~~ believes that the additional time necessary to improve the substance of the investigation outweighs this policy's timeliness principle for dispute resolution. 1 day
4. The impartial investigators report of a Grievance shall be sent to the Chair of the Quality Review Committee. The Quality Assurance Committee shall review the report within 15 days. The Quality Assurance Committee shall make recommendations for action, including taking no action, and submit these to the Director. The Director shall distribute copies of the report to the parties involved, take appropriate actions and report to the Committee on the disposition of case.

5. A report involving a Complaint shall be submitted to the Director who shall have to accept the report or ask the impartial investigator to submit further information within 5 days. If accepted, the Director will provide parties directly involved with a copy of the report.

6. The parties shall have 5 days to respond to the Complaint report. After the response period is ended, the Director shall take appropriate actions regarding the findings. Such actions may include disciplinary actions, if necessary, in accord with PKMHC Personnel Policies and Practices.

7. An appeal to the Director's decision may be made by any non-employee party involved by writing to the CEO of the Providence Kodiak Island Medical Center stating the basis for requesting the appeal. The CEO may elect to review the issues based on the significance of the issue for PKMHC. The CEO's decision shall be final.
8. Employees involved as parties may appeal using the grievance and appeal procedures available to them through the PKMHC Personnel Policies and Practices.

The Client Rights and Responsibilities notice shall include information about the grievance process.

For clients' requests to inspect or receive copy of their own clinical records consistent with policies governing clinical records and policies and procedures as well as the procedure for clients to place a correction or dissenting note in their clinical record, see the relevant section in the Clinical Records policy.

9. No employee ——

Approved:_____

PROVIDENCE
VALDEZ

PROVIDENCE VALDEZ BEHAVIIORAL HEALTH	Revised: Reviewed: New Effective Date: 7/31/07	Page 1 of 2	Number: 500.04
Subject: **Client and their family Grievance Procedure**	**Approved:**		

I. POLICY

In keeping with the philosophy and mission of Providence Health System, the Providence Valdez Behavioral Health shall provide its clients and their families with a way in which they can assert grievances and complaints without fear of retribution and expect them to be reviewed by the organization in a respectful, timely, and impartial manner.

II. PURPOSE SCOPE

To describe how the client grievance process is completed.

III. DEFINITION (S)

Deleted: ¶

Complaint: any issue determined by the client to advocate involving a staff member's failure to perform a required service or duty toward a person in care, performing a service or duty in a manner below generally accepted standards of care acting in an unprofessional manner, using the patient-therapist relationship to take advantage of the client for material gain or which adversely affects the customer's welfare, or other matters of dissatisfaction.

Day: for purposes of this policy, a day shall be considered a calendar day which, for counting purposes, does not include weekends and holidays.

Grievance: any issue determined by the client or advocate involving the organization or program's failure to provide a necessary service which the client had a right to receive, discrimination in service provision except for reason mandated by statute, provision of a service below generally accepted standards of care, abandonment, failure to keep confidentiality as required by statute, and other acts of omission or commission by the organization or by a staff member following its policy.

IV. PROCEDURE

Client Grievances and Complaints

1. Providence staff will not intimidate or retaliate against consumer who has filed a grievance.

2. Clients and their families are encouraged to discuss any concerns they may have about their care and treatment at PVBH with their primary clinician/provider. Attempts to seek informal resolution shall not affect their ability to seek formal redress through the Grievance/Complaint process described below. PVBH staff are expected to respond to grievances and complaints within 24 hours to ensure resolution in a timely and therapeutic manner.

3. The clinician/provider shall then submit in writing to the Director/Administrator their experiences of the complaint and any attempts made to resolve it.

4. Clients and their families are encouraged to submit their grievances orally, in person or via phone or email.

5. Clients and their families may also submit a written grievance on the Grievance Form provided by Providence Staff that includes an optional waiver of confidentiality. Waivers are subject to disclosures in writing outlining specifically to whom and what information is to be given out in the process of an investigation.

6. If a client or their family is not satisfied with the outcome of the resolution they have a right to present the grievance to the Director of PVBH. The Director must address the client or their family that is not satisfied within three days of the request. If the Director is unavailable, the Administrator of Providence Valdez Medical Center will meet with the client. If the grievance is not resolved within the three-day period, a written notification shall be sent to the client by the end of the 3rd day from receipt of grievance explaining why and identifying when the grievance process can reasonably be initiated and should be no longer than 30 days of the receipt of grievance. If the grievance remains unresolved after 30 days, the director or administrator will contact the Division of Behavioral Health for technical assistance.

7. If the client or their family is still not satisfied with the outcome of the resolution they will be provided with the names and contact information the client will be given information for the State Ombudsman, NAMI, Disability Law Center, and/or the Department of Behavioral Health who may be able to provide assistance. Or upon client request, the director/administrator will provide a staff member to assist in filing the grievance that also includes a written referral to consumer advocacy resources such as the Disability Law Center, NAMI, or the State Ombudsman. Contact information will be given to the client within 24 hours of the request from the client.

8. At any time clients and their families have a right to designate a representative or advocate assisting them with all steps of the grievance process.

9. The Client Rights and Responsibilities notice shall include information about the grievance process. At intake each client will be explained the grievance procedure and sign on the Consent to Treatment Form receipt of the grievance Procedure.

10. All allegations of abuse/neglect or unnecessary seclusion or restraint must be investigated and reported to the appropriate authorities and the Advisory Council for Providence Valdez Behavioral Health; typically this would be the local police department. The investigation will result in either a substantiated or unsubstantiated allegation.

11. Providence Staff will store grievance reports and all documents related to the grievance separate from client files. These records will be stored in a locked cabinet and confidentiality shall be maintained throughout the entire process.

V. CROSS REFERENCE

End of Policy

This policy integrates these previous policies:

SEAVIEW COMMUNITY SERVICES

TITLE: CONSUMER RIGHTS, RESPONSIBILITIES, AND GRIEVANCE PROCEDURE Seaview	PROGRAM/SECTION: Administration
FORMS AND ATTACHMENTS: none	INITIATED: 1984
	BOARD REVIEWED: 9/96, 3/98
APPROVED BY EXECUTIVE DIRECTOR:	BOARD REVISED: 9/95, 8/98, 3/00, 2/01, 11/01, 3/06, 4/07

CONSUMER RIGHTS, RESPONSIBILITIES, AND GRIEVANCE PROCEDURE

Persons served by SeaView Community Services, without regard to services used or funding source and all consumers denied access to services have rights and responsibilities. Seaview is firmly committed to full and positive compliance with the provisions of Title VI and VII Civil Rights Act.

SeaView WILL NOT on the grounds of gender, race, color, religion, national origin, handicap or financial condition:

- Deny an individual any service or other benefits for which they are eligible at SeaView Community Services.
- Provide any service(s) or benefits to an individual which are different, or which are provided in a different manner from those services and benefits provided to other persons under the same specific program.
- Restrict an individual from enjoyment or any other advantage or privilege in any way different from restrictions placed on others receiving any service(s) or benefits under our program.
- Treat an individual differently from others in determining whether s/he satisfies any eligibility or other requirement or condition which individuals must meet in order to receive any aid, care, service(s), or other benefits under SeaView programs.

Consumers of SeaView Community Services have a right to the following:

- To take part in designing and evaluating their own treatment/service plan.
- To be informed of their present condition, diagnosis, progress and prognosis.
- To the confidentiality of all records unless written consent is given, except as required by law.
- To access protective and advocacy services.
- To refuse care, treatment, and services in accordance with law and regulation.

In the event the consumer wants to file a grievance, the procedure required by the source funding the consumer's services will be followed.

In the event of any report of any form of physical, sexual or mental abuse, or unnecessary restraint, the Team Leader/Supervisor or Executive Director, will IMMEDIATELY investigate the complaint. It the report is substantiated by the investigation, the employee or employees responsible will be subject to disciplinary action as prescribed in the personnel policies.

TITLE: INTAKE	PROGRAM/SECTION: Behavioral Health
FORMS AND ATTACHMENTS: **Application for Services** form **Treatment Authorization** form **Client Rights and Responsibilities** form **Alaska Screening Tool** **Client Status Review/Follow-up** form	INITIATED: 1972 BOARD REVIEWED:
APPROVED BY EXECUTIVE DIRECTOR:	BOARD REVISED: 2/96, 2/97, 9/00, 3/02, 1/05, 12/06, 4/07

INTAKE

POLICY

Individuals requesting behavioral health services will be scheduled for an intake procedure promptly to get background information on the client, to inform the client of program/treatment expectations, establish financial arrangements, to inform the clients of their rights and responsibilities and the grievance procedure, to sign authorization forms, and to provide basic information about the person(s) responsible for delivery of their care, treatment and services.

PROCEDURE

The Office Coordinator normally schedules a person being admitted to treatment for an intake session and a financial interview with the Accounts Receivable Accountant at the same time. The first appointment with a counselor for the comprehensive assessment may occur following the intake or on another date, whichever the customer chooses.

During intake the person will receive copies/complete the following required paperwork (see administrative policies):

(1) Consumer to sign and receive a copy of the **Client Rights and Responsibilities and Grievance Procedure form.**

(2) Consumer to receive a copy of the **Notice of Privacy Practices** and to sign the **Acknowledgement of Notice of Privacy Practices and Electronic Record**

(3) Consumer will sign the **Authorization for Release of Information** (if applicable)

(4) Consumer will complete the **Application for Services** form (attached) which requests information needed by SeaView for billing, for phone contact, emergency numbers and information needed to complete the AKAIMS reporting requirements. The responses are entered into AKAIMS by the Office Coordinator. ID verification will be performed prior to treatment, however, should not be a barrier to obtaining services. A client signature is required verifying that correct information was obtained.

(5) **Treatment Authorization** (attached) form which gives SeaView authority to provide treatment. If the treatment is for minor child (under the age of 18), this form must be signed by the Parent or legal guardian of the minor child.

(6) **Alaska Screening Tool,** a required State form which assesses for substance abuse and mental health issues and traumatic brain injury to ensure that comprehensive assessment and treatment is provided. The responses are entered into the AKAIMS system by the Office Coordinator.

(7) **Client Status Review (CSR),** a required State form which measures treatment outcomes completed at the time of intake, at discharge, 6 months after discharge, and 12 months after discharge. The responses are entered into the AKAIMS system by the Office Coordinator.

After the client completes the paperwork, administrative staff enter the intake information into the AKAIMS system to start an electronic file on the client. The Office Coordinator also puts together a hard-copy chart where the intake forms are filed.

If the client has special needs, for example, requires language interpretation, these are addressed at intake.

Paperwork relating to fees, payment agreement, insurance, etc., is handled by the Accounts Receivable Accountant as described in the policy, **Fee Setting**.

SeaView Community Services

SEAVIEW COMMUNITY SERVICES

CLIENT'S RIGHTS AND RESPONSIBILITIES AND GRIEVANCE PROCEDURE

SeaView Community Services will treat all clients with dignity, respect, individuality, with consideration for privacy, confidentiality and security. SeaView will provide all of its clients a process for addressing grievances in a respectful, timely, and impartial manner without fear of retribution. All grievances will be treated as genuine and a resolution pursued accordingly.

YOU HAVE A RIGHT:

- To take part in designing and evaluating and periodically reviewing your own treatment/service plan including requesting specific forms of therapy, being informed why requested forms of therapy are not made available, refusing specific forms of therapy that are offered, and being informed of treatment prognosis.
- To the confidentiality of all records except with your written consent.
- A client will be informed by the prescribing physician of the name, purpose, and possible side effects of medication prescribed as part of the client's treatment plan at the center;
- To inspect and copy, request restrictions and confidential communications, amend, and to receive an accounting of disclosures of your protected health information (PHI).
- To file a grievance.

YOU HAVE A RESPONSIBILITY:

- To actively take part in your treatment/service plan.
- To arrive on time for appointments, calling as far in advance as possible if you cannot keep an appointment.
- To maintain the confidentiality of other clients/consumers you may meet during your treatment/service.
- To carry out agreements made between you and your service provider including homework assignments.
- To keep this agency informed of events, emotions and plans that may affect your treatment or condition.
- To provide insurance forms, Medicaid information or other materials necessary for third party reimbursement.
- To be financially responsible for fees not paid by third parties.

The following steps will be followed in processing a formal grievance:

1. Clients are requested to thoroughly review the Client Rights and Responsibilities and Grievance Procedure policy and form presented for client signature upon entry to SeaView services.
2. Clients are encouraged to discuss any concerns they have about their care and treatment with their primary provider and/or that person's supervisor.
3. If the problem cannot be resolved as described in #2, the consumer should briefly describe the grievance in writing and submit it in a sealed envelope to the Team Leader. The client may also report a grievance orally in person or by telephone, if necessary, although written format is preferable to insure accuracy. The consumer must clearly state that the matter is a grievance so there is no misunderstanding about the seriousness of the situation.
4. Upon request, SeaView will provide assistance to clients who wish to file a grievance.
5. In the event there is a concern with the Team Leader or if they have already been involved, submit a grievance statement to the Executive Director.
6. Clients or family members may designate a representative/advocate to assist them and be present during any/all grievance proceedings. SeaView will inform clients interested in filing a grievance of advocacy resources including the Disability Law Center (see list attached).
7. A signed release of information will be required in order for SeaView staff to discuss the grievance with such an advocate. The consumer has the option to waive confidentiality.
8. The Team Leader/Supervisor or Executive Director will schedule an interview with the client together with indicated staff member(s) within five (5) working days of receipt of the grievance. If unable to respond within 5 days a written explanation will be made.
9. The status of findings and results will be communicated in writing to the client no later than five working days after the interview (s). If unable to respond within 5 days a written explanation will be made.
10. Grievances unresolved to the consumer's satisfaction within 30 days will be reported by SeaView to the division that funds the relevant program services.
11. SeaView will maintain separate grievance files, which contain all documents related to grievances, and record all actions resulting from grievances. All grievances will be reported to the advisory board and to the Governing Board. All reports will maintain consumer confidentiality.

I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THIS FORM:			
Signature of Client	Date	Witness/Guardian	Date

8/95, 3/00, 8/01, 11/01, 8/04, 5/05, 3/06

SOUTH PENNINSULA
BEHAVIORAL HEALTH SERVICES

The Center

South Peninsula Behavioral Health Services, Inc.
3948 Ben Walters Lane, Homer, Alaska 99603

Child, Adult & Psychiatric Treatment
907-235-7701
Fax:
907-235-2290

24 hour Emergency Service

Rehab Services
The Annex
907-235-6990

DD Services
PRIDE Program
907-235-7805
Fax:
907-235-7834

A United Way Member Agency

www.spbhs.org

Date: July 11, 2007

To: Diana Weber
Behavioral Health Specialist
3601 C Street, Ste 878
Anchorage, AK 99503

Dear Diana,

We will be reviewing and revising the procedure following the information given at this morning's teleconference and will send you a copy when completed. In the meantime, enclosed are our current Client Grievance Procedure and the accompanying forms.

Thank you for your support and assistance.

Sincerely,

Nina

Nina Allen, LCSW
CEO

ADMIN DIRECTIVE NO.:	212
CATEGORY:	ADMINISTRATIVE
EFFECTIVE DATE:	12/30/97 REVISED 7/02/01, 9/07/01, 5/21/03, 1/26/2005
REFERENCE:	
PAGE:	1 OF 2
POSITION RESPONSIBLE:	EXECUTIVE DIRECTOR

SUBJECT: CLIENT GRIEVANCE PROCEDURE

PURPOSE:

To establish a method for client grievances as governed by the Department of Mental Health and Development Disabilities.

SCOPE:

This procedure applies to all client grievances presented to the Center.

DIRECTIVE:

At the time of intake, each client will be given the **CLIENT GRIEVANCE PROCEDURE** to read and sign that they understand the process. This form will be kept in the clinical file under Section 1.

A client grievance shall be recorded on the Grievance Form and may be submitted in writing, verbally, over the phone, or in person. The form shall be available in each facility of the CMHC and shall be readily available.

The Client Rights Officer (Medical Records Technician) or other staff may assist a client in completing the Grievance Form. It is the responsibility of all staff members to know the client grievance process, inform the client of the correct procedures to file a grievance and the time periods involved.

A claim should be submitted to the receptionist, or to a staff member in an off-site location. Upon receipt, the receptionist will request the client to wait in the lobby while the Client Rights Officer (CRO) is contacted. The CRO will either meet with the client immediately or schedule a meeting at a later time with the client. In the event the CRO is absent from the office, an alternate will be appointed by the Executive Director.

Consumers and family members may have advocates present during all steps of a grievance who may or may not be staff members of CMHC.

Initial Grievance – Step 1:

The CRO will meet with the client to explore and clearly define the problem and will explain the entire grievance process. The CRO will investigate the grievance and talk with involved staff, if necessary, and provide a written response to the client within five working days of receiving the grievance. The CRO will request approval of the response from the client. If the client does not agree with the response, they may proceed to Step 2 of the process.

Step 2:

The CRO will investigate the grievance further, with assistance from the appropriate Program Coordinator, and will assess the situation. If the Program Coordinator is directly involved in the grievance, the Executive Director will appoint another representative.

The CRO will forward the grievance to the Executive Director, or his/her designee, who will conduct a hearing. The Executive Director may hear the information him or herself, or may request the assistance of other objective individuals.

The findings and recommendations will be summarized and will be explained to the client within 5 working days from the previous response. If the client does not agree with the response at this step, the client may go to Step 3.

Step 3 (final):

The Executive Director will forward the grievance to the Board of Directors, who will establish a Hearing Committee and conduct a hearing. The Committee may hear the information, or may request the assistance of other objective individuals. The Committee will propose a resolution within 5 working days.

If the client does not approve a resolution, the grievance shall be reported to the DMHDD Regional Coordinator pursuant to AS 47.30.660(b)(12).

NOTES

All client grievance responses shall be on the Grievance Response Form.

The CRO is an advocate for the client.

A client may have an advocate of any type assist them in any step of the grievance process. A Release of Information must be signed by the client for any advocate to participate on their behalf.

If any time period is not able to be met, the reason for the delay must be documented in writing.

Grievances involving abuse or neglect of any description, or unnecessary seclusion or restraint, will be investigated and reported immediately to the governing body and DMHDD.

All clients shall be given the right to file a grievance, for any reason without intimidation to prevent the filing of a grievance or retaliation if they do. If an employee intimidates or retaliates against a consumer related to a grievance, disciplinary action will be taken against the employee. Refer to personnel manual for levels of, and procedures for, disciplinary action.

Grievances that are unresolved to the consumer's satisfaction within 30 days shall be reported to the DMHDD Regional Coordinator pursuant to AS 47.30.660(b)(12).

Nina Allen, LCSW

Nina Allen, LSCW
CEO

7/11/07

Date

The Center
South Peninsula Behavioral Health Services, Inc

GRIEVANCE FORM

Name:_____ File #:_____

Date Grievance Filed:_____ Date of Occurrence: _____

Grievance Made Against:_____

Description of Grievance:

Expectations For Resolution:

_____ _____

Signature of Complainant DATE Client Rights Officer DATE

South Peninsula Behavioral Health Services, Inc

GRIEVANCE REPSONSE FORM

Name: _____ CMHC File #: _____

Date Grievance Filed: _____ Date of Response: _____ Step No:_____

Summary of Grievance:

Signature of Client Rights Officer: _____ Date: _____

Response to Grievance:

Signature of Client Rights Officer: _____ Date: _____

Resolution Accepted: ☐ YES ☐ NO

Remarks:

Staff Signature	Date	Signature of Complainant	Date
Staff Signature	Date	Client Rights Officer Signature	Date
Staff Signature	Date		

SOUTH PENINSULA BEHAVIORAL HEALTH SERVICES, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Community Mental Health Center's (CMHC's) Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of CMHC. It also describes my rights and CMHC's duties with respect to my protected health information. The Notice of Privacy Practices for CMHC is also provided and posted in both the waiting room at the main clinic at 3948 Ben Walters Lane, and in the common area at the CMHC Annex located at 966 Hillfair Court.

CMHC reserves the right to revise its privacy practices. I understand that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. CMHC is not required to agree to the restrictions that I may request. However, if CMHC agrees to a restriction that I request, the restriction is binding on CMHC and its contractual and employed physicians, clinicians, case managers, and other staff.

_____ _____

Signature of Client or Personal Representative Date

_____

Name of Client or Personal Representative (please print)

_____

Description of Personal Representative's Authority

SOUTHEAST REGION

ALASKA ISLANDS COUSELING CENTER
(WRANGELL)

AICS Grievance Procedure

POLICY:

AICS will inform all clients or prospective clients of a method for grievance and resolution of client concerns. All clients have a right to file a grievance without intimidation or retaliation.

I. AICS' grievance procedures consist of the following steps:

A. AICS desires to adjust the causes of grievances informally whenever possible and therefore request that the client first approach the staff member involved to air the problem as it arises and resolve it through discussion.

B. When an issue cannot be resolved informally with the staff member, the client is requested to discuss this with the Program Director. If the issue cannot be resolved with the Program Director, the client is requested to discuss this with the Executive Director. If the issue cannot be resolved with the Executive Director, the client is requested to bring the matter to the AICS Board of Directors. If the issue cannot be resolved with the Board of Directors, the client may request technical assistance from the Division of Behavioral Health.

C. In the event that the grievance is with the Executive Director, the client is referred to the AICS Board of Directors.

D. Any grievances that involve abuse, neglect or unnecessary seclusion or restraint, may be immediately elevating to the AICS Board level.

E. A client may elect to submit a grievance in writing, by email, or orally to the Director, except when the grievance is with the Executive Director, in which case the grievance will be submitted to the AICS Board of Directors. The written grievance must be signed and dated by the client. The Director or representative of the Board will meet with the client to resolve the grievance. The staff member involved may be called in to explain their actions in the presence of the client if deemed appropriate.

F. Time frames for hearing of grievances:

1. AICS staff will make every effort to initiate resolution within 5 days of receiving a grievance
2. If agency is unable to adequately initiate resolution within 5 days, a written notification shall be sent to the consumer by the end of 5 days from receipt of grievance explaining why and identifying when the grievance process will initiate

3. AICS staff will attempt to reach a satisfactory resolution to grievances within 30 days of receipt of grievance
4. Any grievance not satisfactorily resolved within 30 days, will be referred to the Division of Behavioral Health within 5 business days for technical assistance.

II. A client may designate a representative or advocate to assist them with all steps of the grievance process

A. A client may request agency staff to assist them with filing a grievance, which may include either:

1. Identifying specific agency staff to provide assistance
2. Written referral to other consumer advocacy resources.

III. A report of any and all written grievances filed and action taken will be placed in a confidential client grievance file and a copy in the client's record.

IV. A grievance form is available from the front office staff.

COMMUNITY CONNECTIONS

Customer Grievance/Complaint Policy

Our goal as an agency is to provide the best possible services for the individuals we serve. A most important key to effective services is good communication. If there is something you want, or don't feel you're getting--- we depend on you to let us know. If you aren't happy with the way services are happening that information needs to be shared as soon as possible so that ways can be found to reestablish good working relationships and positive outcomes.

If you have a complaint we ask that you take the following steps:

1. Speak with your service coordinator about your concerns:

   Service Coordinator_____

2. If your complaint is not resolved schedule a meeting with the appropriate Program Director:

   In Ketchikan **225-7825**
   Toll Free **800-478-7825**

   Children's Mental Health, Quinn Lontz*

   Developmental Disabilities Program, Maxwell Mercer*

   Early Learning Program, Laurie Thomas*

   Older Alaskans and Adult Resource Services (O.A.R.S.) Lisa Noland*

3. If you are not satisfied after speaking with the Program Director, then schedule a meeting with Bess Clark, Executive Director*.

4. If you remain unsatisfied after speaking with the Executive Director you may request an opportunity to make a statement to the Board of Directors through the Board President:

   Blake Chupka* (225-4131)

**Check with the front desk for the most current contact information*

Approved Board 12/06

Customer Grievance/Complaint Policy

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   Blake Chupka* (225-4131)

**Check with the front desk for the most current contact information*

Approved Board 12/06

GASTINEAU HUMAN SERVICES

Gastineau Human Services Corporation
"A Chance For Change"
5597 Aisek Street
Juneau, AK 99801

Client Grievance Procedure

Gastineau Human Services (GHS) is committed to treating all of our clients with dignity and respect. GHS will provide clients with a process for making grievances in a respectful, timely and impartial way. **It is the policy of GHS that any client has the RIGHT to file a grievance without fear of intimidation and ensures there will be NO retaliation perpetrated against a client(s) who files a grievance.** ***All client grievances are considered confidential and are regulated under CFR 42.***

Client Name_____Date_____

Procedure: If you have a concern or complaint about services provided by us, GHS will make a reasonable effort to understand your situation and come to a conclusion or solution that is agreeable to all parties involved. The manner by which you express your concerns and/or complaints that will be officially recognized by GHS is outlined in the procedures below. You have a right to submit a grievance within **THIRTY (30)** working days of the aggrieved event.

1. Talk first to your primary counselor about the matter. Allow a reasonable time for the two of you to talk out the situation. Present your viewpoint clearly. You may present your grievance in writing. If that is not possible, an oral grievance provided to your counselor is acceptable. You may submit a grievance via telephone or email to your counselor or the Clinical Director. Your counselor or the Clinical Director is responsible for documentation in writing the receipt of your grievance. All counselors must submit a written summary of your grievance to the Clinical Director.
2. You may request to talk with the Clinical Director. This may require an appointment, but you you may ask the Administrative Assistant to see if the Clinical Director is available. Review the situation with the Clinical Director. Include the solution you wish to see. You will be asked if you covered the information with your counselor before you contacted the Clinical Director. If you did not, you may be referred back to that person, unless you can clearly identify why you should not talk to your counselor about the matter. You will be advised of the actions available to you. It is possible that the Clinical Director may take some time to weigh all viewpoints before making a decision, so do not expect an immediate answer. The Clinical Director shall investigate the issue and respond to the grievance in writing within **FIVE (5)** working days after receipt of the grievance.
   Contact: Sheri Black, LCSW, Clinical Director
   sheri_black@ghscorp.org
   (907) 780-3039
3. Clients or family members have the right to designate a representative or advocate to assist you with all the steps related to the grievance process.
4. GHS staff will inform clients interested in filing grievances of advocacy resources including the Disability Law Center, the Alaska Mental Health Consumer Web and NAMI of Alaska.

5. If you are not satisfied with the decision of the Clinical Director, you can submit your grievance to the Executive Director within **TEN (10)** working days from the time the Clinical Director renders a decision. The Executive Director shall investigate the issue and respond to the grievance in writing within **TEN (10)** working days.
   Contact: Greg Pease, GHS Executive Director
   greg_pease@ghscorp.org
   (907)780-3011
6. **If the grievance concerns an allegation of physical, verbal, emotional or sexual abuse and or brutality on the part of the staff, you have the right to initiate your grievance directly to the Executive Director and the staff member may not interfere with the process.**
7. A written copy of the grievance, results of the investigation and subsequent action shall be placed in the client's case file.
8. Should an investigation reveal the deliberate breach of client rights or the commission of any act of abuse, actions shall be taken against the offending parties that may include termination of employment.
9. If you are not satisfied with the Executive Director's decision regarding the grievance, you have the right to submit a written grievance to the Chairperson of the GHS Board of Directors within **TEN (10)** working days of the receipt of the Executive Director's decision. The Board Chairperson then has **TEN (10)** working days to form a committee of at least three Board members to address the conflict and inform you, the client, in writing of the Board decision. All Board decisions are final.
10. Clients who have followed the grievance procedures as outlined above and are still not satisfied with the Board decision can file a complaint with the Division of Behavioral Health at:
    Division of Behavioral Health
    P.O. Box 110620
    Juneau, AK 99811
    Toll Free: 800-465-4828
11. It is the responsibility of the Executive Director to review all client grievances and report findings in writing to the Board of Directors at the regularly scheduled Board meetings.
12. The agency is obligated to post Client Grievance Procedures in a place where it shall be immediately available to all clients.

I have received a copy of the GHS grievance policy and it has been explained to me to my satisfaction.

Client Signature Date

Printed Name

GATEWAY CENTER
For
HUMAN SERVICES

Gateway Center for Human Services
City of Ketchikan
3050 Fifth Avenue
Ketchikan, Alaska 99901

907-225-4135 Main Office Phone
907-228-6516 Direct Phone
907-247-4135 Fax

Date: August 08, 2007

Marilee Fletcher, Behavioral Health Specialist
State of Alaska, Department of Health & Social Services
Division of Behavioral Health
PO Box 110620
Juneau, Alaska 99811-0620

Re: Agency Grievance Policy & Procedure

Dear Marilee,

I have enclosed the requested agency Grievance Policy and Procedure by which our clients may seed redress of grievances. I apologize for it arriving to you late. I knew there was something I was missing with a deadline, so started at the top of the pile on my desk and worked through it yesterday. Just a couple more items to go! Again, I apologize.

Sincerely,

Dee

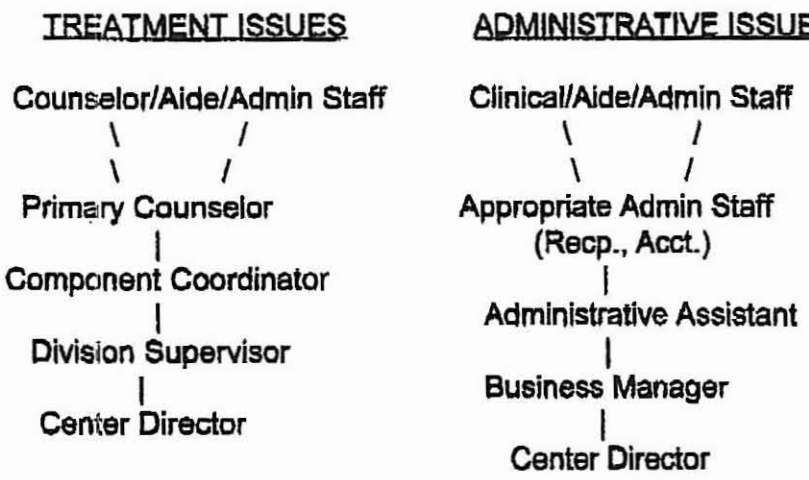
Dee A. McLellan
Acting Executive Director

October 1998

CLIENT COMPLAINTS/GRIEVANCE

The purpose of this policy/procedure is to establish staff responsibility and procedure for addressing complaints/ grievances expressed by clients.

All staff, at some point in time, will come in contact with a client who is expressing complaint(s)/grievances about program procedure/policy or another client or staff person. All staff should listen to the nature of the complaint, resolve the issue if possible and, if unresolvable, refer it to the Primary Counselor or their immediate supervisor. In short, client complaints/problems are to be addressed/resolved at the "lowest" level in the chain of command possible. The chain of command by problem area is as follows:



At all levels, the individual presenting the complaint/grievance should be made to feel that they are being listened to and understood. Staff should attempt to clarify program policy (where applicable), but should not feed into the complaints at the detriment of the program, a fellow staff member, or another client. If the complaint can't be resolved at one level, it should be passed to the next with all information available concerning the complaint.

Formal complaints/grievances of client abuse will be handled as described in the "Client Neglect/Abuse" section of this manual.

A client may also use this mechanism to request referral to another counselor, component, or community service provider.

F:\USERS\ADMIN\PPSAV_CLIENT\GRIEVANC.CLT

Review Committee Incident Report

me of Client or Staff:	DOB:	Location of Incident:	Date/Time:

Circle Course of Action (to be determined by the Incident Review Committee):

Disciplinary Information

Type of Incident Investigated:	
Narrative:	
Copy of Report to Director:	Committee Signatures & Date:
Date: Time:	1. 2. 3. 4.

Disposition:	
Chairperson of Review Committee:	
Member:	Member:

On matters referred to the Department Director as a result of this review, see the Written Report relative to this incident.

Final Copy of Staff/Client:		
Date:	Time:	Staff Signature:

\USERS\ADMIN\PPSA\A_CLIENT\REVCOM.INC

JUNEAU ALLIANCE
For
MENTAL HEALTH
(JAMHI)

JAMHI

Juneau Alliance for Mental Health Inc.
3406 Glacier Hwy.
Juneau, AK 99801
907-463-3303

GRIEVANCE FORM

Grievances may be filed using this form or in other formats, including grievances submitted verbally, in person or over the telephone.

Name _____ Today's Date _____

Advocate (optional)_____ Date of Event _____

Description of event, including persons involved, witnesses (if any), and any attempts to resolve the problem. Use additional sheets if necessary.

Waiver of Confidentiality (optional): For the limited purpose of this grievance, I waive my right to confidentiality.
____Yes ____No

Any retaliation against any JAMHI employee/consumer/board member who exercises their right to file a grievance is strictly prohibited by state code and federal law. Retaliation is prohibited whether or not the charging party prevails in the original charge. Subsequent to, or at the same time as the charge, no agent of JAMHI may harass, coerce, intimidate or discriminate against an individual who has filed a complaint or participated in the complaint resolution process. If this happens, the complaining party may file another complaint alleging such harassment or intimidation.

Charges of retaliation shall be treated as separate and distinct from the original charges and allegations and will be reported to the State of Alaska, Division of Behavioral Health.

_____ _____
Client signature Date

_____ _____
Received By Date

CLIENT NAME:	CLIENT ID:	DATE:

[FORM: Revised 07/19/07]

SUBJECT: Client Grievance Policy

POLICY:

JAMHI is committed to treating all clients with dignity, respect, individuality, and consideration for privacy. JAMHI shall provide all of its clients a constructive process for easily addressing grievances in a respectful, timely, and impartial manner without fear of intimidation or retribution.

At the time of intake a client will be presented with a written and verbal explanation of the JAMHI grievance policy and will be asked to acknowledge this receipt of the policy by signing the Client Grievances form (see Appendix A-14)

PROCEDURES:

1. Clients are requested to thoroughly review the forms entitled *Client Rights and Responsibilities* and Client Grievances, presented for client signature upon entry into JAMHI services.
   a. Clients are allowed to submit a grievance orally, in person or by telephone, via email or in writing.
   b. Clients have the option of waiving confidentiality when submitting a grievance
   .

2. Clients are encouraged to discuss any concerns or grievance they have about their care and/or treatment at JAMHI initially with their primary provider. If the issue is not resolved it can then be presented to that person's supervisor to seek resolution. Upon receipt of a grievance, client will be informed that the agency has begun the process to resolve the grievance.

3. If the problem cannot be resolved as described in Procedure #2;

   a. Briefly describe the grievance in writing and submit it in a sealed envelope to the appropriate Program Supervisor.
   b. In the event there is a concern with a Program Supervisor or if they have already been involved, submit a grievance statement to the Administrator.
   c. If the issue is still unresolved request the written grievance to go to:
      i. Administrator
      ii. JAMHI Board of Directors
      iii. DBH for technical assistance for clients

4. Clients may designate a representative/advocate to assist them and be present during any/all grievance proceedings.

5. Upon request, JAMHI will provide assistance to clients who wish to file grievances by identifying an agency staff person for that purpose.

6. JAMHI will inform clients interested in filing grievances of advocacy resources including the Disability Law Center, the Alaska Mental Health Consumer Web,

and NAMI and will provide written referral to such resources per client request.

7. It is the responsibility of the Administrator to review all client grievances.

P & P No: **C7-G**
Date: MAR-03

8. The status of findings and results will be communicated in writing to the client not later than five (5) working days after receiving a grievance or moving a grievance to the next level. If unable to adequately initiate resolution within 5 days from the receipt of a client grievance, the client will receive written notification explaining the reason and when the grievance process will be initiated. If unable to resolve the grievance in thirty (30) working days, JAMHI will explain the delay in writing to the client..

9. For clients receiving publicly funded services, grievances unresolved to the client's satisfaction within thirty (30) days may be reported to the Division of Behavioral Health for technical assistance.

10. JAMHI has a "no tolerance policy" regarding abuse or neglect as well as intimidation to prevent the filing of a grievance or retaliation for filing a grievance. Any report of abuse, neglect, intimidation or retaliation shall be investigated and immediately reported to the JAMHI Administrator who will immediately report the case to the Board of Directors.

11. The Client Grievance policy will:
    a. Be available to all clients or authorized representative and to those denied services;
    b. Be signed and copied to the client or authorized representative and client's file; and
    c. Be prominently displayed in all JAMHI facilities.

13. Communications, records and actions pertaining to client grievances will be stored in files for each individual grievance and maintained according to appropriate clinical records maintenance standards, protecting client confidentiality throughout the grievance process.

JUNEAU YOUTH SERVICES

JUNEAU YOUTH SERVICES, INC.

SECTION: Rights, Responsibilities and Ethics

Approved By:
Executive Director
Board of Directors

No.: 1.7
Date: March 21, 1997

SUBJECT: CLIENT GRIEVANCES/FILING A COMPLAINT

PURPOSE To ensure that all Juneau Youth Services clients have a fair and equitable opportunity to voice, as well as amend grievances which exist related to their relationship with Juneau Youth Services, and that clients have knowledge of how to file a complaint.

POLICY Clients will be allowed to file grievances against Juneau Youth Services and receive a fair and equitable response to all written grievances.

PROCEDURE

1. Definition of Grievance: Any complaint related to care, treatment, and well-being of any client. Grievance matters may include but are not limited to:
   a. Matters pertaining to physical or mental well-being of any client.
   b. Matters involving the violation of any stated client rights.
   c. Matters involving the right of any client to humane care and treatment.
2. All Juneau Youth Services program staff will be familiar with the grievance procedure.
3. Any client wishing to make a complaint will be informed by staff how to do so in a way that is clear and understandable to the client. The client will also be given a copy of the Grievance Procedure and assisted by a person of his/her choice to help file the complaint, if need be. The client will also be informed of any Advocacy Services available and how to access such services should the client so desire.
4. Grievance Procedure:

   A. **Informal Grievance:**
      1. Initial presentation of client complaint is directed to staff responsible for treatment, for resolution.

2. Unsatisfactory resolution at this level will result in the client completing a grievance form detailing the nature of the complaint and describing the attempts at resolution.

3. The grievance form will proceed up the supervisory chain within the program service to the program coordinator. This process will be documented on the grievance form.

4. Clients receiving services from more than one program will notify both Program Coordinators of their grievance.

5. All information directly related to treatment, in the course of this process, will be documented in the clients treatment file.

6. Should the complaint not achieve a satisfactory resolution at the program level, the grievance will be forwarded to the Executive Director.

7. Complaints against the Executive Director will be forwarded to the Board of Directors through the Administrative Director.

B. **Formal Grievance**

1. The formal grievance procedure is initiated when attempts to resolve the complaint through the informal process fail.

2. Formal grievances require that the grievance be forwarded to the Executive Director. The written complaint should include the nature of the grievance, summary of unsatisfactory attempts at resolution, and the outcome desired by the complainant.

3. The Executive Director or designee, upon receipt of the written complaint, will set a hearing to address the grievance not later than seven working days from the date of receipt. An immediate investigation of facts regarding the complaint should be undertaken within 72 hours. The Executive Director is authorized to summarily address the grievance and to settle , by stipulation, the matter in favor of the complainant prior to the hearing with written consent of the complainant. The complainant may withdraw the complaint prior to the hearing without losing the right to future recourse.

C. **Hearing**

1. The Executive Director or designee, one other client, and one other staff member will comprise the hearing panel. The Executive Director will select one of the panel members, the complainant the other. The complainant may be represented or assisted in presenting their grievance by an advocate of their choosing. When indicated, the Director will designate a member of the staff to respond to the grievance.

2. It will be the responsibility of the hearing panel to render a written response to the grievance within three working days.

3. The panel's response will address specific matters in the complaint and will identify specific steps to be taken to remedy the grievance, persons to be involved in the remedy and the time frame within which necessary action will take place.

4. An attorney is not an appropriate advocate at this level.

5. The written response will be forwarded to the complainant and will be final.

D. **Follow-Up**

1. The Executive Director will be responsible for implementing all hearing decisions.

2. Administration will maintain copies of all grievances and resolutions on file.

Reviewed	Revised
11/15/94	03/21/97

Juneau Youth Services, Inc. PO Box 32839 Juneau, AK 99803
Residential – 796-4191 / Community – 796-4190 / Intake – 789-4733

Grievance Procedure

All recipients are allowed to file a complaint or grievance with
Juneau Youth Services, Inc. and its employees, and
are assured a fair and equitable response to all written grievances.

Definition of a Grievance:

- Matters pertaining to physical or mental well being.
- Matters involving the violation of any stated recipient rights.
- Matters involving the right of any recipient to humane care and treatment.

I have a grievance, now what do I do?
Tell one of the staff members. The staff is here to help you. They will listen to what you have to say and try to help with your problem. This is done verbally.

I am uncomfortable talking to staff about this grievance, now what?
Fill out the Recipient Grievance Form describing your grievance and what you've done to try to clear up the problem. Place the form inside the sealed suggestion box located at each site.
Every attempt will be made to resolve each grievance at the program level.

I have submitted my grievance, but I'm unhappy with the way things have turned out. Who can I turn to?
You can make an appointment to talk with the Executive Director of Juneau Youth Services, Inc., who takes each grievance very seriously.
You can speak with a child advocate from outside of the agency regarding your grievance. A list of these names is available inside your recipient handbook.

Your signature does not signify understanding, only that you have received a copy.

Recipients fourteen years old or older signature _____ Date _____

Printed name: _____

Parent or Legal Guardian signature _____ Date _____

Printed name: _____

RECIPIENT'S NAME:	DOB		DATE:	

Juneau Youth Services, Inc. PO Box 32839 Juneau, AK 99803
Residential – 796-4191 / Community – 796-4190 / Intake – 789-4733

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You can speak with a child advocate from outside of the agency regarding your grievance. A list of these names is available inside your recipient handbook.

Juneau Youth Services, Inc. PO Box 32839 Juneau, AK 99803
Residential – 523-6591 / Community – 523-6590 / Intake – 789-4733

Recipient Grievance Form

Name: _____ Date: _____

Program: _____ Case Manager: _____

Please describe your grievance. List any rights you feel have been violated.

How would you like this grievance/problem resolved?

What have you done to try to resolve this grievance/problem?

Signature Date

RECIPIENT'S NAME:	DOB:

Revised 10/03/06

LYNN CANAL
COUNSELING SERVICES

Lynn Canal Counseling Services
PO Box 90 Haines, Alaska 99827 Phone (907) 766-2177 Fax (907) 766-2977
Dahl Medical Clinic Bldg. Skagway, AK 99840 Phone & Fax (907) 983-2548

CLIENT GRIEVANCE FORM

This form has been designed to assist the client in organizing a grievance. It is not required to file a grievance, but is meant only as a tool to help the client identify all aspects of the grievance.

Clients have the right to make a grievance orally, by phone, email or in writing. Please see the Welcome Packet for your complete rights as a client of LCCS.

Staff Member you wish to file a grievance with:_____

Have you tried to solve the grievance with the Staff Member: _____Yes _____No

If so, how?_____

_____

State the nature of the grievance: _____

_____

_____

_____

Is this an isolated incident or has it happened more than once: (Provide dates and specifics if possible)

_____

_____

What do you think LCCS can do to remedy this situation? _____

_____

_____

_____

OPTIONAL: I wish to waive my right to confidentiality. _____
Sign here ONLY to waive your confidentiality.

_____ _____
Signature of Person Filing Grievance Date

_____ _____
LCCS Representative Date Grievance Received

Section B – Client Rights
4 –Client Communication

Policy:
Lynn Canal Counseling Services is committed to treating all of our clients with dignity and respect. Lynn Canal Counseling Services shall provide all of its clients with a constructive process for addressing grievances in a respectful, timely, and impartial manner. All clients have the right to be informed of and to utilize the client grievance procedure without fear of intimidation or retribution when unable to resolve a conflict with a staff member. The client should attempt to address and resolve the conflict with the staff member directly, but may utilize the following grievance procedure if unable to satisfactorily resolve such conflicts:

Procedure:

1) All clients have the right to make a grievance anonymously.

2) The client shall consult with his/her primary clinician regarding the conflict and the primary clinician shall assist the client in mediating the conflict. If the client indicates that the conflict exists with the primary clinician and has made an attempt to resolve the issue directly with the primary clinician to no avail, the client has the right to: submit a grievance orally by making an appointment with the Program Director, submit a grievance via phone or email to the Program Director (lccs@aptalaska.net), or submit a written grievance to the Program Director within five working days of the aggrieved event. A form is included with this document should the client wish to use it to submit a grievance in writing. The Program Director shall investigate the issue and respond to the grievance in writing within five working days after submission of the grievance.

3) The Program Director shall immediately notify the Executive Director and Board Chair of any grievance filed.

4) The Program Director shall attempt a direct resolution through dialogue with the agency staff member involved or with the staff member's supervisor, or with both as the client requests.

5) Clients or family members may designate a representative/advocate to assist them and be present during any/all grievance proceedings. Lynn Canal Counseling Services staff will inform clients interested in filing grievances of advocacy resources, including the Disability Law Center, the Alaska Mental Health Consumer Web, and Juneau Alliance of Mental Health, Inc. (JAMHI).

6) Upon the request of the client, Lynn Canal Counseling Services shall assign a case manager to the client to assist the client with the grievance process. The case manager may either work directly with the client or may be utilized to coordinate

with advocacy resources by providing a written referral to any of the above referenced resources.

7) If the client is not satisfied with the decision of the Program Director he/she may submit a grievance orally by making an appointment with the Executive Director, submit a grievance via phone or email to the Executive Director (lccs@aptalaska.net), or submit a written grievance to the Executive Director within five working days of receipt of the Program Director's decision. A form is included with this document should the client wish to use it to submit a grievance in writing. The Executive Director shall investigate the issue and respond to the grievance in writing within five working days.

8) If the grievance concerns an allegation of abuse, neglect, or unnecessary seclusion or restraint of the client, or brutality on the part of the staff, the client has the right to initiate his or her grievance directly to the Chairperson of the Board of Directors and no staff member may interfere with this process.

9) A description of the grievance, the results of the investigation and subsequent action shall be placed in the client's case file.

10) Should an investigation reveal the deliberate breach of client rights or the commission of any act of abuse, actions shall be taken against the offending parties that may include termination of employment.

11) If the client is not satisfied with the Executive Director's decision regarding the grievance, he/she has the right to submit a grievance to the Chairperson of the Board of Directors within five working days of the receipt of the Executive Director's decision. The Board Chairperson then has ten working days to form a committee of at least three Board members to address the conflict and inform the client in writing of the Board decision. All Board decisions are final.

12) If the client is not satisfied with the Board of Directors decision, the client has the right to file a complaint with the Division of Health and Social Services, Department of Behavioral Health at:

Division of Behavioral Health
P.O. Box 110620
Juneau, AK 99811
Toll Free: 800-465-4828

13) If at any point, LCCS will be unable to adequately initiate resolution within five days, a written notification shall be sent to the client by the end of the five days from receipt of the grievance explaining why the grievance has not been resolved, and when the grievance process will initiate.

14) It shall be the goal of LCCS to satisfactorily resolve all grievances within thirty (30) days of receipt of the grievance. Should satisfactory resolution not be achieved within this time frame, LCCS shall refer the grievance to the Division of Behavioral Health within five (5) business days for technical assistance with grievances that remain unresolved after thirty (30) days.

15) A copy of any and all grievances filed and action taken as well as all related documents, records, and communications will be placed in a Client Grievance File to be kept by the Executive Director under lock and key, and a copy shall be placed in the aggrieved client's file.

16) Client confidentiality shall be maintained throughout the grievance procedure and beyond by securing all grievance related files under lock and key. Any communications with the aggrieved client shall be handled in a discreet manner.
17) It is the responsibility of the Executive Director to review all client grievances and report findings in writing to the Board of Directors at the regularly scheduled Board meetings.

18) The agency is obligated to post the grievance procedure in a place where it shall be immediately available to all clients.

PETERSBERG

Kolenberg

BEHAVIORAL HEALTH POLICIES AND PROCEDURES

SUBJECT: 6.4.3 CLIENT CONFLICT RESOLUTION AND GRIEVANCE PROCEDURE	
Page 1 of 1	Effective Date: 7/1/04

POLICY:

PMHS will inform all clients or prospective clients of a method for grievance and resolution of client concerns.

I. PMHS' grievance procedures consist of the following steps:

A. PMHS desires to adjust the causes of grievances informally whenever possible and therefore request that the client first approach the staff member involved to air the problem as it arises and resolve it through discussion.

B. When an issue can not be resolved informally with the staff member, the client is requested to discuss this with the Director. In the event that the grievance is with the Director, the client is referred to the PMHS Board.

C. A client may elect to submit a grievance in writing or in person to the Director, except when the grievance is with the Director, in which case the grievance will be submitted to the Board. The written grievance must be signed and dated by the client. The Director or representative of the Board will meet with the client to resolve the grievance within 30 days of receiving the written grievance. The staff member involved may be called in to explain their actions in the presence of the client if deemed appropriate.

II. A report of any and all written grievances filed and action taken will be placed in a client grievance file and a copy in the client's record.

III. A grievance form is available from the front office staff.

Petersburg Mental Health Services, Inc.
GRIEVANCE FORM

If you have any problems or complaints with your services, you may file a formal grievance at any time. However, you are first encouraged to discuss you complaints directly with your service provider whenever possible. You may also contact the Director of the agency at (907) 772-3332 or request an appointment with the office staff.

Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Name of Legal Guardian/Conservator: _____

1. Describe the problem or issue: (Attach additional sheets if necessary.)

2. What have you already done to resolve this problem?

3. How would you like to see this problem resolved?

_____ _____
Signature Date

RAVEN'S WAY

Raven's Way: Contacting Students and Staff

WHERE IS RAVEN'S WAY?
We are based in Sitka, but also go out to a remote island camp located 14 miles south of Sitka called Biorka. All students also go on either a sea kayaking or backing wilderness expedition, called Expo around Southeast Alaska. Our plans for Course #111 are:
Sitka I: 7-17-07
Biorka: 7-27-07
Expedition: 8-6-07
Sitka II: 8-23-07
Transition Ceremony: 8-30-07
Please know that this schedule may change due to weather or treatment strategies.

HOW CAN I REACH MY SON OR DAUGHTER?
You can write, call, or schedule a family therapy appointment if you live close to Sitka. To schedule a family appointment or to visit, contact your assigned therapist.

Mail: Please write. Students always love to get mail from home. You may also send care packages of traditional foods or healthy snacks. For safety reasons all mail is opened in front of staff. Because of the remote location mail will NOT be delivered while on Biorka and Expedition. You may write your child at the following address:

Student Name
Pouch R
SEARHC
222 Tongass Drive
Sitka, Alaska 99835

Telephone: Your student will be calling home within the first 24 hours of arrival (if they did not arrive with their parent), on the first weekend of the course, before leaving for expedition, and upon return from expedition. If you need to reach your son or daughter at another time arrange this through your assigned therapist. Since phone contact on Biorka and expedition is limited, messages can be sent through the therapist or program coordinator. In case of an emergency contact the therapist or the program coordinator. Office: 1-800-770-3063 or 966-8714 (local calls); Office Hours: M-F 8:00am-5:00pm Student House: 966-2255 (You may leave messages at the number).

WHO SHOULD I CONTACT? WHO WILL BE CONTACTING ME?
Rebecca Howe, Intake Specialist, 966-8716
Anita Didrickson, Program Coordinator, 966-8767
Kelly Warren, Treatment Supervisor, 966-8719
Brett Wilcox, Adolescent Therapist, 966-8728
The therapist assigned to work with your youth is your primary point of contact. He/She can provide updates and address any concerns you may have. Concerns or complaints/grievances can be expressed verbally or in writing to the therapist or program coordinator. We are committed to high quality care and will do our best to address any concerns. You may reach staff members during office hours at the numbers above.

CONFIDENTIALITY AGREEMENT
AND
GRIEVANCE PROCEDURE

Confidentiality: As a student at Raven's Way, your records are considered confidential, are protected by federal law and regulations, and will not be released to individuals in other agencies without your written consent. However, certain information may be released without your authorization under the following circumstances: 1) Upon receipt of a legitimate court order, 2) To medical personnel in a medical emergency, 3) To qualified personnel for research, audit, or program evaluation, 4) If you threaten/commit a crime while at the program or against program staff, 5) If there is evidence to suggest child abuse or neglect or risk of harm to a child/adolescent.

I understand that anything I disclose concerning personal safety or the safety of other children will be reported to the Office of Children Services (OCS), as required by state law.

I understand that my confidential information may also be shared with other SEARHC staff who need to know this to provide needed services to me while I am in the Raven's Way Program.

I understand the importance of safeguarding the identity and confidentiality of the other students who are also here in treatment. I understand that by Federal Law I must not reveal the identity of any other students to anyone else AND that all information I hear from other students while I am in treatment is also confidential. By signing below, I am agreeing to maintain the confidentiality of all the students and student information that I may encounter during treatment.

Grievance Procedure: Raven's Way students have the right to fair and professional treatment. If a student feels that she/he has experienced abusive, humiliating or discriminatory behavior from a staff member, is being exploited financially or otherwise, or that an element of her/his treatment is being neglected, the student may take the following steps:

1. The student may present the complaint orally to his/her primary counselor. If the primary counselor cannot be reached he/she can talk to any counselor or therapist. The primary counselor is the student's advocate unless the student requests that another Raven's Way staff function as advocate.

2. The advocate will take appropriate action to address this concern within 5 days of receiving the complaint.

3. If the student is unsatisfied, the student must complete the Student Complaint/Grievance Report in writing, date and sign it, and give it to a staff member to present to the Program Coordinator. Assistance may be provided as needed by the student's advocate. Email complaints will follow the same procedure as written complaints. The Program Coordinator will respond to the student in writing within five (5) working days from the date of receipt of the Report.

4. If steps 1-3 have not solved the problem, the student may ask that the written complaint be presented to the Behavioral Health Director. The Director will call a meeting with the student and relevant staff members for the purpose of resolving the conflict. Action by the Behavioral Health Director will be taken (including a written response) no later than 10 (ten) working days from the date of being first informed.

5. Grievances still unresolved 30 days after the initial complaint will be referred to SEARHC Risk Management or appropriate area for resolution. Staff shall inform the students of their right to pursue civil action if the grievance procedure has not resolved the problem.

Complaints are handled in a fair and professional manner without intimidation, retaliation or barriers to services.

I understand and agree to the above.

_____ _____

Student Signature Date

_____ _____

Staff Signature Date

cc: copy to student
Original: 12/01;
Revised: 8/05; 8/06; 7/07

Grievance Process and Customer Satisfaction

The right to express dissatisfaction with treatment is addressed in orientation. The right to file a grievance and the Grievance Procedure are explained verbally and in writing. Students receive a copy of their signed Confidentiality Agreement and Grievance Procedure (see Appendix). Complaint/Grievance Report forms are available for students, parents/guardians or referrals as needed.

Copies of written Complaint/Grievance Report forms (including staff response) are maintained in a log by the CHS Quality Assurance Coordinator and Program Coordinator and reviewed annually to determine patterns and take appropriate steps to improve program quality.

Feedback regarding satisfaction with services is requested of students, parents/guardians and referrals. Students complete evaluation forms regarding each phase of treatment at Raven's Way throughout treatment. These results are compiled and shared with staff, with recommendations for appropriate program response, after every course. In addition, information regarding satisfaction is requested at their one month follow up interview. These results are compiled and presented to the Behavioral Health Administration team for evaluation and response.

Parents/guardians and referrals are provided report cards which they may complete when they come for the transition ceremony. In addition, these report cards are sent to parents/guardians and referrals every two years requesting feedback regarding program services. These report cards are sent to the CHS Quality Assurance Coordinator. Any concerns or complaints written on these report cards are responded to by the CHS Quality Assurance Coordinator or Program Coordinator.

Raven's Way

Complaint/Grievance Report

What happened?

Date and approximate time of incident: _____

Location of incident: _____

Person(s) involved: _____

Description (sequence of events):

What could have been done better?

Person filing report: _____ Date: _____
(Printed name) (Signature)

Staff receiving report: _____ Date: _____
(Printed name) (Signature)

Referred for follow-up to: _____ Date: _____

Resolution and follow up recommendations:

Person responding to Report: _____ Date: _____
(Printed name) (Signature)

RESIDENTIAL YOUTH CARE
(R Y C)

Jacobson, Yvonne M (HSS)

From: Fletcher, Marilee M (HSS)
Sent: Tuesday, August 14, 2007 8:41 AM
To: Jacobson, Yvonne M (HSS)
Subject: FW: Grievance P & P

This is the P & P from RYC (Residential Youth Care) a BTKH provider in Ketchikan.

Marilee Fletcher

465-5808

Please note my new email address: marilee.fletcher@alaska.gov

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From: Jack DUckworth [mailto:ryc@kpunet.net]
Sent: Tuesday, August 14, 2007 7:16 AM
To: Fletcher, Marilee M (HSS)
Subject: Re: Grievance P & P

Customer Grievance Resolution Procedure

All individuals associated with Residential Youth Care may avail themselves of the following grievances procedure if the person feels that current actions are not effective in resolving a problem. It is the intent of this procedure that problem situations be resolved as quickly as possible.

- If a person feels that a situation has occurred or developed whereby he or she has been treated unfairly, that person is to state the problem verbally to the person or persons involved or directly responsible for the situation. If this verbalization of the problem does not result in a response, which provides a resolution satisfactory to all the persons involved, the injured person then has fourteen days to submit a complaint to the Executive Director. This written complaint must include a description of the problem, identification of the persons involved, specifics of dates and places and times, where appropriate, and must be signed and dated by the complainant. The executive Director shall date and initial receipt of the complaint, and shall file it in an appropriate file. Executive Director and complainant shall meet and discuss the grievance. Complainant may have 3rd party present if desired. The executive Director shall respond to the complaint, in writing, within fourteen days of its receipt. A copy of this response shall be filed with the original complaint.

- If the steps set out above, do not provide resolution of the situation, the aggrieved person shall submit a written grievance to the Board of Directors. This written grievance must provide a description of the problem must identify the persons involved with dates, ties, and places, where appropriate, must identify the procedures already taken to reach a resolution, desired resolution, and must be signed and dated by the complainant.

The Board shall consider the grievance at the next regular board meeting, providing that the grievance is filed at least ten days prior to that meeting. If the grievance is filed closer in time to the next regular meeting then ten days, it shall be considered at the following regular board meeting. IF requested the complainant may request an opportunity to appear before the Board where a verbal statement may be offered, physical evidence may be offered, the complainant may present witnesses, and where the Board members may ask questions of the complainant and any witnesses thus called. If the complainant desires assistance in representing him or herself, the representative may not be the Executive Director, a staff member, or a member of the Board of Directors. The Board may, if necessary to its decision, require other persons to appear before it for questioning, and may also require additional physical evidence prior to making a decision. The Board shall also provide opportunity to other persons identified by the complainant as having been involved in the problem to appear before the Board where these persons may make statements, present physical evidence or witnesses, and where the Board members may ask questions of them or of their witnesses.

Once the Board has heard the information it feels necessary to make a decision, it shall make a decision resolving the grievance. The decision shall be made in executive session. This decision shall be reduced to writing, and the Board shall provide the complainant the written decision within fourteen days of the decision.

Here is what I have on file,

Gabo

907-247-2022

-------Original Message-------

From: Fletcher, Marilee M (HSS)
Date: 08/13/07 16:34:15
To: coho@aptalaska.net; Veit, Doug; greg_pease@ghscorp.org; Sheri_Black@ghscorp.org; deem@city.ketchikan.ak.us; billhupp@hotmail.com; ryc@kpunet.net; dpatton@kictribe.org
Subject: Grievance P & P

Colleagues,

June 27 Melissa Stone, DBH Director sent a letter to all grantees requesting a copy of your agency Policy and Procedures regarding client grievances. Attached above, is a copy of the letter and a copy of a model set of P & Ps. The policies were to be submitted to your regional behavioral health specialist (me) by July 31, 2007. As of this date, I have not received them from you. Please send them electronically if possible, or drop them in the mail. If you mail them, send me an email confirming that you have done so.

I appreciate your timely assistance.

Marilee Fletcher

Regional Behavioral Health Specialist

(907) 465-5808

Please note my new email address: marilee.fletcher@alaska.gov

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SEARHC

Your Partner in Health

REPORTING PATIENT CONCERNS

Please let your doctor or nurse know if you have any safety concerns while you are in the hospital or clinic. To provide you with the best quality health care, we need to hear your concerns and ideas on how we may better serve you.

If you would like to further communicate a concern about patient care, complete a patient report card or write or call us about your concern. If your concern is about care at Mt. Edgecumbe Hospital, you may talk with the patient advocate at 907-966-8860, call toll free and leave a message for the Vice President of Hospital Services (1-800-478-8355), or send an email to: frank.sutton@searhc.org. For the Juneau Medical Center, contact the Administrative Office (907-463-4058) or send an email to: brenda.sturm@searhc.org. Your concern will be shared with the department manager(s) of the areas involved and the manager(s) will evaluate and follow-up.

Don't hesitate to tell us how we can improve patient care and safety. In addition to review of report card responses and other patient comments by the hospital and clinic administration and department managers, a summary of responses is also provided to the SEARHC Accreditation Governing Body.

If you feel that your concern about patient safety has not been adequately addressed by the hospital or clinic, you may also contact the organization which accredits these facilities, The Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission's online complaint submission web address is:
http://www.jointcommission.org/GeneralPublic/Complaint. You may also write to:

Division of Accreditation Operations
Office of Quality Monitoring
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

The Joint Commission will notify us about your patient safety concern and we will respond to the Joint Commission about follow-up.

SEARHC
SouthEast Alaska Regional Health Consortium

SEARHC Community Family Services (CFS)
Client Grievance/Complaint Procedure

CFS staffs are committed to quality service and to responding to any concerns about care expressed by a client or family. This process includes a plan to inform clients and their families of their right to make grievances/complaints and how to go about resolving them. Clients are advised they can file a grievance without intimidation and NO retaliation will be perpetrated against clients who have filed a grievance or complaint.

To reinforce the above standards, the Client Information form, in the client chart, is explained to the client and the client is asked to sign an acknowledgement that they received the information. The client keeps a copy of the signed form. The Client Information form includes Client Rights as well as the grievance/complaint procedure. The next page is a copy of the Client Information form.

CLIENT INFORMATION

I. Bill of Rights

You have the right to competent, respectful service.

You have the right to information that is clear and understandable.

You have the right to confidential handling of all counseling information, as detailed in the client confidentiality statement.

You have the right to a choice regarding releases of information, concurrent services, and the composition of the service delivery team.

You have the right to request specific forms of counseling, and to be informed why, if requested forms of counseling are not made available.

You *have the right* to refuse specific forms of counseling that are offered, and to discontinue counseling at anytime.

You have the right to refuse to participate in research activities.

You have the right to participate in the formulation, evaluation and periodic review of your individualized written counseling plan.

You have the right to request a review of your counseling record with a staff person, at a reasonable time; however, information confidential to other individuals may not be reviewed.

You have the right to receive a copy of all documents you have signed.

You have the right to be treated with respect and to exercise your rights without fear of retaliation.

You have the right to have your requests responded to in a timely fashion.

You have the right to receive services in a tobacco free, drug free, violence free setting

You have the right to have access to guardians and conservators, self-help groups and advocacy services when needed.

II. Civil Rights

The Civil Rights Act of 1964 requires that community service agencies notify consumers that services and benefits are provided without distinction as to age, sex, race, color, national origin, political beliefs, religion, physical or mental

handicap, or disability. Sexual harassment is a form of sexual discrimination, and is against the law. Our ethical guidelines also prohibit discrimination based on sexual orientation or socioeconomic status.

III. Client Grievance Procedure

Clients have the right to fair and professional treatment. If a client feels that s/he has experienced abusive or discriminatory behavior from a staff member or that an element of their treatment is being neglected, the client may take the following steps:

1) You may present your complaint orally to your counselor. If the counselor cannot be reached you may talk to the counselor's supervisor. You may have an advocate present in the meeting or teleconference to discuss the complaint. You may also choose to present your complaint directly to the SEARHC CHS Quality Improvement Coordinator at (907) 966-8803.
2) If you are still dissatisfied, you must write within 180 days of the event, date and sign the complaint and mail it to the Community Family Services Coordinator at SEARHC, 222 Tongass Drive, Sitka, AK 99835. The CFS Coordinator will respond in writing within thirty (30) working days of receipt of the complaint.
3) If you are still dissatisfied, you must ask within thirty (30) working days of this response, that the written complaint be presented to the Behavioral Health Director at SEARHC, 222 Tongass Drive, Sitka Alaska 99835. The Director will contact the client and appropriate staff and community members for the purpose of resolving the conflict. Action by the Behavioral Health Director will be taken (including a written response) no later than thirty (30) working days from the date of receipt of the written complaint.
4) You have the right to pursue civil action if the SEARHC grievance procedures have not resolved the problem.

You will not be retaliated against for filing a complaint.

All Civil Rights complaints will follow State Division of Health and Social Services procedures. Complaints regarding discrimination may also be filed with the Civil Rights Coordinator, Department of Health and Human Services. P.O. Box 110650, Juneau, AK 99811-0605.

Signature of Client Date

Signature of Counselor Date

The Client Rights form is posted in every CFS office. The grievance/complaint procedure clearly outlines options for the client such as having an advocate present with them during the process or bypassing the program and going directly to the CHS QI Coordinator. It also outlines the process for resolution if the for example the client is not satisfied with the response of the CFS program Coordinator, they may go the Director of the Division of Behavioral Health.

The management of information is a critical component of an effective grievance/complaint management system. Record keeping is important because delivery systems cannot be refined or performance problems addressed adequately if management is unaware of what is at the root of repetitive complaints. Records of all grievances/complaints are maintained by the CHS Quality Improvement Coordinator (QIC). CFS and CHS staffs will try to address client grievances/complaints in a just and fair manner in order that client relationships are maintained at an optimal level.

1. Grievances/complaints can come to CHS management in a number of different fashions. Complaints can be received by telephone calls, electronic submission such as fax or email, personal interviews, referrals, customer report cards and customer satisfaction surveys. The CHS "Customer Complaint Form" will be available in all clinics as well as online on the SEARHC Webpage for use by staff when documenting the complaint for the client (telephone calls, etc). The CHS "Customer Complaint Form" will also be sent to clients who send in their concerns electronically to help them understand information that would be helpful for management to have to resolve the issue at hand.

2. Client problem areas can include any CHS Clinic, program such as CFS, department or program administrator and includes all areas where services are provided by SEARHC.

3. Once a grievance/complaint has been filed it is the responsibility of the CFS supervisor or coordinator to investigate the substance of the complaint. The complaint is analyzed and when indicated takes appropriate corrective action. As illustrated in the "Complaint Flow Chart" the flow is:

    a. Grievance/Complaint received.

    b. Program/Department resolution is initiated involving staff as necessary, within five working days of receipt of the grievance/complaint.

    c. If CFS is unable to adequately initiate resolution within five days, a written notification will be sent to the complainant by the end of the five days from the receipt of the grievance/complaint explaining why and identifying when the grievance process will initiate.

    d. If necessary, appropriate releases of information will be secured.

e. If resolved at the program/department level, the data is forward to CHS QIC for tracking. The QIC submits an annual report to the Governing body. Any significant trends will be shared for learning opportunity /future risk prevention.

f. If the issue is not resolved it will be forwarded to the CHS QIC who will initiate the continuing investigation/tracking process. CHS QIC will forward to the Behavioral Health Director or appropriate staff for resolution.

g. If resolved the data is maintained by CHS QIC for tracking. The CHS QIC submits an annual report to the Governing body. Any significant trends will be shared for learning opportunity /future risk prevention.

h. If not resolved case will be referred to Risk Management or appropriate area for resolution and the CFS Coordinator will notify the State of Alaska Division of Behavioral Health of the unresolved grievance/complaint.

4. For grievances/complaints that are received by the CHS QIC, within 24 business hours the identified complainant will be contacted either by phone or letter or both and advised that the complaint has been received and the allegations are being investigated. Calls may only need to say that we are in receipt of the complaint and that it will be investigated. The complainant should be informed as to what to expect from CHS and when CHS will be back in touch.

   Upon receipt of a complaint, the CHS QIC will scan a copy of the complaint and email to the appropriate staff who will respond with a summary/comment via email. The email will be printed and attached to the complaint as part of the documentation process. Any other copies of correspondence (letters to the complainant etc.) will also be attached to the complaint to close the loop.

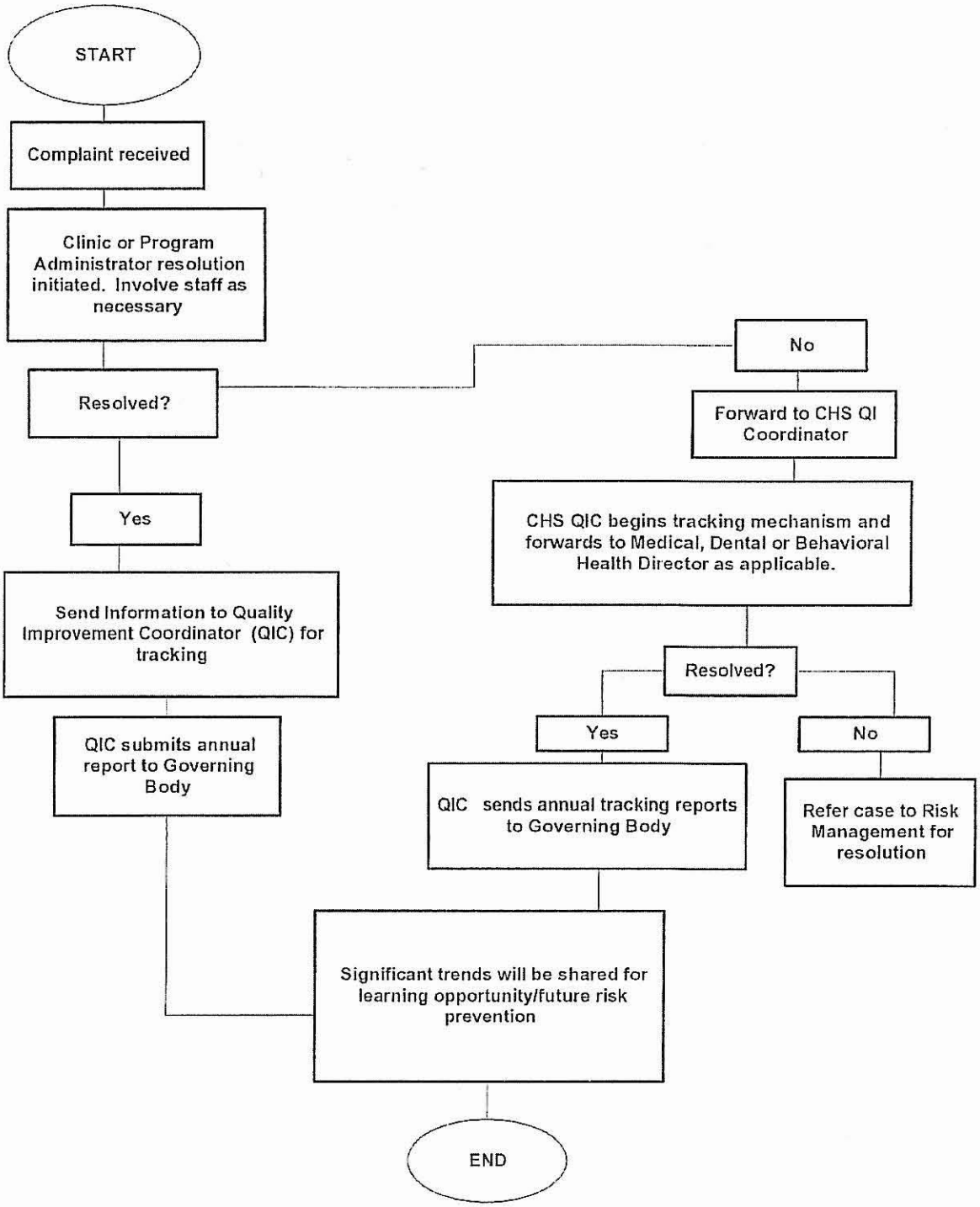
5. In a situation where the grievance/complaint is found to be non-meritorious, the results of the investigation and the conclusion should be explained with the complainant.

6. All grievances/complaints will be consistently followed through, and there will be documentation of investigation of complaint and feedback to complainant.

7. If it is obvious that an amicable settlement of the complainant's grievance cannot be reached, or requires review by the CHS Risk Management Committee, the issue will be forwarded to CHS Risk Management Committee and the CFS Coordinator will notify the State of Alaska Division of Behavioral Health of the unresolved grievance/complaint.

Community Health Services

COMPLAINT FLOW CHART



COMMUNITY HEALTH SERVICES

SouthEast Alaska Regional Health Consortium

Customer Complaint Form

Completed by (**check one**)

Patient/Client Patient Relative Friend Parent

Staff (at patient's request) Other _____

This form is for you to make a complaint in the strictest confidence about care you received at a SEARHC facility. You do not have to use this form or provide your name, but if you do, it will help us to consider your complaint quickly. Please fill in the form, giving us as much detail as you can

YOUR DETAILS - or anonymous – check here

_____

Printed Full Name

PATIENT DETAILS

_____

Full Name DOB Gender

Do you want to be contacted? YES NO (Please circle one)

If so, how would you prefer to be contacted (please check below)

☐ Phone call, my contact phone # with area code is: _____

☐ Email, my email is: _____

☐ Written Letter to this Address: _____

_____

☐ Other: _____

Pl ease tell us a little about your concern:

☐ Customer Service Issue (staff courtesy, billing or delay in service)

☐ Problem with Medical/Dental Care Received

☐ Did you discuss your concern with SEARHC Staff? ☐ Yes ☐ No

☐ Other: _____

Details of your complaint

Please make sure that you have:

- ☑ Given us the full names of SEARHC staff involved
- ☑ Described your complaint as fully as possible
- ☑ Enclosed any other supporting evidence

Given us your name, and if possible your daytime phone number if you want us to contact you.

When you have competed this form you can:

- ☑ Enclose it in a postage paid "report card" that are available at any SEARHC clinic waiting room, and drop in mailbox OR
- ☑ Turn it into the local clinic administrator, OR
- ☑ Mail it to this address:

SEARHC, CHS Quality Improvement Coordinator
222 Tongass Drive
Sitka, AK 99835

SITKA COUNSELING
&
PREVENTION SERVICES

Client Grievance

Sitka Counseling & Prevention Services is committed to treating all of our clients with dignity and respect. Sitka Counseling & Prevention Services offers the following process for addressing disputes or grievances with members of the SC&PS staff, in a respectful, constructive, timely, and impartial manner. All clients have the right to be informed of and to utilize the client grievance procedure without fear of intimidation or retribution.

Procedure:

1. The client should attempt to address and resolve disputes with the staff member directly. If this does not resolve the issue,

2. The client may consult with his/her primary counselor and/or the counselor's supervisor regarding the dispute. The primary counselor and/or the counselor's supervisor will assist the client in resolving the dispute.

3. The client may approach the Consumer Advisory Board or designate someone else to assist her or him. SC&PS will provide the client a waiver of confidentiality form, to be completed for this purpose. The designated assistant may be present whenever there is a dispute or grievance proceeding.

4. The client has the right to submit a grievance with assistance and without interference or impediment.

a. The client may submit a grievance orally by contacting the SC&PS Client Grievance Assistant, in person or by telephone, or

b. the client may submit a grievance by email to grievance@scpsak.org and,

c. the Client Grievance Assistant will prepare a written grievance for the client to review and sign, or

d. the client may request a written referral to consumer advocacy resources, such as the Disability Law Center, the Alaska Mental Health Consumer Web, and NAMI of Sitka, or

e. the client may submit a written grievance in person or by mail, and

5. Upon receipt of a grievance by any of these means, SC&PS will communicate to the client that SC&PS has begun the process of resolution of the grievance.

> A file will be created for each individual grievance which will contain all related documents, records, actions and communications. This file will be made available to the client to read or copy at the client's request.

6. If the grievance concerns an allegation of abuse, neglect, or unnecessary seclusion or restraint of the client the grievance will be taken directly to the Board President. In all other instances, the grievance will first go to the Clinical Director for resolution. The Clinical Director will investigate the matter and respond to the grievance, in writing, within five days.

7. If the matter remains unresolved, the grievance will be forwarded to the Executive Director within five working days. The Executive Director will investigate the issue and respond to the grievance, in writing, within five working days.

8. If the client is not satisfied with the Executive Director's decision regarding the grievance, the grievance will be forwarded to the President of the Board of Directors.

9. The Board President then has ten working days to form a committee of at least three Board members to address the grievance and inform the client, in writing, of the Board decision.

10. This procedure is intended to bring satisfactory resolution of all grievances within 30 days of the receipt of a grievance. If the client is not satisfied with the Board decision, SC&PS will refer the grievance to the Division of Behavioral Health, within 5 business days, for technical assistance with grievances that remain unresolved after 30 days.

14. COMMUNICATION

C. Employee Grievances

Purpose:
To find fair and equitable solutions, at the lowest possible level, to problems which may arise from time to time affecting staff employed by this agency.

Policy:
Employees may utilize the agency's formal grievance procedure if they have failed to resolve the issue of concern through more informal measures. Probationary employees may only utilize the grievance procedure through Step II. Employees must exhaust this grievance procedure before seeking judicial relief.

Definition:
"Grievance" means any alleged violation of agency policy, federal, state or local law or regulation.

Procedure:
(a.) Grievances should be resolved quickly and at the lowest level possible. The employee is expected to discuss grievances with their immediate supervisor and attempt to resolve grievances informally. If a grievance cannot be resolved informally, the following procedure shall be followed.

(b.) Step I – Program Director. The employee shall submit their grievance in writing to the Program Director to be date stamped for receipt within fourteen (14) calendar days after the employee knew, or should have known, that he or she had a grievance, whichever is earlier. The written grievance shall contain a description of the alleged violation, the policy or law involved, and the corrective action desired. A meeting between the Program Director and the employee shall be held within (10) calendar days after the grievance is received by the Program Director. The Program Director shall respond to the employee in writing within (10) calendar days of the meeting.

(c.) Step II – Executive Director. If the grievance is not resolved at Step I, the employee may, within ten (10) calendar days of receiving the Program Director's written response, present the employee's written grievance and the Program Director's written response to the Executive Director or designee. The Executive Director shall meet with the employee within ten (10) calendar days after the grievance is received by the Executive Director for the purpose of resolving the grievance. The Executive Director or designee shall respond to the employee in writing within ten (10) calendar days after the step II meeting.

(d.) Step III - Board Ad Hoc Resolution Committee. If the grievance is not resolved at Step II, the employee may, within ten (10) calendar days of receiving the Executive Director's written response, present the employee's written grievance and the Program Director and Executive Director's written responses to the Board President. The Board President will appoint a Board Ad Hoc Resolution Committee composed of three (3) members including the Board President.

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This committee shall respond to the employee in writing within sixty (60) calendar days after the grievance is received by the Board President.

(e.) The Board Ad Hoc Resolution Committee's function is to interpret the policies. The Board Ad Hoc Resolution Committee shall consider only the particular issues presented in writing by the Executive Director and/or the employee. The Board Ad Hoc Resolution Committee shall have no authority or power to add to, delete from, disregard, or alter any of the provisions of the policies, but shall be authorized only to interpret the existing policies as they may apply to the specific facts of the issue in dispute. The decision of the Board Ad Hoc Resolution Committee shall be final and binding and shall be in writing and forwarded to both parties.

(f.) Time limits set forth in the preceding steps may only be extended by mutual written consent of the parties described above.

(g.) If an employee fails to process a grievance at any step within the time limits described above and the procedure is not waived by mutual written consent of the parties, the grievance shall be considered waived and will constitute a bar to any future actions regarding the grievance.

Approved BOD 2/28/07

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Sitka Counseling and Prevention Services is committed to providing the best service possible to our clients. In the event of a client complaint, we will respectfully and with dignity seek resolution and satisfaction of the complaint. The following elements of SC&PS policy and procedure pertain to the resolution of client complaints and the process by which client grievances are to be resolved.

CLIENT RELATIONS

[This section is from the introduction to the Employee Handbook, and is appended to SC&PS P&P.]

Clients are among our Agency's most valuable assets. Every employee represents SC&PS to our clients and the public. The way we do our jobs presents an image of our entire Agency. Clients judge all of us by how they are treated with each employee contact. Therefore, one of our first priorities is to assist any client or potential client. Nothing is more important than being courteous, friendly, helpful, and prompt in the attention you give to clients.

SC&PS employees should direct clients who wish to lodge specific comments or complaints to the client grievance policy and procedure for appropriate action. Our personal contact with the public, our manners on the telephone, and the communications we send to clients are a reflection not only of ourselves, but also of the professionalism of SC&PS. Positive client relations not only enhance the public's perception or image of SC&PS, but also increase client/public confidence in our services.

Policies & Procedures, Section B – Client Rights
1.B.1 – Inform Clients of Rights

Policy:
SCPS shall inform all individuals presenting for services of their legal and human rights. A person receiving treatment at a community behavioral health center which receives financial assistance under AS 47.30.520 - 47.30.620 has the same legal rights and responsibilities guaranteed to all persons by the Constitution and statutes of the United States and the State of Alaska. Alaska state law and the Ethical Principles of the American Psychological Association/NAADAC provide clients of community behavioral health clinics with specific rights that will be respected by all staff.

Procedure:
1. Each individual who presents for services shall be verbally informed of their client rights by staff, read, and sign a welcome and consent packet containing information on agency policy regarding client rights, client civil rights, client privacy notice, confidentiality, client grievance procedures, the right to assistance in grievance, a confidentiality waiver form to accommodate this, fees and billing, appointment policy, and authorization of consent to treatment. (**Appendix B-1**)

2. Staff shall read the information to any client unable to read the document and/or vision impaired.

3. SCPS client rights shall be posted in a conspicuous place immediately available to all clients and a written copy shall be give to each client upon admission to the program.

Policies & Procedures, Section B – Client Rights
1.B.4 –Client Communication

Policy:
Sitka Counseling & Prevention Services is committed to treating all of our clients with dignity and respect. SC&PS will provide all of our clients with a constructive process for addressing grievances in a respectful, timely, and impartial manner. SC&PS staff will make every effort to respond to client communication in a manner fostering therapeutic aspects of conflict resolution and problem solving.

Procedures:
1) All clients have the right to grieve actions and decisions of facility staff that they believe are inappropriate, including but not limited to actions and decisions which may be perceived as a violation of civil rights.

2) SC&PS maintains a client grievance process for timely resolution of complaints and posts this procedure in a place where it will be immediately available to all clients at each facility location.

3) All clients have the right to be informed of and to utilize the client grievance procedure without intimidation or fear of retribution or other adverse consequences.

4) Client should attempt to address and resolve the conflict with the staff member directly, but may utilize the grievance procedure without interference or impediment.

5) Clients or family members may approach the Consumer Advisory Board or designate a representative/advocate to assist them. SC&PS will provide a waiver of confidentiality which clients may complete and submit for this purpose. The designated representative/advocate may be present during any/all conflict resolution or grievance proceedings.

6) Upon the request of the client, the client will be assisted in filing a grievance, by either
    a. The SC&PS Client Grievance Assistant, or
    b. A written referral by Sitka Counseling & Prevention Services staff to consumer advocacy resources, such as the Disability Law Center, the Alaska Mental Health Consumer Web, and NAMI of Sitka.

[Client Grievance: The following section is appended to the P&P manual.]

YOUTH ADVOCATES
Of
SITKA

Client Grievance Policy and Procedure

Policy:

It is the policy of Youth Advocates of Sitka, Inc. to provide clients (and family members and/or guardians in the case of minors) the opportunity to file grievances, and YAS, Inc. will treat all grievances as genuine and pursue a resolution. The grievance process will be available to all clients without regard to services used or program and to all consumers denied access to services. YAS, Inc. staff will clearly explain the policy to all clients and families upon entry to services. Each family will also be given a simple language document (DMHDD approved) that outlines procedures, rights and responsibilities under the policy. A signed form confirming that the client and family received this document and understands the policy will be part of the client's permanent file and copies given to the client and family. In addition the policy, procedures, and resources will be prominently displayed at all facilities.

Agency Responsibilities:

1. YAS, Inc. will provide a Client Grievance Form with which any client and/or family may use to file a grievance. This form will include an optional waiver of confidentiality. YAS, Inc. will also accept grievances by phone or in person. A staff member will complete a Client Grievance Form if taken via phone or in person (indicating so on the form).

2. YAS, Inc. will maintain separate grievance files that contain all documents related to grievances and record all actions resulting from grievances.

3. All grievances will be reported to the Board of Directors and the Client Advisory Board.

4. Client confidentiality will be maintained throughout the process.

Procedures:

1. Once a grievance is received the Executive Director will respond to the grievance, in writing, within 5 days. If the Executive Director is unable to respond within 5 days the client will receive a written explanation from the Executive Director.

   Any grievance involving abuse or neglect or any description, or unnecessary seclusion or restraint will be investigated and reported immediately to the Board of Directors and the Division of Mental Health and Developmental Disabilities and/or the Division of Children's Services.

2. The grievance process may also include the following:

- Meet with the staff member involved directly (with the staff supervisor present if the client wishes) and/or meet with the staff member's supervisor directly.

- If the grievance is still unresolved after meeting with the staff member and/or the staff member's supervisor involved then the grievance will go to the Executive Director.

- If the grievance is still unresolved after meeting with the Executive Director then the grievance will go to the Board of Directors.

Grievances unresolved to the client's satisfaction within 30 days shall be reported to the DMHDD Regional Coordinator pursuant to AS 47.30.660(b)(12).

Client Grievance Policy Questions and Answers

How do I file a complaint or concern?

You can make your complaint two ways:

1. Fill out the Youth Advocates of Sitka, Inc. Client Grievance Form.
2. Contact the Executive Director by phone or in person.

Youth Advocates of Sitka, Inc. believes that all clients have the right to file a grievance without intimidation. We will not prevent any client from filing a grievance or retaliate in any way.

Can I have someone else present during the grievance process?

Yes, you can. You may have an advocate present during all steps of the grievance process. We can assign a staff member to help you during the grievance process and/or you can choose a staff member to help you. You can also seek outside help. A list of organizations that may be able to help you include:

- Disability Law Center
- Alaska Mental Health Consumer Web
- NAMI Alaska

What is the grievance process?

The grievance process involves 3 steps:

1. Complete a YAS, Inc. Client Grievance Form and give it to the Executive Director and/or contact the Executive Director by phone or in person.

2. The Executive Director will respond to your grievance, in writing, within 5 days of receiving your grievance. If the Executive Director is unable to respond within 5 days you will receive a written explanation from the Executive Director.

   Any grievance involving abuse or neglect or any description, or unnecessary seclusion or restraint will be investigated and reported immediately to the Board of Directors and the Division of Mental Health and Developmental Disabilities and/or the Division of Children's Services.

3. Once the Executive Director responds, in writing, to your grievance any of following actions may occur:

   - Meet with the staff member involved directly (with the staff supervisor present if you wish) and/or meet with the staff member's supervisor directly.

- If your grievance is still unresolved after meeting with the staff member and/or the staff member's supervisor involved then your grievance will go to the Executive Director.

- If your grievance is still unresolved after meeting with the Executive Director then your grievance will go to the Board of Directors.

What if my grievance is still unresolved after going through the process?

If your grievance is still unresolved to your satisfaction within 30 days your grievance will be reported to the Division of Mental Health and Development Disabilities Regional Coordinator pursuant to AS 47.30.660(b)(12).

What will happen if I submit a grievance?

We will maintain a file of each grievance we receive. The file will contain all documents related to the grievance and record all actions resulting from the grievance. All grievances will be reported to the Board of Directors and the Client Advisory Board. Throughout the process we will maintain client confidentiality.

Youth Advocates of Sitka, Inc.

Consumer Rights and Responsibilities

Youth Advocates of Sitka, Inc. (YAS) is a non-profit Community Mental Health Agency. We receive funds from various payers, including clients, insurance, and Medicaid. We have a sliding fee schedule to determine if there is a discount available, based on income, number in household, and certain deductions. We offer limited waivers on an individual basis, and we offer some community services at no charge to the consumer or family.

Client Name: _____ **SSN:** _____

Consumer Rights:

1. To receive helpful treatment regardless of skin color, religion, culture, sexual preference, ethnicity, gender, or disability.
2. To participate in the development and evaluation of your treatment plan and goals.
3. To expect reasonable continuity of care and to be informed of your progress and prognoses.
4. To receive and examine an explanation of billing, regardless of payment source.
5. To records confidentiality, except as released by permission, or required by law.

Youth Advocates of Sitka will take the necessary steps to ensure that persons with qualifying disabilities, including those with impaired sensory or speaking skills, receive reasonable notice concerning benefits or services or written material concerning waivers of rights or consent to treatment. All aids needed to provide this notice are provided without cost to the person being served. It is Youth Advocates of Sitka's intention to offer an opportunity equal to, or as effective as, that afforded others, to apply for, receive or participate in, or benefit from the services the agency offers.

Responsibilities:

1. To actively participate in treatment.
2. To inform your therapist of emotions, events, or commitments which may affect treatment.
3. To maintain the confidentiality of other clients you may encounter at YAS facilities.
4. To be on time for appointments and/or give 24-hour notice if you cannot make an appointment.
5. To provide insurance information, Medicaid coupons, or financial information to determine reduced rates. If you choose not to provide this information, you will be responsible for the full amount. Youth Advocates of Sitka, Inc. bills monthly.

I have read, understand, and agree to the above statements.

_____ _____

Signature of Responsible Party Date

Is the Client receiving Medicaid or Denali Kid Care? Yes ☐ No ☐
Are the Client living outside the parents' home? Yes ☐ No ☐

If **Yes** to either question above, do not complete the Sliding Fee Scale Worksheet. There is no share of cost. If **No** and you are interested in reduced fee, complete the Sliding Fee Scale Worksheet. You must also complete the Insurance Billing Authorization.

Youth Advocates of Sitka, Inc.

Notice of Privacy Practices

For Your Protection

This notice describes the medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Health Care Information is Private

We understand that the information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.
2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees and Shares My Health Care Information

Your health care givers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later. We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How is Payment Made

We may share your health care information with heath plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.

May I See My Health Care Information

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information. If you think some of your health care is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information.

What if My Health Care Information Needs To Go Somewhere Else

You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.

The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old **and, by law, you are able to give consent for your own health care,** then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization
We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:

1. contagious diseases, birth defects and cancer
2. firearm injuries and other trauma events
3. reactions to problems with medicines or defective medical equipment
4. to the police when required by law
5. when the court orders us to
6. to the government to review how our programs are working
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs
8. to Workers Compensation for work related injuries
9. birth, death and immunization information
10. to the federal government when they are investigating something important to protect our country, the President and other government workers
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

May I Have A Copy of This Notice
This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan.

Questions or Complaints
If you have questions or feel your privacy rights have been violated you can contact Colette Martin, Executive Director by calling (907) 747-3687 or by writing to Youth Advocates of Sitka, Inc., P.O. Box 664, Sitka, AK 99835.

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaint made to YAS, Secretary of Health and Human Services or Office of Civil Rights.**

BARTLETT REGIONAL
&
RAINFOREST RECOVERY

Rainforest
Recovery
Center

3250 Hospital Dr., Juneau, Alaska 99801, Telephone 907 796-8690 • fax 907 586-5605

July 12, 2007

State of Alaska
Division of Behavioral Health
Department Health and Social Services
Attn: Marilee Fletcher
P. O. Box 110603
Juneau, AK 99811-0603

Dear Marilee Fletcher

In accordance with Melissa Witzler Stone's, (Director Behavioral Health) letter of June 27, 2007 a copy of Rainforest Recovery Center @ Bartlett's "Patient Complaints/ Grievances" policy and procedures is attached for your review.

If you require any more information please contact me at 907-796-8690 or email me at jwalker@bartletthospital.org .

Sincerely,

Janice Walker

Janice Walker
Director, Behavioral Health Services
Rainforest Recovery Center @ Bartlett

SCOPE: Applies to all patients receiving services from any entities of BRH.

PROCEDURE:

CONCURRENT

A. BRH will provide patients/family members with information concerning the grievance process that is tailored to their level of understanding (i.e. interpreters, note takers, assisted listening devices.)
   A.1. Inpatients will receive a copy of the Patient Rights and Responsibility information in the admission packet.
   A.2. The Patient Rights and Responsibility information will be posted in the business office, outpatient registration, ED, RRC front desk and SDC.
   A.3. Information for initiating a complaint will be available in the information distributed or posted and be available in the public information racks in the main lobby waiting area, the ER waiting room and near the elevators on second and third floor and the JRH information racks.

B. Patients/family members are encouraged to immediately voice concerns to any BRH employee or caregiver for timely resolution. The person receiving the concern/complaint will:
   B.1. Tactfully listen to patient/family.
   B.2. Obtain as many facts about the situation as possible.
   B.3. Assure patient/family members that the presentation of a concern or complaint will not jeopardize the availability of care or service at Bartlett.
   B.4. For documentation purposes, encourage the patient or family to complete a Patient Feedback form.
   B.5. Notify the department manager, house supervisor or the risk manager about the facts of the complaint.
   B.6. The manager or house supervisor will notify the risk manager of the investigation, the intended course of action and/or resolution for information and tracking purposes.

C. If the patient/family member feels the appropriate Department Manager or House Supervisor does not satisfactorily resolve his/her concern, the concern/complaint will be referred to the Risk Manager. The Manager/Supervisor will document the concerns and resolution.

D. If a grievance concerning quality of care or a premature discharge of a Medicare beneficiary is lodged, the Department Manager or House Supervisor will inform the Utilization Management Coordinator. The UM coordinator will inform the patient or family of their right to request a review of the grievance. The UM Coordinator will be responsible to communicate the request to Mountain Pacific Health Foundation.

E. Any grievance involving situations or practices that place the patient in immediate danger will be referred directly to the House Supervisor, who will

attempt to resolve the issue. The House Supervisor will provide documentation of the issue and resolution to the Risk Manager for follow-up and data collection.

F. Patients/family members will be informed of their right to address their concerns or grievance in writing to: Administrator, Office of Health Facilities Licensing & Certification Department of Health and Social Services, 4730 Business Park Blvd., Suite 18, Bldg. H, Anchorage, Alaska 99503-7137, (907) 561-8081. This right exists regardless of whether he/she has first utilized the BRH grievance process.

G. Medicare and Medicaid beneficiaries may also call the Beneficiary Hotline if their concern deals with quality of care issues. This number is 1-800-497-8232.

RETROSPECTIVE

A. Complaints concerning services or care will be immediately referred to the Risk Manager or designee who will collect information sufficient to initiate an investigation.
   A.1. the complaint will be referred to the appropriate Manager/Supervisor for investigation. Information on the investigation will be forwarded to the Risk Manager.
   A.2. Written response will be sent to the patient/family member within 2 weeks of receipt of the complaint or concern
   A.3. If a resolution cannot be reached within 2 weeks; the patient/family member will be informed of the delay in writing.

B. All verbal/telephone compliments and complaints will be documented by the recipient and will be forwarded to the Risk Manager for follow-up and data collection.

C. Department managers or supervisors will initiate follow-up requests from Patient Feedback or Avatar data. Information on the resolution or request with assistance for resolution will be forwarded to QRM.

REFERENCES:

Alaska State Statue 18.20.075
Joint Commission on Accreditation of Healthcare Organizations, Ethics, Rights and Responsibilities, RI 2.120
Medicare Hospital Condition of Participation: Patients" Rights. §482.13(a) (2) (ii) and (iii)
BRH Policy 9500.004 Patient rights and Responsibilities

ATTACHMENTS:

1. Bartlett Regional Hospital Patient Feedback
2. Bartlett Regional Hospital Complaint Form

Approval/Review/Revision					
Date:	Signature:(Medical Director or Committee Chair, as appropriate)	Date:	Signature:(Medical Director or Committee Chair, as appropriate)	Date:	Signature:(Medical Director or Committee Chair, as appropriate)
4/02	New				
4/03	Reviewed				
09/04	Reviewed				
12/05	Revised				
8/06	Revised				

Bartlett Regional Hospital

3260 Hospital Drive • Juneau, Alaska 99801 • Telephone 907-586-2611

COMPLAINT FORM (for internal use only)

(Internal Use Only)

Received Date:

Report Taken By:

Name of Person Initiating Complaint:

Phone Number:

If Applicable, Patient Name: **MR#:** **Visit #:**

Admit Date: **Discharge Date:**

___Outpatient ___Inpatient ___ED __Short Stay

Department Involved:

PROBLEM:

Referred To:

INVESTIGATION:

Complaint resolved satisfactorily: ❑ Yes ❑ No

Signature: _

Title: _ Date: _____

Bartlett Regional Hospital

Patient Feedback (For external use)

To our patients,

Do you have a compliment or complaint that you would like to share with us?

Please take a minute and tell us what you think about our services, staff and facilities, whether good or bad. We value your opinion.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Would you like to discuss your ideas with one of our staff members? ___ Yes ___ No

If yes, please provide us with the following information:

Name: _____ Phone _____Best Time to call _____

FAIRBANKS MEMORIAL

Banner Health

POLICY and PROCEDURE

TITLE: Patient Complaint, Discrimination and Grievance			
Number: 2865	Version: 2865.4		Status: Final
Type: Administrative	Author: Dale Schultz		
Effective Date: 07-18-2007	Original Date: 12-21-2001	Review Date: 12-21-2004	Deactivation Date:
Facility: System			
Entities: Banner Health			
Population (Define): All Patients			
Replaces:			
Approved by: APC, SMT			

TITLE: *Patient Complaint, Discrimination and Grievance*

I. Purpose/Expected Outcome:

A. The purpose of this policy is:
   1. To resolve concerns, complaints, grievances to the satisfaction of the patient, family or their representative.
   2. To provide specific procedures to enable patients, their families or their representatives to file a complaint and when such complaint is not promptly resolved to their satisfaction, to file a grievance about the treatment and/or care they receive at Banner Health (BH).
   3. To provide an organized mechanism for identification, analysis, correction and documentation.
   4. To provide a mechanism for the Board of Directors to evaluate the effectiveness of the complaint/grievance process.

II. Definitions:

A. "Complainant" means any person who believes she or he has a concern about any aspect of his/her visit to our healthcare facilities or has been subjected to discrimination on the basis of color, race, sex, national origin, religion, age or disability.

B. "Complaint" means an expression of concern that can be resolved promptly to the patient/family/representative's satisfaction. A complaint includes a concern that requires a relatively minor change and can be resolved in a more timely manner than through a written response, for example a change in bedding, housekeeping of a room, or serving preferred food and beverages.

C. "Compliant Coordinator" means the Director of Patient Relations, the Patient Representative, or other representative appointed by the Administrator. Where the grievance involves a privacy issue, the Privacy Officer is the Complain Coordinator.

D. "Grievance" means a complaint (other than a billing, **claims, or** a patient valuable issue) that has not been resolved promptly to patient/family/representative's satisfaction through staff present of that has been referred to the Complaint Coordinator, or Administration.
   1. Where other staff must be called in to resolve an issue that cannot be resolved immediately by staff present, the complaint shall be treated as a grievance.
   2. Where the Complaint Coordinator can immediately contact the patient's unit and staff present is able to resolve an issue at that moment, the complaint is not a grievance.
   3. Where the patient requests that his/her complaint be handled as a formal complaint or grievance or where the patient requests that his/her complaint be handled as a formal complaint or grievance or where the patient requests a response from the hospital, the complaint shall be treated as a grievance.

4. Complaints that were neither addressed nor resolved during the patient's stay shall be treated as grievances.
5. Where complaints about billing, patient valuables, or claims contain elements addressing patient service or care issues, those patient care or services issues shall be treated as a complaint, and if not resolved immediately, as a grievance.

III. Policy:

A. **Complaints.**

1. BH has a process for prompt and equitable resolution of complaints received regarding care and service as well as breach of privacy. Banner Health (BH) offers its patients, their representatives and their families the opportunity to express concerns about any aspect of their visit to our healthcare facilities without fear of discrimination or retribution.
2. If patients, families, or representatives' complaints are not promptly resolved to their satisfaction, they have the right to file a grievance and will be informed about the grievance process.
3. Patients are informed of their right to express concerns, the process to resolve concerns and their right to file grievances if their concerns are not resolved promptly to their satisfaction.
4. The Complaint Coordinator will be notified if the concerns are not resolved to the patient's satisfaction.
5. Behavioral health patients will have available a Mental Health Grievance Policy according to applicable state requirements.
6. The existence of this review process does not preclude a patient, patient's representative or family member from filing a complaint with the Department of Health and Human Services Office, Quality Improvement Organization, or the State health department or the Joint Commission as applicable.
7. Patients are informed of their right to file a complaint with the Sate health department, regardless of whether they first use the grievance process, as well as the telephone number and address of the State health department.
8. Patients are informed of their right to see review by the Quality Improvement Organization for quality of care issues, coverage decisions and to appeal a premature denial.
9. Risk Management investigates and takes action on claims and lawsuits involving BH. Complaints about the resolution of claims are not governed by this policy.
10. Complaints about billing, patient valuables, and claim issues are not governed by this policy except to the extent they address patient service or care issues.

B. **Discrimination.**

1. BH facilities do not discriminate against patients or visitors on the basis of color, sex, race, national origin, religion, age or disability. Any individual who believes he/she has been subject to discrimination may file a complaint under this policy. Anti-discrimination policies and complaint procedures related to employment are addressed under BH Employment Policies and are excluded from this policy.
2. BH facilities will not retaliate against any individual who has filed a complaint or who cooperates in the investigation of a complaint.
3. BH facilities will designate a Coordinator to receive and investigate complaints of discrimination.
4. A Complainant has the right to file an appeal and will be informed about the appeal process.
5. BH has a separate process for prompt and equitable resolution of complaints received regarding care, services or alleged actions prohibited by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act and their respective implementing regulations. The existence of this does not preclude a patient, patient's representative or family member from filing a

complaint of discrimination on the basis of handicap with the Department of Health and Human Services Office for Civil Rights, the State Attorney General or the state health department.

6. Complainant has the right to be represented by an attorney or other person. The Complainant and all interested persons have the right to present evidence relevant to the complaint through witnesses, documents and exhibits.
7. The Coordinator will make appropriate arrangements to assure that disabled persons can participate in or make use of this grievance process on the same basis as the non-disabled.

C. **Grievances.**

1. The grievance process shall conform to state law.
2. Patients will be informed of his/her right to file a grievance in advance of furnishing or discontinuing patient care whenever possible. Information will be provided, whenever possible, in a language and method of communication that the patient understands (e.g., through an interpreter, Braille, audio cassette or large printed material).
3. Grievances may be verbal or written.
4. The Hospital Administrator will appoint a Complaint Coordinator to oversee the investigation and resolution of grievances.
5. The Complaint Coordinator will conduct or oversee the investigation of the grievance and will provide the patient with written notice of its decision that contains the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, the date of the completion, the name of the hospital contact person, and the right to request Grievance Committee review.
6. The BH Board of Directors is responsible for the effective operation of the grievance process and delegates responsibility for reviewing and resolving grievances to Regional/Hospital Grievance Committees.
7. In Arizona, the BH Board of Directors has appointed the President of the Arizona Region to appoint BH representatives to Regional Grievance Committees on an ad hoc basis.
8. In the Western Region, the BH Board of Directors has delegated authority to the Hospital CEOs to appoint the Hospital Grievance Committee.
9. Regional/Hospital Grievance Committee will:
    a. Include a Facility patient advocate and a representative from administration if warranted based upon the nature of the grievance.
    b. Include the Privacy Officer or designee if the grievance involves concerns about privacy or confidentiality of patient information.
    c. Provide a reasonable opportunity for the patient, family, or representative to explain their concerns and present evidence in person or by telephone to the Committee.
    d. Inform the patient, family, or representative of the outcome of the review, including the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.
    e. Report its activity and action to the Facility quality committee (ASK???) for inclusion in its continuous quality improvement activities.
    f. Report its activity and actions, in summary form on a quarterly basis to the appropriate BH Care Management Team for analysis and submission to the BH Board's Care Management and Quality Committee.
10. The BH Board's Care Management and Quality Committee will evaluate the effectiveness of the Grievance Policy and submit its findings and recommendations to the Board of Directors on an annual basis.
11. Medical Staff Peer Reviews are confidential in accordance with state law. While Patient Grievances may involve information submitted for Peer Review, such reviews are separate and

apart from the reviews conducted pursuant to the Patient Complaint and Grievance policies. Peer Review information will not be used to resolve Patient Grievances.

IV. Procedure/Interventions:

A. NOTIFICATION OF COMPLAINT/GRIEVANCE PROCESS

1. Post notice outlining patient rights and responsibilities throughout the hospital and at the main entrances of the hospital.
2. Give all patients a copy of the Patient Rights and Responsibilities, including grievance rights, at the time of admission in a language or method of communication that each patient understands. **(IN-PATIENT, OUT-PATIENT AND EMERGENCY CENTER REGISTRATION)**

B. COMPLAINT PROCESS

1. Attempt to resolve concerns immediately at the point of service to the satisfaction of the patient/family member/representative. **(PERSON RECEIVING THE CONCERN, MANAGER)** (See ***Policy: Facility Service Recovery/Patient Reparations Process***)
2. Contact the Complaint Coordinator if the attempt is unsuccessful or, if the concern involves a privacy or confidential contact issue, the Privacy Officer. This starts the grievance process.
3. Where the complaint involves situations or practices that place the patient in immediate danger and the situation or practice cannot be immediately resolved, take such immediate action as appropriate to protect patient safety and contact Administration and Risk Management.
4. Complaints involving a coverage decision, premature discharge, and/or quality of care concerns are addressed promptly; the patient is notified of his/her right to contact the QIO; and the Hospital complies with his/her request when the patient requests QIO review.

C. ALLEGATIONS OF SEXUAL/PHYSICAL/VERBAL ABUSE OF PATIENTS

1. Notify Administration, the Complaint Coordinator and Risk Management immediately regarding all patient allegations of physical, sexual or verbal abuse. **(DEPARTMENT MANAGER OR DESIGNEE)**
2. Take such immediate action as appropriate to protect patient safety. **(ADMINISTRATION)**
3. Coordinate an investigation of the allegation with notification to Human Resources if the alleged abuser is an employee or to the Medical Staff Services Office if the alleged abuser is a medical staff member. **(MANAGER/RISK MANAGEMENT/PEOPLE RESOURCES/AFFIRMATIVE ACTION DEPARTMENT)**
4. Document all contacts with the police, State Board of Nursing, State Medical Board, state health department, and all other state and federal agencies conducting an investigation pertaining to allegations of sexual/physical abuse of a patient. **(DEPARTMENT MANAGER)**
5. Take further steps required in Section E below.

D. SECTION 504 DISCRIMINATION COMPLAINTS

1. File a complaint with the Coordinator within 30 days of the date the Complainant becomes aware of the Discrimination. The complaint should be in writing, containing the name and address of the Complainant, the problem or action alleged to be discriminatory and the remedy or relief desired by the Complainant. **(COMPLAINANT)**
2. Conduct a thorough investigation, which must afford all interested persons an opportunity to submit relevant evidence. **(COORDINATOR)**
3. Issue a written determination within thirty (30) working days after the complaint is filed and inform the Complainant of the right to file an appeal.
4. File a written appeal to the BH Vice President Risk Management within fifteen (15) days of receipt of the determination if findings are not to Complainants' satisfaction. **(COMPLAINANT)**

5. Hear the appeal. (See Grievance Process below.) (**REGIONAL/HOSPITAL GRIEVANCE COMMITTEE**) Any member of the Regional/Hospital Grievance Committee with prior involvement in the substantive aspects of the complaint must refrain from participation in the appeal.
6. Issue a written decision in response to the appeal within thirty (30) working days from receipt of the appeal. (**CHAIRMAN OF THE REGIONAL/HOSPITAL GRIEVANCE COMMITTEE**)
7. Report the nature and results of its investigations, if any, in summary form to the BH Care Management Team and to the Hospital Quality Department. (**CHAIRMAN OF THE REGIONAL/HOSPITAL GRIEVANCE COMMITTEE/BH VICE PRESIDENT RISK/MANGEMENT**)
8. Report activities and actions in summary form to the BH Care Management and Quality Committee. (**BH CARE MANAGEMENT TEAM**)

E. **LEVEL ONE GRIEVANCE**

1. Receipt of grievance is dated and recorded. Verbal grievances are documented. (**COMPLAINT COORDINATOR**)
2. Analyze grievances and identify, investigate and resolve any deeper, systemic problems indicated by the grievance.
3. Refer the grievance to the appropriate Department Director or Manager for follow up and investigation and remind such Director or Manager to alert appropriate staff concerning the grievance.
4. Assure that all grievances involving situations or practices that place the patient in immediate danger are resolved.
5. Conduct internal investigation, submit a report of findings and implement corrective actions and make direct contact with the patient when appropriate. In the case of potential liability/litigation, refer complaints to Risk Management. Where there are compliance issues, refer to the Compliance Officer.
6. Within seven (7) working days of receipt of the grievance, provide each patient, patient's representative or family member making grievance written notice of its decision, in a language and manner that the patient understands, that contains the steps taken on behalf of the patient investigate the grievance, the results of the grievance process, the date of the completion, the name of the hospital contact person and the right to request further review by the Grievance Committee. Where the grievance cannot be investigated and resolved within seven (7) working days, notify the patient that the investigation remains on-going and that the decision will be provided as soon as reasonably practicable.
7. Keep a centralized file system of all grievances at the facility.
8. Track, trend, analyze and report on a quarterly basis.

F. **LEVEL TWO GRIEVANCE – GRIEVANCE COMMITTEE REVIEW**

1. Receipt of written request for Grievance Committee review is dated and recorded. In the Arizona Region, where the grievance is received by Administration/Patient Relations, the BH Vice President Risk Management is notified. In the Western Region, where the grievance is received by Administration/Patient Relations, Risk Management is notified. (**PATIENT REPRESENTATIVE/RISK MANAGEMENT/ADMINISTRATION**)
2. Acknowledge receipt of the request for Grievance Committee review within 5 days.
3. Appoint a patient advocate.
4. Review grievance and provide a reasonable opportunity for the patient, representative or family to present the request for review in person or by telephone to the Committee within 30 working days, absent extenuating circumstances. (**GRIEVANCE COMMITTEE**)

5. Respond to the complainant within ten (10) working days of the meeting, absent extenuating circumstances. The response includes the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. Where the grievance cannot be investigated and resolved within ten (10) working days, notify the patient that the investigation remains on-going and that the decision will be provided as soon as reasonably practicable. (**CHAIRMAN OF HOSPITAL GRIEVANCE COMMITTEE/ADMINISTRATION/BH VICE PRESIDENT RISK MANAGEMENT**)
6. Refer grievances involving premature discharge, coverage decisions or quality of care to the Quality Improvement Organization when so requested by the patient or patient representative.
7. Report activities and actions in summary form to the BH Care Management Team. Report activities and actions in summary form to the BH Board Care Management and Quality Committee. (**BH CARE MANAGEMENT TEAM**)

V. Procedural Documentation:

A. Complaints maintained in facility specific data base.
B. Level One Grievance documentation maintained in facility specific data base.
C. Level Two Grievance documentation maintained at Risk Management.
D. Documentation relating to concerns about privacy or confidentiality of patient information will be retained for a minimum of six years.

VI. Additional Information

A. Complainants have a right to contact the Department of Health and Human Services Office for Civil Rights or the State Attorney General, or the state health department.

AK:
Office for Civil Rights/U.S. Department of Health and Human Services
2201 Sixth Avenue – Mail Stop RX-11
Seattle, WA 98121
Phone: 206.615.2290
Fax: 206.615.2297
TDD: 206.615.2296

AZ/CA/NV:
Office for Civil Rights/U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: 415.437.8910
Fax: 415.437.8329
TDD: 415.437.8311

CO/WY:
Office for Civil Rights/U.S. Department of Health and Human Services
1961 Stout Street – Room 1426
Denver, CO 80294
Phone: 303.844.2024
Fax: 303.844.2025
TDD: 303.844.3439

NE:
Office for Civil Rights/U.S. Department of Health and Human Services
2201 Sixth Avenue – Mail Stop RX-11
Seattle, WA 98121
Phone: 206.615.2290

Fax: 206.615.2297
TDD: 206.615.2296

B. Flow diagram

VII. References:

A. 42 CFR 482.13(a)(2), CMS Conditions of Participation
B. JCAHO Standards RI 1.2 and 1.3
C. 504 of the Rehabilitation Act of 1973, (29 USC, 794)
D. Title VII of the Civil Rights Act
E. The Americans with Disabilities Act (42 USC, Section 12101 et. Seq.)
F. State laws and regulations
G. Health Information Portability and Accountability Act (HIPAA)

VIII. Other Related Policies/Procedures:

A. N/A

IX. Cross Index As:

A. HIPAA
B. HIPAA Privacy
C. Board
D. Patient Relations
E. Allegations of Sexual/Physical Abuse of Patients
F. Patient Complaints
G. Discrimination Complaints

X. Attachments:

A. N/A

KETCHIKAN GENERAL

Ketchikan General Hospital
PeaceHealth

TITLE: Patient Complaints/Grievances

DEPARTMENT: Risk Management	EFFECTIVE DATE: January 01, 2004
APPROVED BY/DATE: February 21, 2004 by Lorrie Mortensen	REVISED. Replaces:
DOCUMENT NUMBER: SEA.RM.002	LAST REVIEWED: June 05, 2007 by LORMOR
KEY WORDS: Physician complaints; Home Health complaints; Long-Term Care complaints	NEXT REVIEW: June 05, 2008

SCOPE: Southeast Alaska Region (SEAR) Ketchikan General Hospital (KGH) employees.

PURPOSE: To provide a mechanism for timely and respectful response to patient complaints and grievances.

POLICY:

Ketchikan General Hospital demonstrates its commitment to quality care and customer satisfaction by respectful acknowledgment, prompt evaluation and reliable follow up when a complaint is expressed by the patient or family members. Any complaint that cannot be resolved promptly by staff present will be considered a grievance requiring administrative review and action. Patients and families will be informed of the right to raise concerns without fear of reprisal and, if requested, to receive a written response from the hospital.

REQUIREMENTS:

A. Patient/Family Concerns.

1. A patient/family may inform the hospital of dissatisfaction by:

    a. Telling any staff member of their concern.

    b. By calling or writing a letter of dissatisfaction to the risk manager, department manager or administrator.

2. When a staff member is notified of a patient/family concern, determine whether it is a complaint (a concern that can be resolved by staff present) or grievance (complaint that cannot be resolved promptly by staff present).

3. If a communication barrier is present, interpreter services or other aides will be made available in accordance with the Sensory Deficits–Hearing and Vision or Interpretation Services Policy.

B. Complaints.

1. Staff acknowledge the complaint without expressing judgment. Ask the patient/family what

action(s) he/she feels are needed to resolve the concern.

2. If staff is able to resolve the issue independently and without delay they should do so.

3. Staff is to follow up soon with the patient/family after the corrective action has been taken and determine if the issue has been resolved.

4. If the issue is not resolved by staff, the complaint should be considered a grievance. Follow grievance procedures below.

5. Any complaint involving a violation of patient confidentiality under HIPAA guidelines should be considered a grievance and reported immediately to the regional privacy officer.

C. **Grievance.**

1. Document all grievances on the electronic incident reporting system within 24 hours from the time of receiving the complaints or grievance.

2. The Manager may do any of the following:

   a. The department manager or administrator will acknowledge receipt of the grievance by calling or writing the grievant within one week. Include documentation of this acknowledgement on the incident report. If acknowledgement is via letter, a copy should be sent to the Risk Manager. If the department manager or administrator is the one who originally received the call, this constitutes acknowledgement of the grievance, as specified above.

   b. Patient safety concerns should be dealt with immediately. The patient/family should be informed of the anticipated time frames.

   c. The department manager may call or meet with the patient/family and explain the hospital's actions and decision. Document this call or meeting on the incident report.

   OR

   d. The Regional Vice-President of Patient Care or Department Manager may provide the patient with written notice of the hospital's actions and decision. This letter will contain the name of the hospital contact person, the steps taken on behalf of the patient, the results of the grievance process and the date of completion.

3. A grievance not resolved by the Department Manager or the Regional Vice-President of Patient Care should be given to the Chief Executive Officer for review. At this point in the grievance process, a patient or family will be notified that he/she may file a grievance directly to the State of Alaska Department of Health and Social Services at the following address:

Department of Health and Social Services
Division of Public Health
Health Facilities Licensing and Certification
4730 Business Park Boulevard, Suite 18
Anchorage, Alaska 99503-7137
Phone: (907) 334-2483

Fax: (907) 561-3011

4. If the patient/family is not satisfied with the actions taken, the Regional Vice-President of Patient Care may request an Ethics Committee consultation to provide ethical analysis and insight within one week of referral. The Regional Vice-President of Patient Care will take the Ethics Committee recommendation into consideration to reach a final decision. The patient/family will be informed in writing of the results, contact person and date of completion of the decision.

5. Documentation of reviews and investigation will be done on the incident report.

6. The Risk Manager will review all grievances for quality of care and premature discharge and refer them to either the Utilization Review Department or the Center for Health Care Improvement Department.

7. The Governing Board will review grievance activities as part of the biannual Risk Management report.

D. **Complaints Involving Long Term Care (LTC) Patients.**

1. Alaska State Health Facilities and Licensing requires the automatic reporting of any neglect, abuse or mistreatment of LTC residents either by staff or by family members.

2. LTC staff will complete an Electronic Incident Report detailing the alleged incident.

3. The department director will review and investigate the incident and, if warranted, will report to the State.

4. The department director will indicate on the Electronic Incident Report in the Manager's Comments section, the results of the investigation and any notification to the State agency.

5. If the alleged abuse is substantiated, the department director will forward a copy of the entire investigation, as well as the State report, to the Risk management department.

E. **Complaints Involving Home Health Care (HHC) Patients.**

1. Upon receiving a HHC complaint, the department manager should follow procedures under Section C for addressing Complaints and Grievances.

2. The Department Manager should also advise the complainant that they may contact the State Ombudsman (home health hotline) between 8:00 a.m. and 4:30 p.m., Monday through Friday, at its toll free number, 1-888-387-9387.

3. Home Health Care staff will include in the Manager's Response section of the incident report information relating to any reports made to state licensing as required by state law, and will forward a copy of the report to the Risk Management department for review.

F. **Patient Complaints Affecting Physicians.**

1. **Patient Complaints Regarding National Emergency Services Healthcare Group Physicians**

(NES). Complaints regarding behavior and/or quality of care issues will be forwarded via additional review in the Electronic Incident Report to the KGH Emergency Room Department Manager, who will work in cooperation with the Emergency Department Medical Director to resolve the issue (see Section C). Additionally, any complaint regarding physician quality of care issues or behavior will also be forwarded to the Quality Services Department for possible peer review, to be conducted in accordance with Medical Staff Bylaws and/or procedures. Such complaints may be reported to NES at the direction of the KGH NES Medical Director. Refer to the policy for NES Reporting

2. **Patient Complaints regarding non-NES Physicians.** Complaints regarding behavior and/or quality of care issues will be forwarded via additional review in the Electronic Incident Report to the KGH Responsible Department Manager to resolve the issue (See Section C). Additionally, any complaint regarding physician quality of care issues or behavior will also be forwarded to the Quality Services Department for possible peer review, to be conducted in accordance with the Medical Staff Bylaws and/or procedures.

    - The Regional Vice-President of Patient Carewill be notified as an additional review for information only.

DEFINITIONS:

1. "*Complaint*" refers to a concern that is voiced by a patient/family member that can be resolved promptly by staff present.

2. "*Patient Grievance*" refers to a formal written or verbal complaint filed by the patient or family member, which cannot be resolved promptly by staff present.

REFERENCES:

Forms:

- Electronic Incident Report

Other:

- Conditions of Participation, Centers for Medicare and Medicaid Services
- Joint Commission for Accreditation of Healthcare Organizations, Standards RI.1.3, RI 1.5, CC.8, GO.2.
- Sample Letter for Contacting a Patient Grievant
- Sample Letter for Responding to a Patient after Investigation

Policy:

- CP.RM.002, System-wide Patient Complaint and Grievance Policy

Procedures:

- Manager's Checklist for Incident Documentation

HELP: For information please contact the Regional Vice-President of Patient Care or Risk Management.

SEARCH
MT EDGECUMB

SEARHC
SouthEast Alaska Regional Health Consortium
Your Partner in Health

PATIENT RIGHTS AND RESPONSIBILITIES

5.1 PURPOSE

To assure that all patients are treated fairly and humanely and to provide for them the opportunity to address all complaints or grievances and to formally state this principle as a hospital policy.

5.2 BACKGROUND

Mt. Edgecumbe Hospital has accepted as guiding principle, the doctrine promulgated by the American Hospital Association, "A Patient's Bill of Rights" adopted by the AHA'S Board of Trustees on October 21, 1992. The statement was adopted with the hope that the observance of these rights would contribute to more effective patient care and greater satisfaction for the patient, the physician, and the hospital.

No catalog of rights can guarantee for the patient the kind of treatment he/she has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his/her dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

The collaborative nature of health care requires that patients, or their families/surrogates, participate in their care. The effectiveness of care and patient satisfaction with the course of treatment depend, in part, on the patient fulfilling certain responsibilities.

5.3 POLICY

5.3.1. Patient Rights

The patient has the right to considerate and respectful care. This includes appropriate assessment and management of pain.

The psychosocial, spiritual, and cultural variables and concerns that influence perceptions of illness and the dying patient should be considered. The patient who is dying has the right to care that will optimize his/her comfort and dignity throughout the treatment, as desired by the patient or his/her next of kin in the absence of an advanced directive.

The patient has the right to, and is encouraged to, obtain from physicians and other direct caregivers relevant, current and understandable information concerning diagnosis, treatment, and prognosis.

Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.

Patients have the right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, residents, or other trainees. The patient also has the right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.

The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and hospital policy and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the hospital provides or information regarding transfer to another hospital. The hospital should notify patients of any policy that might affect patient choice within the institution.

The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision maker with the expectation that the hospital will honor the intent of that directive to the extent permitted by law and hospital policy. Advance directives are included in patient records.

The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each person's privacy.

The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the hospital will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records.

The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.

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PATIENT RIGHTS AND RESPONSIBILITIES ... continued

The patient has the right to expect that, within its capacity and policies, the hospital will make reasonable response to the request of a patient for appropriate and medically indicated care and services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, a patient may be transferred to another facility. The institution to which the patient is to be transferred must first have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.

The patient has the right to ask and be informed of the existence of business relationships among the hospital, educational institutions, other health care providers, or payers that may influence the patient's treatment and care.

The patient has the right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct patient involvement, and to have those studies fully explained prior to consent. A patient who declines to participate in research or experimentation is entitled to the most effective care that the hospital can otherwise provide.

The patient has the right to expect reasonable continuity of care when appropriate and to be informed by physicians and other caregivers of available and realistic patient care options when hospital care is no longer appropriate.

The patient has the right to be informed of hospital policies and practices that relate to patient care, treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. The patient has the right to be informed of the hospital's charges for services and available payment methods.

5.3.2. Patient Responsibilities

Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision making, patients must be encouraged to take responsibility for requesting additional information or clarification about their health status, pain management, or treatment when they do not fully understand information and instructions. This includes potential limitations and side effects of pain management therapies and other treatments.

Patients are responsible for ensuring that the health care institution has a copy of their written advance directive if they have one.

Patients are responsible for informing their physicians and other caregivers if they anticipate problems in following prescribed treatment. Persons entering into patient care contracts are responsible for fulfilling their obligations in the contract and discussing with their providers difficulties they may have meeting their goals, objectives and treatment strategies.

Patients should also be aware of the hospital's obligation to be reasonably efficient and equitable in providing care to other patients and the community. The hospital's rules and regulations are designed to help the hospital meet this obligation. Patients and their families are responsible for making reasonable accommodations to the needs of the hospital, other patients, medical staff, and hospital employees.

Patients are responsible for providing necessary information for insurance claims and for working with the hospital to make payment arrangements, when necessary.

Patients are responsible for recognizing the impact of their life-style on their personal health. A person's health depends on much more than health care services.

Patients are responsible for informing staff if the care provided may create a risk for patient safety.

YUKON KUSKOKWIM

YUKON-KUSKOKWIM HEALTH CORPORATION

POLICY: Customer Comment Process	POLICY NUMBER: OF_002_PI
CATEGORY: Organization Functions	EFFECTIVE DATE: 12/05
SECTION: Performance Improvement	SUPERSEDES: ADM_004_OP 7/03, 2/02

I. POLICY:

It is the policy of YKHC to provide mechanisms for the timely response to customer's comments relating to the services they received.

II. DEFINITION:

Customer comments include both verbal and written complaints or compliments about the services provided by the corporation.

III. PROCEDURE:

A. Department Responsibility

1. Maintains Customer Comment Forms in a location readily available.
2. Trains staff about the purpose of the customer comment form, proper completion (including assisting customers or their representative in completing the form) and proper routing of the forms.

B. Employee Responsibility

1. At the point of service, the employee will take action to resolve the customer's concern immediately.
2. If the issue is not immediately resolved, the employee documents the customer's comments and actions taken on to a Customer Comment Form.
3. Forwards the completed Customer Comment Form to the Performance Improvement department within 24 hours.

C. Supervisor Responsibility

1. Reviews comment and take action as needed.
2. Provides a written response to the customer concerning their comment and who to contact for further information as appropriate.
3. Routes the written summary of closure to the Performance Improvement (PI) department within 5 working days of receipt of the Customer Comment Form. Customer Comment Forms may be interoffice mailed, e-mailed or faxed to the addresses or fax number on the form.

D. Performance Improvement Responsibility

1. Routes the customer comment form to the appropriate supervisor(s).
2. Reviews the comments, actions, and action plans received from the supervisor(s) to determine sufficiency.

a) If PI determines that there is a need for further follow up, PI will return the customer comment back to the supervisor or redirect the comment to another supervisor for further action(s).
b) If the customer is not satisfied with the resolution of their comment, the customer is encouraged by PI to contact JCAHO.

3. Tracks and trend all customer comments and submit reports to the Patient Safety Committee, Napartet Goal Team, Medical Staff, Corporate Leadership Team, and Board of Directors as appropriate.

Standard reference: JCAHO PI.1.10, APR 8
Written by: Performance Improvement

Approval signature _____

YUKON-KUSKOKWIM HEALTH CORPORATION

Yukon-Kuskokwim Health Corporation
Customer Comment Form

MAIL to: Performance Improvement, YKHC, P.O. BOX 287, Bethel, AK 99559 OR
FAX to: (907) 543-6366 OR EMAIL to: customer_comments@ykhc.org

__Customer __Significant
Other
Name of Person Submitting Comment:_____ __Family __Staff Member
Date:_____
Customer Name: _____ DOB: _____ Date of Occurrence:_____

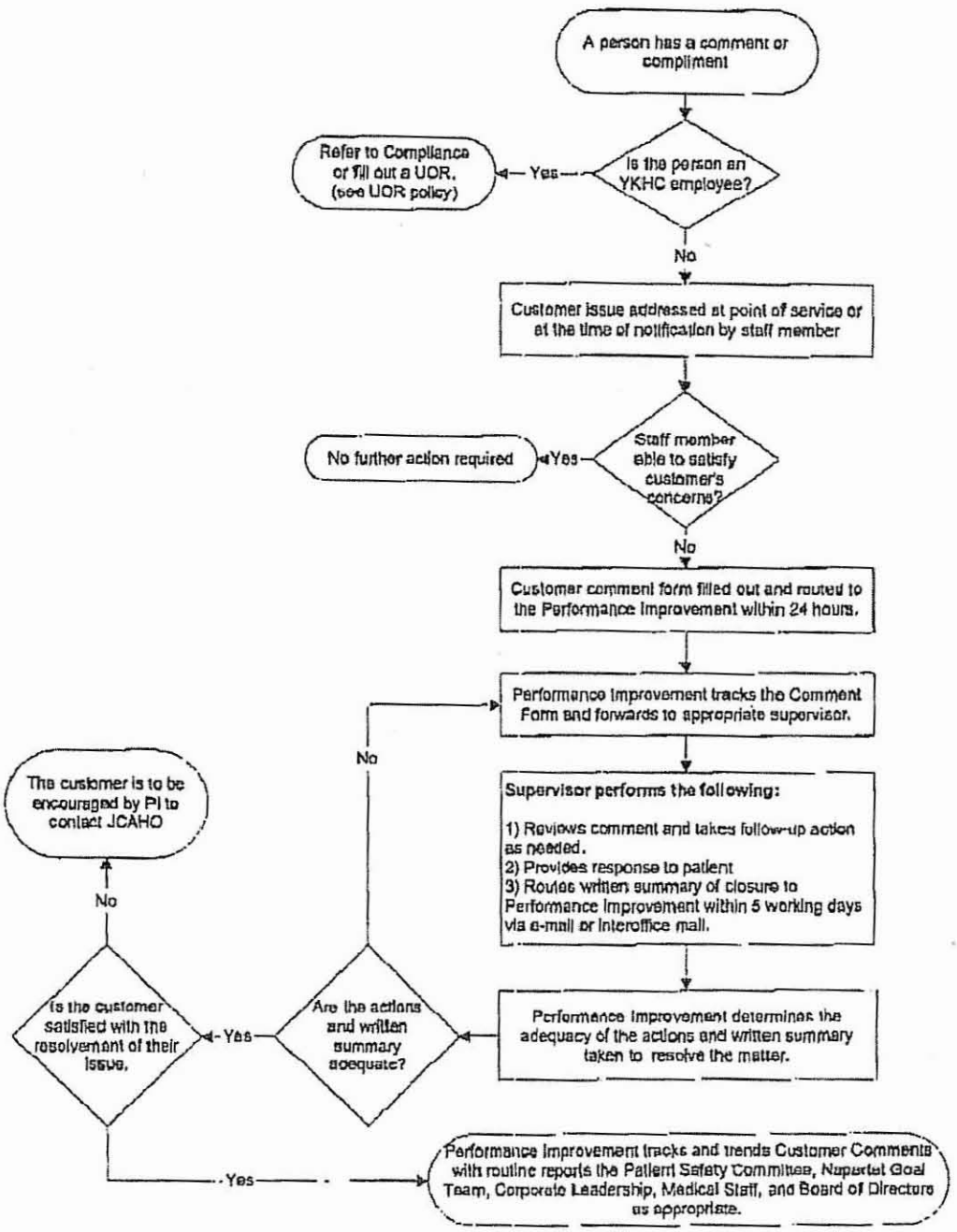
Address: _____, _____, _____ Phone # :_____
PoBox *Village/Town* *zip code*

Where Incident Occurred: _____ Employees Involved: _____
Customer Comments *(Be specific, write on back and use additional paper if needed.):*

YUKON-KUSKOKWIM HEALTH CORPORATION

Yukon-Kuskokwim Health Corporation

Customer Comment Process



NORTH STAR
BEHAVIORAL HEALTH SYSTEM

NORTH STAR
BEHAVIORAL HEALTH SYSTEM
POLICY AND PROCEDURES

DEPARTMENT: Patient/resident Rights CATEGORY: System
TITLE: Guidelines for Addressing Patient/Resident/Family Grievances
POLICY: RI103.06

Formulated: 8/97
Revised: 5/99, 10/01, 7/02 9/02, 11/02, 12/02, 6/03, 4/05, 2/06, 6/06
Reviewed: 8/97, 10/97, 6/99, 2/00, 10/01, 7/02, 9/02, 11/02, 12/02, 6/03, 2/06, 6/06
Reviewed by MEC: 12/02, 6/03, 5/05, 3/06, 6/06

POLICY

It is the policy of North Star Behavioral Health System to offer treatment free of discrimination of race, color, national origin, religion, sex, sexual orientation, ethnicity, age, disability, or sources of payment for care.

It is the policy of the North Star Behavioral Health System to encourage responsive and open communication with patients/residents at all levels in the facility with the objective of resolving grievances through appropriate problem solving actions. The Medical Executive Committee shall designate a Patient Advocate who will act as a liaison between the patient/resident and the facility to facilitate these problem solving actions when necessary. All patients/residents/families will be informed of the grievance process and the availability of the Patient Advocate upon admission. It is the responsibility of each staff member to respond in a timely manner to any concern or complaint voiced by patient/resident and/or their families, no matter how trivial the complaint may appear to be. Presentation of a grievance will not, in itself, serve to compromise the patient/resident's future access to care.

For the purpose of this policy, a *grievance* is defined as *a formal or informal written or verbal complaint that is made to NSBHS by the patient/resident or his/her guardian when the issue cannot be resolved by the staff present or is referred to the Patient Advocate or NSBHS Administration.*

PURPOSE

North Behavioral Health System will provide an effective mechanism for handling patient/resident /family grievances as an important part of providing quality care and service. All patient/residents and their families should have access to a clear process by which they may be heard if they believe their rights or other privileges have not been respected or responded to appropriately by NSBHS staff or physicians.

PROCEDURE

1. The Governing Body will designate, in writing, the committee (Quality Council) responsible for the effective operation of the grievance process and for the review and resolution of grievances, as well as a Patient Advocate, who will act as a liaison between the patient/resident and the facility to facilitate problem-solving actions when necessary.

2. Patient/resident and their family members will be informed of the patient/resident's rights and responsibilities upon admission. Patient/resident and their family members will also be informed of the grievance process by which they can voice any concerns related to their rights and/or treatment. This information includes the name of the Patient Advocate and the method to access this individual, the time frame for review of the grievance, and the provision of a written response to the patient/resident within that time frame. The Patient/resident/family are also provided with the telephone number of the Department of Health Facilities Certification and Licensure – (907) 334-2482. Information regarding the option of contacting the Office for Civil Rights (Seattle Office) also will be given. The number is 1-800-368-1019. You may send concerns in writing to the Joint Commission on Accreditation of Health Care Organizations Office of Quality Monitoring Fax: (630) 792-5636.

3. At each level of this process, the facility staff should listen to the patient/resident's grievance, consider the circumstances and the context of the grievance, assure the patient/resident that his/her concerns will be investigated and seek further information and input as needed.

4. The steps for any Patient/resident/Resident/Family to take to find resolution for a possible violation of rights concern are:

Step 1: The patient/resident or family is to discuss concern with physician, therapist, nursing staff, RTC Administrator, or any other North Star staff member. The Charge Nurse or Supervisor will need to be notified as soon as possible for assistance with resolution or follow-up needed.

Step 2: If the patient/resident/Family is not satisfied, they can either utilize the Patient/Resident's Concern Notification form or they may call the Patient Advocate at 258-7575. If the form is used, give it to the Charge Nurse/Supervisor for forwarding to the Patient Advocate. The Patient Advocate will contact the patient/resident/family by the next business day after receiving the form or request for contact. If the concern is forwarded to the Patient Advocate, documentation of all previous attempts of resolution will be attached for review.

Step 3: The Patient Advocate will initiate an investigation that may include:

- meeting with involved staff members,
- reviewing pertinent medical records, and
- talking with other patient/resident/residents as needed.

This investigation will be concluded within a reasonable time frame based on the complexity of the complaint. All investigations will be concluded within 7 days of receipt. In the event there is extenuating circumstances that delay the investigation beyond 7 days, the reason for the delay must be communicated to the patient/resident/guardian with an anticipated time frame for completion.

Step 4: The Patient Advocate will communicate the actions or resolutions to the Patient/resident/guardian no later than the business day following the conclusion of his/her investigation. This communication may be verbal, but must be accompanied by written notice to the Patient/resident/guardian containing:

- The name of the Patient Advocate
- Steps taken to review the complaint
- Steps taken to resolve the complaint
- Date of completion

6. After Hours/Weekend Process: The appropriate Charge Nurse or Supervisor should investigate and address any grievance that involves Patient/resident safety or other urgent matters within 24 hours of the time the grievance is received. If the situation cannot be resolved by the Charge Nurse/Supervisor, the Administrator on-call will be notified to determine if the issue is to be referred to the Patient Advocate, or if other measures need to be taken. Whatever the decision, the patient/resident/family will be notified during the next business day.

7. The Patient Advocate will maintain a log of all complaints received, and present a monthly report to the designated committee (Quality Council) for review and further action as necessary. Cases may be referred by the Quality Council to the Peer Review Committee or Patient Safety Council when concerns relate to quality of care or premature discharge issues

8. Any grievance received after the patient/resident is discharged from a program should be documented by the staff member receiving the complaint and forwarded to the Patient Advocate. The Patient Advocate will complete an investigation of the allegation and the subsequent steps in the process outlined above.

9. The Governing Body shall have the final authority and responsibility in resolving grievances.

10. If a grievance is received from legal counsel or regulatory authority, it should be forwarded directly to the CEO or designee and Risk Manager. The CEO will delegate investigation to the appropriate staff members.

11. The above procedures are intended to provide guidelines for patient/residents and families to express concerns and for staff to respond to these concerns. They may be modified as necessary to insure prompt and responsive action by the most appropriate staff member in any given situation.

Attachments:

Patient/Resident Concern Notification Form
Patient Advocate Written Notification (Non-patient/resident)
Patient Advocate Written Notification (patient/resident)
Sample Patient/Resident/Family Grievance Log

Patient/Resident Concern Notification

We strive to make every aspect of your treatment as comfortable as possible. We recognize that issues may arise that you become aware of before we do, and urge you to report any issues or concerns to a staff member. If you feel that your concerns are not addressed appropriately OR if you just feel more comfortable reporting them in writing, please use the space below. Include any individuals involved and be as specific as possible if you feel that any Patient/resident rights may have been violated.

Name (Optional): _____ Date: _____

Program: _____ Physician: _____

Area of Concern: _____

_____

_____

_____

_____

Return this to any staff member. Thank you for allowing us an opportunity to improve the quality of care we provide to our patient/residents.

* * * * * * * * * * * * * * *

Disposition: (FOR STAFF USE ONLY)

Date Received: _____ Assigned To: _____ Date Assigned: _____

Pertinent Additional Information: _____

_____

_____

_____

_____

Problem Resolution/Follow Up: _____

_____

_____

_____

Addressed by: _____ Date: _____

CEO/DIR QI/RM Signature: _____

****** Please Forward to the Patient Advocate*******

(This letter is printed on letterhead)

Date:

Dear

We strive to make every aspect of our patient/resident's treatment as beneficial as possible. We recognize unanticipated situations occur. We appreciate you bringing your concern(s) to our attention and allowing us the opportunity to evaluate our services and make improvements when needed.

Regarding your complaint, received on , the following was conducted regarding your concerns.

•

After review, the following occurred:

•

Thank you for allowing us an opportunity to improve the quality of care we provide to our Patient/resident.

Sincerely,

_____

Patient Advocate
North Star Behavioral Health System

(This letter is printed on letterhead) **patient/resident complaint**

Dear ,

We try to make every part of your treatment as helpful as possible. We know that sometimes situations occur. Thank you bringing your concern(s) to our attention so that we can make things better for you and all the Patient/resident here.

Here is what we did to follow up on the complaint you made on (DATE)

-

After reviewing all the information, we did the following;

-

Thank you for helping us to improve the care of Patient/resident at North Star.

Sincerely,

_____

Patient Advocate
North Star Behavioral Health System

(SAMPLE) PATIENT/RESIDENT/FAMILY GRIEVANCE LOG

Please note: UHS requires all Patient Advocate data to be entered into the MIDAS system which maintains a log electronically.

Non-patient/resident complaint

Date of Complaint	Patient/ resident Name/ MR #	Person Initiating- Name/Relationship to Patient/resident	Concern	Person Following- Up	Actions	Admin. / Med. Director Notified	Legal	Resolution