

## SOUTHERN NEVADA COMMUNITY HEALTH CENTER DISTRICT-WIDE POLICY

<b>DIVISION:</b>	FQHC	<b>NUMBER(s):</b>	CHCA-025
<b>PROGRAM:</b>	Division Wide	<b>VERSION:</b>	1.01
<b>TITLE:</b>	Patient Complaints and Grievances	<b>PAGE:</b>	1 of 5
		<b>EFFECTIVE DATE:</b> May 19, 2026	
<b>DESCRIPTION:</b>	Policy and process for responding to informal and formal patient complaints and grievances.	<b>ORIGINATION DATE:</b> November 19, 2024	
<b>APPROVED BY:</b>  <b>CHIEF EXECUTIVE OFFICER - FQHC</b>		<b>REPLACES:</b> Version 0	
Randy Smith, MPA		Date	

### I. PURPOSE

To provide a systematic approach to addressing patient complaints and grievances.

### II. SCOPE

This policy applies to all Southern Nevada Community Health Center (SNCHC) Workforce members.

### III. POLICY

The Southern Nevada Community Health Center (SNCHC) strives to provide high quality clinical care and customer service in a manner that meets or exceeds the expectations of the health center's patients. On occasion, situations may arise whereby a patient feels that the health center has not achieved this endeavor. In such instances, patients and/or their representative family members/caretakers are encouraged to share their grievances so that issues can be addressed in a timely fashion. Every effort will be made by the health center to resolve the complaint informally and at the point of care.

Patient grievances are formal written or verbal complaints made to the health center by a patient and/or their representative family member/caregiver that is of a serious nature and/or that cannot be resolved promptly by Workforce members or management.

Billing issues are not considered patient grievances unless the complaint also contains elements addressing clinical care services and/or related issues.

The Health District Legal Department will be notified of any complaint or grievance in which litigation may be involved.

Complaints that are not specific to the health center will be directed to the appropriate health district division or community partner.

#### **IV. PROCEDURE**

- A. Materials are provided to patients during the time of establishing care that includes information about the patient's right to make a complaint or grievance and who to contact within the health center for resolution.
- B. Reporting
  1. Department managers/supervisors or designees are responsible for "on-the-spot" resolving of patient complaints when possible.
  2. Complaints that become grievances include the following conditions:
    - a. If the complaint is not resolved and requires ongoing investigation.
    - b. The patient requests, completes, and submits a formal complaint.
- C. The following issues are automatically considered patient grievances. In this instance, the health center's Chief Executive Officer (CEO) must be notified within 24 hours:
  1. The exercise of patient rights regarding their care.
  2. Privacy and safety of the patient.
  3. Confidentiality and access to patient records.
  4. Civil rights or issues of disability.
  5. Allegations of unprofessional or disruptive conduct by a Workforce member.
  6. Accusations of abuse.
  7. Complaints otherwise serious in nature.
- D. A patient, their representative family member/caretaker or the public may report a complaint or grievance verbally, in writing, by mail, or phone. Verbal or telephone complaints must be documented, and if possible, read back to

confirm the message with the complainant. It includes the following information:

1. Patient or representative/caretaker.
2. Date of complaint.
3. Description of the concern/issue.
4. Location.
5. Requested action.
6. Injury or harm if appropriate.
7. Contact information and preferred method of receiving a response.

E. Investigation and Resolution.

1. Patient complaints received by the health center's CEO or their designee are investigated and resolved in collaboration with the involved program areas. Patient complaints alleging unprofessional or disruptive conduct by Workforce members will be referred to Human Resources.
2. Patient grievance investigation and resolution is a confidential process. Workforce members involved in or with investigating grievance will only discuss with those individuals who have a need to know, or who are needed to supply necessary background information or guidance.
3. All formal grievances will be acknowledged by a phone call or written response within two working days of receipt. After a written complaint or grievance has been investigated, a written response will be sent to the complainant, usually within 28 working days of the original receipt of the complaint. Face-to-face meetings which result in a resolution do not need to be followed up with a written response.
4. To determine if the standard of care was compromised, cases may be peer reviewed or referred to consultants.
5. Health center management may use additional tools to resolve a grievance, such as meeting with the patient and/or their representative family members, or other methods it finds effective. For patients with special needs, assistance will be provided in accordance with Health District policies.
6. The health center's Administrative Manager or designee will monitor

the grievance resolution process to assure that proper procedures and timelines comply with policy and/or regulatory requirements.

- F. Grievance documentation will be kept and tracked for the purpose of continuous quality improvement. Report tracking includes the number of grievances received, type of grievances, and action/resolution of grievances.

**ACRONYMS/DEFINITIONS**

Not Applicable

**REFERENCES**

Not Applicable

**DIRECT RELATED INQUIRIES TO**

Chief Executive Officer (FQHC)  
FQHC Administrative Manager

**ATTACHMENTS-FORMS-TEMPLATES**

Attachment 1, CHCA-025-ATT-1, Complaint Form

Attachment 2, CHCA-025-ATT-2, Office of HIV/Las Vegas TGA Policies & Procedures

**HISTORY TABLE**

**Table 1: History**

Version No.	Effective Date	Change Made
Version 1		Formatted to current template Attachment 2 added
Version 0	11/19/2024	First issuance

**COMPLAINT FORM**

Name:			
Preferred Method of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email			
Telephone Numbers: Primary		Work	
Email Address:			
Relationship to Client:    Self      Parent      Spouse      Son/Daughter			
Other (please explain)			

<b>Patient Information {complete this information if patient is not the same as above}</b>	
<b>Name:</b>	<b>Date of Birth:</b>
Address:	
Telephone Number:	
Email Address:	

**PLEASE INDICATE NATURE OF YOUR COMPLAINT**

Describe your complaint below. Include specific details: (who, what, when, where, why, any injury involved).


Use back or additional sheets as needed.





## Office of HIV / Las Vegas TGA Policies &amp; Procedures

Grievance Policy	Effective Date: February 14, 2013
	Review/Revise Date: April 8, 2025
Applicable Regulations:	
Policy Applies to:	
<input checked="" type="checkbox"/> Ryan White Part A & Minority AIDS Initiative <input type="checkbox"/> Recipient <input checked="" type="checkbox"/> Subrecipient <input type="checkbox"/> Contractor <input checked="" type="checkbox"/> Ending the HIV Epidemic <input checked="" type="checkbox"/> Status Neutral	
<b>POLICY STATEMENT</b>	
<p>Grievance means an oral or written communication, submitted by a client or by their representative, which addresses issues with any aspect of a subrecipient's operations, activities, or behavior that pertains to the availability, delivery, or quality of care, including utilization review decisions, that are believed to be adverse by the client. The expression may be in whatever form of communication or language that is used by the client or their representative but must state the reason for the dissatisfaction and the client's desired resolution.</p> <p>The subrecipient is the first point of access for all grievances and is responsible for responding, investigating, and attempting to resolve the client's grievance before the client or subrecipient refers the grievance to a funder or governing entity.</p> <p>No retaliatory actions will be taken against any client or client representative filing a grievance. The client shall be assured that information pertaining to the grievance issue is kept confidential except to the extent that sharing of such information between the recipient and the subrecipient and other persons authorized by the client, is necessary to resolve the issue.</p>	
<b>PROCEDURE</b>	
<p>Subrecipients shall develop and implement an agency-wide grievance policy that clearly explains all of the following, at minimum:</p> <ul style="list-style-type: none"> <li>• The definition of a grievance</li> <li>• How a person may submit a grievance</li> <li>• The steps the subrecipient will take to address a grievance</li> <li>• The appeal process</li> <li>• The definition of retaliation</li> <li>• What the subrecipient does to prevent retaliation after a person submits a grievance</li> <li>• How the subrecipient addresses any retaliation that may occur</li> <li>• The entity the person may contact when the grievance is not resolved at the agency level (Note: this will be dependent on the agency's funding sources, for example The City of Las Vegas, SAPTA, Clark County)</li> <li>• That the subrecipient is the first point of access for all grievances and is responsible for responding, investigating, and attempting to resolve the client's grievance before the client or subrecipient refers the grievance to a funder or governing entity</li> <li>• Aligns with the Nevada Ryan White Parts ABCD Common Guidance Document 17-06, Grievance Protocol Guidance <a href="https://endhivnevada.org/wp-content/uploads/2025/04/17-06-Grievance-Protocol-Guidance.pdf">https://endhivnevada.org/wp-content/uploads/2025/04/17-06-Grievance-Protocol-Guidance.pdf</a></li> </ul> <p>Subrecipients shall ensure:</p>	



## Office of HIV / Las Vegas TGA Policies & Procedures

- The grievance policy and forms are available in English and Spanish
- Each client served is aware of and understands the grievance policy
- That at each location where funded services are provided:
  - The grievance policy and procedure are posted in plain sight.
  - Grievance forms are always available in an area clients can access without needing staff permission.
  - There is a locked suggestion box easily accessible to clients to submit input, including grievances. This box must be checked by subrecipient at least weekly to ensure timely response.

Subrecipients shall supply a client or their representative with any of the following, upon client's request:

- A blank agency grievance form
- A copy of their completed agency grievance form
- A pre-addressed and pre-stamped envelope addressed to the subrecipient's Executive Director
- A pre-addressed and pre-stamped envelope addressed to Clark County's HRSA Grants Project Director at the Office of HIV

Grievances are one source of information to evaluate the quality of access, service, or clinical care. Thus, each subrecipient shall submit a completed Grievance Log to the recipient's office on a quarterly basis with the agency's quarterly report. Logs will be tracked and trended by the recipient's office for quality improvement purposes.

Subrecipients shall record each oral and written grievance on the Grievance Log.

- If a grievance covers more than one category, subrecipients shall record the grievance in the predominant category.
- For each grievance listed on the log, documentation must also be submitted to include, at minimum:
  - Copy of written grievance or transcript of oral grievance
  - Records of analysis, investigation, and resolution of the grievance
  - Copy of written notification to the client of the disposition of the grievance and the way to appeal the outcome of the grievance, including contact information of the recipient's office, if grievance was not resolved to the client's satisfaction.

<b>ACCESS</b>		<b>Interaction with Provider - CCSS Staff</b>	
<b>A1</b>	Difficulty contacting Provider	<b>I1</b>	Client feels not treated with dignity or respect
<b>A2</b>	Timely appointment not available	<b>I2</b>	Client disagrees with staff or clinician response
<b>A3</b>	Convenient appointment not available	<b>I3</b>	Lack of courteous service
<b>A4</b>	No choice of clinicians or clinician not available	<b>I4</b>	Lack of cultural sensitivity
<b>A5</b>	Transportation or distance barrier	<b>I5</b>	Other (describe)
<b>A6</b>	Physical barrier to Provider's office	<b>Quality of Service</b>	
<b>A7</b>	Language barrier or lack of interpreter services	<b>Q2</b>	Provider office unsafe
<b>A8</b>	Wait time during visit too long	<b>Q2</b>	Provider office uncomfortable
<b>A9</b>	Other (describe)	<b>Q3</b>	Client did not receive information about available services
<b>Denial of Service, Authorization, or Payment</b>		<b>Q4</b>	Excessive wait times on phone
<b>D1</b>	Desired service not available	<b>Q5</b>	Phone call not returned
<b>D2</b>	Client wanted more service than offered/authorized	<b>Q6</b>	Client doesn't like pre-authorization requirements
<b>D3</b>	Request for service not covered by Ryan White TGA	<b>Q7</b>	Other (describe)
<b>D4</b>	Request for medically unnecessary service	<b>Client Rights</b>	
<b>D5</b>	Payment to non-participating provider denied	<b>CR1</b>	Not informed of client rights
<b>D6</b>	Service authorization denied	<b>CR2</b>	Grievance and appeal procedure not explained
<b>D7</b>	Other (describe)	<b>CR3</b>	Access to own records denied
<b>Clinical Care</b>		<b>CR4</b>	Concern over confidentiality
<b>C1</b>	Client not involved in treatment planning	<b>CR5</b>	Allegation of abuse
<b>C2</b>	Client's choice of service not respected	<b>CR6</b>	Treatment discontinued without proper notification
<b>C3</b>	Disagreement with treatment plan	<b>CR7</b>	Other (describe)
<b>C4</b>	Concern about prescriber or medication issues		
<b>C5</b>	Lack of response or follow-up		
<b>C6</b>	Lack of coordination among providers		
<b>C7</b>	Care not culturally appropriate		
<b>C8</b>	Client believed quality of care inadequate		
<b>C9</b>	Other (describe)		

