

Community Oriented Primary Care
Policy Number: 16.03

PATIENT/VISITOR CONCERNS/GRIEVANCE POLICY

1. Purpose:

The purpose of this policy is to:

1. provide a mechanism by which a patient or visitor can provide feedback to San Francisco General Hospital Medical Center (SFGHMC) and Community Oriented Primary Care (COPC) Services regarding his/her care or concerns; and
2. describe the system for review and follow-up of patient/visitors concerns/grievances.

2. Statement Of Policy:

It is the policy of the SFGHMC and COPC that:

1. All patients who receive services will be informed of:
 - whom to contact with a concern/grievance regarding his/her care,
 - the process for addressing the concern/grievance, and
 - the name, address, and telephone number of the State agency to contact, if the concern/grievance is not resolved to their satisfaction.
2. Oversight for all patient/visitor concern/grievance follow-ups is the responsibility of the Patient Concerns Sub-Committee of the Performance Improvement and Patient Safety (PIPS) Committee as delegated by the governing body, the San Francisco Health Commission.
3. All responses to patient/visitor concerns/grievances will be in writing and will include:
 - the name of the contact person,
 - the steps taken on behalf of the patient/visitor to investigate the concern/grievance,
 - the results of the investigation process, and
 - the date of completion.
4. All patient concern/grievance documentation is handled in a confidential manner in accordance with Department of Public Health (DPH) policy on confidentiality.

3. Procedure:

- I. Initiation of a Patient Concern/Grievance
 - A. Any patient/visitor may file a concern/grievance regarding his/her care or treatment. If the patient/visitor is unable to file the concern/grievance, a family member, spouse, or significant other may file a concern/grievance on his or her behalf.

Health or the Mayor's Office will be forwarded directly to the appropriate staff of immediate attention. After resolution, staff will forward a copy of the concern/grievance resolution to the office of origin.

II. Triaging and Coordinating the Follow-up Response

- A. A concern/grievance that cannot be resolved in the area of origin will be triaged to the following designated members of the Patient Concern Committee or designated COPC staff for review and coordination of the follow-up response:
1. The Director of Patient Relations/Patient Visitor Center (206-5176) will coordinate the follow-up for the following areas:
 - SFGHMC Inpatient Units;
 - Emergency Department (ED); and
 - SFGHMC Clinics and support departments.
 2. Designated COPC staff will coordinate follow-up for clinic patients.
 3. The Department of Psychiatry Quality Improvement Coordinator (206-5964) will coordinate the follow-up for Inpatient and Outpatient Psychiatric Services.
 4. The Mental Health Rehabilitation Facility (MHRF) Quality Improvement Coordinator (206- 6338) will coordinate for the MHRF.
 5. The Managed Care Administrator for Provider and Member Services (206-4785) will coordinate for Managed Care Services.
 6. The University of California San Francisco (UCSF) at SFGHMC Risk Management staff (206-6052) will coordinate for UCSF physicians/staff.
- B. The Patient/Visitor Center's staff and COPC staff will consult with or refer to the Quality Management Department through the SFGHMC Risk Management Office (ext. 6600) any of the following:
1. a request for monetary compensation (except billing issues);
 2. an adverse patient/visitor outcome (death, serious injury/illness);
 3. investigations referred to SFGHMC via the Director of Public Health, Mayor's Office, member of either the Health Commission or Board of Supervisors, and any Patient Advocacy Group;
 4. patients/visitors with multiple concerns;
 5. any situation with media involvement; and
 6. a patient's claim of premature discharge.
- C. Upon receipt of the "Patient/Visitor Concern Statement" form, staff from the Patient/Visitor Center, COPC Center Directors, or the designated members of the Patient Concern Sub-Committee will:
1. acknowledge to the patient/visitor in writing or by telephone the receipt of the concern/grievance within 24 business hours;

Attachment A: "[Patient/Visitor Concern Statement](#)" Form**5. Cross Reference:**

SFGHMC Administrative P&P:

[1.03 Administrator On-Duty](#)[13.10 Health Information Services: Confidentiality, Security, and Release of Protected Health Information](#)

SFGHMC Department of Psychiatry

[8.2 Patient Complaint Policy Procedure](#)

Medical Staff Bylaws: Peer Review

CHN Corporate Compliance Program Policy

6. Supersedes: None**7. Signed by:**

Michael Drennan, MD, Medical Director, Primary Care Service; Barbara Garcia, MPA, Deputy Director, SFDPH; Sheila Kerr, RN, MS, Nursing Director, Primary Care Service

8. Approval date:

This policy was originally approved on: 01 Nov 2007

This version was approved on: 02 Feb 2008

This policy will be reviewed by: 15 Feb 2013

COMMUNITY ORIENTED PRIMARY CARE

COPC Addendum B: PROCEDURES FOR PATIENT COMPLAINTS AND GRIEVANCES**To Policy Number: 16.03** PATIENT/VISITOR CONCERNS/GRIEVANCE POLICY

Posted on the CHN Home Page under Primary Care Policies: Administrative Policies

The Patient Concern Statement (in English, Spanish, Chinese and Russian) for the CHN Community Oriented Primary Care Clinics is posted on the CHN Home Page under: CHN Forms: CPCS Forms.

Patients may express concerns about experiences in the Community Health Network in a variety of places. This addendum gives examples of these situations and outlines the procedure to be followed.

A. CONCERNS ABOUT HEALTH CENTER RECEIVED AT HEALTH CENTER:

1. The Procedure spelled out in Policy and Procedure 16.03 should be followed.
2. In addition, the Medical Director / Center Director of the Health Center should send a copy of any Patient Concern Form completed through "Part IV. Resolution" to Dept. of Quality Management, Bldg. 20, Ward 2300.
3. As stated in Policy and Procedure 16.03, any concern/ grievance that cannot be resolved in the area of origin will be triaged to the Primary Care Administration: Marcellina Ogbu, Chief Operations Officer of Primary Care.
4. All Patient Concerns originating at the Health Center should be tracked in the Health Center Quality Improvement Meeting Minutes.
5. Consider whether incident that prompted patient concern warrants a UO report or a call to Risk Management

B. CONCERNS ABOUT SFGH SERVICES (LAB, X-RAY, SPECIALTY CLINIC, INPATIENT OR EMERGENCY ROOM EXPERIENCE) RECEIVED AT THE HEALTH CENTER

1. Send the patient to the Patient / Visitor Center Room 1C1. If the patient does not wish to go to SFGH to express their concern, offer the Patient Concern form for SFGH (Addendum A to Policy and Procedure 16.3)
2. Send form to Patient / Visitor Center, Room 1C1, Attention: Gloria Garcia-Orme. If there is need for prompt communication about incident, call Gloria Garcia-Orme directly.
3. Consider whether incident that prompted patient concern warrants a UO report or a call to Risk Management.

C. COMPLAINT MADE BY A PATIENT TO SAN FRANCISCO HEALTH PLAN or other Managed Care Plan ABOUT HEALTH CENTER SERVICES:

1. Each Health Plan has a plan specific patient grievance procedure and form. The San Francisco Health Plan Grievance form is available for patients online at their website: www.sfhph.org. Patients may also call their Health Plan directly with any concern.
2. The contact person at San Francisco Health Plan for Patient Grievances is Betsy Price, R.N
3. For any member grievance that is referred from a Health Plan to a COPC Health Center Director, a written response about the incident, investigation and action taken is required by the Health Plan. The report of an incident and the written response should be tracked through the Health Center Quality Improvement Meeting Minutes.
4. Consider whether an incident leading to a managed care patient grievance requires a UO report or a call to Risk Management.

SUMMARY OF CONCERN (CONTINUED)

NAME: _____



☐ Chinatown HC ☐ Castro-Mission HC ☐ Curry Sr. Services ☐ Balboa Teen ☐ Maxine Hall ☐ Ocean Park
☐ Potrero Hill HC ☐ Silver Avenue ☐ Southeast ☐ SPY-Larkin St ☐ SPY-Cole St ☐ Tom Waddell

PATIENT CONCERN STATEMENT – SPANISH VERSION

PARTE III. RESOLUCIÓN DE LA PREOCUPACIÓN:

GRACIAS POR DECIRNOS SU PREOCUPACIÓN. POR FAVOR DÍGANOS LA MEJOR MANERA DE ENCONTRARLO SI NECESITAMOS MÁS INFORMACIÓN: ☐ ESCRÍBANME ☐ LLÁMENME ☐ YO LES LLAMARÉ

FIRMA DEL PACIENTE: _____

NOMBRE/DIRECCIÓN/No. TELEFÓNICO DE ☐ CÓNYUGE ☐ FAMILIAR ☐ VISITANTE **QUE ESCRIBE LA PREOCUPACIÓN :**

NOMBRE	DIRECCIÓN	CIUDAD	CÓDIGO POSTAL	TELÉFONO
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NOMBRE, PUESTO, No. TELEFÓNICO DEL MIEMBRO DEL PERSONAL QUE ESCRIBE ESTA PREOCUPACIÓN:

PART IV. RESOLUTION (TO BE COMPLETED BY CENTER DIRECTOR/MEDICAL DIRECTOR)

DATE RESOLVED: _____ ☐ LETTER OF RESOLUTION REVIEWED BY PRIMARY CARE ADMIN

DATE LETTER OF RESOLUTION MAILED TO PATIENT/FAMILY: _____ **DATE OF RESOLUTION MEETING/**

OR CALL: _____ **SUMMARY OF RESOLUTION:** _____

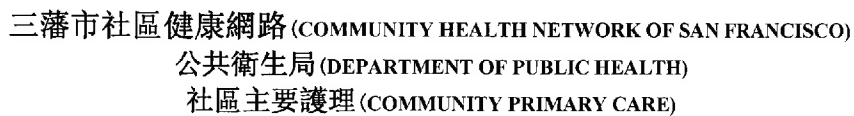
FOR INTERNAL USE ONLY BY QUALITY MANAGEMENT

PART V. CONCERN DISPOSITION

REVIEWED BY: _____ **TODAY'S DATE:** _____ **CONCERN CODE(S):** _____

DEPARTMENT(S) INVOLVED: _____ **STAFF INVOLVED:** _____

SUMMARY: _____



☐ Chinatown HC ☐ Castro-Mission HC ☐ Curry Sr. Services ☐ Balboa Teen ☐ Maxine Hall ☐ Ocean Park
☐ Potrero Hill HC ☐ Silver Avenue ☐ Southeast ☐ SPY-Larkin St ☐ SPY-Cole St ☐ Tom Waddell

如果需要可另加紙

第三部份. 解決憂慮:

多謝您告訴我們有關您的憂慮. 若我們需要更多資訊

請告訴我們最好聯絡您的方法: ☐ 寫信給我

☐ 打電話給我

☐ 我會打電話給你

病人簽名: _____

姓名/地址/電話號碼

☐ 配偶

☐ 家庭成員

☐ 訪客寫的憂慮:

姓名

地址

城市

郵編號碼

電話

職員寫的憂慮的姓名、職位、電話: _____

PART IV. RESOLUTION (TO BE COMPLETED BY CENTER DIRECTOR/MEDICAL DIRECTOR)

DATE RESOLVED: _____

☐ LETTER OF RESOLUTION REVIEWED BY PRIMARY CARE ADMIN

DATE LETTER OF RESOLUTION MAILED TO PATIENT/FAMILY: _____ DATE OF RESOLUTION MEETING/

OR CALL: _____ SUMMARY OF RESOLUTION: _____

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PART V. CONCERN DISPOSITION

REVIEWED BY: _____ TODAY'S DATE: _____ CONCERN CODE(S): _____

DEPARTMENT(S) INVOLVED: _____ STAFF INVOLVED: _____

SUMMARY: _____

Hosp. produced website form (06/04)

РАЗДЕЛ III. РЕШЕНИЕ, ПРИНИМАЕМОЕ ОТНОСИТЕЛЬНО ВАШЕГО НЕДОВОЛЬСТВА:

СПАСИБО, ЧТО ВЫ СООБЩИЛИ НАМ О ВАШЕМ НЕДОВОЛЬСТВЕ. ПОЖАЛУЙСТА, СООБЩИТЕ НАМ, КАК ЛУЧШЕ СВЯЗАТЬСЯ С ВАМИ, ЕСЛИ НАМ ПОНАДОБИТСЯ ДОПОЛНИТЕЛЬНАЯ ИНФОРМАЦИЯ:

☐ НАПИШИТЕ МНЕ ☐ ПОЗВОНИТЕ МНЕ ☐ Я ВАМ ПОЗВОНЮ

ПОДПИСЬ ПАЦИЕНТА: _____

ИМЯ И ФАМИЛИЯ/АДРЕС/№ ТЕЛЕФОНА ☐ СУПРУГА(И) ☐ ЧЛЕНА СЕМЬИ ☐ ЛИЦА, НАПИСАВШЕГО ЗАЯВЛЕНИЕ О НЕДОВОЛЬСТВЕ

ИМЯ И ФАМИЛИЯ

АДРЕС

ГОРОД

ПОЧТОВЫЙ ИНДЕКС

ТЕЛЕФОН

ИМЯ, ДОЛЖНОСТЬ, № ТЕЛЕФОНА ЧЛЕНА ПЕРСОНАЛА, НАПИСАВШЕГО ОБ ИНЦИДЕНТЕ: _____

PART IV. RESOLUTION (TO BE COMPLETED BY CENTER DIRECTOR/MEDICAL DIRECTOR)

DATE RESOLVED: _____ ☐ LETTER OF RESOLUTION REVIEWED BY PRIMARY CARE ADMIN

DATE LETTER OF RESOLUTION MAILED TO PATIENT/FAMILY: _____ **DATE OF RESOLUTION MEETING/**

OR CALL: _____ **SUMMARY OF RESOLUTION:** _____

FOR INTERNAL USE ONLY BY QUALITY MANAGEMENT

PART V. CONCERN DISPOSITION

REVIEWED BY: _____ **TODAY'S DATE:** _____ **CONCERN CODE(S):** _____

DEPARTMENT(S) INVOLVED: _____ **STAFF INVOLVED:** _____

SUMMARY: _____