

Document Number:	Clinical 205
Document Name:	Investigation and Resolution of Complaints
Effective:	October 18, 2022
Document Status:	Active

Investigation and Resolution of Complaints

Purpose / Background

The purpose of Clatsop Behavioral Healthcare's (CBH) clinical policies is to promote practices that are safe, coordinated, accessible and effective to meet the behavioral health needs of those we serve as an outpatient provider and as the local mental health safety net. CBH is dedicated to providing care that is responsive to each person's cultural background, life experience, stage of change, diagnostic presentation and client choice. Services will be informed by evidence based research, accepted national standards of care or practices that have shown promise in producing positive outcomes.

Policy

Clatsop Behavioral Healthcare prioritizes the concerns and complaints of clients and community members. Grievances and appeals are processed and responded to in accordance with Oregon Administrative Rule.

Document History

Policy Approved: March 19, 2019

Initiated: March 19, 2019

Reviewed: August 1, 2020/October 18, 2022

Revised: June 8, 2022/October 18, 2022

Archived:

Policy Owner

CBH Clinical Operations Officer

CBH Executive Director

Appendices / Forms

CBH Complaint Form

Procedure

Any individual or parent or guardian receiving services may file a grievance with the provider or any management personnel at CBH. CBH discusses and resolves any problems as soon as they come up. Concerns about CBH services can be reported to the Clinical Operations Officer by calling 503-325-5722. Investigations will be completed within 30 calendar days.

In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures are completed, the individual or guardian of the individual may request an

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expedited review. The Clinical Operations Officer or designee shall review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response shall include information about the appeal process.

A grievant, witness, or staff member of a provider may not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness.

Individuals and their legal guardians may appeal entry, transfer, and grievance decisions as follows:

If the individual or guardian is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten business days of the date of the Clinical Operations Officer or designee's response to the grievance or notification of denial for services. The appeal shall be submitted to the Oregon Health Authority (OHA). If requested, program staff shall be available to assist the individual. OHA shall provide a written response within ten business days of the receipt of the appeal and if the individual or guardian is not satisfied with the appeal decision, they may file a second appeal in writing within ten working days of the date of the written response to OHA.

In the event a grievance is filed regarding a youth in Wrap Around, the grievance form will be forwarded to the designated Columbia Pacific Coordinated Care Organization (CPCCO) representative within 30 calendar days of initial complaint. CBH will keep the CPCOO representative apprised of any resolution or follow up plan before the end of the investigation.

Contact Information for Complaints and Grievances

- Clatsop Behavioral Healthcare Clinical Operation Officer (503) 325-5722
- Health System Division of the Oregon Health Authority (503) 945-5763
- Disability Rights Oregon 1 (800) 452-1694
- Columbia Pacific Coordinated Care Organization (CPCCO) Members - contact Care Oregon at 1-800-224-4840.
- Department of Human Services - contact the [Governor's Advocacy Office](#) at: (503) 945-5941

There are also additional resources available for certain situations.

- **Abuse or Neglect** - contact the Office of Adult Abuse Prevention and Investigation at: (503) 945-9702 or the CBH Abuse Investigator at 503-325-0241, ext. 107
- **Other Oregon Health Plan Members – contact** the Division of Medical Assistance Programs Client Services at: 1 (800) 273-0557
- **Civil Rights (504 Plans, Medical Issues, etc.)** - contact the Office of Equity and Inclusion, Civil Rights Coordinator at: (971) 673-2000

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Clatsop Behavioral Healthcare adheres to the following Oregon Administrative Rule regarding grievances and appeals.

309-019-0215

Grievances and Appeals

- (1) Any individual or parent or guardian receiving services may file a grievance with the provider, the individual's coordinated care plan, or the Division.
- (2) The provider's grievance process shall:
 - (a) Notify each individual or guardian of the grievance procedures by reviewing a written copy of the policy upon entry;
 - (b) Assist individuals and parents or guardians to understand and complete the grievance process and notify them of the results and basis for the decision;
 - (c) Encourage and facilitate resolution of the grievance at the lowest possible level;
 - (d) Complete an investigation of any grievance within 30 calendar days;
 - (e) Implement a procedure for accepting, processing, and responding to grievances including specific timelines for each;
 - (f) Designate a program staff individual to receive and process the grievance;
 - (g) Document any action taken on a substantiated grievance within a timely manner; and
 - (h) Document receipt, investigation, and action taken in response to the grievance.
- (4) The provider shall post a Grievance Process Notice in a common area stating the telephone numbers of:
 - (a) The Division;
 - (b) Disability Rights Oregon;
 - (c) Any applicable coordinated care organization; and
 - (d) The Governor's Advocacy Office.

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CBH Complaint and Resolution Form

Clatsop Behavioral Healthcare (CBH) welcomes your feedback. This form is designed to provide clients, family members, friends, and community partners, with a method for communicating and resolving complaints regarding client services. *If you would prefer to speak directly to someone about your complaint, please let us know and a supervisor or manager will contact you.*

Please provide the following information to help us investigate and resolve your complaint.

Name: _____ **Date:** _____
(Please Print)

How may we contact you to follow up on this complaint?

- Phone/Email/Other (please list): _____
- Please do not contact me.

Is this complaint urgent? Yes _____ No _____

Please describe concern/complaint including names of people involved and dates if known:

What would you like to have happen in this matter?

Resolution (Completed by the staff member or manager with responsibility for the program involved)

Date received _____ Actions taken to resolve complaint/concern (describe in detail)

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Further action needed? Yes ___ No ___ If yes, what is planned?

Signature and Date: _____

If further action, such as review by Clinical, Medical, or Human Resources/Operations Director is needed, describe review and resolution:

Director Signature and Date: _____

Email to Quality Assurance Department when completed.