Patient Services

The Network's case review responsibilities include investigating and resolving grievances filed with the Network and addressing non-grievance access to care cases. CMS views the investigation and resolution of grievances and non-grievance access to care cases as an opportunity to focus on meeting the needs of ESRD patients as well as an opportunity to create change by listening to and learning from the patient's and/or caregiver's perspective. Change occurs when dialysis facilities understand the root cause(s) of the grievance issue and implement steps to resolve the issue(s). The steps that lead to resolution may be simple and specific to the grievant or there may be a need for a systemic change to correct the issue for the benefit of all patients within a dialysis facility.
Depending on the details of a case, the Network may assume one or more of the following roles in addressing a grievance filed by an ESRD patient, an individual representing an ESRD patient, or another party:

Facilitator
Expert Investigator
Educator
Quality Improvement Specialist
Advocate
Referral Source

The Network may also take on other roles as required by the case, based on an understanding that the Network's primary objective is to resolve the case as successfully as possible for the grievant.

The Role of ESRD Network 18 in Handling Complaints and Grievances.

Network 18 is a non-profit organization funded by the Centers for Medicare & Medicaid Services (CMS). Its mission is to promote optimal dialysis and transplant care for kidney patients in Southern and Central California.

One of its most important responsibilities is to serve as an unbiased, outside review agency. Patients, family members, facility staff, and others may contact the Network regarding the care provided to patients at Medicare-certified facilities.

Patient Toll-Free Number: 1-800-637-4767

Patient Grievances

Grievance: A written or oral communication from an ESRD patient, and/or an individual representing an ESRD patient, and/or another party, alleging that an ESRD service received from a Medicare-certified provider did not meet the grievant's expectations with respect to safety, civility, patient rights, and/or clinical standards of care.
Upon receipt of a grievance the Network shall classify the case as one of the following:

Immediate Advocacy- utilized for non-clinical concerns that do not require complex investigation- resolved in 7 days or less

General Grievance- concerns that are non-clinical in nature, but require complex investigation and records review- resolved in 60 days or less.
Clinical Quality of Care- concerns that involve clinical or patient safety issue and require clinical record review, by an R and/or, the Medical Review Board- resolved in 60 days or less.

Please note that you will be contacted by phone and/or in writing once a grievance has been filed with the Network. You will be required to provide records as requested within the time frame outlined by the Network. Recommendations for quality improvement efforts will be made once all issues have been investigated. The Network will guide you through all quality improvement efforts and will continue to provide support and follow up as deemed necessary. We share your goals to ensure that all care provided to the patients in our service area is of the highest quality possible.
As required by the conditions for coverage, please ensure that all patients are educated on the grievance process and the various options when filing a grievance by providing ongoing individualized education as well as displaying the Network poster in a common area that patients and visitors have access to (such as the unit lobby).

Grievance Resources

- Grievance Poster English – Spanish
- Grievance Brochure English – Spanish
- Grievance Toolkit English – Spanish
- Develop an Anonymous Grievance Process at your Facility English

Templates to improve your internal grievance process

- Grievance Log English
- Grievance Acknowledgement Letter English – Spanish
- Grievance Outcome Letter English – Spanish

Preventing & Reducing Involuntary Discharge

We frequently receive calls regarding the process of involuntarily discharging a patient under the new Conditions for Coverage. Let us first emphasize that involuntary discharge should be the option of last resort. Discharged patients are at high risk for morbidity and mortality. Facilities should train staff in conflict management techniques and work to remove any barriers that patients may be facing. The medical director ensures that no patient is discharged or transferred from the facility unless:

The patient or payer no longer reimburses the facility for the ordered services;
The facility ceases to operate; or
The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs.
The facility has reassessed the patient and determined that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired.

Immediate Severe Threat to the health and safety of others.

In the event that all options have been exhausted, the Network has several recommendations for the involuntary discharge process. Please refer to the resources below for additional information and notify the Network immediately if you are considering an involuntary discharge for any reason:

Managing Retaliation– **New**
Involuntary Discharge Checklist/Guidelines
Interpretive Guidelines V766 and V767
Interpretive Guidelines V520
State Notification of Involuntary Discharge/Transfer

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