

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

STATE OF MINNESOTA

BOARD OF HEALTH

In Re: In the Matter of the
Proposed Adoption of
Rules of the Minnesota
State Board of Health
Relating to the Operation
of Health Facilities
Grievance Mechanisms.

TRANSCRIPT OF PROCEEDINGS

January 18th, 1977

RAY J. LERSCHEN & ASSOCIATES
1026 Soo Line Building
Minneapolis, Minnesota 55402
By Patricia McLean, Court Reporter

COPY

STATE OF MINNESOTA

BOARD OF HEALTH

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FEB 23 1977
DIVISION OF
HEALTH FACILITIES

In Re: In the Matter of the Proposed Adoption of Rules of the Minnesota State Board of Health Relating to the Operation of Health Facilities Grievance Mechanisms.

Hearing of the above-entitled matter was taken by Patricia McLean, a Notary Public in the County of Hennepin, State of Minnesota, on the 18th day of January, 1977 at the University of Minnesota, Department of Health, Minneapolis, Minnesota, with Allan Klein presiding as Hearing Officer, commencing at approximately 9:00 o'clock, a.m.

APPEARANCES:

JOHN A. BREVIU, Esq., Minnesota Department of Health Building, 717 Delaware Street South East, Minneapolis, Minnesota, appeared on behalf of the Minnesota Department of Health.

DANIEL J. McInerney, Jr., Esq., Minnesota Department of Health Building, 717 Delaware Street South East, Minneapolis, Minnesota, appeared on behalf of the Minnesota Department of Health.

* * *

WHEREUPON, the following proceedings were duly had:

* * *

MR. KLEIN: This is a hearing in the matter of the proposed adoption of rules of the Minnesota State Board of Health relating to the operation of health facilities grievance mechanisms. My name is Allan Klein. I am a hearing examiner employed by the State Office of Hearing Examiners. At this point I would like to have the agency panel please introduce themselves by stating their full names and spelling their last names.

MR. BREVIU: My name is John Breviu, that's B-r-e-v-i-u, and I'm from the office of the Attorney General and I'm representing the Board of Health in this matter today.

MR. McINERNEY: My name is Dan McInerney, M-c-I-n-e-r-n-e-y and I'm a consultant to the Health Department, I'm speaking for the agency today.

MR. KLINE: All right. Since you all should have copies of the rules hearing agenda and guidelines in front of you, that's a one-page document printed on both sides, I won't go through all of it except to hit a few of the highlights.

As an employee of the State Office of Hearing Examiners I am not an employee of the Minnesota Department of

Health. After the hearing I will prepare findings of fact, conclusions and recommendations which will then be submitted to the agency. The Department of Health will then make its decision as to whether to adopt, modify or reject the proposed rules. Before making that decision they must wait at least ten days, during which time the findings of fact, conclusions and recommendations, which I will have submitted to them, will be available to all persons.

When you have something to testify to, I would appreciate it if you would please step up to the witness table here and when you begin, please state your full name and spell your last name for the benefit of the court reporter and identify your interest or firm and please speak clearly. If you have any written statement or other matter which you desire to introduce into evidence, it should be presented to the court reporter to be marked as an exhibit and offered at the appropriate time. Written statements may be introduced at the time an individual offers an oral statement. The right of the agency or others to examine the individual presenting this written statement extends to the content of the statement offered in written form. It should be noted that anyone who desires to submit a written brief or other written comments bearing upon the proposed rules may do so within 20 days of the close of the hearing. Such materials should be submitted to me at the Office of Hearing Examiners

at the address which is on the agenda and guidelines. Materials must be received by me within the 20 day period in order to be considered. We've had some people in the past submit materials 40, 50 days after the hearing and generally they are not considered. So, therefore, if at the close of the hearing you have something which you want to bring to my attention, please submit it within the 20 day period. Finally, you are advised that under Minnesota Statute Section 10a, 01, Subdivision 11, any individual representing persons or associations attempting to influence administrative actions such as the promulgation of these rules must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. It is my understanding that within the last month the State Ethics Commission has issued an opinion setting forth the dollar amounts and degree of time spent which they believe will cause you to have to register as a lobbyist. Any of those of you who are in question about this should perhaps contact the Ethics Commission.

All right. I believe that we could introduce the jurisdictional documents at this time. I might say that these documents will be available for inspection at the office of the State Hearing Examiners any time during the 20 day period that the record is open.

MR. BREVIU: Mr. Hearing Examiner, I request the

record reflect that the following documents be filed with the Office of Hearing Examiners in accordance with the Administrative Procedures Act and the Rules of the Office of Hearing Examiners on November 18th, 1976. First, an order for hearing setting the hearing for this matter on January 18th, 1977 at 9:00 a.m. The order is signed November 17th by Dr. Alan Fifer.

MR. KLINE: Could you please spell the name Fifer?

MR. BREVIU: F-i-f-e-r. Second, a notice of hearing signed on November 17th, 1976 by Alan Z. Fifer. Third, filed on that day was a copy of the proposed rules, which are being promulgated or are being heard today and last a draft of the resolution adopted by the Board of Health on October 14th, 1976 setting the hearing in this matter.

On December 23rd, 1976 the following documents were filed in accordance with Minnesota Regulations HE 103. First, an order for hearing. Second, a copy of the notice of hearing as mailed. Third, an affidavit of receipt of the Secretary of State's list indicating that the Health Department had received a list of all those persons who had registered with the Secretary of State seeking notice of any agency rules hearing. We also received on that day, received a list of those seeking notice of any Health Department rules hearings as well as all other agency rules hearings. Fourth--I should backtrack a bit here. Attached to the affidavit of

receipt of the Secretary of State's list is an affidavit of mailing indicating that notice of this hearing was mailed to all persons whose names were on the Secretary of State's list and a certificate of the Secretary of State indicating that indeed the proper document had been handed over to the agency. Next, there's a combined statement of need and statement of evidence, which was filed with the Office of Hearing Examiners on December 23rd. That document I should note sets forth the reasons the Board of Health is promulgating these rules, the reasoning behind the rules. We have gone through in that document and taken the rules pretty much on a rule by rule basis and set forth the evidence which we believe supports the reasonableness of the rules. Also, a part of that document is a copy of the notice of hearing, which was published in the State Register on December 7th, 1976 and a copy of the notice of intent to solicit information from non-agency sources, which was published in the State Register on November 8th, 1976. Last filed on that day was a statement of agency personnel who will represent the Board of Health at the hearing. I request that all these documents be accepted into evidence at this time.

MR. KLINE: Is there any objection to the acceptance into evidence of these jurisdictional documents? Hearing none, they will be received.

MR. BREVIU: Mr. Hearing Examiner, I'd also like

the record to reflect that we have handed out today a list of a, I think it's about a six-page document, five-page document containing some amendments, proposed amendments to these rules. This document is available at the door. I believe everybody should have a copy and I would request that this document be marked for identification and accepted into evidence.

MR. KLINE: All right. I'm going to mark this document as State's Exhibit 16.

MR. BREVIU: I would offer it into evidence at this time.

MR. KLINE: Is there any objection to the introduction into evidence of what has been marked as State's Exhibit 16, which are the proposed modifications of these rules? Hearing none, it will be received.

Does that complete the introduction of the jurisdictional documents?

MR. BREVIU: Yes, it does.

MR. KLINE: I would like to note for the record that I have received a number of letters, some of which have been transmitted directly to me, others of which have been transmitted to the Board of Health and given to me and I'm just going to note these for the record. If any of you have submitted letters of comment that I don't mention, I'd like to hear about it, please.

The first is a letter from John E. Thames, that's T-h-a-m-e-s, of Group Health Plan, Inc., dated November 17th, 1976. Second is a letter from Ronald J. Daigle, that's D-a-i-g-l-e of Group Health Association of Northeastern Minnesota, Inc., dated December 21, 1976. The third, I think to speed things up I'll just mention the entity, is St. Mary's Hospital and Home dated December 15, 1976. The next is from Golden Valley Health Center dated January 6th, 1977 and the final one is from Med Center Health Plan dated January 12, 1977.

If there is no objection, I would like to have these received into evidence as well. Hearing none, they will be received.

At this point the agency may make its presentation.

MR. McINERNEY: Mr. Hearing Examiner, before proceeding to discussing the proposed rules, I would like to make note of a transposition in the agency's statement of authority in need. The first seven lines on the top of page twelve should be placed below the first seven lines on the top of page thirteen.

MR. KLINE: Just to make sure, Mr. McInerney, that I understand this, are you stating that page twelve should begin with the words, "Whom or for whom"?

MR. McINERNEY: That is correct.

MR. KLINE: Thank you.

MR. McINERNEY: The agency presentation of the proposed rules will take the format of a description of what each broad section is supposed to do and the reasons for the approach the agency has taken. These reasons will essentially be precis or synopsis of the reasons presented in the agency documents statement of statutory authority need and reasonableness. At the end of each broad section I believe the hearing examiner will ask for comments and questions.

MR. KLINE: Mr. McInerney, it seems to me we have two alternative ways of doing it. The first would be for you to complete your entire presentation and then open the board to public or we can do it section by section. Have you any ideas?

MR. McINERNEY: I have no preference.

MR. KLINE: I'm tempted just to have you complete your whole presentation, because it's my reading of these rules that they're very much interlocked one with the other. I must admit I haven't had the opportunity to read the additions which you propose, but if they're like the earlier proposals they were very much interlocked and it's very hard to understand the relationship between one and the other without a total picture. So, therefore, if you could do your whole thing I think it would be desirable.

MR. McINERNEY: The applicability section, MHD 521 just specifies that this section of rules Chapter 29 of

the Health Department rules apply to hospitals and outpatient surgery centers. There is a section later on applying to HMOs, but only insofar as they must report on the experience of their complaint mechanisms to the Board of Health on an annual basis.

MHD 522 is a definition section. Definitions are necessary in order to describe the universe of activities that the department is talking about. Grievance mechanism, hospital, outpatient surgery center and one additional definition you will see in the changes which the agency had prepared for you at the door today, definition of representative. At the end of the word representative there should be quotation marks. The reason it was felt that representative be defined was essentially to limit the kinds of people and the characteristics of individuals who could complain on behalf or in behalf of a patient, so that a facility, be it a hospital or surgery center, would not be confronted with conflicting requests from say members of the same family.

MHD 523, the minimum standard just specifies that hospitals and surgery centers must operate grievance mechanisms in conjunction with these rules as required by the statute.

The procedural requirements which were required to be specified by the statute are relatively lengthy and there have been some changes, so I'll try and highlight those as

clearly as I can.

Designated person, MHD 524A, the section has been changed to delete the phrase "through their respective governing authorities" and with the addition of the phrase "by name or by title" after "individual" for the following reasons. Changes in personnel in a facility might be frequent enough or changes in the duties of specific personnel in a facility might be frequent enough to necessitate the governing authority meeting more frequently than it actually needs to to perform the act of designation. In order to address this problem yet make an individual accountable for the operation of the mechanism within the facility, the approach has been to permit the hospital or surgery center to designate an individual either personally or by title. For example, Mr. Smith is accountable for the operation of our grievance mechanism or the chief executive officer or the assistant administrator or the chief of nursing.

Complaints themselves, it's clearly the intent of the statute to encourage the voicing of complaints at a very low level so that they might be resolved so as to minimize their impact upon potential filing of claims in malpractice suits. Therefore, any patient or his representative is permitted under these proposed rules to complain and the complaints are related to some subjects which we'll talk about briefly later.

To whom these complaints are made, essentially the individual or essentially the officer who is designated as the accountable individual or to any other individual who is authorized by the facility to receive these kinds of complaints. Initially, this section read that someone able to receive complaints should be present during both ordinary business and visiting hours. In view of the fact that requiring the facility to take staff away from essentially patient care activities during visiting hours and in view of the fact that phone calls can be made during the day by concerned parties, whether they be representatives or the patient who might be recently discharged, it was felt that eliminating the requirement that someone be present to receive complaints during visiting hours would not do violence to the intent of the statute, which was just to provide a conduit for resolution.

Now, it's important to point out before I proceed to the next section, which is 524C, that the affect of these rules is to mandate a response to a complaint, not resolution of a complaint. The statute in attempting to create a climate which would minimize potential malpractice suits and claims did not specify or mandate resolution at the facility level and the agency feels that it would be inappropriate to mandate an essentially quasi judicial proceeding at that level. So, the attempt is to create a climate which is conducive to

resolution through requiring response. Now, the time limits for response are tied in essentially to the types of complaints which can be made by patients and I'd like to describe them generally and when we get to that rather long list of complaints, I hope the time limits in.

There has been a change eliminating the requirement for written response. Because of the cumbersomeness of this, because of the potential adverse psycho-social implications of a nurse handing a written statement saying your complaint was hogwash to an individual, which might essentially trip over the intent of the statute and the rules, the requirement of a written response is eliminated unless the patient requests it or the complainant more accurately requests it. So, the complainant has a right to a written response, but as a matter of form the rules do not require that such a written response be given to him or her.

The time limits. A time limit of 24 hours is specified for complaints which the Health Department feels are intimately related to essentially the medical care of the individual. In view of the fact that the average length of stay in acute care facilities is seven days or less and in view of the fact that medical care complaints are rather important in the hierarchy of the kinds of grievances that patients might voice in the facility, 24 hours seems to the agency a reasonable time for response, again response, not

resolution to a complaint pertaining to those complaints which are referred to in that section.

Complaints relating to psycho-social things which are not of a hard core medical care nature, while clearly important to the well-being, the speedy recovery of the patient, are not quite as important as the hard core medical care kinds of complaints and the Health Department feels that 72 hours or three days is a reasonable time for the facility to garner some kind of a response.

Complaints related to billing and to the release or withholding of medical records are perhaps very common, but are not normally voiced until after the patient is out of the facility. Generally speaking complaints related to billing will not arise until after a bill has been received. That typically does not occur until a month after the patient is discharged. The special problems of determining to whom records should be released and under what conditions seem to militate for the fact that -- to the conclusion that 30 days is a reasonable kind of time limit to require for response to such complaints.

Now, in view of the fact that the facility in possession of these rules will be in a state of really superior knowledge to the complainant or the patient and in view of the fact that there are some time limits here which allow for say three days to pass between the time the complaint is

initiated and the time a response is required, it seems reasonable to require someone speaking on behalf of the facility to give an essentially ball park estimate of when they're required to get back to the complainant. Now, there has been a change in that section. Essentially two changes. This is the 524 D. First change relates to oral complaint. If there is a written complaint received it's clear that by virtue of the speediness of the mails a response might not be made within four hours. Secondly, the four hour requirement might be excessively burdensome and upon receipt of the complaint a best judgment in behalf of the facility on the part of the authorized individual, whether it be a facility officer or even a charge nurse, seems reasonable. This might also minimize the likelihood that subsequent complaints related to the same subject matter would be repeated and repeated and repeated.

524E and F relating to exception and denials have been deleted in toto. The reason --

MR. KLINE: I was going to ask if you could please state why.

MR. McINERNEY: The reason for deleting 524E relevant to exceptional circumstances, which would extend the time limits for response is essentially that if a patient is in an emergency situation or if a patient has perhaps passed on, the response might be considered to have been made. This

might have been in a way a situation of regulatory overkill. Common sense dictates that there're going to be situations in which there are emergency situations, emergency conditions or in fact the patient has passed on and requiring response to a deceased patient is clearly unreasonable and spelling that out in rule seems to be a little onerous.

524F relevant to denials is essentially not important to the rules for the following reasons. The rules only require response. They don't require resolution. So, language specifying grounds which could be used to deny the kind of action that a complainant would request are probably extraneous to the body of the rules themselves, which just focus on response. However, the grounds for denial, if any, would be required to be placed in the records of complaints and that change is made in the next section, which is 524G, reading now 524E.

Changes in that section. It was pointed out to the agency after this proposed rule was published that a facility might want to classify its complaints according to subject matter as opposed to patient. It's reasonable to do so, for instance, to highlight say an individual or a certain area which might be giving the facility a problem. There's no intent on the part of the department to require that the records be kept only according to patient. What the department would like to be able to do and I think the changes

in the rule, this section of the rule reflect that intent, what the department would like to be able to do would be to be able to identify the patient or the complainant from whatever record keeping system is kept and the changes essentially permit the maintenance of records according to patient or according to subject matter. In addition, a further change relevant to the time limit that such records should be kept specifies one year. The facility has to report to the Board of Health on an annual basis on the experience of its mechanism and one year is felt to be consonant with the needs of the department in terms of perhaps going in on a complaint request and inspecting such records and the needs of the facility in preparing a document for transmittal to the Board of Health on February 1st.

Patient notification. The statute requires that the department specify in a rule the means by which individual patients be notified of the existence or availability of such mechanisms. In view of the fact that patients already are required to be notified of the existence of the patient bill of rights, it was felt to be reasonable to hook in notification of the existence of grievance mechanisms to the same act and the approach of this particular section is to essentially say that notice of the grievance mechanism shall be furnished along with the notice required under the patient bill of rights to the patient upon admission to the facility.

The content of the notice so that the patient is not only aware of the existence of the mechanism, but aware of to whom he can go and aware of under what conditions he can request its operation, essentially states that these rights that you have received in a list, these bill of rights, are the kinds of rights -- complaints deriving from which might be able to be resolved or addressed in the facility. So, there is a reference in the type of notice required here to the patient's bill of rights. Secondly, a statement that the facility maintains a grievance mechanism for the express purpose of attempting to resolve disputes of this nature. Thirdly, a statement specifying an individual or type of individual to whom complaints or grievances can be directed, for instance, your charge nurse or the assistant administrator or Mr. Smith, who is someone we've hired for the express purpose of processing complaints. Finally, in order to make it clear to the individual that he or she has a right to receive a written response to a complaint, that statement is included in the notification.

The statute requires the Board of Health to use data which it derives from conducting this regulatory venture, to publish reports periodically on ways of improving grievance mechanisms, changing them, tailoring them. In addition, the statute requires at least an annual report to the Board of Health by the facilities which are subject to

the provisions of this statute. MHD 526 specifies when reports are due and essentially the kinds of information which should be -- which must be in such reports. Such information includes general identification information, for instance, the name and location of the reporting institution, the name of the accountable individual or officer responsible for operating the mechanism, the total number of complaints filed under the provisions of these rules, the classification of such complaints according to the list of complaints, which is specified in MHD 525 and numbers of other complaints, numbers of patients who complained more than once or for whom more than one complaint is made. The purpose of that particular provision is to discount the affect of someone who is overly complaining might have upon the experience of a facility's mechanism. There was a change in Subsection D of the report section specifying that the complaints would be -- the total number of complaints in the report would be those filed with the facility under these rules, not all complaints. For example, there may be complaints or gripes not relevant to anything which is the subject matter of the statute or the rules. The department is not interested in that information. It's clear that only the information that's received pursuant to the operation of this specific mechanism is desired. The last section of the reporting requirements Section H, the total number of complaints resolved to the patient's apparent

satisfaction. It's clear that the facility may feel somewhat uncomfortable in saying the individual is satisfied. It's a judgmental call and we would like to have an idea of what the facility felt, what percentage of complaints the facility felt were resolved by virtue of the existence of this mechanism. Now, the kinds of complaints MHD 5 --

MR. KLINE: Excuse me, I just wanted to state we're getting some people standing in the back there. There are chairs up here in the front if you'd like to use them. I'm sorry.

MR. McINERNEY: Now, the kinds of complaints themselves, which is specified in MHD 525, are essentially derived from the Minnesota patient bill of rights. The statute is specific in that it requires the board to develop and rule a list of complaints which can be processed through such mechanism. Since the legislature has decided that by and large the patient's bill of rights expresses rights and privileges which belong to people who are admitted to such facilities, it was felt that deviations or breaches from those rights would be most likely the kinds of situations which would create the opportunity for a patient to complain and, therefore, that statute was used for the development of the list of complaints. Some of these complaints were referred to in statute as -- some of these rights from which the complaints were derived were referred to in statute as being

relevant only to residents, however, upon examination residents would be individuals in long term care institutions, not in acute care facilities like hospitals and surgery centers. However, the department's examination of the statute led it to believe that many of the rights which were accorded only to residents in fact were rights which might be breached in an acute care facility, for instance, L, 525L, retaliatory, arbitrary or otherwise medically unjustifiable discharge. Premature discharge or release of an individual from an emergency room or outpatient department, that's a situation in which an individual might complain. Similarly, 525B, no reference was made in these patient bill of rights to billing practices, although there was reference made to the amount of money to be charged for specific type of care, however, very often patients do complain about a specific bill, the amount of the bill and the items charged on a specific bill and it was felt that this is a situation in which no response or a poor response might create a climate for suit relevant to the care that was delivered and, therefore, a reference to failure to respond to questions about billing practices was included.

Lastly, the schedule of fines. The statute does require the specification of a schedule of fines not -- fines not to exceed $200 per violation. The schedule of fines that is proposed here is essentially a bifurcated one. It

focuses both retrospectively and prospectively. The retrospective focus is upon the treatment of an individual patient by the grievance mechanism. The prospective focus is on the actual function of the mechanism itself. 527A relates to the retrospective part, patient notification and complaint mishandling. The fines which are proposed here and the conditions under which the fines would obtain are essentially a failure to give notice as required by the rules upon admittance to the facility along with the patient bill of rights and a failure to respond to a complaint by a particular patient within applicable time limits. These fines are proposed to be automatic, that is, not subject to the initial issuance of a correction order and then only obtaining upon failure to comply with the correction order for this reason. Correction orders cannot correct something which has occurred in the past and notification of the patient and failure to notify the patient is a breach which cannot be remedied by a correction order. So, to that extent automatic fines are proposed to be imposed under the conditions of 527A. A ceiling on those fines is $200 with respect to the current stay of a particular patient. Although the statute does not require this ceiling, it seems to be the intent of the statute to focus on the mechanism itself as a conduit for resolution as opposed to remedying individual patient grievances, hence the dollar amount is a maximum of $200 for multiple violations

The prospective part of the schedule of fines relates to how the mechanism functions, reports made to the Board of Health and the like. These are subject to the issuance of a correction order, that is to say if there is non-compliance with a particular section of these rules, which is referred to in 527B, then an order to correct the situation can be issued. If that order is not complied with in the period of time allocated by the department up to a maximum of 60 days, then and only then would a fine be assessable. Now, the grounds relate to failure to have a mechanism, failure to have a designated person to be accountable for the conduct of the mechanism, failure to maintain the complaint records which are specified, failure to post the notice that's required along with the patient bill of rights notice posting, failure to submit the annual report, which is required by both the rules and the statute, failure to fulfill the criteria for the content of the report, which are specified in the report section.

Time periods for correction. None of the violations of these rules appears to be such that more than 60 days be needed to correct, therefore, an upper limit of 60 days was placed.

The fine amounts are essentially described in descending order of the significance of the violation. Given the fact that the $200 limit was placed upon the per

violation fine by the legislature and given the fact that the main focus of the statute is upon the function of the mechanism, the fine amounts relate to the relative importance of the failure of the facility to meet the order to correct essentially and they range from 200 down to 100. In both situations the automatic fines and the fines which would be assessable upon failure to comply with an order to correct, administrative procedures are avilable to the facility in terms of its desire to dispute or contest an agency action or decision.

Finally, since HMOs are referred to in the statute as being required to report along with the surgery centers and hospitals, it was felt that hooking into the existing HMO rules and reporting requirements was desirable here. HMOs parenthetically are required to have a function of grievance mechanism under their own statute and under the rules promulgated pursuant to that statute and to that end MHD 370 is proposed to be amended as follows: Now, there are changes on the Health Department additions and deletions sheet which would be of interest to you. Instead of requiring a submission on February lst by the health maintenance organization of a complaint mechanism or grievance mechanism report, it was felt more appropriate and more streamline to require the submission of this data along with the annual report which the HMO is required to submit to the Board of

Health anyway. Secondly, in Subsection 5 of MHD 370G, concerns were raised about individual privacy, the privacy of individuals, whether they be enrollees in the HMO or practitioners affiliated with the HMO or employees of the HMO. The board has no concern with the identity of individuals in this particular situation. It merely wants to know how the mechanism functioned and to that end a phrase was added to Subsection 5 indicating that the privacy of these individuals could be respected. Similarly, to the reporting requirements in the hospital and surgery center section of the rules, Subsection 7 of MHD 370G7 proposed specifies the numbers of complaints which would be resolved to the enrollee's apparent satisfaction. The word apparent again was added to indicate that in some situations the facility or in this case the HMO might feel fairly that the enrollee was satisfied, but the enrollee might not at a later date, again to give us a ball park estimate of the success of the mechanism. That ends the agency's presentation.

MR. KLINE: I'm a little bit embarrassed to note that the agenda and guidelines which were furnished to you is an old version and that it differentiates between attorneys and other interested persons as to who can speak first. More recent versions of this do not make such a differentiation and I would propose to follow the order on the register to the extent I'm going to be able to figure it out,

because there were four different sheets, of who would like to speak and take them in that order.

When you do speak, please state your full name, spell your last name, state the name of any organization or firm which you represent and finally when making comments about the rules it would be very helpful if you could referenc the specific rule number. I have some written comments which talk generally about all the rules and it's very difficult for me to go through, what I'm going to have to go through and annotate them and say, "Ha, ha, they're really talking about 525F." To the extent that you're able to in your presentations, I think it would be helpful if you could reference which rules you're talking about.

All right. Gordon Sprenger, would you like to speak at this point?

MR. SPRENGER: Mr. Diehl, University of Minnesota, has asked if he could speak first because he's got to go to another meeting and that's fine with me.

MR. KLINE: All right.

MR. DIEHL: If that's all right with you, Mr. Hearing Examiner. I will be brief, uncharacteristically brief. My name is John Diehl, D-i-e-h-l and I am appearing on behalf of the University of Minnesota Hospitals and Clinics and to begin with I would like to address the purpose of this entire regulatory process as described in Minnesota

Statutes 1976, Section 144.691, Section or Subdivision 1, which says that every hospital, which is that part that I'm interested in, to paraphrase, shall have -- shall establish a grievance or complaint mechanism designed to process and resolve promptly and effectively grievances by patients related to factors and it lists billing and inadequate treatment and other factors which may have an impact on the incidents of malpractice and suits.

As the hearing examiner knows and for the record, for the board to remind them, the authority of an administrative agency constitutionally is limited to that which is specifically granted by statute and it may properly promulgate administrative rules and regulations only if those rules and regulations are consistent with the statute upon which they are based. Furthermore, as a part of the principles that I'm referring to and as part of the requirements of the Administrative Procedure Act, no administrative agency may arbitrarily or capriciously adopt rules and a part of the safeguard that regulated entities have towards this requirement is that the agency has a burden to prove that its regulations or proposed regulations are consistent with the law. I submit and I have had an opportunity to review the statement of need as submitted by the department to date, I see not one shred of evidence that shows why any of this process is going to impact malpractice litigation or other suits and it seems

to me that without that we have not even gotten off the starting block in terms of justifying these regulations. I think that the department has done a yeoman's job in trying to meet a January 1 statutorily mandated date for promulgating regulations, but I don't believe that it can go beyond its existing statutory authority to meet that deadline and I think that that means that they may not promulgate rules unless they can show that there is going to be some relevance relating to malpractice, which was the purpose of this statute. The statute, the justification takes off on the point that these are rules to facilitate the processing of complaints, but that's only secondary. The statute is designed to do that so that it will impact on malpractice and if -- malpractice litigation and if it won't, then the agency is beyond its jurisdiction. I guess my comments then to refer to the-- specifically tie those to the proposed rules relate to proposed MHD 52 -- the laundry list, 525. There's no evidence in the submissions that those subjects that are going to be of regulated complaint process -- within the regulated complaint process have anything to do with malpractice. Furthermore, the agency in its documentation has relied on the patient's bill of rights, which is a pronouncement by the legislature of certain privileges or opportunities that patients in different kinds of statutorily defined facilities have and contrary to the presentation by the agency, it seems to

me when the legislature says that a patient, which is a defined technical legal term to mean people in an acute care hospital, have certain rights and when residents, which is a defined technical legal term meaning people that are confined in certain other kinds of health care facilities, nursing homes so-called, this agency does not have the power to abrogate that statutory scheme that the legislature has set down granting certain rights to a certain statutory class of people and certain other rights to another statutory class of people. This agency cannot arbitrarily say, well, gee, the legislature should have extended all those rights to all those people. You just can't do that. So, not only do we not have a tie-in between the purpose of the statute and this list of events that trigger the proposed mechanism. That proposed mechanism goes beyond the statutory limitations established by the legislature.

That then relates to my other concern, which is found in MHD -- proposed MHD 524C, which to quote the late statesman Baldy Hanson, is the lawyer's assistance act of 1977 to figure out when you have to give a 24-hour notice, a 72-hour notice. A 30-day notice I can see is reasonably susceptible to interpretation and implementation, but it just seems to me that this approach is unrelated to any rational criteria and is so burdensome and onerous to be implemented, I submit costly, to be outside of any reasonable

approach to implementing this statute. I agree and my client has tried in every way that it can to practice the belief that a patient who evidences concern is entitled to an immediate response in the circumstances of the case and that may be one hour or it may be a week. I think the point is that the patient is entitled to a prompt, as prompt a response as is humanly possible in the situation and the department tried to acknowledge that in the emergency exception, which has now apparently been deleted. The circumstances vary and I might add and I would like our patient relations person to describe this some more, but I might add that you could get a situation where you're giving perhaps in response to a single complaint three notices that we're going to respond to this at such and such and I think that the people implementing this would be strung out on keeping track of which paragraph in the letter of complaint has to be responded to on which moment and which other paragraphs have to be responded to later and I think that kind of detail while it seeks to achieve the purpose that we have embraced, goes to extremes and becomes unworkable and, therefore, we would urge that that be withdrawn in favor of a time scheme that would be -- that might employ some subjective criteria such as I described, that is, as prompt response as possible in the circumstances of the case not to exceed X, whatever that might be, 72 hours or 30 days or something of that sort I think would make this a

much better set of rules. I might add, in terms -- in order to be positive to the extent that I can, the list of criteria that or list of things that we complain about, I would urge that that be withdrawn and substituted there for the statutory provisions that exist in the form of patient rights for patients in hospitals and such other, perhaps such additional items that can be demonstrated by case law and other qualified authorities that are substantial contributors to malpractice litigation, which I submit the department would have to research and prove and this would be in keeping, by the way, to the extent that an administrative interpretation of a statute has persuasive value, this would be in keeping with the position of this very administrative agency, which in the implementation of the patients' rights law has required that the rights be described verbatim as articulated in the statutes. In the face of concern by hospital management throughout Minnesota when that law was first adopted, there was a desire to paraphrase those statutes to be what people thought would be more meaningful to a layman reading their statement of rights and this agency interpreted the law to say you have to pass out a printed document that states verbatim those requirements and it seems odd for the department to depart from that standard at this point and we urge that those be withdrawn and those verbatim statements and other properly established criteria be substituted therefor. So,

I appreciate this opportunity to comment. We have gone through at the University Hospitals, we have gone through this process as contemplated in the proposed rules to see how it would work and I would like to defer to Mrs. Cathy Countryman, who is the coordinator of patient relations at the University Hospitals and who is also the president elect of the American Hospital Association Society of Patient Representatives to describe our experience with the proposed rules in our experimental implementation. Thank you very much. I would submit to examination if that's appropriate.

MR. KLINE: Thank you. It's required if they want to do it. Have you any questions that you'd like to ask?

MR. BREVIU: I have none.

MR. McINERNEY: No.

MR. DIEHL: Thank you.

MR. KLINE: Thank you. Mrs. Countryman, how long do you think your presentation might take?

MRS. COUNTRYMAN: Probably ten minutes.

MR. KLINE: Why don't we do it and then we'll take a break. If you could come up now, please.

MRS. COUNTRYMAN: My name is Cathy Countryman, C-o-u-n-t-r-y-m-a-n. I work as coordinator at the University of Minnesota Hospitals and Clinics, the Department of Patient Relations. I'm also president elect of the Society of Patient Representatives of the American Hospital Association.

I have to concur with Mr. Diehl, with whom I work very closely, in relation to his comments on Section 524C, the issue of time limit and notification, as well as the section on 525, the issues of complaints.

I'd like to cover briefly each of those topics and then talk with you a bit about our program and about the study that we did in the past week or so. In reference to 524C, my impression of the legislation is that it wishes to resolve patient problems, not mollify patients. If the response to a patient is within an arbitrary time limit specified to the type of complaint, it wastes time when it's in no more than 72 hours to arrive at resolution. My point is you could spend a great deal of time running around getting back to the patient within your predesigned arbitrary limits where if you invested the time in resolving the issue to the best of your ability and the best of the facility's ability there would in my opinion be less frustration to the patient or to the family. It's also my opinion that there are two particular issues that would be very difficult to resolve within 22 hours, that would be the issue of medical record release and of the billing issues. I think this section of the State Department of Health rules creates a very artificial division in relation to human beings who present very complex problems, also which may be multiple in nature. I think the time limits force response, not resolution with very

minimal consideration of the human beings who are presenting their concerns. I think the more formal and more bureaucratic this grievance mechanism becomes, the less effective it will be in responding to patients on a human level and also helping them in their time of need. Further, I think that all the issues as presented to our department have ended up within these rules prioritizing the patient issue or the type of patient, which I believe is prejudicial to patients who have been discharged. Often we find that our patients reserve their discomforts with the facility until post discharge when they are less susceptible to what they perceive to be very real fears and anxieties. If we unilaterally deal with inpatient issues only or first, we prejudice significantly the outpatients in our facility, as well as the patients who have been discharged. I don't feel that that's appropriate, nor do I feel that that's consistent with the intent of the legislation.

Our facility runs a program that responds to all issues presented to us as very relevant to the patient and, therefore, a valid issue. Whether the facts that exist within the circumstance are real facts or whether it is in fact a real problem is not relevant to the way we deal with the person who's presenting the complaint. So, I have great difficulty with the separation and the dichotomy that's created within the rules.

My response to the complaints section listing 525 in the State Department of Health rules is essentially the same as Mr. Diehl's was. I feel if all are to be listed it would seem appropriate that they reflect consistently with the listing in the bill of rights. In my review of the complaints as listed in the rules, I find that three of the rights, in my interpretation and I've been in the grievance business since 1969, I feel this list skips .6, .12 and .20 of the bill of rights as listed in that legislation. I think some of the issues in the State Department of Health list complaint 525 are cited in more than one of the points within the bill. If the legislature at some future point in time is interested in measuring the effectiveness of the patient's bill of rights legislation, it would seem appropriate for this list to be consistent with the legislation for better facilitation if measuring that law.

I have had some frustration with that bill within the three years of working with it, not only because it's ambiguous in my opinion, but also because it's very difficult to measure and to determine what it is that we are dealing with. Often patients present issues which they do not perceive to be issues covered within the bill of rights. It takes interpretation of the grievance mechanism to apply them to the appropriate rights point. I think it would be very beneficial if we are going to do the documentation within

this grievance mechanism as listed within the rules that we also be able to apply that documentation to the bill of rights to better understand how we are standing within compliance to that law.

In terms of my formal presentation, I believe that's all I have to say except to share with you some of my overwhelming frustrations in attempting to deal with the rules as they exist now. Our department was designed in 1967. I came on staff in 1969. It is one of the more matured programs I believe on a national basis and I think it's relatively credible as a professional program. We have a staff of myself, a full time assistant and a full time secretary. We also heavily utilize 15 highly trained volunteer patient representatives as extensions of our department. The purpose of this is to expand our contacts to the degree that it's feasible in our best effort to resolve and to respond to all issues that patients may choose to share with us and with the facility. On a corrective basis it allows us an opportunity to respond very spontaneously to the very immediate issues of patients. It also allows us to look at preventive problem solving in areas where we perceive a number of issues to reoccur within a short span of time.

In this last week at the University my staff, including the volunteer patient representatives, listed each issue presented to them, the name of the patient, the time,

the resolution, the number of contacts with the patient that existed, the number of contacts that were required to resolve the issue to our satisfaction, potentially as well to the satisfaction of the patient. I then attempted to estimate the time that it would take to notify, to resolve the problem, to take written resolution of that problem to the patient and to maintain files on each patient. We also took information relevant to whether the patient had been a previous patient who had presented an issue to our department and whether it was a patient who had multiple problems when they presented to us.

It's very difficult within a week's span of time to determine whether the problem is in fact resolved. If the issue is that of insensitive care from nursing personnel to the patient, we can respond to the best ability within the circumstance, but it's difficult to arrive at the end of the line and say resolved, yes.

To the degree that it was feasible, we did so. I'll run down some of my statistical information for your benefit. Within the week there were a total of 106 issues presented to our department by 84 patients or their representatives. I expanded that and found that by multiplying within a 52-week period of time we would have close to 6,000 issues or an average of 21 issues a day to be dealt with. Of the 106 issues, 39 were valid under the State Department of Healt

Health's inpatient criteria as well as the classification criteria, while 38 were not valid because they were not covered under the list of complaints. I might add again --

MR. KLINE: Excuse me, may I ask about that 39 and 38 division. Are you referring to the list contained in 525 or some other --

MRS. COUNTRYMAN: Yes, the list contained in 525 as well as the fact that we have to deal with inpatients first.

MR. KLINE: Okay.

MRS. COUNTRYMAN: Okay? Also out of the 106 issues, 20 of the issues would have been valid criteria under 525, that were not valid because they were outpatient issues. So, of the 106 --

MR. McINERNEY: Excuse me, I'm not sure how you're using the term valid.

MRS. COUNTRYMAN: I don't mean to be judgmental.

MR. McINERNEY: You mean classifiable, is that what you're saying?

MRS. COUNTRYMAN: Yes. Thank you.

MR. McINERNEY: You were able to classify them under the proposed scheme?

MRS. COUNTRYMAN: Yeah. Of the 106, 20 of them were issues that were covered by the classification, the 21 classifications.

MR. McINERNEY: So that 86 did not fit under any of the criteria that are proposed in that rule, they related to extraneous, things that were outside of what is described?

MRS. COUNTRYMAN: Let me clarify for you. Of the 106, 39 issues would have been covered under the State Department of Health rules as inpatients whose issues were listed within the rules. Sixty-seven would not have been covered under the rules.

MR. McINERNEY: Sixty-seven people?

MRS. COUNTRYMAN: Issues.

MR. McINERNEY: Issues. For example, these are just very broad and I'm trying to get a feel for the areas that you didn't touch on.

MRS. COUNTRYMAN: I'm trying to be very specific and I also would comment that part of what I think our difficulty here is is that we deal with each issue as if it was a very valid and relevant complaint. It may be confusion in terms of information. It may be I'm blocking.

MR. McINERNEY: Perhaps you could provide the hearing examiner and us with a copy of that?

MRS. COUNTRYMAN: I'd be more than happy to summarize it for you. In terms of the issue of patients who have multiple complaints, of the 84 patients that presented our initial number, 17 patients were responsible for multiple issues, which equaled 39 issues. So, 67 patients registered

individual complaints. In terms of context from the 106 issues presented to the department, the end outcome was that we generated 312 contacts to resolve and to communicate back to the patient. Under the State Department of Health rules with the classifications as they previously existed and in dealing with inpatients only, 114 of those 312 contacts would have been relevant to the documentation process and to the prioritization process under the State Department of Health rules.

We looked at when the problems or issues were most resolvable and found that 95 of the 106 issues were most resolvable within business hours, so I was pleased to see that change. One of the things that I had some great concern about is that of the 106 issues 63 were referred to us or collected by the volunteer patient representatives and if in fact volume is a difficulty, which I perceive it to be, the most functional thing that we could do to have an effective grievance mechanism consistent with the State Department of Health rules would be to delete the use of our volunteers in order to decrease the volume so that we could handle our own volume in a qualitative manner. That program which has been in existence since November of 1971 I feel is the most humane personal contact our patients experience on an ongoing basis and I think it would be very destructive to cut it.

I think in terms of statistics that may be all

that's appropriate or relevant at this point in time. I'd be more than happy to answer any questions.

MR. BREVIU: One point, you indicated that you also have problems with the time limits that are set out in the one rule. Do you have some specific wording that you would propose as an alternative to that?

MRS. COUNTRYMAN: I would suggest that, as Mr. Diehl had, I concur completely, if it were listed or proposed that all problems would be responded to or resolved -- responded to within no more than 72 hours, this would allow you an opportunity to deal with the patient as a coordinated unit. I think one of the things that patients are very frustrated with in terms of the medical care that they receive is this specialization which exists. Everybody deals with a small section or appendage of the patient and doesn't put the package together. I don't believe it enhances the problem solving function to separate the patient's issues in a similar manner and deal with some in 24 hours and some in 72 hours and some in 30 days, because I think again that specializes and divides a person who is presenting their problem to the unit for them as a person, whether it's one issue or ten issues.

I would agree that it's very difficult to respond to the billing issues and the release of medical information issues within a period of 72 hours, so those may be more

appropriate as an exception with a 30-day clause, but I -- often if you have a patient even with some of the critical care issues which Mr. McInerney addressed in his presentation, let's assume that a patient approaches our department with a single issue of complete and current information regarding a diagnosis, treatment and prognosis. Often it's impossible to respond to that with resolution within a period of even 72 hours, because there's tests and procedures that have to be done. The time limits to date have not taken into consideration the fact that often weekends occur, on a weekly basis as a matter of fact.

MR. McINERNEY: Sometimes twice a week.

MRS. COUNTRYMAN: Yes, it would be nice if it were more regular, but if we get a complaint of that nature on a Friday, for example, I find that it's much better to deal with problem solving resources which I know to be very responsive not only to patients, but to our function, our problem solving function. I think on a national basis people who work in this type of field have a great deal of difficulty because other services or departments within a hospital are slightly threatened by grievance mechanism. Nursing, for example, may perceive us to be taking over their primary contact with the patient as a total package. Physicians are often unresponsive until they find that you are either credible or you have the authority by the administrative system

to be working within those particular areas. People within our own system have asked me how is it that you respond to a problem that's generated against a physician, for example. That's very difficult to address, because I don't have a checklist when I resolve patient problems. I look first at the area in which the patient is having the problem. If that is a station that has a particularly responsive head nurse or charge nurse, I would approach her. If I know the resident to be a responsive person, I would maybe approach the resident If I know that that particular physician or nurse is not as approachable as I might wish, my option would be to find a more reasonable alternative for the benefit of the resolution of the immediate issue for the patient. If I find that there is no resolution within the confines of the patient's geographic circumstance or service circumstance, my approach would be to find the chief of service responsible for the physician who's delivering the care or if that did not occur or did not work to the benefit of the resolution, I would approach the chief of staff of the hospital who could go back down through his system. My point is that if I have the limitation of dealing with only the individual who is available within the patient care area, I may not only create a further burden and further problem for the patient, but I may decrease my potential as being a functional individual within that unit That does not benefit either the grievance mechanism or the

patient. If anything, it has the potential of making the patient, who's concerned to begin with, more vulnerable within their patient care area.

I would like to just briefly share a personal experience. Having worked in hospitals for a period of four years, I was hospitalized in 1973 as a patient and it was shortly after the patient's bill of rights had been passed as legislation and I had been working with patients' rights for a year previous to that and I went in thinking, "Wow, I am really an informed patient and, boy, nobody's going to overlook my rights and I'm going to know what's going on and I'm going to ask all the questions that I get frustrated with patients for not asking." It took me about three hours in the bed before I was being very quiet, I was being a good patient. I didn't want to ask for medications too fast. I didn't want to bother the physician, because he was a very busy person. I found that I was reduced very rapidly to feeling dependent and vulnerable. One of the things that our program attempts to do is encourage the patient to do their own thing for themselves to the degree that that is feasible, to take a stand for themselves and to educate themselves within the communication of physicians and nursing personnel. To the degree that they request our support in doing so, that is our role to facilitate the patient in acting in his own behalf as his own patient representative. When they are not

capable of doing that, we intervene until they are capable of doing that. I think that it's difficult for us sitting here to perceive how vulnerable and how threatened patients may feel in attempting to use the bill of rights or the grievance mechanism.

MR. McINERNEY: I have one question. You seem to be saying, and correct me if I'm wrong, the criteria in this 525 failed to really address the situations in which a hospital is functioning as a primary care kind of deliver in terms of outpatient and emergency room care, is that what you were saying?

MRS. COUNTRYMAN: In part. In part.

MR. McINERNEY: How so and how can they better address the problems of outpatients and people who use the emergency room, for example, as their primary care treatment?

MRS. COUNTRYMAN: I'm not sure how you could address emergency room. I would perceive that to be a very valid criteria, although it's not covered within this legislation, nor is outpatients. I recognize that we are functioning in a facility that is slightly different than the average hospital in the State of Minnesota, because many do not have outpatient or ambulatory care systems. I think that the point that I was attempting to make, Mr. McInerney, was that there are particular issues that become prioritized because of the classification. I'm not suggesting that the classifications

should be expanded to cover all of the issues, because many of them are informational, many of them were confusion, many of them were easily resolved with communication about the way our system functions. I'm not sure that any legislation can effectively write a checklist of what it is that patients may run into in terms of problems. It would seem to me that the majority of these address the kinds of things that the legislation is attempting to address and that is a decrease of malpractice, which as Mr. Diehl stated, has not yet been proven.

MR. McINERNEY: Thank you.

MR. BREVIU: What do you feel the affect of your program has been?

MRS. COUNTRYMAN: I think initially it was very slow. In the first year I could have been basket weaving as well as anything else except I spent a great deal of time trying to build up the relationships and rapport. I think once that's established, sometimes our best patient representatives are the staff who are delivering the care who are having frustrations with the system or who are finding that it's very difficult to relate with a particular patient in a particular circumstance. We deleted the volunteer patient representative program over a year ago for a period of four months, because I did not have an assistant and I could not handle the volume that had been generated. The response from the physicians

and the nursing staff as well as the patients who had learned to expect that the volunteer patient representatives would be there was very negative. That response helped re-initiate that program. To respond simplistically, I think our program has nothing but positive support within the system as well as from patients and relatives. Often I think people need someone who is not bureaucratic, who is not rushing around from one point to another to sit down and talk to them on a one to one level. I think that the trend on a national basis in terms of these programs growing is slightly frightening, but really beautiful to observe within its growth and development. I think three or four years ago there were many token programs that were purely on a stroking mollifying basis and as this profession matures and as hospitals recognize it and also as legislation, positive legislation is implemented within states, I think there will be a greater trend and greater growth and much greater knowledge and satisfaction on the part of patients who are experiencing our health care delivery system.

MR. BREVIU: Do you feel the program at University Hospital in any way has reduced or kept the incidents of malpractice claims from climbing?

MRS. COUNTRYMAN: I think that factually that would be very difficult to assess, because we were covered under governmental immunity until the 1st of August. I think,

however, in terms of patients satisfaction with the care delivered or understanding of the care delivered, it's definitely increased the satisfaction, which would be my impression would decrease the claims or suits generated out of frustration and anger and misunderstanding. I don't believe it can or should address suits, valid suits generated for valid reasons.

MR. BREVIU: Would you feel that the patients' satisfaction is a result of the existence of the program rather than your ability to attempt to look into certain specific areas of patient complaints? It seems to me you've described a program which increases staff satisfaction in ability to deal with certain frustrations and which has increased patient satisfaction with the staff as a result. Is it this general, the type of atmosphere that has been created that has what you -- that has resulted in decrease in-- has resulted in some patients not bringing malpractice claims when they might otherwise have?

MRS. COUNTRYMAN: I think that's an assumption that could be made, most definitely. I think that's probably one of the reasons that hospitals are looking to funding these types of programs, that people who are satisfied are less inclined to sue or more inclined to evaluate the appropriateness of suit. I think one thing that this legislation or the rules does not address and shouldn't address that I would

like to comment on is that when you have a functioning grievance mechanism within a facility that is responsive and supportive to staff as well as patients, the long range benefits are very great, because you multiply your ability to deal with problems within the facility. You don't just add. Our staff is very much more attuned in to patient dissatisfaction and response to that than it was four or five years ago when they were unfamiliar with a department within the facility that is particularly set aside to prioritize concerns of patients. I'm sure that there are other people in this room who also have programs of this nature or very similar to it who may be interested in addressing this in the future.

MR. KLINE: Any other questions?

MR. BREVIU: No.

MRS. COUNTRYMAN: Thank you.

MR. KLINE: Thank you very much. At this point I would like to take a 15 minute break. I would point out there is a cafeteria on the third floor, is that correct, Mr. Breviu?

MR. BREVIU: Yes.

MR. KLINE: Which is available for coffee, etcetera.

(Recess)

MR. KLINE: Mr. Gordon Sprenger.

MR. SPRENGER: I'm Gordon Sprenger, president of

Abbott Northwestern Hospital in Minneapolis representing the Minnesota Hospital Association testimony today.

MR. KLINE: Could you please spell your last name?

MR. SPRENGER: S-p-r-e-n-g-e-r. Mr. Kline, I have written comments which I could present to you at this time to put as a matter of record and then what I will do, as you indicated earlier, many of these rules interrelate one with another and so if you make a change in one place it necessitates a change in another place and some of them are minor kinds of changes, but it is included in our written testimony and I won't try to review all of those in my verbal presentation. I'll just hit the highlights.

MR. KLINE: All right. I think that's fine. I'm going to mark this for reference in the future as Public Exhibit 1 and it's the Minnesota Hospital Association testimony.

MR. SPRENGER: First of all, I would like to state that the Minnesota Hospital Association by making our comments today in no way want to be inferred that we do not strongly support the legislation which has been passed regarding the patient rights mechanism. Recently we did a poll of our hospitals and we know right now at least 40 hospitals within our state currently have mechanisms that have been developed over the years to deal with patients' complaints, formal kinds of mechanisms and our concern today is the fact that we believe that some of the proposed

regulations as we interpret them go beyond establishing the minimum standards and procedures as outlined within the law and that's the basis of which we'll be making our comments today.

We have several major concerns and I'll just articulate them and then if it's agreeable, I'll go to the specific rule and regulation and comment about that. You've heard today the concern about the time constraints, the 24, the 72, the 30 day and that's one that we have great concern about in being able to manage it within our institutions as we feel that those restraints are inappropriate. The complaint record that's referred to in the rules and regulations, we're concerned that the latitude be left to the individual institution to keep those records as they see fit. I think the legislation as we see it refers to the process, refers to the records or the information that they would like to receive from the individual hospital, but we do believe that each individual hospital ought to be able to determine their own process as to how to keep those records in order to meet that requirement of reporting back to the State Board of Health.

You heard a little bit earlier, we are very concerned about prioritizing the bill of rights. We think that by breaking it down into the 24, the 72, the 30-day limitation you are prioritizing them and we really feel that that's

going beyond the extent of the legislation.

The other major area we're concerned about and has not been talked about this morning is the fines schedule. We really believe that the intent of the legislation again is to establish a process. It is not to be punitive as such and we believe that to immediately impose a fine upon finding an error in handling a patient's complaint or the mechanism of handling a complaint is inappropriate and that there ought to be an appropriate time in which policies can be changed or procedures can be changed within an institution in order to correct that action. I know that the comment was made that patient complaints are different and that you cannot go back and undo what's been done. That's true, but the fines aren't going to do that either and we do believe that there ought to be an appropriate period of time in which we can change our procedures or policies before fines are automatically imposed upon us.

Many of the changes which we have seen this morning which the Department of Health have recommended, some of the modifications from the original document, Mr. Kline, we find that have cleared up some of our concerns, but I'd like to then dwell on these specific ones that we're concerned about.

The first one I'd like to address myself to has to do with the item of the 24 hours, the 72 hours and the

30 days, the time constraints. We feel that our concern is that as soon as we get a complaint within an institution that we should immediately respond and I noticed in the modifications today 524D talks in terms of a response should be required immediately upon receiving a complaint. The legislation does not deal with resolution. It deals with response. Then we feel that this could be much more simplified by taking the position that it be a reasonable time period not to exceed 72 hours, eliminate the 24, eliminate the 30 days. Again when resolution isn't required, we really feel that we ought to be able to respond and hopefully resolve most of the issues within a 72 hour period. The hospitals don't want to just respond. That's what I think you heard from Mrs. Countryman this morning, our great concern so we don't get tied up in some bureaucracy that puts really the intent of the legislation at risk where in order to fulfill some bureaucratic system we give really inappropriate responses back to patients, you know, to get a complaint and say, well, we have to tell you that we're going to respond, we're going to respond but it's going to be such and such a time before we really can resolve it for you is just an inappropriate way we feel to deal with patients. The intent of the legislation I don't think would in any way be violated by going to a general category of saying, you know, patient complaints ought to be resolved within a reasonable time and we're suggesting

the 72 hours as being a reasonable time. It would eliminate the whole need to have someone immediately upon receiving the complaint to say, "Let's see, does it fall into complaint A, B, C, D, F, G, T or I?" That kind of process we just feel is inappropriate to have to do and we don't think that there would be anything lost in that process.

We have noted on the written responses the changes which have been suggested this morning by Mr. McInerney and we certainly agree with that. That the many complaints just in my own hospital here this week, as Mrs. Countryman mentioned at the University Hospital, we tried to look at a four-day period and what kind of complaints we're talking about, you know, on a week like this 40 complaints we had in a four-day period dealt with temperature of the room. You can imagine why with setting thermostats down and the cold weather we've had, but we can immediately give a response, we can talk to the person that filters our clog, we can get them corrected, but you shouldn't have to give a formal written kind of response in order to get that kind of complaint taken care of and so we certainly agree that if the patient requires a written response, that is appropriate. So, we're pleased to see that has been and support that modification in the regulations.

The notice of the time limit, again we're pleased to see that four hour having been dropped and we really feel

that this takes care of that whole time limit constraint where you say that the authorized individual to whom the complaint is made shall upon receipt of the complaint inform the complainant of the applicable time limit. So, we are responding immediately upon getting the complaint. So, in our minds we're really talking about we hope within 72 hours not only to respond, but also to resolve the complaint in that period of time.

I'd like to comment on the section dealing with complaint records and that specifically we are concerned, as I mentioned in my opening statements, about the fact that our facility should maintain records of an operation of our grievance mechanism sufficient to report to the State Board of Health as required in the statutory requirements and that we're pleased to see that now a time limit has been put in there of one year in order to maintain those records, but we strongly urge your concurrence with the modification that Mr. McInerney has put forward this morning that the records are really left to the discretion of the individual institution and they're not mandated by some regulations as to specifically how you should keep those records within the individual institutions.

Another one of our concerns has to do with regulation 525 as it deals with patient complaints.

MR. KLINE: Excuse me, I'm sorry to bother you,

interrupt you, but could you go back to the complaint records section you were just talking about, that's 524 what has now been marked as E?

MR. SPRENGER: It's G on mine.

MR. McINERNEY: Formerly G.

MR. KLINE: Okay. Are you saying that you are satisfied with what has been proposed as 524E or not?

MR. SPRENGER: Yes, I'm supporting what Mr. McInerney has recommended.

MR. KLINE: Okay. Thank you.

MR. SPRENGER: On 525 here is a wording change that would be necessary. We're very much concerned about the listing of the patient bill of rights. As Mr. Diehl commented earlier this morning, we just feel that if we're going to refer to the patient bill of rights, then it ought to be verbatim. It's very clear in the patient bill of rights that some of them were geared to the nursing home. Nursing homes are not covered by the legislation and thus we feel it's inappropriate that those patient rights now suddenly be applied to this legislation. We would suggest and as indicated in our written comments to you, that we refer to the patient bill of rights, that there's really no necessity to restate all of them again in these rules, but we can refer to the specific Minnesota statute that lists the patient bill of rights, then there's no confusion in the wording of them.

The one thing we would have to add to that would be the word billing. As has been indicated earlier today, there is no right that particularly pertains to billing and so you'll notice in our written comments that we suggest that it be reworded to state complaints relating to at least billing and the rights described in the patient bill of rights Minnesota Statute 144651, shall be subject to being processed through a grievance mechanism rather than repeating all of them all over again.

Under Section 526 on the reports, again that would necessitate a change in 526E where we specifically would refer to the Minnesota statute bill of rights rather than back to a previous regulation within the draft of the regulations.

We've also recommended under 526H that the total number of complaints resolved to the patients' apparent satisfaction. We have been very concerned that we do not have to go back and do polls of patients to absolutely determine whether or not they've been satisfied with a specific complaint, but to the apparent satisfaction of the patient.

The next major area of concern that we have has to do with the schedule of fines. Again, reiterating, in our minds fines do not correct past actions and we believe that again the intent of the legislation is a process, is to insure that there's openness between the institution and the patients so that problems can be resolved. There may be

very innocent things that are overlooked and given a mechanism and to immediately impose a fine on the institution without giving some reasonable period in which to correct those deficiencies we feel is inappropriate. We have taken under 527, the schedule of fines, and in our rewording we have suggested that parts A and B be consolidated in order to eliminate that immediate assessment of the fines. I think that rather, again, than me re-reading all of this to you, Mr. Kline, it's included in our written testimony and we have not changed the intent of when there would be violations, but it's been when the fines would be imposed. We have no argument with the violations as such, but it's when the fines would be imposed on the specific institutions. Then under part B of that same rule and reg under the time period for correction, obviously some changes would need to be made there in order to follow through with the consistency of this and we would suggest that it be re-worded to state, "In no case may the allowable period for correction of any violation of Rule 527 be less than 20 days nor more than 60 days." We feel this is very important, that if a facility's compliance with Rule 527 is adequate in the opinion of the inspector -- is inadequate, excuse me, in the opinion of the inspector, it may be necessary for new notices to be printed, for instance, if the annual report that had been submitted was inappropriate, to create, rewrite a new annual report or to

create a new filing system, if for some reason the records weren't available as they want this, we feel there has to be a minimum so that an inspector cannot just come in and say in two days you have to be able to correct a deficiency and we feel that less than 20 days nor more than 60 days would be a reasonable solution to that problem.

MR. KLINE: Do you see that as a possible problem where, for example, the compilation of new annual report or the printing of a new notice, an inspector might come back two days, three days, what I think reasonable people might say was an unreasonably short period of time and ask where is it? Do you think that's a potential problem?

MR. SPRENGER: I guess what we're trying, obviously, is to protect ourselves against a potential problem. I can't say that that specifically is going to happen. Our feeling is that 20 days is a fairly short period of time in order to correct a deficiency and we just feel that that would add that added protection that that could not occur in less than the 20 days.

Then under Subsection D regarding to the hearings, again this is an addition where we suggest that we insert that all hearings provided for in the Rule 527 will be conducted in accordance with Minnesota Statutes 150411. This section really was added to inform persons where the rules of administrative contested cases can be found. That's a clarificatio

for our members to know how those contested cases will be handled, but in summary those are our main concerns. We have been very pleased with many of the changes that have been suggested this morning and just to recap them again, it's the rigid time constraints that we feel are inappropriate, the 24, 72, 30 days. We really sincerely believe that we can do a much better job by simplifying that mechanism, by including a statement that says not to exceed 72 hours and that we will be able to then hopefully resolve the problem within that time period rather than to just respond to the patient. Also, the fact of the multiplicity of problems that patients have and to have to go through and categorize their different problems and say that they fall into different categories we feel is just unworkable and if you can allow us to keep our records as we want to keep them so when we submit our reports, as long as it meets your requirement, let us keep the records the way we want to and refer to the patient bill of rights as they are written and not trying to paraphrase them or interpret them as has been talked about this morning. Don't be punitive to us. We intend to do the best we can in trying to respond to patients' complaints. I think the hospitals are most anxious to work with the system, but give us a chance. If we violate something, don't impose a fine on day one. Give us a reasonable time in which to correct that deficiency. Those are our

major concerns.

MR. KLINE: Thank you very much. Have you got anything you wanted to ask about?

MR. McINERNEY: Mr. Sprenger, would you object to the time limit, the lower time limit of 20 days being eliminated with reference to say a failure to post notice, which is one of the violations which is subject to a correction order? Certainly it wouldn't take 20 days to do that. Your problem, I think as I identify it, is principally related to in that area the annual report?

MR. SPRENGER: That's one of them which would take some time in which to correct. You know, if for some reason we aren't keeping a filing system that can give you the information that you want, that we would need to correct that, we could not do that in a couple days period.

MR. McINERNEY: Failure to have a mechanism at all, that would be perceived from our standpoint as being immediately necessary to correct.

MR. SPRENGER: I would not have a problem with that.

MR. McINERNEY: So that if that limit were imposed with reference to the annual report and the criteria for the content of the annual report, would that be more reasonable for you?

MR. SPRENGER: I guess I'd rather go at it from

the other point of view in saying, you know, if there are one or two specific items that you feel are such gross negligence that they should have an immediate fine such as failure to post a notice or not having a mechanism at all, I think that would be reasonable, but I wouldn't try to develop a shopping list again to try and categorize all the different kinds of potential fines that might be imposed.

MR. McINERNEY: Okay. Thank you.

MR. KLINE: Thank you very much.

Doug Shaw. I'm not sure I'm pronouncing it correctly, from Physicians Health. All right. Tom Galligan.

MR. GALLIGAN: My name is Tom Galligan. I'm the director of planning for the Minnesota Medical Association.

MR. KLINE: Could you please spell your last name?

MR. GALLIGAN: Sure. G-a-l-l-i-g-a-n and we will be submitting a formal written response. Our response will deal mainly simply with supporting the proposed amendments of the Minnesota Hospital Association, particularly Section 524C in time frames, 525 with the patient complaints and 527B3 with fines. We support the intent of the legislation and in reviewing the proposed criteria and in discussing it with the hospital association, we support their amendments after those discussions and that's basically what our report is.

MR. KLINE: Thank you very much. Have you got anything you want to ask?

MR. McINERNEY: No.

MR. BREVIU: No.

MR. KLINE: Is there anybody else who would like to make any statement at all? Yes, sir.

MR. McCORMICK: My name is Dan McCormick. I represent Mount Sinai Hospital, assistant director of the hospital.

MR. KLINE: Could you please spell your last name?

MR. McCORMICK: M-c-C-o-r-m-i-c-k. We too support the intent of the legislation. We are having a bit of a difficulty with the method by which the Health Board is proposing to achieve the desired results. Our concerns are really two-fold, both general and specific. If the specific concerns that were addressed by Mr. Sprenger and Mrs. Countryman are adopted by the Board of Health, I think they will serve to satisfy our general concerns as well. I think in order to provide a little focus it might be helpful to tell you a little bit about the program that we have at Mount Sinai Hospital and how it would be impacted by the regulations as they are presently being proposed.

About a year ago a group of people in the hospital got together for the express purpose of trying to address different ways in which we could improve the quality of

service to our patients, not only the medical and nursing quality, but also those non-medical aspects of care that somehow these days tend to get lost a little more easily than they were in previous years. I think we all know that with the cost control measures that are taken by hospitals, the productivity reporting system, those measures that are taken to increase the resource efficiency of the institution, one of the undesirable results which occurs because of this is I think we over time develop a less humanistic kind of environment in the hospital setting. This particular program was meant to address that deficiency as we see it with, I guess, a two-fold objective. One was to re-humanize the hospital environment and two was to I guess develop a sense or an attitude on the part of each member of the hospital staff regardless of the discipline that they would in a sense function as the patient's representative. That second goal is a very long term goal and it will require a lot of indoctrination, a lot of training and a lot of exposure to the processes which we've already implemented. We do things such as we visit each patient upon admission. For the longer term patients we re-visit those patients. We describe in a summary fashion what kind of system we have at the hospital for resolution of complaints. We aggressively seek out comments from our patients regarding what their perception of their hospitalization is at that point in time and the

regulations, although I can support the intent of the regulations, paradoxically the more effective we try to be under the proposed regulations, and I think Mrs. Countryman stated this quite well, the more effective we try to be in aggresively seeking out concerns that our patients have, the more time we will have to spend administratively in documenting these concerns, the more money it will cost in terms of staff and ultimately our program will become less effective or ultimately our program will probably become impotent and unable really to be responsive to the patient. So, I think the proposed regulations, while the intent is noteworthy, I think philosophically they're in opposition to the objectives that we have set forth for our program and I think they would have a totally undesirable affect on the program as we see it in our hospital today.

MR. KLINE: If I may ask a question, of course, even with your existing program the more aggressively that you seek out complaints, the more complaint solving you're going to have to do, isn't that correct?

MR. McCORMICK: That's correct.

MR. KLINE: So what you're saying is that the bureaucratic mechanisms, if I can call them that, which these proposed rules would impose on you would force you to probably not seek out those complaints as aggressively?

MR. McCORMICK: That could be one conclusion. The

second one is, though, I think our organism or our program would change. Right now we're able to effectively carry out our program using a patient representative coordinator who is staff to the hospital and a cadre of volunteers who we utilize we feel most effectively in terms of visiting patients and doing a preliminary evaluation of those complaints, which ultimately are referred to the staff person responsible for patient complaints in the institution. I don't believe that we can insure that kind of accountability for responsiveness to patient complaints as well through a volunteer program. I think we have to have -- under the proposed regulations, if adopted, I think it would limit our ability to utilize volunteers in this program and by doing so it would certainly increase the cost and that cost would be passed on to the patient.

MR. McINERNEY: Mr. McCormick, how specifically would you recommend that the proposed rules be altered in order to attain the goals that are intended by the legislation and by everyone here?

MR. McCORMICK: Our position is that we could support the position taken by the Minnesota Hospital Association as delineated in their text.

MR. McINERNEY: In terms of specifics, beyond what they described, you have nothing more to add?

MR. McCORMICK: No.

MR. McINERNEY: Okay. Thank you.

MR. KLINE: Is there anything more?

MR. BREVIU: No.

MR. KLINE: Thank you very much. Is there anybody else who would like to testify? Yes, sir.

MR. BROWN: Joe Brown from the Gillette Hospital. I'd like to just support the Minnesota Hospital Association's amendments, number one; and number two, ask that at least some consideration be given by the Department of Health and those who would be in charge of these regulations and rules that they might consider a -- instead of a legislative approach, although that they might go ahead and have the rules and regulations, turn it over to the Minnesota Hospital Association to run it on a voluntary system such as being considered by the rules and regulations as set forth by the Rave Review Board. I think when you set up a legislative program you lose the kind of relationship with a patient or anyone you're dealing with that is supportive to a good relationship, one that can work in the best interest of both parties and certainly would assist the institutions in I think giving the kind of support to the program that you're wanting and that we want. I think a lot of hospitals have already had these programs and certainly have attempted to do an excellent job of it as indicated by the University Program, the Mount Sinai and I personally have had a program on a voluntary

system in another state that I feel did a much better job under the voluntary system than it ever could have done under some legislative program where you have problems of coordination and cooperation in meeting some of the rules and regulations by rule rather than by some kind of an interested effort in a voluntary program and I think the voluntary program would bring that to you, bring what you want to your program and also provide the institutions with a better mechanism for accomplishing their ends.

MR. KLINE: Do you have a program in effect right now at Gillette?

MR. BROWN: Yes.

MR. KLINE: And does that use volunteers or is it done by your --

MR. BROWN: Presently we do not use volunteers. I think that's an excellent approach. The program that was set forth in the other state was, the intent was to use volunteers and I think through the volunteers you often get a great deal of information that you would not otherwise get, because sometimes they fear the hospital system and they're more willing to talk to somebody outside the system than someone in the system. I think this is an excellent concept that's been promoted by Mount Sinai and I believe the University program.

MR. BREVIU: I think the record should reflect

that I would have some concerns with turning the program -- with the Board of Health turning the program over to the Minnesota Hospital Association. I believe that would likely constitute an unlawful delegation of authority by an administrative agency to a private organization.

You made reference to the Hospital Rave Review rules. I think the difference there is that the statutory authority permitting the Board of Health to implement those rules created an alternative system involving a voluntary organization. The statutory authority relative to these grievance mechanism rules vests the authority to implement them in the Board of Health. I simply don't believe that an administrative agency can abandon that authority and turn it over to a voluntary organization such as the Hospital Association.

MR. BROWN: Of course, our interest is in the best system and if in fact that might present you the best system, we thought you might have some interest in it. That's the basis on which it's being proposed. Thank you.

MR. KLEIN: Anything more?

MR. BREVIU: No.

MR. KLEIN: Thank you. Mr. Sprenger, you don't have to come up again, but I just wanted to clear up one thing. You had stated earlier that approximately 40 of your members had current formal grievance mechanisms. How many

total members do you have?

MR. SPRENGER: 184.

MR. KLINE: 184. Okay. And that's not comparing apples and oranges, is it, the 40 is in the same classification as the 184 is?

MR. SPRENGER: That's correct.

MR. KLINE: Thank you very much. Is there anybody else who would like to testify or present any information? Is there anybody else who would like to testify?

As I stated at the beginning of this hearing, the record will remain open for 20 days. You have in the agenda and guidelines an address where you can send comments, criticisms, suggestions, alternatives and you are welcome to do so. Thank you very much.

* * *

STATE OF MINNESOTA)
)ss
COUNTY OF HENNEPIN)

REPORTER'S CERTIFICATE

I do hereby certify that the foregoing is a true and correct transcript of the proceedings as taken at the time and place indicated.

Patricia McLean, Court Reporter

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE MINNESOTA STATE BOARD OF HEALTH

In the Matter of the Proposed Adoption of Rules of the Minnesota State Board of Health Relating to the Operation of Health Facilities Grievance Mechanisms

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing before Allan W. Klein, duly appointed Hearing Examiner, on January 18, 1977, in the Board Room of the Minnesota Department of Health Building, Minneapolis, Minnesota.

This was a rules hearing pursuant to Minn. Stat. Chapter 15, to determine whether proposed rules should be adopted.

Daniel J. McInerney, Jr., Consultant, and John A. Breviu, Special Assistant Attorney General, appeared on behalf of the Minnesota State Board of Health. Fifty-one persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard.

Pursuant to Minn. Stat. § 15.0412, subd. 4 (1975 Supp.), this Report shall be available for review to all affected individuals upon request for at least ten days.

The Board shall, if it proposed to adopt the rules as originally proposed or amended, submit the complete hearing record to the Chief Hearing Examiner no earlier than ten days subsequent to the receipt of this Report. The Board shall include the rules as originally proposed and the rules as proposed for adoption in final form. The Chief Hearing Examiner shall complete his review and submit his report to the Board on the issues of substantial changes in the rule and compliance with Minn. Stat. § 15.0412 within ten calendar days. Thereafter, the Board shall be responsible for filing the rules with the Attorney General.

Based upon the proceedings herein, the Examiner makes the following:

FINDINGS OF FACT

Procedural Requirements

1. That on October 14, 1976, the Board adopted a resolution authorizing the hearing in this matter. On November 8, a Notice of Intent to Solicit Outside Opinion was published at 1 State Register 741.

2. That on November 22, 1976, the Board filed the following documents with the Chief Hearing Examiner:

(a) a copy of the proposed rules;
(b) a proposed Order for Hearing;
(c) a proposed Notice of Hearing; and
(d) a copy of its October 14 resolution.

3. That on November 30, 1976, the Board mailed a copy of the Notice of Hearing to all persons and associates who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. That on December 7, 1976, a Notice of Hearing and a copy of the proposed rules were published at 1 State Register 890.

5. That by December 23, 1976, the Board had filed with the Office of Hearing Examiners the following documents:

(a) The Order for Hearing;
(b) The Notice of Hearing as mailed;
(c) The Affidavit of Receipt of the Secretary of State's list;
(d) The Secretary of State's Certificate and list;
(e) The Affidavit of Mailing;
(f) The Statement of Need;
(g) The Statement of Evidence;
(h) A copy of the Notice to Solicit Outside Opinion;
(i) The proposed rules; and
(j) The Statement of Agency Personnel.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

6. The record remained open through February 7, 1977 for the receipt of written comments. Nine post-hearing submissions were received, all on or before February 7, 1977.

Statutory Authority

7. That while the Board cited five different statutes as authority for these rules (See Combined Statement of Need and Statement of Evidence, dated December 22, 1976), the most relevant is Laws of Minnesota, 1976, Chapter 325, Section 8 [now codified as Minn. Stat. § 144.691 (1976)], which states, in Subdivision 3, the following:

> The [Board] shall, by January 1, 1977, establish by rule promulgated pursuant to Minnesota Statutes, Chapter 15:
>
> (a) Minimum standards and procedural requirements for grievance and complaint mechanicism [sic];
>
> (b) A list of patient complaints which may be processed through a complaint or grievance mechanism;
>
> (c) The form and manner in which patient notices shall be made; and
>
> (d) A schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of this section.

Earlier subdivisions of the same section, and later sections of the same Act make it clear that the primary intent of the legislature was to reduce the incidence of malpractice claims and suits. Essentially, the relevant section requires each hospital and outpatient surgery center to establish a grievance mechanism, to notify its patients of the existence of the mechanism, and report at least annually to the Board on the operation of its mechanism. In connection with this reporting requirement, the Board is empowered to prescribe, by rule, the frequency, form and content of the reports, which must be filed not only by hospitals and outpatient surgery centers, but also by health maintenance organizations (Minn. Stat. § 144.691, subd. 4).

General Comments

8. That in order to better understand later Findings, a brief overview of the proposed rules is given here.

Proposed MHD 521 is a brief statement of applicability of the rules.

Proposed MHD 522 contains definitions of terms used in the rules.

Proposed MHD 523 is an operative rule which states, as a minimum standard, that every hospital and outpatient surgery center shall establish, operate and maintain a grievance mechanism designed to process and resolve grievances.

Proposed MHD 524, sets forth procedures for who can make complaints, who should handle them, time limits for response, notice to patients of the existence of the mechanism, and record-keeping requirements.

Proposed MHD 525 lists the types of complaints to which the facility must respond through the formal grievance mechanism.

Proposed MHD 526 requires facilities to make reports to the Board on the experience of their mechanisms.

Proposed MHD 527 sets forth penalties for violating the rules, including fines.

Proposed MHD 370(g) is an addition to existing Board rules for health maintenance organizations, and requires them to make reports to the Board about the operation of their grievance mechanisms.

9. Sometime prior to the hearing, the Board prepared a number of suggested revisions to the rules as originally proposed. These were made available to all persons at the hearing, but were not published in the State Register, nor were they mailed to the Secretary of State's List. They were, however, described in detail by D. McInerney of the Board, at the beginning of the hearing. Almost all of the proposed changes, however, were also proposed by the Minnesota Hospital Association in its 27 pages of written testimony submitted at the hearing. Each of these proposed changes will be discussed below.

In addition to those changes, the Board also proposed three additional changes which were submitted to the Hearing Examiner in the afternoon of the last day for submitting comments. These will also be discussed below.

10. That a number of the written comments submitted prior to the hearing (and apparently with no knowledge of the changes which the Board proposed at the hearing) were of a general nature and impossible to classify as relevant to a specific rule. Those comments were:

> 1. That the proposed rules are too detailed, that they would require that time be spent responding to complaints rather than treating patients, and that they are not "cost-effective" in that they will cost more to follow than they will save in malpractice claims. These comments came from Golden Valley Health Center, and St. Mary's Hospital and Home of Winsted.
>
> 2. That the proposed rules are unrealistic in that they would require response to the complaint of a five year-old to the same extent as an adult and that they do not recognize that there are certain groups, such as the mentally ill and chemically dependent, which must be recognized as being different than the ordinary hospital patient. These comments also came from the Golden Valley Health Center.

11. That a number of comments made at the hearing were also of a general nature, but should be noted.

> 1. The Minnesota Hospital Association representative stated that a recent poll of its 184 members indicated that 40 had grievance mechanisms in operation. (T. p. 70). Representatives from University of Minnesota Hospitals and Clinics, Mount Sinai Hospital, and the Gillette Hospital described the operation of their programs and commented on the changes which the adoption of the rules would have on their programs. All three stated that the general effect of the rules would be to "dehumanize" existing programs by forcing bureaucratic and legalistic responses to what are often emotional and human problems. (T. pp. 34, 65, and 68)
>
> 2. Joe Brown, of the Gillette Hospital, asked that consideration be given to delegating the whole program to the Minnesota Hospital Association, and have the Association sponsor it as a voluntary program which facilities could follow or ignore as they chose. (T. pp. 67-69)

With these general comments as background, the evidence for each proposed rule will be discussed, rule by rule.

Proposed MHD 521

12. That proposed MHD 521 drew no criticism or public comment either before, during, or after the hearing.

D. McInerney of the Board pointed out at the hearing that this rule just specifies that these grievance rules apply

only to hospitals and outpatient surgery centers (T. pp. 9-10).

Proposed MHD 522

13. That proposed MHD 522 is necessary to set forth definitions of terms used in subsequent rules. When read together with proposed MHD 521, it will define the applicability of the grievance rules.

At the hearing, the Board proposed that a definition of "representative" be added to the original definitions because there was some concern raised by the Minnesota Hospital Association that a facility might have to deal with a variety of persons who might express conflicting concerns about the same patient (Public Ex. 1., p. 2). This concern was shared by the Board (T. p. 10). The two differed, however, on the solution. The Board proposed:

> "representative" means a person designated by the patient as a responsible party, a parent of a minor, or a guardian.

The MHA proposed:

> "representative" means a parent of a minor child, a guardian or other person designated by the patient as a responsible party or one who is in loco parentis to a patient unable to act for himself.

The difference is that the MHA's proposal adds an additional category of "one who is in loco parentis to a patient unable to act for himself" to the categories proposed by the Board. While it is difficult to foresee a situation in which a representative would be selected using this phrase, it might be necessary in the case of a patient without a parent or guardian who is so incapacitated, whether mentally or physically, that he cannot designate a representative. Since such an eventuality might arise, and since both parties intend to assure that every patient have one, but no more than one, representative, the MHA proposal is the more complete of the two. Either of the two, however, is needed and reasonable.

14. That after the hearing, in its final submission, the Board proposed the addition of a definition of "patient" to read:

"patient" means an individual in or admitted to a hospital or outpatient surgery center for the purpose of prevention of disease, medical diagnosis or medical treatment. The term "patient" includes inpatient, outpatient, and emergency room patient.

In an explanation accompanying this proposal, the Board stated that the change was necessary to clarify the original rules. It stated that the rules as originally proposed might have been construed as not covering persons treated in emergency rooms or outpatient departments of hospitals or outpatient surgery centers. This construction could have been arrived at by a technical reading of another proposed rule [MHD 524(H)(1)] in conjunction with a completely different statute (the so-called "Patient's Bill of Rights, Section 144.651 as amended by Laws of Minnesota, 1976, Chapter 274). The original proposal for MHD 524 (H)(1) would have required that written notice of the existence of the grievance mechanism be posted "along with the notice required under Minn. Stat. § 144.652, and furnished, along with the notice required under Minn. Stat. § 144.652, to the patient or his representative upon admittance to the facility." The Board had tied the notice requirement to a similar notice requirement of Section 144.652 in order to avoid duplication of existing effort (Statement of Need, p. 9). What the Board apparently overlooked was the fact that Chapter 274, Section 1, defines "patient" for the purposes of the Patient's Bill of Rights Act to exclude persons admitted to an acute care facility for less than 24 continuous hours, and arguably excludes all persons who are not "admitted" to an "acute care facility". Since the statute creating the grievance mechanism and mandating these rules specifically includes patients of outpatient surgery centers, and since outpatient surgery centers are defined, for purposes of this Act, to be facilities which can offer only surgical procedures which do not require overnight inpatient care, the Board had created a procedural problem by tying the notice requirement of the grievance mechanism rules to that of the Patient's Bill of Rights. In order to remedy this problem, the Board, in its final submission, proposed to modify MHD 524(H)(1), and, in

addition, to include the definition of "patient" which is at issue here.

Did affected facilities have adequate notice that these grievance mechanism rules would apply to emergency room and outpatient department patients? The Board claims that they did, because it was clear that these rules applied to outpatient surgery centers, which treat the same types of problems as emergency rooms and outpatient departments.

This understanding, however, may not have been that of at least two persons. The following dialogue is from the hearing.

> MR. McINERNEY: I have one question. You seem to be saying, and correct me if I'm wrong, the criteria in this 525 failed to really address the situations in which a hospital is functioning as a primary care kind of deliver in terms of outpatient and emergency room care, is that what you were saying?
>
> MRS. COUNTRYMAN: In part. In part.
>
> MR. McINERNEY: How so and how can they better address the problems of outpatients and people who use the emergency room, for example, as their primary care treatment?
>
> MRS. COUNTRYMAN: I'm not sure how you could address emergency room. I would perceive that to be a very valid criteria, although it's not covered within this legislation, nor is outpatients. I recognize that we are functioning in a facility that is slightly different than the average hospital in the State of Minnesota, because many do not have outpatient or ambulatory care systems.
>
> (Transcript, p. 45)

In a letter dated well after the hearing, representatives of Rochester Methodist Hospital and St. Mary's Hospital wrote:

> Further, we are also concerned that MDH [sic] 524f, regarding Patient Notice, may be interpreted to require posting and handout in the emergency room setting of hospitals. At the time of the January 18, 1977 hearing, Mr. Daniel J. McInerney stated during an informal conversation that, in his opinion, the "Patient Notice" requirements proposed are basically the same as those contained in the Patient Bill of Rights, Minnesota Statute 144.652, and that it would be inappropriate to apply them to emergency or outpatient visits. This point may need clarification in Section 524f.

There are two alternative explanations for these responses. The first would be that there was a misunderstanding as to whether any of the rules applied to patients in emergency room and outpatient departments. In other words, Mrs. Countryman may

have believed that none of the rules (or the statute) applied. The second alternative is that raised by the above-quoted "Rochester" letter: That only the notice requirements of 524(H)(1) [later changed to 524(F)(1)] did not apply to the emergency room and outpatient setting, while the remainder of the proposed rules did apply to those settings. It is this second alternative which makes the most sense in light of the record.

The only clue in the statute to suggest that the legislature did not intend to include emergency room and outpatient department patients is in the definition of "outpatient surgery center". Subdivision 1 of Section 144.691 reads, in relevant part, as follows:

> For the purposes of...this act, "outpatient surgery center" shall mean a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

What is meant by the phrase in the last sentence which excludes "emergency medical services"? Does it mean emergency rooms? That seems unlikely because there is no logical reason to predict any lower probability of malpractice claims from patients treated in the emergency room of a hospital than from patients in an outpatient surgery center. And, as the Board argues, there is little difference between the outpatient surgery center and the outpatient department of a hospital. Had the legislature intended to exclude emergency rooms and outpatient departments, it is improbable that it would have chosen to do so by the phrase "emergency medical services". Therefore, the legislature must have intended that patients in these settings be included, along with patients of outpatient surgery centers.

Based on the above, it is the finding of this Examiner that the Board's proposed inclusion of a definition of "patient"

does not exceed the Board's statutory authority in that it is not contrary to the intent of the legislature, and that there is no reasonable basis for affected persons to claim that they did not believe that emergency room and outpatient department patients were included in the protection of the grievance mechanism statute or the operation of these proposed rules. Thus, affected persons did have adequate notice of the scope of the rules. The inclusion of the Board's proposal, however, will serve to clarify any such questions in the future.

15. That the only other comment regarding proposed MHD 522 came in a post-hearing letter from the Mental Health Association of Minnesota, Inc., which stated:

> The legislation applied to "grievances by patients or their representatives" (144.691, subd. 1) and, therefore, applies to all patients, including mental health patients. We assume this is understood by the institutions that will be affected and that the Board of Health will, through its review procedures, make certain that all groups of patients are included.

As was noted earlier, the Golden Valley Health Center understood this to be the case. Vera J. Likins, Commissioner of Public Welfare also understood this, and she submitted comments to the proposed rules in which she stated:

> ...I hope that the board will realize that these regulations will effect facilities licensed as psychiatric hospitals. Thus, such complaints as...will have special implications for patients committed under the Minnesota Hospitalization and Committment Act....

There is no evidence to suggest that any person did not understand that these rules would not apply to mental health patients, and thus, the Association's comment requires no further action in these proceedings.

16. That MHD 522, as originally proposed, and with the addition of the definitions of "representative" suggested by MHA, and "patient" suggested by the Board, is needed to provide definitions for the operative portions of these rules; that the definitions are reasonable; and that the Board has statutory authority to adopt them.

Proposed MHD 523

17. That proposed MHD 523 drew no comments or criticism from the public; that the Board has proposed no charges from its original form; that it was justified by the Board as needed to fulfill one of the requirements of the statute (Section 144.691, subd. 3(a) quoted in Finding No. 7, above); and that it is reasonable response to the statutory mandate.

Proposed MHD 524

18. That because of the length and controversy of some sections of this proposal, each section of the original proposal will be treated separately below.

MHD 524(A)

19. That the original proposal for this section would have required each facility, through its "governing authority" to designate an individual to be accountable for the operation of its mechanism. The MHA's written testimony proposed two changes in the rule, both of which were also proposed by the Board at the hearing. The first change would be to delete the requirement that the individual be designated by the "governing authority" of the facility. The second change would be to permit the designation of an individual "by name or by title". The Board stated that changes in personnel or work duties might require an otherwise unnecessary meeting of the governing authority just to designate a new person (T. p. 11). The proposed rule section, including both changes, is needed and reasonable.

MHD 524(B)

20. That proposed MHD 524(B) sets forth a variety of matters generally relating to complaints. Public comment and Board reaction focused on one proposed requirement: That a person authorized to receive complaints be physically within the facility during visiting hours, as well as business hours. MHA argued that this requirement reduced a facilitiy's flexibility in implementing its own system and that small hospitals

might be forced to delegate the responsibility for taking complaints during visiting hours to persons whose primary duty is patient care, thus reducing their time available for patient care. It also argued that some facilities might desire to assign the complaint mechanism to one person, and that would be impossible if he or she had to be present for visiting, as well as business hours. The University Hospital's Department of Patient Relations conducted a study, during one week, of the effects of operating under the proposed rules. During the week, there were 106 separate complaints made by 84 patients or their representatives. Of those 106, 95 were "most resolvable" within business hours. Based on this, K. Countryman, coordinator of the department, stated she was pleased to see the Board propose to delete the visiting hours requirement (T. pp. 36-40). DPW stated that due to the length of visiting hours in state institutions, it would be forced to add three to five full-time positions if the rule were adopted without this change. The Board proposed deletion of the words "and visiting" at the hearing, stating that concerned parties having a complaint could telephone during the day.

21. That the second change proposed by the Board at the hearing follows from the change discussed in Finding No. 19 above. It merely substitutes the words "a person" for the words "the person" when discussing the person designated in MHD 524 (A).

22. That DPW suggested the deletion of the limitation, contained in MHD 524(B)(1), that a complaint be "related to those subjects specified in MHD 525", but offered no reason for their suggestion. It is possible that DPW does not want to have the limitation in the rule because some hospital employee might infer that he did not have to consider, in any fashion, any complaint not related to the list in MHD 525. Such a reading is strained. This limitation is reasonable in that it clarifies the fact that the formal grievance mechanism is limited to a certain list of subjects, but does not preclude individuals or facilities from responding to, or resolving,

other matters outside the formal mechanism proposed by these rules.

MHD 524(C)

23. That one section of MHD 524 drew far more criticism than any other. It was proposed MHD 524(C), which would have established three different time limits (24 hours, 72 hours, or 30 days) for responding to a complaint, depending on which of three categories (medical, psycho-social, or billing) the complaint fell into. At the hearing, the Board proposed the deletion of the requirement that all responses or resolutions be in writing, and suggested, as a substitute, that they be required to be in writing only if requested by the complainant. (T. p. 13). While MHA agreed with this change (T. p. 54), as did DPW, that change did not meet the thrust of a majority of the criticisms, which opposed any classification of complaints for differing response times, and argued that if there be any arbitrary time limit, it should be a 72 hours limit, which was proposed by MHA and supported by numerous facilities and groups.

The Board pointed out at the hearing that the proposed time limits are limits for responding, rather than resolving, complaints (T. p. 12). It also pointed out that these time limits apply only if the complaint is made while the patient is in the facility. It justified the classification scheme based on its own idea of reasonableness (T. pp. 13-14):

> ...in view of the fact that medical care complaints are rather important in the hierarchy of the kind of grievances that patients might voice in the facility, 24 hours seems to the agency a reasonable time for response....
>
> Complaints relating to psycho-social things which are not of a hard core medical care nature, while clearly important to the well-being, the speedy recovery of the patient, are not quite as important as the hard core medical kinds of complaints and the Health Department feels that 72 hours or three days is a reasonable time for the facility to garner some kind of a response.
>
> (Transcript, pp. 13-14)

In its Statement of Need, the Board included, as Exhibit VI, a report of the average length of stay in various types of health care facilities during the year ended September 30, 1974. That

report stated that the average length of stay in hospitals was seven days. The Board used this to support its 72 hour limit for "psycho-social" complaints, stating that while these issues may not be susceptible of rapid resolution, they may have a great impact upon the incidence of malpractice suits, and the 72 hour time limit afforded the facility a realistic opportunity for the complaint to be resolved during the patient's current stay.

In contrast, the Board argued that the 24 hour limit for medical complaints was reasonable because such complaints are susceptible of rapid resolution, and 24 hours balanced the rights of the patient with the rights of the facility.

MHA, which was in essence supported by Golden Valley Health Center, University of Minnesota Hospital, Mount Sinai Hospital, Saint Cloud Hospital, the Minnesota State Medical Association, St. Mary's Hospital and Rochester Methodist Hospital gave four reasons for opposing the classifications:

> 1. Confusion will be reduced, both on the part of staff and patients, if there is only one limit.
>
> 2. Subdividing a patient's complaint into a number of categories, and treating them differently, depersonalizes the response in the eyes of the patient, and thus thwarts the purpose of these rules.
>
> 3. Twenty-four hours is inadequate in many cases due to difficulty in contacting key people and other extenuating circumstances, and a timely, but inadequate, response will only exacerbate the problem.
>
> 4. Classification results in prioritizing and since the legislature did not prioritize the Patient Bill of Rights (which is the basis of the complaint list in 525) the Board should not prioritize them.

While a complete list of all of the arguments made by others against the time limits would be too lengthy to be useful, some of the more relevant are:

> 1. The classifications are unrelated to any rational criteria (University of Minnesota Hospital; T. p. 29).
>
> 2. The classifications and limits have not been shown to have any relationship to malpractice claims (Saint Cloud Hospital).

3. The classifications discriminate against the outpatient and the discharged patient (University of Minnesota Hospi[illegible]; T. p. 34).

The first two require a greater exposition, as they were asserted in the context of a challenge to the Board's authority to adopt this (and one other) rule. Essentially, the argument is that the Board may not adopt rules based on malpractice-oriented statutory authority unless it can demonstrate the relationship of any particular rule to the incidence or malpractice claims. When placed in the context of the classification scheme proposed in MHD 524(C), the argument becomes: Unless the Board can demonstrate that failure to respond promptly to medical grievances is a greater cause of malpractice claims than failure to respond promptly to psycho-social grievances, the Board cannot require that they be treated differently. The record contains no such evidence, other than the Board's unsupported judgments of what seems reasonable quoted above.

The Board's statutory burden is clear: It must demonstrate, by an affirmative presentation of facts, the need for and reasonableness of each rule. [Minn. Stat. § 15.0412, Subdivision 4 (1976)] In this case, the most compelling testimony which could be used to support the classification scheme came not from the Board, but rather from one who opposed the scheme. K. Countryman, who has worked in the University Hospital's Department of Patient Relations since 1969 (and who is also the president-elect of the Society of Patient Representatives of the American Hospital Association), related her own experience as a patient:

> I would like to just briefly share a personal experience. Having worked in hospitals for a period of four years, I was hospitalized in 1973 as a patient and it was shortly after the patient's bill of rights had been passed as legislation and I had been working with patients' rights for a year previous to that and I went in thinking, "Wow, I am really an informed patient and, boy, nobody's going to overlook my rights and I'm going to know what's going on and I'm going to ask all the questions that I get frustrated with patients for not asking." It took me about three hours in the bed before I was being very quiet, I was being

> a good patient. I didn't want to ask for medications too fast. I didn't want to bother the physician, because [redacted] was a very busy person. I found that I was reduced very rapidly to feeling dependent and vulnerable.
>
> (Transcript, p. 44)

While the two examples she chose would both require 24 hour response under the Board's proposed scheme, the real value of her testimony is to point out the psychological condition of a patient. For a person in that condition who feels compelled to make a complaint, 24 hours may be a very long time, and 72 hours may be an eternity. The ideal practice (which is followed by the three institutions who testified about their existing programs) is to respond immediately if possible, or as soon thereafter as possible.

Specific proposals for response time limits ranged from an acknowledgement of receipt within 24 hours, excluding weekends and holidays (DPW) to 72 hours (MHA and numerous supporters). The Board, in its post-hearing response, stated:

> With respect to Ms. Countryman's urging of the adoption of an overall 72-hour limit, it must be pointed out that three days to respond to a complaint is an extremely long time when the complaint relates to the quality of medical care. This would be the kind of unacceptable situation which would obtain if a complaint were made on a Friday and to which response were not made until the following Monday. If the Health Department were to consider consolidating the 24 and 72 hour time limits into one, it could not support a time limit of more than 48 hours.

The Board did not meet its statutory burden with respect to the classification scheme. The next question is whether there has been an affirmative presentation of facts to demonstrate the reasonableness of <u>any</u> time period. There was not. The only time period supported by the record is "as soon as possible".

24. For the reasons stated above, the Board's proposed changes regarding written response should be adopted, but that the three different time limits for response should be consolidated into one, which should be "as soon as possible".

MHD 524(D)

25. That as originally proposed, MHD 524(D) would have

required an authorized individual receiving a complaint to inform the complainant, within four hours of receipt, of the applicable time limit for response. The purpose for this was to inform the patient as to when he would be hearing about his complaint, so he would not be as apt to repeat it again in the interim. As a secondary purpose, the Board argued, the facility's management of its mechanism would be assisted because it would be more aware of the applicable time limits (Statement of Need, p. 6).

At the hearing, the Board proposed two changes. First, it limited the notice requirement to oral complaints, for the reason that the mails would not permit the facility to give notice in four hours (T. pp. 14-15). The second change was the deletion of the four hour time lag, and the substitution of a requirement that the recipient tell the complainant about the applicable response time immediately upon receipt of the complaint. The first of these changes was not mentioned by any person (other than D. McInerney of the Board) at the hearing or in subsequent submission, but the second was advocated and supported by MHA (T. pp. 53-55, written testimony, pp. 9-10).

As has been noted earlier, providing the complainant with some idea of when he could expect to hear from the facility has been justified on the basis that it may prevent him from repeatedly lodging the same complaint again and again. However, in light of the Finding on MHD 524(C), (if it is adopted by the Board), there must be a modification of the last phrase proposed MHD 524(C). A possible modification, consistent with the Finding of 525(C) would be:

> D. Notice of Time for Response. The authorized individual to whom any oral complaint is made shall, upon receipt of the complaint, inform the complainant of the recipient's best estimate of when the facility could respond to his complaint.

MHD 524(E)

26. That the Board originally proposed that the time limits for response contained in MHD 524(C) be extended for

48 hours if the condition of the patient presented an emergency situation. In addition, the proposal would require that a record of such an extension be made.

At the hearing, the Board proposed that this section be deleted in its entirety. The reason given was that "common sense dictates that there're going to be...emergency situations, emergency conditions, or in fact the patient has passed on and requiring response to a deceased patient is clearly unreasonable and spelling that out in the rule is clearly onerous." (T. p. 16). This deletion was supported by MHA in its written testimony, which argued that if MHA's 72 hour time limit were adopted, this rule would be "less necessary". The deletion is reasonable.

MHD 524(F)

27. That this proposal, in its original form, would have set forth three specific grounds for denial of any remedial action requested by a complainant. While it is unclear from the rule itself or the Statement of Need, it appears that the Board intended these to be the only grounds on which a facility could refuse to take action demanded in a complaint.

At the hearing, the Board recommended that this section be deleted entirely. The Board argued that since the orientation of these rules is response, not resolution, this proposal would have been "probably extraneous" to the remainder of the rules. In its written testimony, the MHA challenged the original proposal as going beyond the intent of the law, approaching a requirement to resolve, not merely respond to, a complaint. The MHA proposed to replace the Board's proposal with a requirement that any denial, and the grounds therefore, be placed in the patient's complaint record. This proposal was adopted by the Board for inclusion in another section. In light of the evidence outlined above, the Board's proposed deletion of this section is reasonable.

MHD 524(G)

28. That this proposal sets forth record-keeping requirements for grievance mechanisms. As will be discussed below, proposed MHD 526 requires a facility to file annual

reports with the Board, and proposed MHD 527 sets forth fines for various violations. Adequate records are essential for both of those sections.

At the hearing, the Board proposed to make a number of changes to the rule as originally proposed. The first was to delete the word "Patient" from the title of the section, so that it would read "Complaint Records". The Board also proposed to delete the original requirement that the records be maintained "according to patient". These changes were justified on the basis that:

> It was pointed out to the agency after this proposed rule was published that a facility might want to classify its complaints according to subject matter as opposed to patient. It's reasonable to do so, for example, to highlight say an individual or a certain area which might be giving a facility a problem.
>
> (Transcript, p. 16)

This explanation follows a suggestion made by the Mental Health Association of Minnesota that the number of complaints and complainants in each service or department be identifiable. These changes were also supported by MHA (T. pp. 55-56).

The Board proposed another change, which would require that the arrangement of the records be such that the identity of particular patients and complainants could be ascertained. This appears to be a compromise between the "no restriction" approach advocated by MHA and the Board's original proposal. The Board's compromise proposal was supported by MHA, and, in light of the evidence, is reasonable.

The next change proposed by the Board related to the length of time that the records be maintained. The original proposal required the governing authority of the facility to approve a written policy setting forth whatever time period the facility elected. The Board proposed that this be deleted in favor of a requirement that the records be maintained for at least one year. The Board justified the one year period by pointing out that a facility is required to submit an annual report to the Board, and that the Board might want to inspect

a facility's records pursuant to a public complaint (T. p. 17). MHA supported this change (T. p. 55). It is desirable in that it sets forth a reasonable minimum time for retention.

The final change proposed by the Board is the insertion of the requirement that complaint records contain an annotation of the substance of any denial of a complaint. This was done in conjunction with the elimination of a more complicated procedure deleted in MHD 524(F) discussed earlier. This was supported by MHA (T. p. 56), and is reasonable.

MHD 524(H)

29. That proposed MHD 524(H) would require that potential grievants be notified of the existence of the grievance mechanism by both posting, and giving, a notice setting forth certain specified information about the mechanism.

At the hearing, the Board proposed that an additional piece of information be added to the list of required information in the notice. This new piece of information is "a statement that any complainant has the right to request and to receive a written response to, or written resolution of, any complaint." This would be consistent with the proposed change, discussed earlier, which would require a written response or resolution to a complaint only if it were specifically requested. Both changes were supported by the MHA, and are reasonable balance between the rights of the patients and costs to the facility.

An extended discussion of whether these proposed rules would apply to users of emergency rooms and outpatient departments has preceded, and as was explained therein, the quesion arose because the original proposal for this section required that notice of the mechanism be "furnished, along with the notice required under Minnesota Statutes 144.652, to the patient or his representative upon admission to the facility." (Emphasis added). The Board explained that the timing requirement for furnishing notice was tied to the Patient's Bill of Rights in order to avoid duplication of effort. However, as has also been explained earlier, patients in emergency rooms and outpatient

department do not have to be furnished with a copy of the Patient's Bill of Rights, and it is unclear whether users of those facilities are "admitted".

After the hearing, in a letter to the Hearing Examiner quoted earlier (the so-called "Rochester letter"), concern was raised that the rule might be interpreted to require posting and hand out in emergency rooms. The concern was well-founded, because the Board did, in its post-hearing submission, recommend that the rule be changed so as to require the furnishing upon entry to the facility, except in those cases where the Patient's Bill of Rights is furnished, when notice of the grievance mechanism should be furnished at the same time.

Thus, by changing the word "admission" to "entry" and by reordering phrases (as well as adding a comprehensive definition of "patient", the Board has attempted to clarify what may have been its original intent--that patients in emergency rooms and outpatient departments are to be given notice of the existence of the mechanism, and are covered by these rules.

This change, submitted in the afternoon of the last day for comments, provoked a telegraphic response from MHA, which argued that "entry" was an inappropriate substitution to achieve the desired clarification. MHA suggested that "entry" be deleted, and there be substituted the phrase "upon admittance or initiation of services". MHA justified its proposal as reducing administrative burden while still providing effective notice to the appropriate parties. Although unstated, it appears that the concern with "entry" is that there are persons who physically enter or walk into emergency rooms and outpatient departments who are neither "admitted" nor provided with health care services. MHA's proposal is more precise than the Board's, and it appears that its adoption would satisfy the intent of the Board and alleviate the concerns of the Association. While the Board's proposal is reasonable, in light of MHA's concern, MHA's proposal is far preferable.

Its adoption would not, however, alleviate the concerns raised in the Rochester letter. While it has already been found

that there was no reasonable basis for affected persons to claim that the rules, in toto, did not apply to emergency room and outpatient department patients, there certainly is a reasonable basis for affected persons to claim that they did not expect that this particular section (on patient notice), would apply to those two categories. The post-hearing "clarification" proposal of the Board is based on adequate statutory authority, is needed to clarify, and is reasonable. But it may be a "substantial change" within the meaning of Minn. Stat. Section 15.052, Subdivision 4 and Minn. Rule HE 107. This will have to be determined by the Chief Hearing Examiner when (and if) the Board proposes to adopt this change. Interested parties should acquaint themselves with those authorities and should feel free to submit argument to the Chief Hearing Examiner.

The final change proposed by the Board to this section was the addition of a phrase which would exempt a facility from furnishing notice if "an emergency prevents such furnishing". The Board argued, in its post-hearing submission, that this was needed to cover situations where the furnishing of such a notice would be a practical impossibility. It is reasonable.

30. In summary, proposed MHD 524(A), as amended by the Board, has been found to be adequately based on statutory authority (hereinafter "authorized"), needed, and reasonable, as is proposed 524(B). The time limits and categories of proposed 524(C) have been found to be lacking in any affirmative presentation of facts supporting their reasonableness, and they have been recommended for consolidation into one "as soon as possible" time limit. Proposed MHD 524(D), as proposed to be amended by the Board, is authorized, needed, and reasonable, but that it must be modified to be consistent with change in MHD 524(C). The deletions of both proposed MHD 524(E) and (F) are authorized, needed, and reasonable. Proposed MHD 524(G), with modifications suggested by the Board, is authorized, needed, and reasonable. Because of the deletions, it would be reclassified MHD 524(E). Proposed MHD 524(H), with modifications suggested by the Board, is authorized, needed, and reasonable, with one exception: MHA's proposal for a phrase to be substi-

tuted for "entry" is more precise and should be adopted by the Board. Due to the deletions, this would become MHD 524(F).

Proposed MHD 525

31. That proposed MHD 525, which is the list of complaints which must, at a minimum, be processed through the grievance mechanism, is taken substantially from the Patient's Bill of Rights, Minn. Stat. § 144.651, as amended by Chapter 274 of the Laws of Minnesota, 1976. There are, however, some differences between the two, and those differences provoked substantial criticism from public participants.

The authority of the Board to promulgate such a rule is clearly set forth in Minn. Stat. § 144.691, subd. 3(b), which directs the Board to promulgate, by rule, "a list of patient complaints which may be processed through a complaint or grievance mechanism". In response to that mandate, the Board used the Patient's Bill of Rights "as the genesis for a concomitant list of complaints..." (Statement of Need, p. 10). Because of the controversy the Board's proposed list has generated, the Statement of Need is worth repeating at this point to understand the Board's reasoning:

> Subd. 3(b) of the grievance mechanism statute requires the establishment, by rule, of a list of patient complaints which are capable of being processed through a grievance mechanism. Since most complaints are arguably related to the alleged breach of a duty owed to the complainant by the party against whom the complaint is made, and since the existence of such a duty derives from a right or a privilege belonging to the complainant, a list of complaints can be developed by an examination of the rights and privileges accorded such complainants. There is already a list of patient rights which are recognized by the Legislature (Minnesota Statutes 144.651; Exhibit VII). It seems reasonable to use this list of statutorily-recognized rights as the genesis for a concomitant list of complaints of the type intended by the Legislature. Hence, the Patient Bill of Rights, as amended, serves as the basis for the list of complaints set forth in this rule. Some provisions of that statute which do not appear to apply to patients, as opposed to residents in long-term care settings, were considered inappropriate for these purposes (e.g., provisions relating to the right of residents to manage personal finances, with a quarterly accounting by the facility of transactions made in the residents behalf). On the other hand, other provisions of

that statute, which were not expressly applied to patients, do seem appropriate in this context because they relate to complaints which might well be voiced by patients (e.g., provisions relating to the right of residents to be free from medically unjustifiable discharge can also be related to the potential similar problem of premature release of emergency room patients from an acute care facility). Two other sections of the Bill of Rights [(6), (21)] were not used in the generation of the complaint list because they seem to be adequately addressed through the patient notification rule [MHD 524(H)]. The remaining sections of the Bill of Rights are couched here in negative terms in order to make clear the situations in which such rights may be abrogated. For example, if a patient is guaranteed the right to considerate and respectful care, then a violation of that right (or a breach of the duty to observe that right) is characterizable as a failure to provide or lack of, considerate and respectful care. The complaint related to the abrogation of that right, which would be made by a patient, would be to the effect that he or she was not being afforded considerate and respectful care. The list of rights from which the list of complaints is culled often includes rights of varying degrees of magnitude in the same section [e.g., the coupling of the right to participate in the planning of medical treatment with the right to refuse to participate in experimental research in Minnesota Statutes 144.651, S. (10)]. The replication of this technique in these rules is inappropriate because of the attempt to set differing times for response under proposed MHD 524(c). It seems reasonable to require a faster response time when the complaint relates to medical issues than when the complaint relates to psycho-social issues. Hence, where sections of the Bill of Rights include both medical and psycho-social rights, the list of complaints derived from those sections separates the medical components from the psycho-social components; in this fashion, the listing of complaint response times in proposed MHD 524(c) more clearly reflects the magnitude of a particular type of complaint. Finally, since patient dissatisfaction resulting from perceptions of billing practices arguably has an impact upon the subsequent incidence of suit, it appears appropriate to include a reference to billing concerns in this complaint list.

Prior to the hearing, two facilities (Golden Valley Health Clinic and St. Mary's Hospital and Home of Winsted) submitted criticisms of the Board's proposal. They can be summarized as follows:

1. The list is not all inclusive, allowing significant leeway for a facility in dealing with complaints which don't fit into any of the specified categories.

2. The list is vague--how can a facility know if it is providing "understandable" information about diagnosis? What steps will satisfy a complaint that a patient has not been "afforded an opportunity to participate" in the planning of his treatment? How should mentally ill or chemically dependent patients be treated?

3. Some are responsibility of the physician, not the hospital [MHD 525(b), (j), (l) and (q)].

4. Some are a matter of judgment based upon the condition of the patient, hospital rules, and the medical knowledge of the individuals involved.

5. Were malpractice insurance carriers consulted to determine the correlation between the proposed list and malpractice claims?

The Board has not proposed any changes to the original list.

At the hearing, a number of complaints were voiced regarding the Board's proposed list:

1. The Board has presented no evidence to demonstrate that these areas have any relationship to malpractice (U. of M.; T. p. 28).

2. The Board has taken some "rights" granted to residents of nursing homes, but not patients in hospitals, in the Patient's Bill of Rights, and had arbitrarily granted them to patients. (U. of M.; T. p. 29 and MHA; T. p. 56).

3. The Board should be consistent with the Patient's Bill of Rights and either incorporate it by reference or repeat it verbatim (MHA; T. p. 56), and add to it, at some later date, other categories of complaints which have been found to result in malpractice claims (U. of M.; T. p. 31).

4. Lack of consistency with the Patient's Bill of Rights makes it difficult for the legislature or a facility to use the grievance mechanism reports as a information-gathering tool to assist it in deciding whether to change the Bill of Rights or amend its procedures (U. of M.; T. pp. 35-36).

In an attempt to determine how these rules would impact on its existing grievance mechanism, the University of Minnesota Hospitals conducted a one week study. Of the 106 complaints raised during the week, 59 would have been included in the Board's proposed list, while 47 would not have been (T. pp. 37-38). This was used by opponents of the Board's proposal to argue that the adoption of the Board's list would place undue emphasis on those classes of complaints that fell within the list, and might result in a detrimental change in the operation of complaint

resolution mechanisms in those facilities which already had them in operation (40 of the 184 members of MHA). At present, at least in the three facilities which presented testimony about their existing mechanisms, all types of complaints are handled. But all three representatives supported MHA's proposal that the Board's list be replaced with either a reference to the Patient's Bill of Rights or a list taken, verbatim, from that statute.

After the hearing, criticism of the Board's list continued. Summarized, those criticisms argued:

1. The list should be eliminated since it has not been shown to be related to malpractice claims.

2. The list is too vague. It would require responses to complaints about room temperature, improperly drawn drapes, a loud television, a nurse's dressing habits.

3. The proposal of MHA should be adopted.

In response to the University of Minnesota's criticisms raised at the hearing, the Board, in its post-hearing submission argued:

1. Mr. Diehl's statement that the non-delegation doctrine requires a proven nexus between the list of complaints enumerated in rule and the incidence of claim or suit is without merit. Subdivision 1 of the grievance mechanism statute (Laws 1976, Ch. 325, Section 8, Subdivision 1) indicates that the Legislature, not the agency, has made a determination that grievances related to billing and inadequacies of treatment may impact on the incidence of claim or suit. Hence, insofar as the list of complaints specified in rule relates to these things, there is no delegation problem. Those things specified in the list of complaints which do not relate to billing or inadequacies of treatment can still be included without the agency acting ultra vires since the language of the statute (subdivision 1) permits the inclusion of other factors which, although not proven, may have an impact on the incidence of claim or suit.

2. Mr. Diehl's testimony questioning the appropriateness of including complaints which derive from the rights of residents (as opposed to patients) as expressed in the Patient Bill of Rights overlooks the recent expansion of hospital services to provide care to persons who would formerly be considered "residents," not "patients" - e.g., chemical dependency and detoxification units, rehabilitation services. etc.

3. Lastly, Mr. Diehl's suggestion that the Patient

> Bill of Rights be referenced in the rules is not appropriate. First, the legislation [subd. 3.(b)] commands the development of a "list" of complaints in rule. Secondly, it would be impossible to tie the Patient Bill of Rights statute, as it stands, into the specified time limits for response which are proposed to be promulgated.
>
> 4. With regard to whether post-discharge complaints are covered by the rules, it is clear that they may, indeed, be processed through such a mechanism. The statute, however, is arguably directed at ameliorating potential problems while the individual is in the institution, i.e., while he is a "patient." Once discharged the individual is no longer a "patient;" hence the main thrust of the proposed rules is directed toward the former situation.
>
> 5. Ms. Countryman's criticism that some types of complaints were not mentioned is not really tenable because she offered no examples and because the list is specifically described as not being all-inclusive.

Special note must be taken of Board's Response No. 4 quoted above. There is no basis for the Board's position that the statute's use of the word "patient" can be interpreted to mean that the legislature did not intend for complaints received after an individual has been discharged to be processed through the grievance mechanism. Indeed, by specifically including complaints related to billing (which can be assumed not to arise at least until the time of discharge) and complaints of patients of outpatient surgery centers (which are, by definition, providers of shorter-than-overnight services), the inference is that the intent was to include post-discharge complaints.

Beyond that, there are really two major criticisms which must be overcome if the Board's proposal can be deemed to meet the statutory standards of Section 15.0412, subdivision 4. The first allegation is that the Board has not demonstrated any relationship between its proposed list and malpractice claims. The second is that the Board's "tinkering" with the Patient's Bill of Rights is improper.

With respect to the first of these, very little evidence was presented at the hearing, or otherwise, regarding the actual history of malpractice claims in the state. Really, the only relevant evidence is contained in a dialogue at the hearing

between J. Breviu, representing the Board and K. Countryman, from the University of Minnesota Hospitals:

> MR. BREVIU: Do you feel the program at University Hospital in any way has reduced or kept the incidents of malpractice claims from climbing?
>
> MRS. COUNTRYMAN: I think that factually that would be very difficult to assess, because we were covered under governmental immunity until the 1st of August. I think, however, in terms of patients satisfaction with the care delivered or understanding of the care delivered, it's definitely increased the satisfaction, which would be my impression would decrease the claims or suits generated out of frustration and anger and misunderstanding. I don't believe it can or should address suits, valid suits generated for valid reasons.
>
> MR. BREVIU: Would you feel that the patients' satisfaction is a result of the existence of the program rather than your ability to attempt to look into certain specific areas of patient complaints? It seems to me you've described a program which increases staff satisfaction in ability to deal with certain frustrations and which has increased patient satisfaction with the staff as a result. Is it this general, the type of atmosphere that has been created that has what you -- that has resulted in decrease in--has resulted in some patients not bringing malpractice claims when they might otherwise have?
>
> MRS. COUNTRYMAN: I think that's an assumption that could be made, most definitely. I think that's probably one of the reasons that hospitals are looking to funding these types of programs, that people who are satisfied are less inclined to sue or more inclined to evaluate the appropriateness of suit.
>
> (Transcript, pp. 47-48)

Mrs. Countryman has articulated, in her last response, the logical conclusion that can be drawn regarding legislative intent: That by establishing a grievance mechanism, the incidence of malpractice suits will be decreased.

The puzzle presented by the critics of the Board's list is that in one breath, they argue that the Board has failed to meet its statutory burden to demonstrate the reasonableness of its proposed list, but in the next breath, they recommend adopting the Patient's Bill of Rights verbatim. It seems as if they are hard pressed to find any better list than that in the Patient's Bill of Rights. Indeed, apart from one recommendation that there be no list at all, none of the critics proposed anything but the Patient's Bill of Rights.

The repeated argument of the Board that it is reasonable to use the rights from the Patient's Bill of Rights as the basis of the list since malpractice claims are arguably related to

an alleged breach of a duty owed by the facility to the complaint, and since such a duty arises from some right of the complainant, and since the Patient's Bill of Rights spells out a list of such rights, is not as sophistic as it may appear at first blush. There is no statutory definition of malpractice. Rather, a malpractice action is just one form of a negligence action. Indeed, in a 1966 medical malpractice case, the Minnesota court has quoted from Professor Prosser's Torts Treatise to lay the conceptual framework for analyzing the merits of the specific case. Miller v. Raaen, 273 Minn. 109, 139 N.W.2d 877 (1966). And the first three sentences which the Court quoted from Prosser are:

> The traditional formula for the elements necessary to such a cause of action may be stated briefly as follows:
>
> 1. A duty, or obligation, recognized by the law, requiring the action to conform to a certain standard of conduct, for the protection of others against unreasonable risks.
>
> 2. A failure on his part to conform to the standard required.

These are really the basis for the Board's logic. While it is admitted that the best support for a list would be data from actual malpractice claims, it is the finding of this Examiner that the conceptual approach of the Board--looking to the Patient's Bill of Rights--is an adequate response to the legislative mandate that the Board adopt a list. To paraphrase an oft-quoted rule of judicial review, it is not for this Examiner to substitute his judgment for that of the Board except to determine if the proposed list is a reasonable response to the statutory mandate (not the best response--just a reasonable response).

The second complaint was that the Board should not have modified the Patient's Bill of Rights at all, but rather should incorporate it by reference or adopt it verbatim. Obviously, it would have been easy for the legislature to direct, by statute, that the grievances to be processed shall be those arising from the Patient's Bill of Rights. This they

did not do, but rather directed the Board to come up with its own list. In this statutory setting, the Board has statutory authority to do what it did. But is it reasonable to have altered the list in the way that it did? A rereading of the Statement of Need and a companion of the list as proposed by the Board with the Patient's Bill of Rights indicates that there was a reasonable basis for each of the changes made by the Board.

For example, which "rights" guaranteed to residents of nursing homes were transferred to patients in facilities? They are MHD 525(I), (L-O), and (Q-U):

> I. failure to provide requested information, prior to or at the time of admission and during the period spent in the facility, relating to charges for care;
>
> L. retaliatory, arbitrary, or otherwise medically unjustifiable discharge;
>
> M. interference with or retaliation for the free exercise of any legally prescribed rights;
>
> N. mental and/or physical abuse;
>
> O. medically unjustifiable physical and/or chemical restraints;
>
> Q. requiring the performance of services not included for therapeutic purposes in the plan of care;
>
> R. restriction of the right to associate and communicate privately with others;
>
> S. interference with the sending and receipt of personal mail;
>
> T. restriction of the rights to meet with representatives and to participate in commercial, religious and community activities;
>
> U. restriction of the right to retain and use personal clothing and possessions, to the extent that space permits.

While some appear to be more reasonably related to malpractice claims than others (I, L, N and O as opposed to S, T, and U), it would be impossible to predict (except in light of past data) that even the most unlikely of them might not be the real motivating factor for a suit.

The argument that verbatim repetition of the Patient's Bill of Rights is preferable, because it will enable to the

legislature, the Board, or a facility to use data from the complaint mechanism in evaluating proposed changes to the Patient's Bill of Rights, is a sensible point. But the primary purpose of having a list of complaints in a rule is not to facilitate evaluation of the Patient's Bill of Rights. For that reason, this argument against the Board's proposal cannot sustain a finding of unreasonableness.

In summary, it is found that the Board has statutory authority to adopt proposed MHD 525, and that it has demonstrated the need for, and reasonableness of its proposal.

Proposed MHD 526

32. That proposed MHD 526 would set forth the information required to be filed with the Board annually by each hospital and outpatient surgery center relating to the experience of its grievance mechanism.

The authority for such a rule is clear. Minn. Stat. § 144.691, subd. 4 states that the reports shall be filed, and goes on to state that the "frequency, form, and content of each report shall be as prescribed by rule of the state board of health."

Prior to the hearing, Golden Valley Health Center criticized the proposal as being "too bureaucratic" and questioned its efficacy.

At the hearing, the Board made two suggestions for changes. First, it suggested that the section of the report which would require the reporting of the total number of complaints "received by" a facility be changed to the total number of complaints "filed with" the facility "pursuant to MHD 524B.1." The purpose of this change was to clarify that the Board wanted only information relating to the operation of the formal grievance mechanism, not all complaints of whatever nature. This was supported by MHA.

The second change comes in the section which would require the facility to report the number of complaints resolved "to the patient's satisfaction". The Board proposed

to insert the word "apparent" so that it would require a report of the number of complaints resolved "to the patient's apparent satisfaction". This proposal was justified by the Board on the basis that whether a patient is, or is not, satisfied is somewhat of a "judgement call" (T. p. 20) and that the Board was interested only in a rough estimate. This reasoning, and the proposed change, was supported by the University of Minnesota Hospitals and MHA (T. pp. 37 and 57, respectively).

MHA proposed that the section of the rule which would require a facility to report the total complaints "according to classification under MHD 525" be modified, to be consistent with their proposal that the Patient's Bill of Rights be substituted for the list in 525. In light of the previous finding, there would be no point in making this change.

After the hearing, the Minnesota Mental Health Association supported a non-controversial Board proposal that the facility have to report the number of patients making multiple complaints. It went on to suggest that the facility have to report the number of complaints against a single service or department. It argued that such information will enable the institution and the Board to identify areas where improvements may be needed. While such information may, indeed be helpful, this Examiner does not have enough evidence to find that the insertion ought to be made. It would be better for the Association to petition the Board, pursuant to Minn. Stat. § 15.0415 (1976) for such a change, in order that all affected persons have an opportunity to comment on the merits and demerits of the proposal.

In summary, the original proposal, as proposed to be amended by the Board, is based on adequate statutory authority, is needed, and is reasonable.

Proposed MHD 527

33. That proposed MHD 527 is a penalty section, imposing automatic fines for some enumerated violations and

empowering the Board to issue correction orders for other enumerated violations.

The statutory basis for such a rule is Minn. Stat. § 144.691, subd. 3(d), which directs the Board to promulgate by rule:

> A schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of this section.

The threshold question, raised by MHA in its written testimony, is whether the Board's statutory authority extends to promulgating a rule providing for a schedule of fines for violation of another rule, as opposed to a violation of the statute. In effect, MHA is focusing on the last three words of the statute quoted above. Their position is well taken. There are a limited number of acts required of facilities by the statute:

1. That every hospital and outpatient surgery center establish a mechanism (Subd. 1).
2. That each patient receiving treatment be notified of the mechanism (Subd. 2).
3. That each facility submit a report on the operation of its mechanism (Subd. 4).

Absent some other authority, those are the only acts for which fines may be imposed if they are violated.

As was noted earlier in this Report, the Board cited five separate bases as their statutory authority for these rules. Each of these has been examined, and none of them would provide support for the Board's proposal. Indeed, to the extent that they mention penalties, the statutory process is one of correction orders, rather than automatic fines.

It was the position of MHA and numerous others that there be no provision for automatic fines at all (even for a violation of the statute). Rather, they urged that the correction order process be the sole method of penalizing violations. This suggestion, however, would be contrary to the legislative language quoted at the beginning of thie Finding. Therefore, to the extent that the Board's proposed rule would impose fines

for statutory violations, the Board has the statutory authority and has demonstrated the need for such a rule. Specifically, such a test would permit the Board to retain proposed MHD 527 (A)(1)(a), fining for failure to give individual patient notice, because that is the act required by Subdivision 2 of Minnesota Statutes Section 144.691. But the second violation for which the Board proposed an automatic fine (proposed MHD 527(A)(1)(b)--failing to respond to a patient complaint within applicable time limits) is not permitted. There would have to be one minor change in MHD 527(A)(1)(a), the substitution of a statutory referent for the present rule referent. Also, the first sentence following MHD 527(A)(1)(b) should be deleted, as it makes sense only if MHD 527(A)(1)(b) had been retained. What was proposed as MHD 527(A)(1)(b) may, at the discretion of the Board, be added to the violations listed in MHD 527(B)(1) and (3).

Finally, with regard to the automatic fine issue, has the Board demonstrated the reasonableness of its automatic fine proposal? The Board's justification is that failure to give an individual the required notice is a past violation, rather than an ongoing one, and the use of a correction order is inappropriate because the effect of such an order would merely be the granting of "one free bite" for a type of violation that is not susceptible to reinspection to determine whether the correction order has been acted upon. In light of the amount of the fine ($50) and in light of the right to a hearing to protect the unjustly accused facility, the Board's automatic fine proposal is justified.

MHA also made a number of other proposals regarding the schedule of fines. Some were mere "housekeeping" to make this rule consistent with charges in other rules proposed by MHA (which were, in many cases, adopted as Board proposals at the hearing). But other MHA suggestions were more substantive. The substantive will be discussed first.

The Board had proposed that there be a 60-day time limit for correction of any violation for which an order had been issued. MHA agreed with the 60-day "outside" limit, but

suggested that there be a 20-day "inside" limit to give facilities at least 20 days to correct violations. Under this MHA proposal, proposed MHD 527(B)(2) would read:

> In no case may the allowable period for correction of any of the violations [in MHD 527(B)(1)] be less than 20 days nor more than 60 days.

In justification of this proposal, the MHA representative raised the specter, at the hearing, of a correction order being issued one day, requiring the reprinting of the patient notice, for example, and the time for correction being only two days, with an immediate reinspection and fine being assessed for failure to correct, in what MHA felt was an unreasonably short time span. He stated "I guess what we're trying, obviously, is to protect ourselves against a potential problem. I can't say that that specifically is going to happen." (T. p. 59).

The Board responded, at the hearing, in opposition to this proposal, by pointing out that while some violations could be reasonably anticipated to take longer than a few days to cure (reprinting notices, resubmission of an annual report, reordering of a facility's filing system), other violations (which would also be subject to the 20 day minimum) were those which could be cured more quickly, and to permit a 20 day minimum correction time would defeat the intent of the statute. Examples cited by the Board were failure to post the notice and failure to have any mechanism at all. The MHA representative agreed with the Board that failure to have any mechanism at all should be cured immediately (T. p. 61), but the two disagreed over whether there should be a 20 day minimum, with a few exceptions (MHA); or whether there should be no minimum, with a few exceptions (Board). While either would be reasonable, and while the Board should realize that it has the final decision, this Examiner would recommend that there be no minimum except for a 20 day minimum in the case of MHD 527(B)(1)(d)(e)(f) and (g).

The next substantive change proposed by MHA was in the amount of the fines. The Association proposed that in no event should the fine exceed $50 per violation, except that in

the case of multiple violations, the amounts originally proposed by the Board as maximum per violation amounts be retained. No justification for this proposal was offered by the Association. The Board's desire for flexibility--tailoring the amount of the fine to the seriousness of the violation--seems eminently logical, and the adoption of the Association's proposal would remove that flexibility.

The final "substantive" change proposed by the Association is arguably merely a matter of clarity or convenience. The proposal would add a section to the rule which would specify that all hearings provided for in the rule be conducted in accordance with Minnesota Statutes Section 15.0411. The Board has assumed that any person who is given automatic fine or a correction order which leads to a fine is entitled to a hearing. Its proposed rule specifies, in both cases, that the fines are payable within 30 days of assessment "unless there is a facility request for a hearing within that period". This Examiner cannot conceive of a situation in which such a hearing would not be a "contested case" within Minn. Stat. § 15.0411, nor can he conceive of a situation in which the affected facility would not know that. It is left to the Board to include such a reference if they feel it would be helpful.

The "housekeeping" changes relate to the descriptions of violations in MHD 527(B)(1). They should be changed in order to be consistent with the changes recommended in earlier findings. These changes need not be spelled out beyond referencing the affected subsection of MHD 527(B)(1) in which they must be made, which are (b), (c), and (d).

34. In summary, the Board has demonstrated statutory authority, the need for, and reasonableness of, proposed MHD 527 with the exception of an automatic fine for MHD 527(A)(1)(b). With the changes discussed above, the rule is recommended for adoption.

Proposed MHD 370(g)

35. That the final rule proposed by the Board relates solely to health maintenance organizations (hereinafter "HMO"), and for ease in reference, it is placed in the Department's rules for HMOs. The rule would require each HMO to make an annual report to the Board on the operation of its grievance mechanism.

The statutory authority for the rule is contained in Minn. Stat. § 144.691, subd. 4 (1976), which places HMOs in the same status as other facilities in requiring such reports and authorizing the Board to adopt rules relating to the "frequency, form and content" of such reports.

Prior to the hearing, a number of changes were proposed by Group Health Plan, Inc., Group Health Association of Northeastern Minnesota, Inc., and MedCenter Health Plan. All three recommended that the filing date of the report be changed to April 1, so as to be consistent with a different Annual Report that must be filed by HMOs on that date. The Board, at the hearing, adopted this proposal because "...it was felt more appropriate and more streamline (sic) to require the submission of this [grievance mechanism] data along with the annual report..." (T. p. 24).

Another prehearing comment was that proposed MHD 370 (g)(5), which required a copy of written summaries of actions taken pursuant to complaints be included in the HMO's report, raised a problem of patient confidentiality. The Board agreed with this, and at the hearing, proposed to modify the rule to state that the identity of specific individuals should not be disclosed.

Other prehearing criticisms, however, were not responded to by the Board. Group Health Association of Northeastern Minnesota, Inc. (hereinafter "GHANM") proposed that MHD 370(g)(4), which required HMO's to include in their report "the total number of complaints received", be modified to require a report of the total number of written complaints received. The Board's proposal (covering both written and oral) is consistent with

MHD 526(D) for other facilities, and appears to be consistent with the malpractice-reduction orientation of the Act. It is inconsistent, however, with the existing HMO rules, which relate solely to written complaints [see Minn. Rule MHD 370(d)-(f)]. It is especially noteworthy that the record-keeping rule for HMOs, MHD 370(f), requires that records be kept solely for written complaints. The adoption of the Board's proposal, in its present form, therefore, would require that HMOs either keep two sets of records or else that they expand their present records to include oral complaints. The Board offered no justification for this inconsistency. The rule, as proposed by the Board, can be justified in light of the statutory purpose. However, because of the inconsistencies noted above, it is recommended that the Board give consideration to whether or not the limitation proposed by GHPNM should be adopted. The same reasoning would lead to the same result in MHD 370(g)(6) and (g)(7).

One change the Board did propose at the hearing would decrease the reporting requirements of HMOs. That change is in MHD 370(g)(5), already discussed, and would permit HMOs to include in their report synopses of actions taken as a result of complaints, rather than copies of summaries of such actions.

Another change proposed by the Board at the hearing would be to modify the requirement that HMOs report the number of complaints "resolved to the enrolee's satisfaction". The Board, as in MHD 526(H), proposed to modify the rule so that it would require the reporting of the number of complaints "resolved to the enrolee's apparent satisfaction". The logic for the change is the same as that in MHD 526(H).

After the hearing, Physician's Health Plan recommended that proposed MHD 370(g)(5) be deleted in toto. A similar suggestion came from MedCenter Health Plan before the hearing. Both argued that this rule (which, if adopted with the Board's proposed changes noted above, would require HMOs to include in their reports synopses of actions taken in response to complaints) was too burdensome, and Physician's went on to say that it was

unreasonable to require the reports to be so extensive "as to serve as [redacted] investigative tool of the [Board] in understanding the nature of complaints".

The Board offered no justification for this section of the proposed rule, and the Examiner can only assume that the purpose of this rule is analogous to the purpose of MHD 526(E)--to gather data about the types of frequent complaints to identify problem areas. The need for such speculation, however, is an indication that the Board did not meet its statutory burden. As Physician's stated:

> Since reporting requirements ultimately translate into time and dollars which must be spent by the regulated organization in assuring compliance with such requirements, we feel that a careful documentation of need be made before additional requirements are cast in stone (e.g. become rules). This documentation was not included in the presentation made by the Department of Health staff members at the public hearing.

The Examiner agrees, and for this reason, it is recommended that proposed MHD 370(g)(5) be deleted.

36. In summary, the Board has shown the authority, need, and reasonableness of proposed MHD 370(g), with the modification to MHD 370(g)(7) relating to "apparent", with the exception that the Board has failed to demonstrate the need for proposed MHD 370(g)(5). The Board should also consider the proposal to require the reporting of only written complaints.

Based upon the foregoing Findings of Fact, the Hearing Examiner hereby makes the following:

CONCLUSIONS

1. That the Board gave due, timely and proper notice of the hearing herein. All other substantive and procedural requirements of the statute and applicable rules have been fulfilled.

2. With the exception noted in Finding No. 33, the Board has statutory authority to adopt the proposed rules.

3. With the exceptions noted in the Findings, the Board has demonstrated the need for and reasonableness of the proposed rules.

4. The Board offered a number of changes and modifications to the proposed rules both at the hearing and in its post-hearing submission. Except as expressly found otherwise above, the changes are reasonable, necessary, and non-substantial.

5. The Examiner has offered several suggestions which would appear to correct some of the provisions which were found to be unreasonable or that would improve already reasonable provisions. Such suggestions are not intended to preclude the Board from making its own changes and improvements.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

RECOMMENDATIONS

1. That the proposed rules be modified as suggested in the Findings and that, so modified, they be adopted.

Dated: March 10, 1977.

Allan W. Klein

ALLAN W. KLEIN
Hearing Examiner

Proposed Rules Relating to the Operation of Health Facilities Grievance Mechanisms

Statutory Authority and Statement of Need

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Laws, 1976, Chapter 325, Section 8, (see attachment) requires the State Board of Health to promulgate rules relating to methods by which hospitals and outpatient surgery centers must address patient complaints. Under this statute, certain types of health facilities must establish grievance mechanisms designed to process and resolve such complaints so as to minimize their apparent impact on the incidence of malpractice claims and suits. Specifically, the statute requires that rules promulgated pursuant to its grant of authority address the following areas:

(1) the delineation of minimum standards and procedural requirements for grievance mechanisms;

(2) the presentation of a list of patient complaints which may be processed through such a mechanism;

(3) the description of the form and manner in which patient notices are to be made;

(4) the specification of a schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of the statute; and

(5) the requiring of the submission of an at least annual report on the operation of such mechanisms by hospitals, outpatient surgery centers and health maintenance organizations.

The rules which are proposed here (see attachments) are aimed at fulfilling all of these statutory criteria. They are intended to apply to hospitals and outpatient surgery centers. Since health maintenance organizations are only required to report under this statute, and since an existing H.M.O. Rule (MHD 370), pursuant to a portion of the H.M.O. Act (Minn. Stat. 62D.11), requires the

the existence of a functional complaint system, the reporting requirement for such complaint systems, under Laws, 1976, Chapter 325, is proposed as an amendment to the existing H.M.O. rules (below). This would avoid duplication and ambiguity, and place the statutorily required reporting provision in an appropriate context.

Procedural Requirements

A notice of intent to obtain information on proposed rules from non-agency sources, required under Minn. Stat. 15.0412, subd. 6, was mailed to persons on the Secretary of State's list (Minn. Stat. 15.0412, subd. 4) on May 28, 1976 and published in the State Register on November 8, 1976 (Exhibit I). The Health Facilities Advisory Council to the State Board of Health (Minn. Stat. 144.571) provided input to staff prior to the submission of a draft to the Board (Exhibit II). The State Board of Health authorized its Secretary to call a hearing for the purpose of promulgating these rules on October 14, 1976 (Exhibit III). Notice of the hearing and the text of the proposed rules were published in the State Register on December 7, 1976 (Exhibit IV). A hearing notice and copy of the proposed rules were mailed to persons on the Secretary of State's list and to members of the Legislature on November 30, 1976 (Exhibit V).

Reasonableness of Proposed Rules

MHD 521: These are the types of facilities to which Laws, 1976, Chapter 325, section 8 generally applies. Since health maintenance organizations are only required by this statute to report on the experience of their complaint systems, (subd. 4), that requirement is reflected in a proposed amendment to the existing H.M.O. rules, below.

MHD 522:

(a) For ease of understanding and clarity, these two terms, apparently equivalent, which are used interchangeably in the grievance procedure statute (subd. 1, 2, 3(b), and 4), are defined as meaning only the former ("grievance mechanism").

(b) This definition ties into the statutes under which such facilities are licensed, and is suggested by the grievance procedure statute (subd. 1).

(c) This is the definition which is in the grievance procedure statute (subd. 1).

MHD 523: Subd. 3(a) of the grievance procedure statute requires the establishment of minimum standards for grievance mechanisms in rule. The minimum standard expressed here relates to establishing, operating and maintaining such a mechanism (as required by subd. 1 of the grievance procedure statute). Other criteria, which can arguably be considered as minimum standards, are placed in MHD 524, in order to locate all the procedural requirements more conveniently in one rule.

MHD 524:

(a) In order for such a mechanism to be coordinated and work efficiently, it would seem reasonable to require a single person to supervise and monitor its functioning, and to be ultimately responsible for its conduct. Since the governing authority is legally responsible for the facility, it would also seem reasonable for it to be heavily involved in making a decision about an activity, the performance of which is required by law.

(b)(1) It is clearly the intent of the grievance procedure statute to encourage the voicing of complaints by patients. Recognizing the fact that some patients will be unable to voice a complaint, it seems reasonable to permit spouses, children, counsel, etc., to do so in the patient's behalf.

(b)(2) In recognition of the fact that the person designated under proposed MHD 524(a) may not always be available, it is reasonable to permit other authorized individuals to receive complaints. Although a patient may be able to make a complaint during ordinary business hours, those patients who are unable to complain must

rely on their representatives, who may not be able to visit them or be in the facility until some time outside of ordinary business hours. Hence, it is reasonable to require the presence of a person authorized to receive complaints outside of ordinary business hours. The most reasonable additional time period for such an authorized individual to be present would seem to be during visiting hours (which can occur both during and after ordinary business hours) when the patient is likely to meet with his family and friends.

(c) Written response to or written resolution of complaints would appear to be necessary to give the complainant some formal evidence that his complaint has been considered, to provide the facility with the information it needs to make its annual report (subd. 4 of the grievance procedure statute), and to provide the State Board of Health with the data it needs in order to publish reports and studies designed to improve such mechanisms, as required under subd. 4 of the grievance procedure statute. It is important to point out that these rules do not compel resolution of every complaint; rather, they mandate that at least a response be given to each complaint. The apparent intent of the Legislature, as expressed in subd. 1 of the grievance procedure statute, was to minimize malpractice claims and suits. In specifying that a conduit for low-level resolution of claims be present in all facilities, it refrained from requiring that such complaints be formally resolved at that level. It is reasonable to infer that the Legislature did not wish to layer on another level of formal adjudication (resolution). Had it wished to do so, it could have simply required participation in arbitration, pre-trial screening, or the like.

(c)(1) The complaints to which reference is made here are all related to issues of immediate medical concern and susceptible of rapid resolution. A 24 hour time limit for response (not resolution) would seem to be a reasonable period, balancing the rights of the patient with the needs of the facility.

(c)(2) The complaints to which reference is made here are related to issues which are psycho-social and are not medical, in nature. A 72 hour time limit for response appears to be reasonable. These issues may not be susceptible of rapid resolution, but they may have a great impact upon the incidence of malpractice suits. Furthermore, inasmuch as the average length of stay in an acute care facility is only 7 days (Exhibit VI), a realistic opportunity for the complaint to be resolved during the patient's current stay should be afforded.

(c)(3) The complaints to which reference is made here relate to billing and release of records. In view of the complicating element of insurance coverage with respect to billing, and the legal and medical confusion with regard to the release of patient records, a time period of 30 days for response seems reasonable.

(d) Even though the patient may be aware of the existence of the grievance mechanism (proposed MHD 524(h)), he will not be aware of the appropriate time limit for response, unless he reads these rules. It is unreasonable to expect the complainant to digest these rules and ascertain for himself the appropriate time limit, particularly in view of the fact that the patient is in the facility because of an illness or disability. It is desirable for the complainant to know of the applicable time limit because it gives him a rough estimate of when he should be hearing from the facility

on the matter in question, and it makes it less likely that the complaint will be formally reiterated. It is most likely that the facility will have more knowledge of the rules, and hence, the time limits, than the complainant. Being in a position of superior knowledge, it should bear the onus of making a good faith determination of the applicable time limit known to the patient. Such a requirement should also assist the facility itself in managing its complaint system so as to meet the applicable time limits.

(e) This section recognizes the fact that, in an emergency situation with respect to the patient in question, there may be no ability to respond to a complaint within the required time limits, or an attempt to respond may be useless. In view of those possibilities, an extra two days is thought to be a reasonable extension of time to respond to such complaints. It is important to have a record of the reason for operating under this extension, so that the facility can show that the threshold requirement was not met because of an emergency involving the patient in question. Requiring that an individual who asserts that such an emergency exists be the one who signs the annotation assures that persons with superior knowledge of the existence of such a condition be the individuals who record the existence of the condition.

(f) There are clearly cases in which facilities are faced with denying the action which the complainant seeks.

(f)(1) Clearly, the facility can refuse to take requested action where such action would be medically or therapeutically unsound. It is unreasonable to expect that such action need to be comtemplated.

(f)(2) A balancing of the rights of individual patients is important

to note. At some point such rights conflict. It appears appropriate to recognize the fact that a facility can refuse to act in the fashion sought by the complainant, should such action be likely to violate the rights of any other patient. Minnesota Statutes 144.651 (the Patients' Bill of Rights) is chosen as the source of the rights which should be considered in such deliberations. This Bill of Rights is selected rather than another document, or no document at all, because it appears to be clear and convincing evidence of what the Legislature believes to be important issues in the delivery of health services, and seems to be representative of the rights which must be balanced in considering the effect of complying with a complaint request upon the rights and prerogatives of other patients.

(f)(3) Since there is some difference of medical and administrative opinion about certain details involved in the functioning of a health facility, a perfectly permissible spectrum of trans-facility differences may exist. For instance, Facility A may not permit the presence of fathers in the delivery room, because of a concern for maintaining a relatively sepsis-free environment. Facility B may encourage the presence of fathers at delivery, because of the psycho-social benefits involved. In areas such as this, in response to a patient complaint, it seems advisable to permit the use of a facility policy as dispositive of a patient complaint. However, in order to assure that what is held out to be facility policy is, in fact, facility policy, it seems reasonable to require it to be a written policy and to require that it be approved by the facility's governing authority, the legal "parent" of the facility.

An annotation of the assertion of any of these grounds is proposed

to be required for purposes of making the records required to be kept under MHD 525(g), and the reports required to be made, under MHD 526, more complete in terms of data. This would, in turn, make the products resulting from the Board's collection of such data arguably more valid, and more usable for the purposes for which the grievance mechanism statute intended them.

(g) In order for the facility to generate the information required by proposed MHD 526 to be in the annual report, and in order for the Board/Department to monitor timely response performance (proposed MHD 524(c)), some ongoing recordkeeping is necessary.

(g)(1) A record describing the nature of the complaint is essential if the Board/Department is to fulfill the mandate of the grievance mechanism statute (subd. 4) to collect such data as will enable it to publish reports and studies designed to improve complaint and grievance mechanisms.

(g)(2) The information sought to be acquired here will be useful in discounting the effect that frequently-complaining, litigious patients might have on assembled data.

(g)(3) This proposed section would provide the Board/Department with the information necessary to monitor timely response performance (proposed MHD 524(c)).

(h)(1) Subd. 2 (c) of the grievance mechanism statute requires notification of all patients with respect to the availability of the grievance mechanism. Since all patients currently receive notice of their rights under Minnesota Statutes 144.652, and since these rights are also required, under the latter statute, to be conspicuously posted in the facility, it seems advantageous to attach the notice

requirements of the statute at hand to those already existing. Duplication of existing effort is thus avoided, and coordination is substituted. This coordination with the Bill of Rights notice procedure becomes even more important because the areas in which complaints may be raised (proposed MHD 525) are themselves derived from the Bill of Rights statute (Minnesota Statutes 144.652). It is reasonable to require that the notice be written, in order that the existence of the mechanism be known to patients. A verbal communication of the existence of the mechanism will arguably not have the same impact as a verbal notice in tandem with a written notice.

(h)(2) This specification of the content of the notice is directed at informing the patient of the following: that the facility maintains a grievance mechanism (subd. 2(c) of the grievance mechanism statute); that there is a specific individual, or type of individual, to whom complaints may be directed (proposed MHD 524 (a), and (b)); and, that complaints or grievances related to the rights expressed in the document which they have been given (pursuant to Minnesota Statutes 144.651), or to any other rights, may be able to be resolved by the facility's grievance mechanism. In this manner, the patient is informed of the existence of the statutorily-required mechanism, he is told to whom grievances may be directed, and he is given an indication of a minimum list of rights, the breach of any of which are subject to being processed through the mechanism.

MHD 525: Subd. 3(b) of the grievance mechanism statute requires the establishment, by rule, of a list of patient complaints which are capable of being processed through a grievance mechanism. Since most complaints are arguably related to the alleged breach of a duty owed to the complainant by the party against whom the complaint is made, and since the existence of such a duty derives from a right or a privilege belonging to the

complainant, a li[illegible] of complaints can be develope[illegible]by an examination of the rights and privileges accorded such complainants. There is already a list of patient rights which are recognized by the Legislature (Minnesota Statutes 144.651: Exhibit VII). It seems reasonable to use this list of statutorily-recognized rights as the genesis for a concomitant list of complaints of the type intended by the Legislature. Hence, the Patient Bill of Rights, as amended, serves as the basis for the list of complaints set forth in this rule. Some provisions of that statute which do not appear to apply to patients, as opposed to residents in long-term care settings, were considered inappropriate for these purposes (e.g., provisions relating to the right of residents to manage personal finances, with a quarterly accounting by the facility of transactions made in the residents behalf). On the other hand, other provisions of that statute, which were not expressly applied to patients, do seem appropriate in this context because they relate to complaints which might well be voiced by patients (e.g., provisions relating to the right of residents to be free from medically unjustifiable discharge can also be related to the potential similar problem of premature release of emergency room patients from an acute care facility). Two other sections of the Bill of Rights ((6), (21)) were not used in the generation of the complaint list because they seem to be adequately addressed through the patient notification rule (MHD 524 (H)).

The remaining sections of the Bill of Rights are couched here in negative terms in order to make clear the situations in which such rights may be abrogated. For example, if a patient is guaranteed the right to considerate and respectful care, then a violation of that right (or a breach of the duty to observe that right) is characterizable as a failure to provide or lack of, considerate and respectful care. The complaint related to the abrogation of that right, which would be made by a patient, would be to the effect that he or she was not being afforded considerate and respectful care. The list of rights from

which the list of complaints is culled often includes rights of varying degrees of magnitude in the same section (e.g., the coupling of the right to participate in the planning of medical treatment with the right to refuse to participate in experimental research in Minnesota Statutes 144.651, S. (10)). The replication of this technique in these rules is inappropriate because of the attempt to set differing times for response under proposed MHD 524(c) . It seems reasonable to require a faster response time when the complaint relates to medical issues than when the complaint relates to psycho-social issues. Hence, where sections of the Bill of Rights include both medical and psycho-social rights, the list of complaints derived from those sections separates the medical components from the psycho-social components; in this fashion, the listing of complaint response times in proposed MHD 524(c) more clearly reflects the magnitude of a particular type of complaint. Finally, since patient dissatisfaction resulting from perceptions of billing practices arguably has an impact upon the subsequent incidence of suit, it appears appropriate to include a reference to billing concerns in this complaint list.

MHD 526: Subd. 4 of the grievance mechanism statute requires an at least annual report to the State Board of Health by every facility required to operate a grievance mechanism. These reports appear to be intended by the Legislature to provide a data base from which the Board can develop reports and studies designed to improve grievance mechanisms. The kind of data sought to be elicited under this proposed rule seems to be of the variety necessary to meet the statute's command. The total number of complaints will give the Board/Department a rough baseline from which to develop some answers about the effect of the existence of grievance mechanisms upon malpractice suits. Total numbers of complaints, according to type, will provide information relative to any frequently occurring problems. The number of patients by

schedule of fines, and since these retrospective violations appear to be less serious, from a regulatory standpoint, than violations relative to not having a mechanism at all, etc., it seems reasonable both to attach the $50 figure as the appropriate amount for a single violation and to place a $200 ceiling on the amount for multiple violations with respect to the current stay of a particular patient. Finally, it is possible that a facility may disagree with the automatic assessment whom or for whom more than one complaint is made coupled with the total number of such complaints will enable the Board/Department to discount the skewing effect a litigious complainant may have on the data collected. Finally, in order to more fully assess the impact of the statute upon the incidence of malpractice suits, it appears reasonable to assemble data relating to the proportion of complaints resolved to the patient's satisfaction. In this way, it may be observed whether there is an association between any decrease in the incidence of suit and the percentage of complainants satisfied with the resolution of their complaints by a grievance mechanism.

MHD 527: Subd. 2(d) of the grievance mechanism statute requires the establishment, by rule, of a schedule of fines, not to exceed $200 per offense, for failure of a hospital or surgicenter to comply with the provisions of the statute. The approach taken in the proposed rules is bifurcated - focusing both retrospectively and prospectively.

(a) This section addresses the retrospective handling of violations of the statute as articulated through the proposed rules. Failure to notify patients individually as required under proposed MHD 524(h) and failure to respond to a complaint within the applicable time limit under proposed MHD 524(c) both result in the automatic assessment of a fine. These fines relate to situations in which the mechanism fails to function appropriately with respect to a particular patient. It seems reasonable to address these instances

as well as those of a generally dysfunctional mechanism (see proposed MHD 527(b)). The fines are able to be imposed automatically since the mechanism has demonstrated failure in the past to comply with these proposed rules as they related to particular patients. A prospectively-oriented approach (the use of correction orders) seems inappropriate because no correction order can remedy these past failur Since the Legislature placed a per violation limit of $200 on the of such a fine; in this case, fairness requires the staying of the collection of the fine until the facility has had the opportunity to contest the fine.

(b) This portion of the fine schedule relates to general problems with the grievance mechanism, as opposed to functional failures with respect to an individual patient. In this case, prospectively oriented correction orders are appropriate, because they can have the effect of preventing the facility from operating an inadequate mechanism, or inadequately operating an otherwise adequate mechanism. If there is compliance with such orders, then problems with respect to patient notice and complaint mishandling (proposed MHD 527(a)) should diminish or be obviated. Furthermore, a fine may not attach unless there is no timely compliance with such an order. An upper limit of 60 days is placed on the allowable period of correction since corrective action relative to any of these violations is entirely possible within that period, and since the Legislature's recognition of the importance of a <u>functional</u> grievance mechanism appears quite clear. As mentioned above, subd. 3(d) of the grievance mechanism statute places an upper limit of $200 per violation upon the fine schedule. For this reason, the proposed fines for violations relate directly to the importance of the particular rule which has been violated. Hence, in what seems to be a reasonable decreasing order of

significance the fines are as follows:

Violation	Amount per violation
Not having a grievance mechanism -	Up to $200
Failure to submit an annual report -	Up to $200
Failure to have an individual able to receive complaints within the facility at the specified times -	Up to $150
Failure to designate a person to operate the mechanism -	Up to $100
Failure to post notice -	Up to $100
Failure to fulfill the criteria for the annual report -	Up to $100
Failure to maintain patient complaint records -	Up to $50

Clearly, not having any mechanism, as prescribed by the statute, is a violation of the highest order. Failure to submit an annual report, also required by statute for purposes of improving grievance mechanisms, seems to be of similar rank. Not having an individual able to receive complaints in a timely fashion appears only slightly less important - the absence of such an individual vitiates the existence and efficiency of the mechanism. The necessity of maintaining coordination over the functioning of the mechanism, as expressed in the requirement that a designated individual be responsible for it, mililates for the conclusion that a failure to measure up to this requirement is a violation only slightly less serious than the immediately preceding one. Failure to post notice and failure to submit a complete annual report also appear to be violations best slotted at this particular dollar range. Finally, since the failure to maintain patient complaint records makes it very difficult for the Board/Department to carry out its monitoring functions, it is reasonable to include it here as a violation, the implications of such a failure in regard to a particular patient (as opposed to the complaint mechanism in general), having been addressed

in proposed MHD 527 (a).

MHD 370: Subd. 4 of the grievance mechanism statute also requires H.M.O.'s to report on the experience of their respective complaint system. Since H.M.O.'s are already required to have such a mechanism, it seems prudent to tie the reporting requirement into the relevant portion of the existing H.M.O. rules. The reasonableness for the criteria of such reports is discussed above, with reference to proposed MHD 526.

EX I

2. Rules relating to the transfer of patient's x-ray records. Contact: Dr. Ellen Z. Fifer
Assistant Commissioner for Programs
Phone: (612) 296-5391

3. Rules relating to the nature and requirements of all general formal and informal procedures (as distinguished from procedures for specific programs which will be promulgated as separate rules) related to the administration of official duties of the State Department of Health and the State Board of Health which directly affect the rights of or procedures available to the public.
Contact: Michael Moen
Phone: (612) 296-5463

Any materials submitted shall be reviewed and considered by the Department of Health during the preparation of the proposed rules. Notice of the public hearing on the proposed rules shall be published in the State Register and given to all interested parties who have registered with the Secretary of State's Office in accordance with the provisions of the Administrative Procedure Act.

Under the provisions of Minn. Stat. § 10A.01, subd. 11 (1974), any individual representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. The State Ethics Commission is located at Room 401, State Office Building, Saint Paul, Minnesota 55155.

Warren R. Lawson, M.D.
Secretary and Executive Officer

Department of Health
State Board of Health
Amendments to Rules Regulating the Operations of Health Facilities

Notice of Intent to Solicit Outside Opinion

Notice is hereby given, pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6 (Supp. 1975) that the Minnesota State Board of Health will propose the adoption of new rules and the amendment and revision of existing rules.

All interested parties desiring to submit data or views relating to the proposed adoption, amendment or revision of the rules noted below should address their comments (either written or oral) to the Minnesota Department of Health, Division of Health Facilities, 717 Delaware Street S.E., Minneapolis, Minnesota 55440, by writing or calling the persons designated. Evidence submitted for consideration should be pertinent to the matter at hand. Written material received by the Department of Health will become part of the hearing record.

1. Rules implementing the provisions of Laws of 1976, ch. 173, relating to the licensing and regulation of nursing homes. Contact: H. Michael Tripple
Phone: (612) 296-5418

2. Proposed amendments to MHD 391-410, Supervised Living Facilities, and to MHD 411-430, Out-patient Surgical Centers, with respect to the establishment of levels of assessments for violations of rules pursuant to Minn. Stat. § 144.653. Contact: H. Michael Tripple
Phone: (612) 296-5418

3. Rules relating to implementation of hospital rate review by the State Board of Health to include financial reporting requirements, rate review procedures, standards for approval of voluntary rate review procedures and establishment of a filing fee to be charged for submission of hospital rate modifications to the Board.
Contact: Kent E. Peterson
Phone: (612) 296-5365

4. Rules implementing Laws of 1976, ch. 325, relating to complaint or grievance mechanisms in hospitals, outpatient surgery centers, and health maintenance organizations. Contact: Janet G. Brodahl
Phone: (612) 296-5441

5. Rules relating to the establishment and approval of education courses in the health related subject of administration of medications by unlicensed personnel in health facilities. Contact: Robert A. Hamilton
Phone: (612) 296-5487

6. Proposed amendments to MHD 44 to 71, rules for the construction, equipment, maintenance, operation and licensing of boarding care homes, for establishing standards

for noncertified boarding care homes, and for establishment of levels of assessments for violation of the rules.

Contact: H. Michael Tripple
Phone: (612) 296-5418

7. Proposed amendments and rewriting of MHD 44-71, rules for the construction, equipment, maintenance, operation and licensing of nursing homes and boarding care homes, in addition to establishing standards for certified boarding care homes, and establishing levels of assessments for violations of the rules.

Contact: H. Michael Tripple
Phone (612) 296-5418

8. Rules relating to procedures for review of assessment hearings of all health care facilities.

Contact: H. Michael Tripple
Phone: (612) 296-5418

9. Proposed amendments to and rewriting of MHD 76-116, rules for the construction, equipment, maintenance, operation and licensing of hospitals, and for the establishment of levels of assessments for violations of the rules.

Contact: Daniel McInerney
Phone: (612) 296-5511

10. Rules relating to the award of emergency medical services grants. Contact: Bernard Webber
Phone: (612) 296-5281

11. Proposed amendments to MHD 391-410, Supervised Living Facilities, to include but not be limited to adding detoxification centers as a facility covered by these rules. Contact: Hans Larsen
Phone: (612) 296-5451

12. Rules relating to the "reasonable volume of uncompensated care" and the "community services" requirements of the hospital survey and construction (Hill-Burton) program.

Contact: Robert Manske
Phone: (612) 296-5442

Any materials submitted shall be reviewed and considered by the Department of Health during the preparation of the proposed rules. Notice of the public hearing on the proposed rules shall be published in the State Register and given to all interested parties who have registered with the Secretary of State's Office in accordance with the provisions of the Administrative Procedure Act.

Under the provisions of Minn. Stat. § 10A.01, subd. 11 (1974), any individual representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. The State Ethics Commission is located at Room 401, State Office Building, Saint Paul, Minnesota 55155.

Warren R. Lawson, M.D.
Secretary and Executive Officer

Minnesota Housing Finance Agency

American Indian Housing

Notice of Extension of Emergency Rules

Notice is hereby given that the Minnesota Housing Finance Agency's Emergency Rules Governing American Indian Housing, published at 1 S. R. 208-09, have been extended, as published, for an additional 75 day period, dated from the date of the order readopting the said rules and the refiling of said rules with the Secretary of State, October 26, 1976, pursuant to authority vested in me by the Board of the Agency, pursuant to Resolution of the Board, under the provisions of Laws of 1976, ch. 254, § 9 and as authorized by Minn. Stat. § 15.0412, subd. 5.

James F. Dlugosch
Executive Director

Pollution Control Agency

Proposed Rules Governing Installation and Operation of Individual Sewage Treatment Systems

Notice of Intent to Solicit Outside Opinion

Notice is hereby given that the Minnesota Pollution Control Agency (MPCA) has begun consideration of proposed

MINUTES OF THE HEALTH FACILITY ADVISORY COUNCIL MEETING OF August 24, 1976

Members Present:

Dennis Boland
Delmar Gillespie, M.D.
Evelyn Staus
David Van Wyk

Members Absent:

John Haines
Norman Kaye
William Kreykes
John Lannon
Cyril D. Tifft, M.D.

Staff Present:

Janet Brodahl
Dan McInerney
Deborah Rickard

Guests:

Margo Struthers, Minnesota Hospital Association
Roland Peterson, Cannon Falls Community Hospital

The meeting began at 1:15 p.m. in the Board Room of the Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis.

Mr. McInerney explained that the task of reviewing hospital rules would be temporarily interrupted in order to review rules for grievance mechanisms. The 1976 Legislature mandated the development of rules requiring establishment of a grievance mechanism in hospitals and outpatient surgery centers. The rules have been drafted as close to the statutes and legislative intent as possible. The rules will be brought to the Board of Health at its September meeting and a request will be made for a public hearing.

Mr. Van Wyk asked whether there are Federal regulations relating to grievance mechanisms. Mr. McInerney responded that Federal regulations for long term care facilities require protection of patient rights. Also, HMO's are already required by State law to have a grievance mechanism. However, Minnesota Statutes Ch. 325 will require HMO's to develop a reporting system to the Board of Health.

The Council began discussion of the grievance procedure rules.

E Procedural Rules

E(1) Mr. McInerney explained the first requirement directs the hospital to designate one person who is accountable for the grievance mechanism.

E(2)(b) Mr. McInerney stated that the designated person must be physically in the facility during business and visiting hours. The inclusion of the

visiting hour requirement is important because the patient's relatives may wish to verbalize their complaints. Mrs. Brodahl stressed the importance of this requirement by stating it is important to respond immediately to patient complaints although not necessarily possible to resolve the complaint right away. Mr. McInerney stated that the law does not mandate resolution to complaints, but its intent was to provide a mechanism to encourage hospitals to respond to complaints in order to prevent future litigation.

Mr. Van Wyk questioned whether the procedure requires more than one level of response from the facility. Mr. McInerney stated that the designated person must receive reports of all grievance resolutions.

Dr. Gillespie mentioned that some hospitals have already started a grievance procedure in order to protect themselves.

Ms. Staus stated that we know there are abuses at times in hospitals but we want to prevent or resolve them. Patients have not always known or been informed that there was a grievance procedure available. Mr. McInerney explained that the new rules will require that the patient be informed.

Mrs. Brodahl explained that an outside vehicle of resolution of patient complaints is available through the Office of Health Facility Complaints established in the Department of Health by the 1976 Legislature.

Mr. McInerney reported that another vehicle of resolution is available in the metropolitan area. The Minnesota Medical Association, the Minnesota Hospital Association and the Minnesota Lawyers Association have combined efforts in an attempt to resolve patient problems.

E(4) In reference to the requirement that the authorized individual inform the complainant of the time limit for response to complaints, Mr. Van Wyk asked why the phrase "in his best judgement" was included. Mr. McInerney stated that the statement gives the hospital leeway in categorizing and setting time limits for complaints. Ms. Struthers added that although the wording does not add anything legally the language seems reassuring and sets a good tone.

E(6)(c) Mr. McInerney added the following as grounds for denial based upon discussion with the Hospital Association: Regulation E(6)(c) should read, "The action sought by the claimant would violate a written policy which has been approved by the facility's governing body."

E(6)a Based on a suggestion by Mr. Van Wyk, the Council decided to change the regulation to "is medically and/or therapeutically contra-indicated."

E(7) Heading should read, "Patient Complaint Records." Ms. Staus asked whether the complaint record should be a part of the patient's medical record. Mr. McInerney explained that the hospital could decide whether the complaint should also be contained in the medical record.

Mr. Van Wyk asked how long the complaint records must be retained by the hospital. The Council suggested that the regulations address the issue. Mr. McInerney will add as 7(d), records must be kept at least one year.

F Complaint Areas

Mr. McInerney explained that this section lists complaints related to breeches in patient rights. He stated that the rules are designed to help facilities decide what categories complaints fall into. Time limits for responding to complaints are defined for each item.

F(9) The regulation was amended to read "failure to provide requested information, prior to . . . ."

Ms. Staus questioned whether the categories listed include complaints related to maternal and child health questions. Mr. McInerney stated that they do and that the grievance mechanism should encourage the development of hospital policies for questions or problems raised and previously not addressed in policy statements.

Ms. Staus asked whether hospitals should furnish a copy of the policies to the patient. Ms. Brodahl responded that many hospitals provide patients with information about policies. Ms. Struthers stated that most hospitals try to incorporate this information into one informative brochure.

G Reports

Mr. McInerney explained the reporting procedure. Because the legislature wants information and recommendations relating to prevention of malpractice cases, it is important that the Board be provided with the best data available. Specific data is more accurately analyzed.

Mr. Van Wyk suggested that an alternative reporting approach would be to require a statistical summary from each facility with their recommendations for future improvements. Mr. Boland agreed and stated that he felt it would be beneficial for the facility to do their own analysis of trends, etc. Also, collection and summation of specific data would be an immense job for the Department. Mr. Van Wyk suggested that each hospital should submit reports and provide the State Board of Health with a plan for correction. Ms. Struthers suggested that this approach is getting close to requiring resolution of complaints which is not included in the law. Mrs. Brodahl stated that it is difficult to imagine why hospitals would not want to analyze results anyway. She asked whether the Department could develop a reporting form. Mr. McInerney replied in order to do that the form would have to be promulgated.

Mr. McInerney will redraft regulation G(1)(d) to reflect the Council's recommendations for requiring a report which summarizes and evaluates complaints.

E(3) Time limits for responding to complaints were discussed. 24 hours is the allowable response time for matters relating to items intimately associated to patient care, 72 hours for problems relating to psycho-social conditions, and 30 days allowable for complaints relating to billing questions or information requests.

Ms. Staus and Ms. Struthers raised the questions of what happens if the patient is discharged before, for example, the 72 hours given for response. Mr. McInerney stated that the facility could mail its response to the patient within the time limit. Ms. Struthers suggested that priority be given to responding to complaints of patients in the hospital.

The Council questioned whether written responses to complaints were necessary. Mr. Boland stated that this would create additional paperwork. Dr. Gillespie stated that if the patient complaint is verbal, the hospital should not be required to respond in a written manner. This approach, he added, could increase hospital costs. Mr. McInerney stated that the hospital is more protected if the response is written. Studies have shown that patients often do not remember the hospital's response to their complaints. Ms. Struthers stated she felt it was not necessary for the hospital to provide a written response to the patient for each complaint but the complaints must be recorded and annotated. Ms. Struthers reminded the Council that "complaints", as referred to by the regulations, means only those complaints referred to the designated person. Mr. McInerney will redraft E(3) to make it more clear. Mr. Van Wyk suggested that a definition of "complaint" be added to the regulations.

H Schedule of Fines

Mr. McInerney stated that the reference in H 1(a)(i) should be E(9) not E(8).

Grounds for issuance of orders and assessments were discussed. Mr. McInerney stated that fines are issued only if orders are not complied with. There is an up to 60-day time limit for compliance with orders and that facilities should have ample time to correct problems. The fine schedule is as follows:

1. Failure to have mechanism - up to $200 fine
2. Failure to have designated person - up to $100 fine
3. Failure to have designated person physically present in facility - up to $150 fine
4. Failure to maintain records - up to $50 fine
5. Failure to post notice - up to $100 fine

6. Failure to submit annual report - up to $200 fine
7. Failure to fulfill criteria for content of report - up to $100 fine

Mr. Van Wyk asked whether the Department could request an order to be corrected in less than 60 days. Mr. McInerney replied that there should be discretion used in requesting correction time limits so both the surveyor and the facility are not locked into rigid requirements. Mr. Van Wyk suggested that an alternative be written which would set a minimum time requirement for correction, for example, 20-60 days and offer protection for hospitals. Mr. McInerney will revise the regulations to include this alternative.

Mr. McInerney stated that the next meeting of the Advisory Council is scheduled for September 8, 1976. Mr. McInerney announced that Mr. Robert Sundberg has resigned from the Council.

Mr. Boland expressed his thanks to Dr. Lawson and the staff for investigating the room size interpretation problem at Hastings State Hospital.

Mr. Van Wyk expressed his desire that formulation of chemical dependency and alcoholic treatment rules be included in the basic services section of the hospital regulations. Mr. McInerney stated that the chemical dependency and alcoholic treatment services would be considered supplemental services but that development of the rules could be completed earlier and promulgated at the same time as the basic services. Mrs. Brodahl agreed and stated she had sensed a strong feeling that the Health Department should develop the rules quickly and survey without involving another agency.

There being no further business, the meeting adjourned at 3:30 p.m.

Deborah Rickard
Recorder

RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of promulgating rules of the Board of Health relating to Health Facility Grievance Mechanisms as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing and notice of hearing as well as requesting the appointment of a hearing examiner for all hearings.

1/14

Allen Klein says
he doesn't have
this. It should
be introduced at
the hearing after
the jurisdictional
statement, he said.

Ex 10

Each utility shall explain in writing any significant deviation in its customer assignments which would affect the delivery figures reported under this section.

(d) In 1975 a utility which files FPC Report 12, Schedule 10, or its equivalent, and whose service area is wholly within Minnesota, shall submit copies of FPC Report 12, Schedule 10, for the years 1965 to 1974 to the director by July 1, 1975. Data for 1975 sales based on FPC Report 12, Schedule 10, shall be reported to the agency within 10 days after it is submitted to the Federal Power Commission.

(e) A utility which files FPC Report 12, Schedule 10, or its equivalent, and whose service area is not wholly within Minnesota, or a utility which does not file FPC Report 12, Schedule 10, or its equivalent, shall submit actual data or estimates if data is not available based on the Schedule 10 categories for the year 1965 to 1974 to the director by July 1, 1975.

EA 211 Advance forecasting for power plant siting. This rule requires reporting of the same information required by the Minnesota Environmental Quality Council for advance forecasting for power plant siting under MEQC 74. It is intended that each utility may submit a single document which will cover the needs of both the MEQC and the Agency. Each reporting utility shall submit three (3) copies of the document to the director.

Each utility required to report under EA 204 (a) shall provide the following information concerning its facilities:

(a) Identification of the location, generating capacity (over one megawatt), type, and fuel of all existing electric power generating plants and of the location, transmission capacity, and type of all existing transmission lines designed to operate at a nominal voltage of 100 Kilovolts or more intended to be removed from service within 20 years from the current year; description of land use plans for the sites and routes involved;

(b) Identification of the location, generating capacity (over one megawatt), type, and fuel of all electric power generating plants and of the location, transmission capacity, and type of all transmission lines designed to operate at a nominal voltage of 100 kilovolts or more removed from service in the preceding five-year period; statement of the disposition of the sites and routes involved (real property and easements);

(c) Description of the tentative regional location, generating capacity, type, land and water areas involved, anticipated maximum water demand (maximum rate and yearly volume), and source of water for all new LEPGP's and the tentative regional location, transmission capacity, and type of all new HVTL's to be constructed, owned, or operated by the utility within 15 years from the current year;

(d) Description of the current transmission grid and of the forecasted grid together with the reasons for changing the capacity and reliability of the grid;

(e) Description of the utility's relationship to other utilities and regional association, power pools or networks.

The ability of the MEQC to require information other than that listed above is not limited or abrogated by the inclusion of this section in the rules and regulations of the Agency.]

EA 212 Corrections. Substantial corrections of any report or statement must be filed with the agency within 10 days following the date of the event prompting the change in reported information or the date upon which the person filing became aware of the inaccuracy. The change or correction shall identify the form and the paragraph of the information to be changed or corrected.

EA 213 Federal or state data substitution for Energy Agency data requirements. Upon written request by any utility, the director may allow [any utility] it to substitute data provided to the federal government or another state agency in lieu of data required by these regulations if the data required by both agencies is substantially the same.

Department of Health
State Board of Health
Establishment of Grievance Procedures for Patients in Hospitals and Surgery Centers

Notice of Hearing

Notice is hereby given that a public hearing in the above-entitled matter will be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Tuesday, January 18, 1977, commencing at 9:00 A.M., and continuing until all persons have had an opportunity to be heard.

KEY: New rules and material proposed to be added to an existing rule are printed in boldface. Material proposed to be deleted from an existing rule is printed in [single brackets]. Underlining indicates additions to proposed rules, while [[double brackets]] indicate matter stricken from proposed rules. Existing material is printed in standard type face.

All interested or affected persons will have an opportunity to participate. Statements may be made orally and written materials may be submitted at the hearing. In addition, written materials may be submitted by mail to Allan Klein, Hearing Examiner, Room 300, 1745 University Avenue, St. Paul, Minnesota, (612) 296-8112, either before the hearing or within 20 days after the close of the hearing.

The proposed rules, if adopted, would implement the requirements of Laws of 1976, ch. 325, § 8, including:

1. The delineation of minimum standards and procedural requirements for grievance mechanisms;

2. The presentation of a list of patient complaints which may be processed through such a mechanism;

3. The description of the form and manner in which patient notices are to be made;

4. The specification of a schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of the statute; and

5. Requiring the submission of at least an annual report on the operation of such mechanisms by hospitals, outpatient surgery centers and health maintenance organizations.

Copies of the proposed rules are now available and one free copy may be obtained by writing to Daniel J. McInerney, Jr., Room 212, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of the hearing. The authority to promulgate the proposed rules is contained in Laws of 1976, ch. 325, § 8. A "statement of need" explaining why the agency feels the proposed rules are necessary and a "statement of evidence" outlining the testimony the Board of Health will introduce at the hearing, will be filed with the Office of Hearing Examiners at least 25 days prior to the hearing and will be available there for public inspection.

Please be advised that pursuant to Minn. Stat. § 10A.01 subd. 11 (1974), any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules must register with the State Ethics Commission as a lobbyist within five (5) days of the commencement of such activity by the individual. The State Ethics Commission is located at 410 State Office Building, St. Paul, Minnesota, 55155.

It is suggested that, to save time and avoid duplication, those organizations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests.

Warren R. Lawson, M.D.
Secretary and Executive Officer

Rules as Proposed

MHD 521 Applicability. These rules apply to hospitals and outpatient surgery centers.

MHD 522 Definitions. Definitions for these rules are as follows:

A. "grievance mechanism" means grievance and/or complaint procedures.

B. "hospital" means any entity licensed as such pursuant to Minn. Stat. §§ 144.50 to 144.56.

C. "outpatient surgery center" means a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

MHD 523 Minimum standard. Every hospital and every outpatient surgery center shall establish, operate and maintain a grievance mechanism designed to process and resolve patient grievances in accordance with these rules.

MHD 524 Procedural requirements.

A. Designated person. Every hospital and every outpatient surgery center, shall, through their respective governing authorities, designate an individual to be accountable for the operation of a grievance mechanism.

B. Complaints, generally.

1. Any patient, or his representative, may initiate any oral or written complaint related to those subjects specified in MHD 525.

2. Such complaints may be made to the person designated by the facility under MHD 524 A., or to any other person authorized to receive complaints by the facility. A person authorized to receive complaints shall be physically within the facility and able to receive complaints during ordinary business and visiting hours. Persons authorized to receive complaints, other than the

person designated under MHD 524 A., shall, in all complaint cases, report any response or resolution, or refer the complaint, to the person designated under MHD 524 A.

C. Time limits for response. When such complaints are made while the patient is in the facility, written response to them, or written notice of the resolution of the complaint, shall be provided to the complainant within the following time periods:

1. 24 hours for complaints relating to the following provisions of MHD 525: A.; B.; C.; G.; I.; K.; L.; M.; N.; O.; Q.; and T.

2. 72 hours for complaints relating to the following provisions of MHD 525: D.; E.; F.; H.; J.; R.; S.; and U.

3. 30 days for complaints relating to the following provisions of MHD 525: P.; and V.

D. Notice of time limit. The authorized individual to whom the complaint is made shall, within 4 hours, inform the complainant of the applicable time limit, in his best judgement, for response or resolution under MHD 524 C.1., 2., or 3.

E. Exception. If the condition of the patient in question presents an emergency situation preventing timely response to, or the resolution of, a complaint, the time limits specified in MHD 524 C.1. and 2. shall extend an additional 48 hours. In all such cases, a dated annotation of the existence of such an emergency situation shall be placed in the record required to be kept under MHD 524 G. and signed by the person asserting them in behalf of the facility.

F. Denials. The grounds on which denial of the action requested by the complainant can be based include the following:

1. the action sought by the claimant is medically and/or therapeutically contraindicated;

2. the action sought by the claimant would be violative of any of the rights, as prescribed in Minn. Stat. § 144.651, of other facility patients; or,

3. the action sought by the claimant would violate a written policy, approved by the facility's governing authority.

A dated annotation of any of the above grounds shall be placed in the patient's record and signed by the person asserting them.

G. Patient complaint records. The following complaint records shall be maintained according to patient by the facility for periods of time determined in a written policy approved by the facility's governing authority:

1. an annotation of the date, time and substance of each complaint made by, or in behalf of, any patient;

2. a reference to any previous complaints made by, or in behalf of, the same patient during his current stay in the facility; and

3. an annotation of the date, time and substance of any response to, or resolution of, the complaint.

H. Patient notice.

1. Notice of mechanism. Written notice of the existence and availability of the grievance mechanism shall be posted conspicuously in all facilities, along with the notice required under Minn. Stat. § 144.652, and furnished, along with the notice required under Minn. Stat. § 144.652, to the patient or his representative upon admittance to the facility.

2. Content of the notice. Such written notice shall include the following:

a. a statement that complaints or grievances related to rights expressed in the Patients' Bill of Rights (Minn. Stat. § 144.651), or to any other rights, may be able to be resolved within the facility;

b. a statement that the facility maintains a grievance mechanism for this purpose; and,

c. a statement specifying an individual or type of individual to whom such complaints or grievances can be directed.

MHD 525 Patient complaints. Complaints relating to at least the following shall be subject to being processed through a grievance mechanism;

A. lack of considerate or respectful care;

B. failure to provide complete, current and understandable information concerning diagnosis, treatment or prognosis;

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C. failure to provide the name and specialty, if any, of the physician responsible for coordination of care;

D. failure to afford consideration or privacy;

E. failure to afford consideration of individual social, religious and psychological well-being;

F. failure to preserve the confidentiality of the medical care program;

G. failure to provide, upon request, information bearing on the individual case with respect to any relationship of the facility to other health services facilities, medical groups and other similar entities;

H. failure to afford continuity of care;

I. failure to provide requested information, prior to or at the time of admission and during the period spent in the facility, relating to charges for care;

J. failure to afford the opportunity to participate in the planning of medical treatment;

K. failure to inform of, or to offer an opportunity to refuse to participate in, experimental research;

L. retaliatory, arbitrary, or otherwise medically unjustifiable discharge;

M. interference with or retaliation for the free exercise of any legally prescribed rights;

N. mental and/or physical abuse;

O. medically unjustifiable physical and/or chemical restraints;

P. failure to comply with lawful requests to release or to withhold medical records;

Q. requiring the performance of services not included for therapeutic purposes in the plan of care;

R. restriction of the right to associate and communicate privately with others;

S. interference with the sending and receipt of personal mail;

T. restriction of the rights to meet with representatives and to participate in commercial, religious and community activities;

U. restriction of the right to retain and use personal clothing and possessions, to the extent that space permits; and,

V. failure to respond to questions concerning billing practices, the amount of a specific bill, and the like.

MHD 526 Reports. Every hospital and every outpatient surgery center, shall, on or before each February first, submit to the state board of health a report on the experience of their respective grievance mechanisms during the immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting institution;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the grievance mechanism;

D. the total number of complaints received by the facility;

E. the total number of complaints, according to classification under MHD 525;

F. the total number of any other complaints;

G. the number of patients by whom or for whom more than one complaint was made and the total number of such complaints; and,

H. the total number of complaints resolved to the patient's satisfaction.

MHD 527 Schedule of fines.

A. Patient notification and complaint mishandling.

1. Grounds; fine amounts. The following violations of these rules shall constitute grounds for the automatic assessment of a per violation $50 fine:

a. failure to given individual patient notice, as required under MHD 524 H.; and,

b. failure to respond to a patient complaint within the applicable time limits, as required under MHD 524 C.

Multiple violations with respect to the current stay of a particular patient shall result in fines which in no case exceed $200. Such fines are payable within 30 days of the automatic assessment, unless there is a facility request for a hearing. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.

B. Inadequate or improperly functioning mechanism.

1. Grounds. The following violations of these rules shall constitute grounds for the issuance of a correction order:

a. failure to have a grievance mechanism, as required under MHD 523;

b. failure to designate a person to be responsible for the operation of a grievance mechanism, as required under MHD 524 A.;

c. failure to have an individual within the facility and able to receive complaints during ordinary business and visiting hours, as required under MHD 524 B.2.;

d. failure to maintain patient complaint records, as required by MHD 524 G.;

e. failure to post notice, as required by MHD 524 H.;

f. failure to submit an annual report, as required by MHD 526; and,

g. failure to fulfill the criteria for content of the annual report, as required by MHD 526 A.

2. Time periods for correction. In no case may the allowable period for correction of any of the violations in MHD 527 B.1. exceed 60 days.

3. Fine amounts. The amounts which shall be assessed in the event that the facility does not comply with correction orders within the allocated period of time are as follows:

a. violations as described in MHD 527 B.1.a. — up to $200 per violation;

b. violations as described in MHD 527 B.1.b. — up to $100 per violation;

c. violations as described in MHD 527 B.1.c. — up to $150 per violation;

d. violations as described in MHD 527 B.1.d. — up to $50 per violation;

e. violations as described in MHD 527 B.1.e. — up to $100 per violation;

f. violations as described in MHD 527 B.1.f. — up to $200 per violation; and,

g. violations as described in MHD 527 B.1.g. — up to $100 per violation.

Such fines are payable within 30 days of the assessment, unless there is a facility request for a hearing within that period. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.

MHD 528-535: Reserved for future use.

MHD 370 Governing body; consumer members; enrollee participation; complaint system.

Sections (a) through (e) remain unchanged.

F. Records of complaints. Every health maintenance organization shall maintain a record of each complaint filed with it during the prior three years. The record shall, where applicable, include:

1. The complaint or a copy thereof and the date of its filing.

2. A brief written summary of the outcome of all informal discussions, consultations or conferences held relative to each complaint and the date or dates on which each such informal discussion, consultation or conference occurred. Such summary shall include an acknowledgment by those participating in the form of their signatures.

3. The date or dates of any hearing and a copy of the hearing findings given the enrollee complainant.

4. The dates of commencement and conclusion of another processing conducted in accordance with MHD 370(e); and a copy of the concise written record of all findings and recommendations arising therefrom, which record shall include an acknowledgment by those participating in the form of their signatures.

5. The date of submission of any complaint to arbitration; a copy of the arbitrator's decision; and the date of the decision.

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6. A brief written summary, including the filing date, of each complaint which becomes a subject of litigation; a brief written summary, with dates, of the findings or outcome of any prior processing held relative to the complaint; and a brief written statement describing the outcome of the complaint or claim as determined in litigation.

G. Complaint reports. Every health maintenance organization shall, on or before each February first, submit to the state board of health a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

1. the name and location of the reporting health maintenance organization;

2. the reporting period in question;

3. the name of the individual(s) responsible for the operation of the complaint system;

4. the total number of complaints received by the health maintenance organization;

5. a copy of the written summaries of informal discussions, consultations and conferences required to be kept for each complaint under (f)(2) of this rule;

6. the number of enrollees by whom or for whom more than one complaint was made and the total number of such complaints; and,

7. the total number of complaints resolved to the enrollee's satisfaction.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

In the Matter of the Proposed Rules Relating to the Operation of Health Facilities Grievance Mechanisms

AFFIDAVIT OF MAILING

Judy Hoffman, being first duly sworn, deposes and says:

That on the 30 day of November, 1976, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof, as well as to all members of the Minnesota Legislature as of the date of mailing.

Judy Hoffman

Subscribed and sworn to before me this 30th day of November, 1976.

MILDRETH OLSON
Notary Public, Hennepin Co., Minn.
MY COMMISION EXPIRES
October 21, 1980

Mildreth Olson

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55303

HYDROLOGIST
CHIPPEWA NATL FOREST
CASS LAKE MN
56633

HYLAND DEAN
1501 W 50TH ST
MPLS MN
55419

ILLINGWORTH ROBERT C
6750 FRANCE AVE S RM250
MPLS MN

INGERSTSEN DR K H
23 SE 4TH ST
MPLS MN
55414

INGVALSON VERN MN.FARM BUR.
3110 WOODDALE DR PO 337
OST PAUL MN
55165

INS FED OF MINN
902 SOO LINE BLDG
MPLS MN
55402

INTERSTATE POWER RM STEEL
1000 MAIN ST
DUBUQUE IA
52001

IOOE LOC 49 CHAS SKENSON
2500 UNIV AVE
ST PAUL MN
55101

IVERSON DR JOS DEPT ED
ST OLAF COLLEGE
NORTHFIELD MN
55057

IZAAK WALTON MN DIV
111 E FRANKLIN RM-210
MPLS MN
55404

4023 S LAKE ST
MPLS MN
55406

1220 GLENWOOD AVE
MPLS MN
55405

525 LAKE AVE SO
DULUTH MN
55801

2215 W OLD SHAKOPEE RD
BLOOMINGTON MN
55431

JENSEN CARL A
127 E MAIN ST
LEROY MN
55965

JENSEN MRS GAYNOLD
111 WEST 107TH ST
MPLS MN
55420

JOHANSEN BUS SERV INC
19 DAYTON RD
CHAMPLIN MN
55316

JOHNSON & SANDERSON
ST MARYS HOSPITAL
ROCHESTER MN
55901

JOHNSON CLARENCE IBEW LU 292
3615 37TH AVE S
MPLS MN
55406

JOHNSON G ROBERT
4344 IDS CENTER
MPLS MN
55402

JOHNSON LEROY
9939 BLUEBIRD ST NW
COON RAPIDS MN
55433

JOHNSON M.D. FRUNDT & FRU

BLUE EARTH MN
56013

JOHNSON LANCE J
265 S LAFAYETTE RD
ST PAUL MN
55107

KABLE RICHARD W

BETHEL MN
55005

KAVANEY RICHARD
1220 NORTHERN FED BLDG
ST PAUL MN
55102

KEABLE MIKE
909 6TH AVE N
ST CLOUD MN
56301

KEENAN RICHARD J
4444 IDS BLDG
MPLS MN
55402

KEILY DANILE
3549 V2 PLEASANT AVE
MPLS MN
55408

KIMBALL ROBERT
647 CAPITOL SQ BLDG
ST PAUL MN
55101

KJERVIK DIANE
4302 ROWEL HALL U OF M
MPLS MN

KLOSTER MARION PEAVEY CO
730 2ND AVE S
MPLS MN
55402

KLUZ STEVEN J
1910 1ST NATL BK BLDG
MPLS MN
55402

KNAPP J A
RM 3 CAPITOL
ST PAUL MN
55155

KNOPP TIMOTHY
COLLEGE FORESTRY U OF M
ST PAUL MN
55108

KNUTSON DR KEITH, BIOLOGY DPT
ST CLOUD STATE
ST CLOUD MN
56301

KNUTSON R N GRANNIS ETAL
F J SCHULT BLDG
ST ST PAUL MN
55075

KNUDSON ROBT
4375 BROWNDALE AVE
MPLS MN
55424

KOLLER MR & MRS ERWIN A
1555 DULUTH ST
ST PAUL MN
55108

KOPP MRS VERNON
2050 65TH ST E
INVER GR HGHT MN
55075

KRAMER ERNEST W
717 DELAWARE ST SE
MPLS MN
55440

KROEGER CHARLES
122 NW 7TH STREET
ST CROIX MN
55021

KRONLOKKEN J E
10048 NORD RD
BLOOMINGTON MN
55437

KROON H CLIFTON
210 E WALNUT
MANKATO MN
56001

KUHL CARL
4421 4TH ST NE
COL HEIGHTS MN
55421

KVR ENGINEERING INC
600 S CO RD 18
MPLS MN
55426

LABELLE JUANITA MRS
5810 AQUILA AVE NO
NEW HOPE MN
55428

LAKE SUPERIOR INDUSTRIAL BUR
828 FIRST AM. BK. BLDG.
DULUTH MN
55802

LANAMAN E F - SIBLEY CC
184 E 6TH ST
ST PAUL MN
55101

LANGVIN DAVID
7500 80TH ST S
COTTAGE GROVE MN
55016

LANSING & OAKES
400 SIBLEY ST
ST PAUL MN
55101

LAPP LAZAR LAURIE ET AL
1200 BUILDERS EXCHANGE
MINNEAPOLIS MN
55402

LARSON C L
3200 MINNEHAHA AVE SO
MPLS MN
55406

LARSON HANS P DIV HOSP SERV
717 DELAWARE ST SE
MPLS MN
55440

LEAGUE MN MUNIC
300 HANOVER 480 CEDAR
ST PAUL MN
55101

LEAGUE WOMEN VOTERS OF MINN
555 WABASHA
ST PAUL MN
55102

LEG.REF.LIB-Z. DEWITT
RM 111 STATE CAPITOL
ST PAUL MN
55155

LEWIS JR.G.M JR.
ABBOTT 110 E 18TH ST
MPLS MN
55403

LIEBEY LEONARD
BOX 17011 NOKOMIS STA
MPLS MN
55417

LINDALL & JONATHAN DEVELOP.
VILLAGE ONE CENTER
CHASKA MN
55318

LOCKNER GARY
R R 1 BOX 23
BAUDETTE MN
56623

LOOS CALVIN J
6109 LYNDALE AVE SO
MPLS MN
55423

LOWE DOUG
2701 N LEXINGTON AVE
ROSEVILLE MN
55113

LUTH SOC SERVICE OF MN
2414 PARK AVE
MPLS MN
55404

LYNCH DONALD SIBLEY CO
184 S 6TH ST
ST PAUL MN
55102

MALONE E I COMM LABOR & INDU
444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

MANKATO STAT STUDENT SENA
CENTENNIAL STUDENT UN
MANKATO MN
56001

MANKATO STATE STUDENT ASSN
BOX 53 MANKATO COLLEGE
MANKATO MN
56001

MANSFIELD LARRY HCARC
1800 CHICAGO AVE S
MPLS MN
55404

MANTHEY T J PICKANDS MATHER
1100 SUPERIOR AVE
CLEVELAND OH
44114

MARRINAN MARGARET M
1117 COMMERCE BLDG
ST PAUL MN
55101

MASTOR & MATTSON LTD
315 PEAVEY BLDG
MPLS MN
55402

MAUL WARREN E
320 S 4TH ST
MPLS MN
55415

MAYO FOUNDATION G CRWOLL
200 FIRST AVE NW
ROCHESTER MN
55901

MCDONALD PHILIP M
2077 SELBY AVE
ST PAUL MN
55104

MCFARREN G H DISPATCH-PRESS
55 E 4TH ST
ST PAUL MN
55101

MCKIBBON MRS SHIRLEY
11 EVERGREEN LN
BABBITT MN
55706

MCLELLAN LARKIN
215 ADM BLDG ST CAPITOL
ST PAUL MN
55101

MECCA
667 GRAND AVE
ST PAUL MN
55105

MET. WASTE CONTOL COMM.
350 METRO SQ BLG
ST PAUL MN
55101

METEROTTO, JOAN
1794 SO LEXINGTON
ST PAUL MN
55118

MET TER MEN ASSN A ROSENTHAL
1821 UNIV AVE
ST PAUL MN
55104

METROPOLITAN COUNCIL LIBR
300 METRO SQUARE
ST PAUL MN
55155

MEYER HERBERT
10824 ZENITH AVE S
BLOOMINGTON MN
55431

MEYERLE KATHLEEN
1528 GRAND AVE APT 4
ST PAUL MN
55105

MIDLAND GLASS-HC SPURLING
PO BOX 69
SHAKOPEE MN
55379

MILLER PAUL J PHARMACY SE
ST MARYS HOSP
ROCHESTER MN
55901

MILLER RICHARD A
1020 PLYMOUTH BLDG
MPLS MN
55402

MILLER TOM
2311 PILLSBURY AVE S
MPLS MN
55404

MINN APT ASSN
GRIGGS-MIDWAY BLDG
ST PAUL MN
55104

MINN ASPHALT PAVEMENT ASS
555 WABASHA RM 209
ST PAUL MN
55102

MINN ASSN COOPERATIVES
55 SHERBURNE AVE
ST PAUL MN
55103

MINN ASSN ELEC COOPERATIVES
4901 W 77TH ST
MPLS MN
55435

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN ASSN VOL SOC SERVICE
1821 UNIV SUITE 389
ST PAUL MN
55114

MINN ASSN WATERSHED DIST'S

ADA MN
56510

MINN AUTOMOBILE DEALERS ASSN
GRIGGS MIDWAY BLDG
ST PAUL MN
55104

MINN CHAP ASSOC BLDRS-CONTRS
7204 W 27TH ST
MPLS MN
55426

MINN COMM FOR HANDICAPPED
METRO SQ 492 7TH C FLOOR
ST PAUL MN
55101

MINN COMMUNITY DEVELOP SERV
512 ROSSMOR BLDG
ST PAUL MN
55101

MINN COUNCIL STATE EMP NO 6
475 RICE ST
ST PAUL MN
55103

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINN FARMERS UNION PRES C
1275 UNIV AVE
ST PAUL MN
55104

555 WABASHA
ST PAUL MN
55101

2400 SHERWOOD HILL RD
MINNETONKA MN
55343

BUFFALO LAKE MN
55314

2001 UNIVERSITY AVE
ST PAUL MN

MINN HOUSING INST N T CARTER
7601 METRO PKWY
MPLS MN
55420

MINN HWYS MANAGEMENT SERVICE
407 HWY BLDG
ST PAUL MN
55101

MINN LAND USE COMMITTEE
4044 IDS CENTER
MPLS MN
55402

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINNE MINE CREDIT UNION
3000 HUDSON PK S 100
ST PAUL MN
55119

MINN.MTR.TRANSP. .J.N.DENN
1621 UNIV.
ST.PAUL MN
55104

MINN PETROLEUM COUNCIL
1020 NORTHERN FED BLDG
ST PAUL MN
55102

MINN POLLUTION CONTROL AG
1935 W CO RD B2
ROSEVILLE MN
55113

MINN POULTRY & HATCHERY ASSN
BOX 198
MADELIA MN
56062

MN REP STATE CENTRAL COMM
555 WABASHA AVE
ST PAUL MN
55102

MINN RESTAURANT ASSN
2001 UNIVERSITY AVE.
ST PAUL MN
55104

MINN RETAIL FED INS
131 METRO SP
ST PAUL MN
55101

MINN RETAIL HARDWARE ASSN
3033 EXCELSIOR BLVD 313
MPLS MN
55416

MINN SOCIETY ARCHITECTS AIA
NW NATL BK BLDG
ST PAUL MN
55101

MINN SOC CERTIFIED PUB ACCTS
1102 WESLEY TEMPLE BLDG
MPLS MN
55403

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

MINN STATE BD PHARMACY
717 DELAWARE ST SE #351
MPLS MN
55414

MINN STATE MED ASSN
375 JACKSON ST
ST PAUL MN
55101

MINN STATE RETIREMENT SYSTEM
529 JACKSON ST
ST PAUL MN
55101

MINN TEAMSTERS CREDIT UNI
2021 MINN AVE E
MPLS MN
55413

MINN TRR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

MINN.TURKEY GROWERS ASSN
2303 UNIV AVE
ST PAUL MN
55114

MINN VETERANS MED ASSN
2175 W HWY 36
ROSEVILLE MN
55113

MINN WATER RESOURCES BD
RM 200 555 WABASHA ST
ST PAUL MN
55102

MINN-WISC BOUNDARY AREA COMM
600 2ND ST
HUDSON WI
54016

MN. ASN.COUNS H.D.PETERSON
480 CEDAR ST.
ST.PAUL MN
55101

MN AFL-CIO L.O. LASHOMB
175 AURORA
ST PAUL MN
55103

MN.BD OF NURSING
717 DELAWARE ST SE
MPLS MN
55414

MN ELECTRICAL ASSN
3100 HUMBOLT SO
MPLS MN
55408

MN PUB INT RESEARCH GROUP
3036 UNIV AVE SE
MPLS MN
55414

MN SOC SERV ASS J HOOD
614 PORTLAND
ST PAUL MN
55102

MN STATE SER BLIND-K NATA
1745 UNIVERSITY AVE
ST PAUL MN
55104

MOFFITT R C
RM 301 M MPLS CITYHALL
MPLS MN
55415

MOOD R BLOOMINGTON HLTH DEPT
10200 PENN SO
BLOOMINGTON MN
55431

MORTON BUILDINGS INC
R #1
FOLEY MN
56329

MPIRG
BOX 45 ST MARYS COLLEGE
WINONA MN
55987

MPLS ASSN RETARDED CITIZENS
2100 W LAKE ST
MPLS MN
55416

MPLS CITY ATTORNEY
329M CITY HALL
MPLS MN
55415

MPLS STAR PRESS ROOM
STATE CAPITOL
ST PAUL MN
55101

MPLS TRIBUNE CITY DESK
425 PORTLAND AVE
MPLS MN
55415

MT OLIVET ROLLING ACRES
R 1 BOX 576
EXCELSIOR MN
55331

MURPHY DIANA E
4200 IDS-LINDQUIST VENN
MPLS MN
55402

NASS GEO V HENN CO GEN HO
5TH AND PORTLAND AVE
MPLS MN
55415

5901 GREEN VALLEY DR
MPLS MN
55437

NCEC INC C/O DR DAHLBERG
CONCORDIA COLLEGE
MOORHEAD MN
56560

NIELSEN STOCK & BLACKBURN
415 730 BLDG
MPLS MN

NW COUNTRY ELEVATOR ASSN
902 GRAIN EXCH BLDG
MPLS MN
55415

NW BELL TEL CO LEGAL DEPT
224 S 5TH ST RM 2000
MPLS MN
55402

O'BRIEN J.DENNIS
1100 1ST NATL.BANK BLDG
MINNEAPOLIS MN
55402

OLSON KATHLEEN
192 SEYMOUR AVE SE
MPLS MN
55414

PATTISON ORVIS
BOX 645
WILLMAR MN
56201

PFEIFER AND SHULTZ, INC
1433 UTICA AVE S
MPLS MN
55416

POPOVICH PETER S
314 PINN BLDG
ST PAUL MN
55101

POSS DONALD G
6301 SHINGLE CREEK PKWY
BROOKLYN CTR MN
55430

PULSCHER FBT SPRINGSTED INC
613 OSBORN BLDG
ST PAUL MN
55102

NATL COUNCIL JEWISH WOMEN
4330 CEDAR LK RD
MPLS MN
55416

NEBELL HAROLD - MEINEKE
6300 W LOOP S SUITE 200
BELLAIRE TX
77401

NO SUB MONTESSORI-S SADDLER
2487 HELEN COURT
NO ST PAUL MN
55109

NURSING HOME ADMRS BD EXAMRS
RM 340 717 DELAWARE SE
MPLS MN
55414

NW REG. DEV. COMM
425 WOODLAND AVE
CROOKSTON MN
56716

OFFICE OF THE GOVERNOR
130 STATE CAPITOL
ST PAUL MN
55101

OSTRUM DONALD E
PO BOX 33163
COON RAPIDS MN
55433

PAYNE COL ALVIN

DEGRAFF MN
56233

PHAR MFGRS ASSN WM D PATTON
1155 15TH ST NW
WASHINGTON DC DC
20005

PORTER DAVID
5217 27TH AVE S
MPLS MN
55417

POYZER ROBT
BOX 675
FERGUS FALLS MN
56357

NATL FAMILY INS CO
2147 UNIV AVE
ST PAUL MN
55114

NEREN MADONNA
376 NEAL AVE S
AFTON MN
55001

NORTH CENTRAL ELEC ASSN
PO BOX 202
BATTLE LAKE MN
56515

NURSING HOME RES ADV CO.
111 E FRANKLIN S210
MPLS MN
55404

NYQUIST DEAN A
3707 53RD PL N
BROOKLYN CTR MN
55429

OLD COLONY GAS & OIL COMPANY
17TH AVE N AT 2ND ST
MPLS MN
55411

OTTER TAIL POWER CO.
215 S. CASCADE ST.
FERGUS FALLS MN
56537

PAYNE WM B
2400 FIRST NATL BK BLDG
MPLS MN
55402

PHILLIPS LEGISLATIVE SERVICE
459 RICE ST
ST PAUL MN
55103

PORTER LYLE O

TRACY MN
56175

PRAUSE JOS.C.
2220 105TH AVE.N.W.
COON RAPIDS MN
55433

NATL SOLID WASTES-R. ERA
1730 RHODE ISLAND AV.NW
WASHINGTON DC
20036

NELSON RALPH W
RT 2 BOX 125
EMBARRASS MN
55732

NUGENT, CYNTHIA L.
3581 CHASSC ST #209
ST PAUL MN
55112

NUTTER JULIA
743 W MONTANA
ST PAUL MN
55117

OLOFSON ARTHUR MBO & MAI
927 SOO LINE BLDG
MPLS MN
55402

PETERSEN GARY
854 MIDLAND BK BLDG
MPLS MN
55401

PINNETTI NICK M HALEY & A
40 CENTRAL PARK S
NEW YORK NY
10019

PORT AUTH CITY OF ST PAUL
330 MINNESOTA BLDG
ST PAUL MN
55101

PROCTOR&GAMBLE L THECHAR
IVORYDALE TECH CENTER
CINCINNATI OH
45217

RADMAN RICHARD-LABOR TEMP
418 AUDITORIUM
ST PAUL MN
55102

7710 COMPUTER 55101
MPLS MN
55435

800 CENTRAL AVE N E
MPLS MN
55413

900 AM NATL BK BLDG
ST PAUL MN
55101

7900 XERXES S. S-2200
MPLS MN
55431

REAGAN MICHAEL
E MINN LEARNING CTR
BRAINERD MN
56401

REARDON MRS HELEN
1125 S E 6TH ST
WILLMAR MN
56201

REID DAVID H
6469 N GRAHAM RD
INDIANAPOLIS IN
46220

RED OWL STORES INC
215 E EXCELSIOR AVE
HOPKINS MN
55343

REGION FIVE REG. DEV. COMM.
102 6TH ST N
STAPLES MN
56479

REGION NINE DEV. COMM.
709 S FRONT ST
MANKATO MN
56001

REIERSON G
1035 WHITE BEAR AVE
ST PAUL MN
55106

REINC C LAINE 3M COMPANY
3M CENTER
ST PAUL MN
55101

RENNER R.H. ST PAUL AREA CC
300 OSBORN BLDG.
ST PAUL MN
55102

RENQUIST ARTHUR NSP CC
414 NICOLLET MALL
MPLS MN
55401

RICHARDSON THOS
7851 METRO PKWY S 103
MPLS MN
55420

RICHARDS MONTGOMERY ET AL
1430 RAND TOWER
MPLS MN
55402

RIEKS DAVID R
P O BX 509
THIEF RIV FLS MN
56701

RIERSON G
1335 WHITE BEAR AVE
ST PAUL MN
55106

ROE DAVID
175 AURORA
ST PAUL MN
55103

ROESIE JOSEPH
904 CARGILL BLDG NO CTR
MPLS MN
55402

ROBERTS DR ALAN
BOX 297 MAYO U OF M
MPLS MN
55455

ROBERTS DAVID E
1200 NW NATL BK BLDG
ST PAUL MN
55101

ROSS ALFRED
6356 WARE RD
LINC LAKES MN
55014

ROSS ROY J.
CLK TREAS
LITCHFIELD MN
55355

RUDY FLOYD
118 AVE C
CLOQUET MN
55720

SAN SIMEON DEVELCP CORP
OLD 1ST STATE BK BLDG
PAYNESVILLE MN

SANFORD S M
7000 PORTLAND AVE
RICHFIELD MN
55423

SATHRE, HARVEY
375 MARION STREET
ST PAUL MN
55102

SAX DOVE & STENSON
310 ENDICOTT BLDG
ST PAUL MN
55101

SE MN REG DEV COMM
301 MARQ BK BLDG
ROCHESTER MN
55901

ST PAUL BUR HLTH DR P CCX
555 CEDAR ST
ST PAUL MN
55101

ST PAUL FOOD RETAILERS ASSN
1220 ARCADE
ST PAUL MN
55106

SW REGIONAL DEV COMM
2011 BDWY
SLAYTON MN
56172

SCARBOROUGH WILLIAM
DIV.ED. U.M.
MORRIS MN
56267

SCHLICHT REV ROBT
611 N MAIN ST
BELLE PLAINE MN
56011

SCHMIDT G P MN ASSN REALTORS
6101 WAYZATA BLVD
MPLS MN
55416

SCHMIDT H % TCHRS RETIREMENT
302 CAPITOL SQ BLDG
ST PAUL MN
55101

SCHMIDT LARRY WCCO-TV NEWS
50 S 9TH ST
MPLS MN
55402

SCHMIDT WARREN WELLCOME M
GARDEN CITY MN
56034

SCHNEIDER MAHLON
GREEN GIANT
LE SUEUR MN
56058

SCHUTZ LINDA
RM 328 CAPITOL BLDG
ST PAUL MN
55155

SCHWARTAU NEAL METH HOSP
201 W CENTER ST
ROCHESTER MN
55901

SCHWERMAN EARL JR
1535 6TH AVE SE
ROCHESTER MN
55901

SCHWINN ROBT.P.
1400 SEC LINE BLDG.
MPLS. MN
55402

SCHNEIDER & NEESER
706 1ST ST SO PO BX 876
WILLMAR MN
56201

SCHROEDER ALFRED H
2172 CARROLL AVE
ST PAUL MN
55104

SELECTVISION INC FR VALEN
245 PARK AVE
NEW YORK NY
10017

1503 S ROBY
ROCHESTER MN
55901

STATE CAPITOL
ST PAUL MN
55101

413 STATE CAPITOL
ST PAUL MN
55101

RM 303 STATE CAPITOL
ST PAUL MN
55155

SHABATURA EUGENE M
2933 LAKE AVE SO
DULUTH MN
55811

SHARP BOB
4125 HIGHWOOD RD
ST LOUIS PK MN
55416

SHAW ROBERT M
616 MOBIL OIL BLDG
MPLS MN
55402

SILVERMAN JUDITH
8545 W 28TH ST
ST LOUIS PARK MN
55426

SITE ENGINEERS INC
900 REDWELL LANE
APPLE VALLEY MN
55124

SIX EAST REG. DEV. COMM.
311 W 6TH ST
WILLMAR MN
56201

SIX W REG. DEV. COMM
128 W SORENSON
APPLETON MN
56208

SNERIKA NN.
BOISE CASCADE PAPERS
INTL FALLS MN
56649

SNELL LYN
BOX 314
EDEN VALLEY MN
55329

SNYDER, R.W. U OF M
RM 240C CLASS OFF BLDG.
ST PAUL MN
55108

SODERBERG HAROLD J
1900 MIDWEST PLAZA BLDG
MPLS MN
55402

SODERMAN ANTHONY
1414 FOSHAY TOWER
MPLS MN
55402

STANSFIELD ARLENE LAND DLKS
PO BOX 116
MPLS MN
55440

STATE BD VETERINARY EXAMINER
C/O DR A C SPANNAUS DVM
WACONIA MN

STATE&FED ASSOC
1101 15TH ST NW S.309
WASHINGTON DC
20005

STATE & FED ASSOCIATES
1101 15TH ST NW S 309
WASHINGTON DC
20005

STATE REGISTER
95 SHERBURNE, RM 208
ST PAUL MN
55103

STD AM LIFE & ANNUITY CO
3801 W 50TH ST
MPLS MN
55410

STEELWORKERS CREDIT UNION
BOX 250
BABBITT MN
55706

STOLPESTAD BROWN & SMITH
1550 NW BK BLDG
ST PAUL MN
55101

STUPKA & MOREM
MIDTOWN BLDG
AUSTIN MN
55912

SULLIVAN J KIRK
PO BOX 200
BOISE ID
83701

SULLIVAN JEANETTE
COIC SW STATE UNIV
MARSHALL MN
56258

SUMMIT NATL BANK D L MCRP
205 AURORA AVE
ST PAUL MN
55103

SUSSEL CO.ATTN:TED SCHWENKER
1550 COMO AVE.
ST PAUL MN
55108

SWANSON BURT E
W-2162 1ST NATL BK BLDG.
ST PAUL MN
55101

SWANSON DALE
P O BOX 339
FOREST LAKE MN
55025

SWANSON GERALD H
212 CITY HALL
ROCHESTER MN
55901

SWANSON MORTIMER C
5624 FRANCE AVE S
EDINA MN
55410

TATE VERN 3M CO
3M CENTER 220/6W
ST PAUL MN
55101

THOMPSON CONRAD
1107 23RD ST NW
ROCHESTER MN
55901

THOMPSON MESSIAN ET AL
1550 MIDWEST PLAZA BLDG
MPLS MN
55402

TIMESAVERS INC ATT R S VOLD
5270 HANSON COURT
MPLS MN
55422

TOUCHE ROSS & CO K H STOCKE
780 NORTHSTAR CNTR
MPLS MN
55402

TWIN CITIES PIPING IND AS
5304 UNIV AVE SE
MPLS MN
55414

TWIN CITY RETAIL DRUGGIST AS
2365 UNIV AVE
ST PAUL MN
55104

UNION STOCK YARDS
ATTN PRES
SO ST PAUL MN
55075

VANDERVOORT T J MET WASTE
550 METRO SQUARE BLDG
ST PAUL MN
55101

VAN DRAKE STEPHEN R
BOX 353
PELICAN RAPID MN
56572

VAN EVERA MUNDT ET AL
700 TORREY BLDG
DULUTH MN
55802

VERRILL JOHN E
DEPT SECONDARY ED UOF M
DULUTH MN
55812

HONEYWELL PLAZA
MPLS MN
55408

VOS LEROY
2137 BURNS AVE
ST PAUL MN
55119

WANQUIST ALLEN
RM 252 FEDERAL BLDG
ST PAUL MN
55101

WEST CENTRAL REG. DEV.
ADM BLDG.COMMUNITY COLL
FERGUS FALLS MN
56537

WILCOX J PATRICK
1220 NORTHERN FED BLDG
ST PAUL MN
55102

WILSON F GARY PPG INDUSTR
1 GATEWAY CENTER
PITTSBURGH PA
15222

WYANT CLINTON A ATTY.

ATKIN MN
56431

ZIMMERMAN & OFFERMAN
CAMBRIDGE STATE HOSP
CAMBRIDGE MN
55008

VILLAGE OF WOODBURY
2100 RADIO DRIVE
WOODBURY MN
55042

WATERS, DONNA M.
110506 WINDMILL COURT
CHASKA MN
55318

WESTIN CHAS W
220 MEDICAL ARTS BLDG
DULUTH MN
55802

WM.MITCHEL COLLEGE LAW LIB.
2100 SUMMIT AVE.
ST.PAUL MN
55105

WIS FEEDER PIG MARKET CO-OP

FRANCIS CREEK WI

VOLENESS PERRY
IDS 8TH & MARQUETTE
MPLS MN
55402

WALD JEAN
5746 SANDER DR
MPLS MN
55417

WELK G V NORTHERN STATES
414 NICOLLET MALL
MPLS MN
55401

WHITING RALPH
555 WABASHA SUITE 204
ST PAUL MN
55102

WILEY ENTERPRISES
101 5TH AVE SE
OSSEO MN
55369

WOLKERSTORFER THEODORE
675 17TH AVE NW
NEW BRIGHTON MN
55112

VOSS REV GORDON G
11120 NE 7TH ST
BLAINE MN
55434

WALTERS THOS H
4510 W 77TH ST STE 235
MPLS MN
55435

WELLINGTON R R SKELLY OIL
PO BOX 1650
TULSA OK
75102

WHITLOCK A G
ECON LAB OSBORN BLDG
ST PAUL MN
55102

WILLIAMS THOS W
4915 W 35TH ST
MPLS MN
55416

WOZNIAK D D
401 FIRST FED BLDG
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Abrahamson. Dr. Dean E., 243 Space Science Center, Mpls 55455

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Cassell, Dr. Carl V.E., MN State Dental Ass., 2236 Marshall Ave., St. Paul 55

Damon Corp., Att: B.G. Goodman, 115 4th Ave., Needham Heights, MA 02194

Elston, Elaine, Box 44, Cottonwood, MN 56229

Environment Reporter, 1231 25th St., N.W., Washington D.C.

40 Club, Aitkin 56431

Fox, Howard, 244 Dayton Ave., St. Paul 55102 (CEMETERIES ONLY)

Hawley, Lyle, Graco, P.O., Box 1441, Mpls. 55440

Higgins, J.C., Brotherhood Rwy. Clerks, 2317 W. 7th St., Duluth

Houghton, Charles, Vendo, 7246 Troost Ave, Kansas City, MO 64131

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Smith, Gary D., 5237 Chicago Ave. S., Mpls. 55417

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Wahl, Jack, Inver Hills Comm. College, Inver Grove Heights 55075

Walgreen, J.E. Krahulec, 4300 Peterson, Ave., Chicago Ill 60646

Wilson, David, Health Care Adm., 1645 Cargill Bldg., Northstar Center, Mpls 55

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U.S. Soil Conservation Serv., 517 Red Courts Bldg., St. Paul (Swimming Pools)

HOTELS, RESORTS, RESTAURANTS

U.S. Soil Conservation Serv., 517 Red Courts Bldg., St. Paul (Trailer Parks, c

MINN PLUMBING CODE ONLY

Hendricks, Manley, & Tyler Pipe Industries, Box 2027, Tyler, Texas 50701

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Edina, MN 55435

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Wayzata, MN 55391

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Facilities
July 15, 1975

REPORTING PERIOD 10/1/73 - 9/30/74

STATEWIDE

Hospitals	Average Length of Stay-	7.0 days
Chronic & C&NC	Average Length of Stay-	179.7 days
Freestanding Nursing Homes	Average Length of Stay-	456.5 days

Hospitals	State Average Occupancy-	61%
Chronic & C&NC	State Average Occupancy-	89%
Freestanding Nursing Homes	State Average Occupancy-	92%

METRO BASE AREA

Hospitals	Average Length of Stay-	7.1 days
Chronic & C&NC	Average Length of Stay-	108.1 days
Freestanding Nursing Homes	Average Length of Stay-	360.4 days

Hospitals	Average Occupancy-	66%
C&NC's	Average Occupancy-	88%
Freestanding Nursing Homes	Average Occupancy-	89%

Averages arrived at by using beds utilized for the full reporting period. Any facility that had prorated data was not included.

PATIENTS' BILL OF RIGHTS—EXPANSION

CHAPTER 274

H.F.No.2039

An Act relating to health care; clarifying and expanding the patients' bill of rights; requiring certain notices; providing penalties; amending Minnesota Statutes 1974, Sections 144.651 and 144.652.

Be it enacted by the Legislature of the State of Minnesota:

Section 1. Minnesota Statutes 1974, Section 144.651, is amended to read:

144.651 Patients of health care facilities; bill of rights; public policy

It is the intent of the legislature and the purpose of this section to promote the interests and well being of the patients and residents of health care facilities. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

For the purposes of this section, and section 144.651, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and board and care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age.

It is declared to be the public policy of this state that the interests of each patient and resident be protected by a declaration of a patients' bill of rights which shall include but not be limited to the following:

(1) Every patient and resident shall have the right to considerate and respectful care;

(2) Every patient and resident can reasonably expect to obtain from his physician or the resident physician of the facility complete and current information concerning his diagnosis, treatment and prognosis in terms and language the patient can reasonably be expected to understand. In cases in which it is not medically advisable to give the information to the patient or resident the information may be made available to the appropriate person in his behalf;

(3) Every patient and resident shall have the right to know by name and specialty, if any, the physician responsible for coordination of his care;

(4) Every patient and resident shall have the right to every consideration of his privacy and individuality as it relates to his social, religious, and psychological well being;

(5) Every patient and resident shall have the right to respectfulness and privacy as it relates to his medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly;

(6) Every patient and resident shall have the right to expect the facility to make a reasonable response to his requests;

EXPANSION

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alties; amending Minne-

Minnesota:
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of these rights.
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or treatment bearing on
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a patients' bill of rights
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to expect the facility to

(7) Every patient and resident shall have the right to obtain information as to any ownership of the facility to other health care [redacted] related institutions insofar as his care is concerned;

(8) Every patient and resident shall have the right to expect reasonable continuity of care which shall include but not be limited to what appointment times and physicians are available;

(9) Every resident shall be fully informed, prior to or at the time of admission and during his stay, of services available in the facility, and of related charges including any charges for services not covered under medicare or medicaid or not covered by the facility's basic per diem rate;

(10) Every patient and resident shall be afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

(11) No resident shall be arbitrarily transferred or discharged but may be transferred or discharged only for medical reasons, for his or other residents' welfare, or for nonpayment for stay unless prohibited by the welfare programs paying for the care of the resident, as documented in the medical record. Reasonable advance notice of any transfer or discharge must be given to a resident;

(12) Every resident may manage his personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on his behalf if he delegates this responsibility in accordance with the laws of Minnesota to the facility for any period of time;

(13) Every resident shall be encouraged and assisted, throughout his period of stay in a facility, to understand and exercise his rights as a patient and as a citizen, and to this end, he may voice grievances and recommend changes in policies and services to facility staff and outside representatives of his choice, free from restraint, interference, coercion, discrimination or reprisal;

(14) Every resident shall be free from mental and physical abuse, and free from chemical and physical restraints, except in emergencies, or as authorized in writing by his physician for a specified and limited period of time, and when necessary to protect the resident from injury to himself or to others;

(15) Every patient and resident shall be assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except as otherwise provided by law or a third party payment contract;

(16) No resident shall be required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

(17) Every resident may associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated and documented by his physician in the medical record;

(18) Every resident may meet with representatives and participate in activities of commercial, religious, and community groups at his discretion; provided, however, that the activities shall not infringe upon the right to privacy of other residents;

(19) Every resident may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients or residents, and unless medically contraindicated and documented by his physician in the medical record;

(20) Every resident, if married, shall be assured privacy for visits by his or her spouse and if both spouses are residents of the facility, they shall be permitted to share a room, unless medically contraindicated and documented by their physicians in the medical record; and

(21) Every patient or resident shall be fully informed, prior to or at the time of admission and during his stay at a facility, of the rights and responsi-

bilities set forth in this section and of all rules governing patient conduct and responsibilities.

Sec. 2. Minnesota Statutes 1974, Section 144.652, is amended to read:

144.652 Notice to patient; violations

Subdivision 1. The policy statement contained in section 144.651 shall be posted conspicuously in a public place in all facilities licensed under the provisions of sections 144.50 to 144.58 or any law providing for the licensure of nursing homes. Copies of the policy statement shall be furnished the patient or resident and the patient or resident's guardian or conservator upon admittance to the facility. The notice shall include a brief statement describing how to file a complaint with the nursing home complaint team of the health department or any division or agency of state government which succeeds it concerning a violation of section 144.651 or any other state statute or rule.

Subd. 2. A substantial violation of the rights of any resident as defined in section 144.651, shall be grounds for issuance of a correction order pursuant to section 144.653. The issuance of a correction order shall not preclude private action by or on behalf of a resident to enforce his rights.

Approved April 13, 1976.

AGING—STATE POLICY

CHAPTER 275

H.F.No.2041

[Coded]

An Act relating to the elderly and handicapped; requiring the board on aging to develop a proposal for a state policy for citizens dependent on long-term care and services; amending Minnesota Statutes 1974, Section 256.975, by adding a subdivision.

Be it enacted by the Legislature of the State of Minnesota:

Section 1. Minnesota Statutes 1974, Section 256.975, is amended by adding a subdivision to read:

Subd. 3. Policy. The board shall recommend to the state legislature no later than January 1, 1977, a proposed state policy for citizens dependent on long term care and services. The proposed state policy shall address, but need not be limited to, the following:

(a) Developing alternatives to institutionalization in long term care facilities and other programs which will assist each citizen dependent on long term care and services to maintain the highest level of self-sufficiency and independence which his mental and physical condition allows;

(b) Developing methods for ensuring citizens dependent on long term care and services an effective voice in determining which programs and services are made available to them;

(c) Protecting citizens dependent on long term care and services from unnecessary governmental interference in private and personal affairs; and

(d) Informing citizens dependent on long term care and services of the programs and services for which they are eligible.

Sec. 2. This act is effective the day following its final enactment.

Approved April 13, 1976.

States Ex 76
1/18/77
AWK

Additions are indicated by underlining;
deletions are indicated by ~~lining through~~;

MHD 522 D. "representative" means a person designated by the patient as a responsible party, a parent of a minor, or a guardian.

MHD 524 A. Every hospital and every outpatient surgery center shall, ~~through their respective governing authorities,~~ designate an individual, by name or by title, to be accountable for the operation of a grievance mechanism.

MHD 524 B.2. Such complaints may be made to ~~the~~ a person designated by the facility under MHD 524 A., or to any other person authorized to receive complaints by the facility. A person authorized to receive complaints shall be physically within the facility and able to receive complaints during ordinary business ~~and visiting~~ hours. Persons authorized to receive complaints, other than ~~the~~ a person designated under MHD 524 A., shall, in all complaint cases, report any response or resolution, or refer the complaint, to ~~the~~ a person designated under MHD 524 A.

MHD 524 C. Time Limits for Response. When such complaints are made while the patient is in the facility, ~~written~~ response to them, or ~~written~~ notice of the resolution of the complaint, shall be provided to the complainant within the following time periods:

1. 24 hours for complaints relating to the following provisions of MHD 525: A.; B.; C.; G.; I.; K.; L.; M.; N.; O.; Q.; and T.
2. 72 hours for complaints relating to the following provisions of MHD 525: D.; E.; F.; H.; J.; R.; S.; and U.
3. 30 days for complaints relating to the following provisions of MHD 525: P.; and V.

Such responses, or notices of resolution, shall be in writing if requested by the complainant.

MHD 524 D. Notice of Time Limit. The authorized individual to whom ~~the~~ any oral complaint is made shall, ~~within 4 hours~~, upon receipt of the complaint, inform the complainant of the applicable time limit, in his best judgement, for response or resolution under MHD 524 C.1, 2., or 3.

MHD 524 E. ~~Exception. If the condition of the patient in question presents an emergency situation preventing timely response to, or the resolution of, a complaint, the time limits specified in MHD 524 C.1. and 2. shall extend an additional 48 hours. In all such cases, a dated annotation of the existence of such an emergency situation shall be placed in the record required to be kept under MHD 524 G. and signed by the person asserting them in behalf of the facility.~~

MHD 524 F. ~~Denials. The grounds on which denial of the action requested by the complainant can be based include the followings~~

~~1. the action sought by the claimant is medically and/or therapeutically contraindicated;~~

~~2. the action sought by the claimant would be violative of any of the rights, as prescribed in Minnesota Statutes 144.651, of other facility patients; or,~~

~~3. the action sought by the claimant would violate a written policy, approved by the facility's governing authority.~~

~~A dated annotation of any of the above grounds shall be placed in the patient's record and signed by the person asserting them.~~

MHD 524 ~~G.~~E. ~~Patient~~ Complaint Records. The following complaint records shall be maintained ~~according to patient~~ by the facility for ~~periods of time determined in a written policy approved by the facility's governing authority.~~ at least one year:

1. an annotation of the date, time and substance of each complaint made by, or in behalf of, any patient;
2. a reference to any previous complaints made by, or in behalf of, the same patient during his current stay in the facility; and,
3. an annotation of the date, time and substance of any response to, denial of, or resolution of, the complaint.

The arrangement of such records shall be such that identification of particular patients and complainants is possible.

MHD 524 H.F. Patient Notice.

1. Notice of Mechanism. Written notice of the existence and availability of the grievance mechanism shall be posted conspicuously in all facilities, along with the notice required under Minnesota Statutes 144.652, and furnished, along with the notice required under Minnesota Statutes 144.652, to the patient or his representative upon admittance to the facility.
2. Content of the Notice. Such written notice shall include the following:
   a. a statement that complaints or grievances related to rights expressed in the Patients' Bill of Rights (Minnesota Statutes 144.651), or to any other rights, may be able to be resolved within the facility;
   b. a statement that the facility maintains a grievance

mechanism for this purpose; ~~and~~,

c. a statement specifying an individual or type of individual to whom such complaints or grievances can be directed; and,

d. a statement that any complainant has the right to request and to receive a written response to, or written resolution of, any complaint.

MHD 526 Reports. Every hospital and every outpatient surgery center, shall, on or before each February first, submit to the state board of health a report on the experience of their respective grievance mechanisms during the immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting institution;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the grievance mechanism;

D. the total number of complaints ~~received by the facility;~~ filed with the facility pursuant to MHD 524 B.1.;

E. the total number of complaints, according to classification under MHD 525;

F. the total number of any other complaints;

G. the number of patients by whom or for whom more than one complaint was made and the total number of such complaints; and,

H. the total number of complaints resolved to the patient's apparent satisfaction.

[References to MHD 524 G and H are changed to MHD 524 E and F, respectively.]

MHD 370 GOVERNING BODY; CONSUMER MEMBERS;

ENROLLEE PARTICIPATION; COMPLAINT SYSTEM

(g) Complaint Reports. Every health maintenance organization shall ~~on or before each February first~~ submit to the state board of health, along with its annual report, a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

(1) the name and location of the reporting health maintenance organization;

(2) the reporting period in question;

(3) the name of the individual(s) responsible for the operation of the complaint system;

(4) the total number of complaints received by the health maintenance organization;

(5) a copy of the written summaries of informal discussions, consultations and conferences required to be kept for each complaint under (f)(2) of this rule; the identity of specific individuals shall not be disclosed in such summaries;

(6) the number of enrollees by whom or for whom more than one complaint was made and the total number of such complaints; and,

(7) the total number of complaints resolved to the enrollee's apparent satisfaction.

STATE OF MINNESOTA
MINNESOTA DEPARTMENT OF HEALTH

In the Matter of the Proposed Rules)
of the State Health Department)
Governing the Operation of Health)
Facilities Grievance Mechanisms)

FINDINGS OF FACT
AND CONCLUSIONS

The above-entitled matter came on for hearing before Allan W. Klein, duly appointed Hearing Examiner, on January 18, 1977, in the Board Room of the Minnesota Department of Health Building, Minneapolis, Minnesota.

This was a rules hearing pursuant to Minn. Stat. Chapter 15, to determine whether proposed rules should be adopted.

Daniel J. McInerney, Jr., Consultant, and John A. Breviu, Special Assistant Attorney General, appeared on behalf of the Minnesota State Board of Health. Fifty-one persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard.

Pursuant to Minn. Stat. § 15.0412, subd. 4 (1975 Supp.), this report shall be available for review to all affected individuals upon request for at least ten days.

The Commissioner (Laws, 1977, Ch. 305, § 39 transferred the powers of the Board of Health to the Commissioner of Health) will submit the complete hearing record to the Chief Hearing Examiner. The Commissioner will include the rules as originally proposed and the rules as proposed for adoption in final form. The Chief Hearing Examiner will complete his review and submit his report to the Commissioner on issues of substantial changes in the rule and compliance with Minn. Stat. § 15.0412 within ten calendar days. Thereafter, the Commissioner will file the rules with the Attorney General.

Based upon the proceedings herein, the Commissioner makes the following:

FINDINGS OF FACT

Procedural Requirements

1. That on October 14, 1976, the Board adopted a resolution authorizing the hearing in this matter. On November 8, a Notice of Intent to Solicit Outside Opinion was published at 1 State Register 741.

2. That on November 22, 1976, the Board filed the following documents with the Chief Hearing Examiner:

(a) a copy of the proposed rules;
(b) a proposed Order for Hearing;
(c) a proposed Notice of Hearing; and
(d) a copy of its October 14 resolution.

3. That on November 30, 1976, the Board mailed a copy of the Notice of Hearing to all persons and associates who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. That on December 7, 1976, a Notice of Hearing and a copy of the proposed rules were published at 1 State Register 890.

5. That by December 23, 1976, the Board had filed with the Office of Hearing Examiners the following documents:

(a) The Order for Hearing;
(b) The Notice of Hearing as mailed;
(c) The Affidavit of Receipt of the Secretary of State's list;
(d) The Secretary of State's Certificate and list;
(e) The Affidavit of Mailing;
(f) The Statement of Need;
(g) The Statement of Evidence;
(h) A copy of the Notice to Solicit Outside Opinion;
(i) The proposed rules; and
(j) The Statement of Agency Personnel.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of hearing.

6. The record remained open through February 7, 1977 for the receipt of written comments. Nine post-hearing submissions were received, all on or before February 7, 1977.

Statutory Authority

7. That while the Board cited five different statutes as authority for these rules (See Combined Statement of Need and Statement of Evidence, dated December 22, 1976), the most relevant is Laws of Minnesota, 1976, Chapter 325, Section 8 [now codified as Minn. Stat. § 144.691 (1976)], which states, in Subdivision 3, the following:

> The [Board] shall, by January 1, 1977, establish by rule promulgated pursuant to Minnesota Statutes, Chapter 15:
>
> (a) Minimum standards and procedural requirements for grievance and complaint mechanism;
>
> (b) A list of patient complaints which may be processed through a complaint or grievance mechanism;
>
> (c) The form and manner in which patient notices shall be made; and
>
> (d) A schedule of fines, not to exceed $200 per offense, for the failure of a hospital or

outpatient surgery center to comply with the provisions of this section.

Earlier subdivisions of the same section, and later sections of the same Act make it clear that the primary intent of the legislature was to reduce the incidence of malpractice claims and suits. Essentially, the relevant section requires each hospital and outpatient surgery center to establish a grievance mechanism, to notify its patients of the existence of the mechanism, and report at least annually to the Commissioner on the operation of its mechanism. In connection with this reporting requirement, the Commissioner is empowered to prescribe, by rule, the frequency, form and content of the reports, which must be filed not only by hospitals and outpatient surgery centers, but also by health maintenance organizations (Minn. Stat. § 144.691, subd. 4).

General Comments

8. That in order to better understand later Findings, a brief overview of the proposed rules is given here.

Proposed MHD 521 is a brief statement of applicability of the rules.

Proposed MHD 522 contains definitions of terms used in the rules.

Proposed MHD 523 is an operative rule which states, as a minimum standard, that every hospital and outpatient surgery center shall establish, operate and maintain a grievance mechanism designed to process and resolve grievances.

Proposed MHD 524, sets forth procedures for who can make complaints, who should handle them, time limits for response, notice to patients of the existence of the mechanism, and record-keeping requirements.

Proposed MHD 525 lists the types of complaints to which the facility must respond through the formal grievance mechanism.

Proposed MHD 526 requires facilities to make reports to the Board on the experience of their mechanisms.

Proposed MHD 527 sets forth penalties for violating the rules, including fines.

Proposed MHD 370(g) is an addition to existing Board rules for health maintenance organizations, and requires them to make reports to the

Commissioner about the operation of their grievance mechanisms.

9. Sometime prior to the hearing, the Board prepared a number of suggested revisions to the rules as originally proposed. These were made available to all persons at the hearing, but were not published in the State Register, nor were they mailed to the Secretary of State's List. They were, however, described in detail by D. McInerney of the Board, at the beginning of the hearing. Almost all of the proposed changes, however, were also proposed by the Minnesota Hospital Association in its 27 pages of written testimony submitted at the hearing. Each of these proposed changes will be discussed below.

In addition to those changes, the Board also proposed three additional changes which were submitted to the Hearing Examiner in the afternoon of the last day for submitting comments. These will also be discussed below.

10. That a number of the written comments submitted prior to the hearing (and apparently with no knowledge of the changes which the Board proposed at the hearing) were of a general nature and impossible to classify as relevant to a specific rule. Those comments were:

> 1. That the proposed rules are too detailed, that they would require that time be spent responding to complaints rather than treating patients, and that they are not "cost-effective" in that they will cost more to follow than they will save in malpractice claims. These comments came from Golden Valley Health Center, and St. Mary's Hospital and Home of Winsted.
>
> 2. That the proposed rules are unrealistic in that they would require response to the complaint of a five year-old to the same extent as an adult and that they do not recognize that there are certain groups, such as the mentally ill and chemically dependent, which must be recognized as being different than the ordinary hospital patient. These comments also came from the Golden Valley Health Center.

11. That a number of comments made at the hearing were also of a general nature, but should be noted.

> 1. The Minnesota Hospital Association representative stated that a recent poll of its 184 members indicated that 40 had grievance mechanisms in operation. (T. p. 70). Representatives from University of Minnesota Hospitals and Clinics, Mount Sinai Hospital, and the Gillette Hospital described the operation of their programs and commented on the changes which the adoption of the rules would have on their programs. All three stated that the general effect of the rules would be to "dehumanize" existing programs by forcing bureaucratic and legalistic responses to what are often emotional and human problems. (T. pp. 34, 65, and 68).
>
> 2. Joe Brown, of the Gillette Hospital, asked that consideration be given to delegating the whole program to the Minnesota Hospital Association, and have the Association sponsor it as a voluntary program which facilities could follow or ignore as they chose. (T. pp. 67-69).

With these general comments as background, the evidence for each proposed rule will be discussed, rule by rule.

Proposed MHD 521

12. That proposed MHD 521 drew no criticism or public comment either before, during, or after the hearing.

D. McInerney of the Board pointed out at the hearing that this rule just specifies that these grievance rules apply only to hospitals and outpatient surgery centers (T. pp. 9-10).

Proposed MHD 522

13. That proposed MHD 522 is necessary to set forth definitions of terms used in subsequent rules. When read together with proposed MHD 521, it will define the applicability of the grievance rules.

At the hearing, the Board proposed that a definition of "representative" be added to the original definitions because there was some concern raised by the Minnesota Hospital Association that a facility might have to deal with a variety of persons who might express conflicting concerns about the same patient (Public Ex. 1., p. 2). This concern was shared by the Board (T. p. 10). The two differed, however, on the solution. The Board proposed:

> "representative" means a person designated by the patient as a responsible party, a parent of a minor, or a guardian.

The MHA proposed:

> "representative" means a parent of a minor child, a guardian or other person designated by the patient as a responsible party or one who is in loco parentis to a patient unable to act for himself.

The difference is that the MHA's proposal adds an additional category of "one who is in loco parentis to a patient unable to act for himself" to the categories proposed by the Board. While it is difficult to foresee a situation in which a representative would be selected using this phrase, it might be necessary in the case of a patient without a parent or guardian who is so incapacitated, whether mentally or physically, that he cannot designate a representative. Since such an eventuality might arise, and since both parties intend to assure that every patient have one, but no more than one, representative, the MHA proposal is the more complete of the two, needed and reasonable, and will be reflected in the definition which is adopted.

14. That after the hearing, in its final submission, the Board proposed the addition of a definition of "patient" to read:

> "patient" means an individual in or admitted to a hospital or outpatient surgery center for the purpose of prevention of disease, medical diagnosis or medical treatment. The term "patient" includes inpatient, outpatient, and emergency room patient.

In an explanation accompanying this proposal, the Board stated that the change was necessary to clarify the original rules. It stated that the rules as originally proposed might have been construed as not covering persons treated in emergency rooms or outpatient departments of hospitals or outpatient surgery centers. This construction could have been arrived at by a technical reading of another proposed rule [MHD 524(H)(1)] in conjunction with a completely different statute (the so-called "Patient's Bill of Rights, Section 144.651 as amended by Laws of Minnesota, 1976, Chapter 274). The original proposal for MHD 524(H)(1) would have required that written notice of the existence of the grievance mechanism be posted "along with the notice required under Minn. Stat. § 144.652, and furnished, along with the notice required under Minn. Stat. § 144.652, to the patient or his representative upon admittance to the facility." The Board had tied the notice requirement to a similar notice requirement of Section 144.652 in order to avoid duplication of existing effort (Statement of Need, p. 9). What the Board apparently overlooked was the fact that Chapter 274, Section 1, defines "patient" for the purposes of the Patient's Bill of Rights Act to exclude persons admitted to an acute care facility for less than 24 continuous hours, and arguably excludes all persons who are not "admitted" to an "acute care facility". Since the statute creating the grievance mechanism and mandating these rules specifically includes patients of outpatient surgery centers, and since outpatient surgery centers are defined, for purposes of this Act, to be facilities which can offer only surgical procedures which do not require overnight inpatient care, the Board had created a procedural problem by tying the notice requirement of the grievance mechanism rules to that of the Patient's Bill of Rights. In order to remedy this problem, the Board, in its final submission, proposed to modify MHD 524(H)(1), and, in addition, to include the definition of "patient" which is at issue here.

Did affected facilities have adequate notice that these grievance mechanism rules would apply to emergency room and outpatient department patients? The Commissioner believes that they did, because it was clear that these rules applied to outpatient surgery centers, which treat many of the same types of problems as emergency rooms and outpatient departments.

This understanding, however, may not have been that of at least two persons. The following dialogue is from the hearing.

> MR. McINERNEY: I have one question. You seem to be saying, and correct me if I'm wrong, the criteria in this 525 failed to really address the situations in which a hospital is functioning as a primary care kind of deliver in terms of outpatient and emergency room care, is that what you were saying?
>
> MRS. COUNTRYMAN: In part. In part.
>
> MR. McINERNEY: How so and how can they better address the problems of outpatients and people who use the emergency room, for example, as their primary care treatments?
>
> MRS. COUNTRYMAN: I'm not sure how you could address emergency room. I would perceive that to be a very valid criteria, although it's not covered within this legislation, nor is outpatients. I recognize that we are functioning in a facility that is slightly different than the average hospital in the State of Minnesota, because many do not have outpatient or ambulatory care systems.
>
> (Transcript, p. 45)

In a letter dated well after the hearing, representatives of Rochester Methodist Hospital and St. Mary's Hospital wrote:

> Further, we are also concerned that MDH [sic] 524f, regarding Patient Notice, may be interpreted to require posting and handout in the emergency room setting of hospitals. At the time of the January 18, 1977 hearing, Mr. Daniel J. McInerney stated during an informal conversation that, in his opinion, the "Patient Notice" requirements proposed are basically the same as those contained in the Patient Bill of Rights, Minnesota Statute 144.652, and that it would be inappropriate to apply them to emergency or outpatient visits. This point may need clarification in Section 524f.

There are two alternative explanations for these responses. The first would be that there was a misunderstanding as to whether any of the rules applied to patients in emergency room and outpatient departments. In other words, Mrs. Countryman may have believed that none of the rules (or the statute) applied. The second alternative is that raised by the above-quoted "Rochester" letter: That only the notice requirements of 524(H)(1) [later changed to 524(F)(1)] did not apply to the emergency room and outpatient setting, while the remainder of the proposed rules did apply to those settings. It is this second alternative which makes the most sense in light of the record.

The only clue in the statute to suggest that the legislature did not intend to include emergency room and outpatient department patients is in the definition of "outpatient surgery center". Subdivision 1 of Section 144.691 reads, in relevant part, as follows:

> For the purposes of...this act, "outpatient surgery center" shall mean a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

What is meant by the phrase in the last sentence which excludes "emergency medical services"? Does it mean emergency rooms? That seems unlikely because there is no logical reason to predict any lower probability of malpractice claims from patients treated in the emergency room of a hospital than from patients in an outpatient surgery center. And, as the Board argues, there is little difference between the outpatient surgery center and the outpatient department of a hospital. Had the legislature intended to exclude emergency rooms and outpatient departments, it is improbable that it would have chosen to do so by the phrase "emergency medical services". Therefore, the legislature must have intended that patients in these settings be included, along with patients of outpatient surgery centers.

Based on the above, it is the Commissioner's finding that his proposed inclusion of a definition of "patient" does not exceed his statutory authority in that there is no reasonable basis for affected persons to claim that they did not believe that emergency room and outpatient department patients were included in the protection of the grievance mechanism statute or the operation of these proposed rules. Thus, affected persons did have adequate notice of the scope of the rules. The inclusion of the Board's proposal, however, will serve to clarify any such questions in the future.

15. That the only other comment regarding proposed MHD 522 came in a post-hearing letter from the Mental Health Association of Minnesota, Inc., which stated:

> The legislation applied to "grievances by patients or their representatives" (144.691, subd. 1) and, therefore, applies to all patients, including mental health patients. We assume this is understood by the institutions that will be affected and that the Board of Health will, through its review procedures, make certain that all groups of patients are included.

As was noted earlier, the Golden Valley Health Center understood this to be the case. Vera J. Likins, Commissioner of Public Welfare also

understood this, and she submitted comments to the proposed rules in which she stated:

> ...I hope that the board will realize that these regulations will effect facilities licensed as psychiatric hospitals. Thus, such complaints as...will have special implications for patients committed under the Minnesota Hospitalization and Commitment Act....

There is no evidence to suggest that any person did not understand that these rules would not apply to mental health patients, and thus, the Association's comment requires no further action in these proceedings.

16. That MHD 522, as originally proposed, and with the addition of the definitions of "representative" suggested by MHA, and "patient" suggested by the Board, is needed to provide definitions for the operative portions of these rules; that the definitions are reasonable; and that the Commissioner has statutory authority to adopt them.

Proposed MHD 523

17. That proposed MHD 523 drew no comments or criticism from the public; that the Board has proposed no changes from its original form; that it was justified by the Board as needed to fulfill one of the requirements of the statute (Section 144.691, subd. 3(a) quoted in Finding No. 7, above); and that it is reasonable response to the statutory mandate.

Proposed MHD 524

18. That because of the length and controversy of some sections of this proposal, each section of the original proposal will be treated separately below.

MHD 524(A)

19. That the original proposal for this section would have required each facility, through its "governing authority" to designate an individual to be accountable for the operation of its mechanism. The MHA's written testimony proposed two changes in the rule, both of which were also proposed by the Board at the hearing. The first change would be to delete the requirement that the individual be designated by the "governing authority" of the facility. The second change would be to permit the designation of an individual "by name or by title". The Board stated that changes in personnel

or work duties might require an otherwise unnecessary meeting of the governing authority just to designate a new person (T. p. 11). The proposed rule section, including both changes, is needed and reasonable.

MHD 524(B)

20. That proposed MHD 524(B) sets forth a variety of matters generally relating to complaints. Public comment and Board reaction focused on one proposed requirement: That a person authorized to receive complaints be physically within the facility during visiting hours, as well as business hours. MHA argued that this requirement reduced a facility's flexibility in implementing its own system and that small hospitals might be forced to delegate the responsibility for taking complaints during visiting hours to persons whose primary duty is patient care, thus reducing their time available for patient care. It also argued that some facilities might desire to assign the complaint mechanism to one person, and that would be impossible if he or she had to be present for visiting, as well as business hours. The University Hospital's Department of Patient Relations conducted a study, during one week, of the effects of operating under the proposed rules. During the week, there were 106 separate complaints made by 84 patients or their representatives. Of those 106, 95 were "most resolvable" within business hours. Based on this, K. Countryman, coordinator of the department, stated she was pleased to see the Board propose to delete the visiting hours requirement (T. pp. 36-40). DPW stated that due to the length of visiting hours in state institutions, it would be forced to add three to five full-time positions if the rule were adopted without this change. The Board proposed deletion of the words "and visiting" at the hearing, stating that concerned parties having a complaint could telephone during the day.

21. That the second change proposed by the Board at the hearing follows from the change discussed in Finding No. 19 above. It merely substitutes the words "a person" for the words "the person" when discussing the person designated in MHD 524(A).

22. That DPW suggested the deletion of the limitation, contained in MHD 524(B)(1), that a complaint be "related to those subjects specified in MHD 525", but offered no reason for their suggestion. It is possible that DPW does not want to have the limitation in the rule because some hospital employee might infer that he did not have to consider, in any fashion, any complaint not related to the list in MHD 525. Such a reading is strained.

This limitation is reasonable in that it clarifies the fact that the formal grievance mechanism is limited to a certain list of subjects, but does not preclude individuals or facilities from responding to, or resolving, other matters outside the formal mechanism proposed by these rules.

MHD 524(C)

23. That one section of MHD 524 drew far more criticism than any other. It was proposed MHD 524(C), which would have established three different time limits (24 hours, 72 hours, or 30 days) for responding to a complaint, depending on which of three categories (medical, psycho-social, or billing) the complaint fell into. At the hearing, the Board proposed the deletion of the requirement that all responses or resolutions be in writing, and suggested as a substitute, that they be required to be in writing only if requested by the complainant. (T. p. 13). While MHA agreed with this change (T. p. 54), as did DPW, that change did not meet the thrust of a majority of the criticisms, which opposed any classification of complaints for differing response times, and argued that if there be any arbitrary time limit, it should be a 72 hours limit, which was proposed by MHA and supported by numerous facilities and groups.

The Board pointed out at the hearing that the proposed time limits are limits for responding, rather than resolving, complaints (T. p. 12). It also pointed out that these time limits apply only if the complaint is made while the patient is in the facility. It justified the classification scheme based on its own idea of reasonableness (T. pp. 13-14):

> ...in view of the fact that medical care complaints are rather important in the hierarchy of the kind of grievances that patients might voice in the facility, 24 hours seems to the agency a reasonable time for response....
>
> Complaints relating to psycho-social things which are not of a hard core medical care nature, while clearly important to the well-being, the speedy recovery of the patient, are not quite as important as the hard core medical kinds of complaints and the Health Department feels that 72 hours or three days is a reasonable time for the facility to garner some kind of a response.
>
> (Transcript, pp. 13-14)

In its Statement of Need, the Board included, as Exhibit VI, a report of the average length of stay in various types of health care facilities during the year ended September 30, 1974. That report stated that the average length of stay in hospitals was seven days. The Board used this to support its 72 hour limit for "psycho-social" complaints, stating that while these issues may not

be susceptible of rapid resolution, they may have a great impact upon the incidence of malpractice suits, and the 72 hour time limit afforded the facility a realistic opportunity for the complaint to be resolved during the patient's current stay.

In contrast, the Board argued that the 24 hour limit for medical complaints was reasonable because such complaints are susceptible of rapid resolution, and 24 hours balanced the rights of the patient with the rights of the facility.

MHA, which was in essence supported by Golden Valley Health Center, University of Minnesota Hospital, Mount Sinai Hospital, Saint Cloud Hospital, the Minnesota State Medical Association, St. Mary's Hospital and Rochester Methodist Hospital gave four reasons for opposing the classifications:

> 1. Confusion will be reduced, both on the part of staff and patients, if there is only one limit.
>
> 2. Subdividing a patient's complaint into a number of categories, and treating them differently, depersonalizes the response in the eyes of the patient, and thus thwarts the purpose of these rules.
>
> 3. Twenty-four hours is inadequate in many cases due to difficulty in contacting key people and other extenuating circumstances, and a timely, but inadequate, response will only exacerbate the problem.
>
> 4. Classification results in prioritizing and since the legislature did not prioritize the Patient Bill of Rights (which is the basis of the complaint list in 525) the Board should not prioritize them.

While a complete list of all of the arguments made by others against the time limits would be too lengthy to be useful, some of the more relevant are:

> 1. The classifications are unrelated to any rational criteria (University of Minnesota Hospital; T. p. 29).
>
> 2. The classifications and limits have not been shown to have any relationship to malpractice claims (Saint Cloud Hospital).
>
> 3. The classifications discriminate against the outpatient and the discharged patient (University of Minnesota Hospital; T. p. 34).

The first two require a greater exposition, as they were asserted in the context of a challenge to the Commissioner's authority to adopt this (and one other) rule. Essentially, the arguement is that the Commissioner may not adopt rules based on malpractice-oriented statutory authority unless it can demonstrate the relationship of any particular rule to the incidence of malpractice claims. When placed in the context of the classification

scheme proposed in MHD 524(C), the argument becomes: Unless the Commissioner can demonstrate that failure to respond promptly to medical grievances is a greater cause of malpractice claims than failure to respond promptly to psycho-social grievances, the Board cannot require that they be treated differently. The Hearing Examiner found that the record contains no such evidence, other than the Commissioner's judgment of what seemed reasonable, and that the only time period supported by the record was "as soon as possible." The Commissioner disagrees with the Hearing Examiner on this point. The statute implies that the more rapid the response and the more efficient the mechanism, then the lower the incidence of claim or suit will be (Minn. Stat. 144.691, subd. 1 (1976)). The Hearing Examiner's finding that the only supportable time limit was "as soon as possible" overlooks what he himself calls the "malpractice - reduction orientation" (see p. 38, line 2 of his report) of the statute. The statute is directed not only at reducing the incidence of suit or claim, but also at reducing the incidence of malpractice itself. To believe otherwise would be to impute a completely mechanistic view of the malpractice crisis to the Legislature. For grievance mechanisms to have an effect upon the incidence of malpractice itself, they must function while the patient is in the facility, not after he is discharged and health services are no longer being provided. Hence, at least some of the time limits for measuring the promptness of response of the mechanism must, of necessity, be less than the period of time that the average patient spends in the facility: 7 days for hospitals; considerably less, by definition, for outpatient surgery centers. Therefore, in the very least, time limits for response which are less than 7 days are reasonable. As to whether, within this period, a correlation between relative rapidity of response and subsequent incidence of suit or claim need be made in order to justify different time limits for response to medical, as opposed to psycho-social, complaints, as the Hearing Examiner urges, the Commissioner believes several important points were overlooked. First, in the absence of more specific (and presently unavailable) data, time limits within the seven-day period are somewhat normative; however, some time limits need be specified in order for the Commissioner to execute his statutorily-required monitoring functions adequately. Secondly, it is quite clear that a distinction between medical care complaints and psycho-social complaints, which prioritizes the former in terms of response time, may be made. As indicated above, the statute is not only directed at reducing the incidence of suit, but also at

reducing the incidence of malpractice. In all cases, actual malpractice relates to the quality of medical care (see, generally, Curran, "How Lawyers Handle Medical Malpractice Cases: An Analysis of an Important Medicolegal Study," Washington, DHEW/NCHSR (1976)), and not merely to exclusively psycho-social complaints. Hence, it is reasonable to require a more rapid response to complaints relating to medical care problems, both because they must be at the heart of any tenable malpractice claim, and also because quick attention to valid medical care complaints can minimize or preclude serious injury. This is not to deny either the validity of psycho-social complaints or the exacerbating effect that inattention to such complaints can have upon the quality of medical care and the frequency of suit or claim - it merely serves to justify prioritizing response time to medical care complaints over response time to psycho-social complaints. These facts notwithstanding, the Commissioner is aware that such time limits may create staff and patient confusion and possibly detract from the utility and beneficial effects of having such mechanisms in the first place. For the present time, then, the Commissioner will adopt the Hearing Examiner's recommendation, reserving the right to impose specific time limits at some future date.

24. For the reasons stated above, the Board's proposed changes regarding written response will be adopted, but the three different time limits for response will be consolidated into one, which will be "as soon as possible".

MHD 524(D)

25. That as originally proposed, MHD 524(D) would have required an authorized individual receiving a complaint to inform the complainant, within four hours of receipt, of the applicable time limit for response. The purpose for this was to inform the patient as to when he would be hearing about his complaint, so he would not be as apt to repeat it again in the interim. As a secondary purpose, the Board argued, the facility's management of its mechanism would be assisted because it would be more aware of the applicable time limits (Statement of Need, p. 6).

At the hearing, the Board proposed two changes. First, it limited the notice requirement to oral complaints, for the reason that the mails would not permit the facility to give notice in four hours (T. pp. 14-15). The second change was the deletion of the four hour time lag, and the substitution of a requirement that the recipient tell the complainant about the applicable

response time immediately upon receipt of the complaint. The first of these changes was not mentioned by any person (other than D. McInerney of the Board) at the hearing or in subsequent submission, but the second was advocated and supported by MHA (T. pp. 53-55, written testimony, pp. 9-10).

As has been noted earlier, providing the complainant with some idea of when he could expect to hear from the facility has been justified on the basis that it may prevent him from repeatedly lodging the same complaint again and again. However, in light of the Finding on MHD 524(C), there will be a modification of the last phrase of proposed MHD 524(D). A modification, consistent with the Finding of 525(C) is:

> D. Notice of Time for Response. The authorized individual to whom any oral complaint is made shall, upon receipt of the complaint, inform the complainant of his best estimate of when the facility could respond to his complaint.

This modification will be adopted.

26. That the Board originally proposed that the time limits for response contained in MHD 524(C) be extended for 48 hours if the condition of the patient presented an emergency situation. In addition, the proposal would require that a record of such an extension be made.

At the hearing, the Board proposed that this section be deleted in its entirety. The reason given was that "common sense dictates that there're going to be...emergency situations, emergency conditions, or in fact the patient has passed on and requiring response to a deceased patient is clearly unreasonable and spelling that out in the rule is clearly onerous." (T. p. 16). This deletion was supported by MHA in its written testimony, which argued that if MHA's 72 hour time limit were adopted, this rule would be "less necessary". The deletion is reasonable.

MHD 524(F)

27. That this proposal, in its original form, would have set forth three specific grounds for denial of any remedial action requested by a complainant. While it is unclear from the rule itself or the Statement of Need, it appears that the Board intended these to be the only grounds on which a facility could refuse to take action demanded in a complaint.

At the hearing, the Board recommended that this section be deleted entirely. The Board argued that since the orientation of these rules is response, not resolution, this proposal would have been "probably extraneous"

to the remainder of the rules. In its written testimony, the MHA challenged the original proposal as going beyond the intent of the law, approaching a requirement to resolve, not merely respond to, a complaint. The MHA proposed to replace the Board's proposal with a requirement that any denial, and the grounds therefore, be placed in the patient's complaint record. This proposal was adopted by the Board for inclusion in another section. In light of the evidence outlined above, the Board's proposed deletion of this section is reasonable.

MHD 524(G)

28. That this proposal sets forth record-keeping requirements for grievance mechanisms. As will be discussed below, proposed MHD 526 requires a facility to file annual reports with the Commissioner, and proposed MHD 527 sets forth fines for various violations. Adequate records are essential for both of those sections.

At the hearing, the Board proposed to make a number of changes to the rule as originally proposed. The first was to delete the word "Patient" from the title of the section, so that it would read "Complaint Records". The Board also proposed to delete the original requirement that the records be maintained "according to patient". These changes were justified on the basis that:

> It was pointed out to the agency after this proposed rule was published that a facility might want to classify its complaints according to subject matter as opposed to patient. It's reasonable to do so, for example, to highlight say an individual or a certain area which might be giving a facility a problem.
>
> (Transcript, p. 16)

This explanation follows a suggestion made by the Mental Health Association of Minnesota that the number of complaints and complainants in each service or department be identifiable. These changes were also supported by MHA (T. pp. 55-56).

The Board proposed another change, which would require that the arrangement of the records be such that the identity of particular patients and complainants could be ascertained. This appears to be a compromise between the "no restriction" approach advocated by MHA and the Board's original proposal. The Board's compromise proposal was supported by MHA, and, in light of the evidence, is reasonable.

The next change proposed by the Board related to the length of

time that the records be maintained. The original proposal required the governing authority of the facility to approve a written policy setting forth whatever time period the facility elected. The Board proposed that this be deleted in favor of a requirement that the records be maintained for at least one year. The Board justified the one year period by pointing out that a facility is required to submit an annual report to the Board, and that the Board might want to inspect a facility's records pursuant to a public complaint (T. p. 17). MHA supported this change (T. p. 55). It is desirable in that it sets forth a reasonable minimum time for retention.

The final change proposed by the Board is the insertion of the requirement that complaint records contain an annotation of the substance of any denial of a complaint. This was done in conjunction with the elimination of a more complicated procedure deleted in MHD 524(F) discussed earlier. This was supported by MHA (T. p. 56), and is reasonable.

MHD 524(H)

29. That proposed MHD 524(H) would require that potential grievants be notified of the existence of the grievance mechanism by both posting, and giving, a notice setting forth certain specified information about the mechanism.

At the hearing, the Board proposed that an additional piece of information be added to the list of required information in the notice. This new piece of information is "a statement that any complainant has the right to request and to receive a written response to, or written resolution of, any complaint." This would be consistent with the proposed change, discussed earlier, which would require a written response or resolution to a complaint only if it were specifically requested. However, the inclusion of the words "or written resolution of" create the impression that these proposed rules mandate resolution of, as opposed to response to, complaints. For this reason, these words will be omitted from the rule which is adopted. These changes reasonably balance the rights of patients against costs to facilities.

An extended discussion of whether these proposed rules would apply to users of emergency rooms and outpatient departments has preceded, and as was explained therein, the question arose because the original proposal for this section required that notice of the mechanism be "furnished, along with the notice required under Minnesota Statutes 144.652, to the patient or

his representative upon admission to the facility." (Emphasis added). The Board explained that the timing requirement for furnishing notice was tied to the Patient's Bill of Rights in order to avoid duplication of effort. However, as has also been explained earlier, patients in emergency rooms and outpatient departments do not have to be furnished with a copy of the Patient's Bill of Rights, and it is unclear whether users of those facilities are "admitted".

After the hearing, in a letter to the Hearing Examiner quoted earlier (the so-called "Rochester letter"), concern was raised that the rule might be interpreted to require posting and handout in emergency rooms. The concern was well-founded, because the Board did, in its post-hearing submission, recommend that the rule be changed so as to require the furnishing upon entry to the facility, except in those cases where the Patient's Bill of Rights is furnished, when notice of the grievance mechanism should be furnished at the same time.

Thus, by changing the word "admission" to "entry" and by re-ordering phrases (as well as adding a comprehensive definition of "patient"), the Board attempted to clarify the fact that patients in emergency rooms and outpatient departments are to be given notice of the existence of the mechanism, and are covered by these rules.

This change, submitted in the afternoon of the last day for comments, provoked a telegraphic response from MHA, which argued that "entry" was an inappropriate substitution to achieve the desired clarification. MHA suggested that "entry" be deleted, and there be substituted the phrase "upon admittance or initiation of services". MHA justified its proposal as reducing administrative burden while still providing effective notice to the appropriate parties. Although unstated, it appears that the concern with "entry" is that there are persons who physically enter or walk into emergency rooms and outpatient departments who are neither "admitted" nor provided with health care services. MHA's proposal is more precise than the Board's, and it appears that its adoption would satisfy the intent of the Board and alleviate the concerns of the Association. While the Board's proposal is reasonable, in light of MHA's concern, MHA's proposal is far preferable.

Its adoption would not, however, alleviate the concerns raised in the Rochester letter. While it has already been found that there was no

reasonable basis for affected persons to claim that these rules, in toto, did not apply to emergency room and outpatient department patients, there certainly is a reasonable basis for affected persons to claim that they did not expect that this particular section (on patient notice), would apply to those two categories. The post-hearing "clarification" proposal of the Board is based on adequate statutory authority, is needed to clarify, and is reasonable. But it may be a "substantial change" within the meaning of Minn. Stat. § 15.052, Subdivision 4 and Minn. Rule HE 107. For this reason, the Commissioner will adopt a rule which will require individual notice to be given, along with the Bill of Rights, to patients actually admitted. Although emergency room patients and outpatients shall be able to process complaints through such mechanisms, the rule will not require individual notice, unless and until such patients are "admitted." Thus the notice such patients will receive will consist of that in the general notice required to be "conspicuously posted" in the facility.

The final change proposed by the Board to this section was the addition of a phrase which would exempt a facility from furnishing notice if "an emergency prevents such furnishing". The Board argued, in its post-hearing submission, that this was needed to cover situations where the furnishing of such a notice would be a practical impossibility. It is reasonable.

30. In summary, proposed MHD 524(A), as amended by the Commissioner, has been found to be adequately based on statutory authority (hereinafter "authorized"), needed, and reasonable, as is proposed 524(B). The time limits of proposed 524(C) will be consolidated into one "as soon as possible" time limit. Proposed MHD 524(D), as proposed to be amended by the Commissioner, is authorized, needed, and reasonable, but it will be modified to be consistent with change in MHD 524(C). The deletions of both proposed MHD 524(E) and (F) are authorized, needed, and reasonable. Proposed MHD 524(G), with modifications suggested by the Board, is authorized, needed, and reasonable. Because of the deletions, it would be reclassified MHD 524(E). Proposed MHD 524(H), with modifications suggested by the Board, is authorized, needed, and reasonable, as modified by MHA's proposal for a phrase to be substituted for "entry." Due to the deletions, this would become MHD 524(F); however, because of a potential "substantial change," the rule will be modified as indicated above.

Proposed MHD 525

31. That proposed MHD 525, which is the list of complaints which must, at a minimum, be processed through the grievance mechanism, is taken substantially from the Patient's Bill of Rights, Minn. Stat. § 144.651, as amended by Chapter 274 of the Laws of Minnesota, 1976. There are, however, some differences between the two, and those differences provoked substantial criticism from public participants.

The authority of the Board (now, the Commissioner) to promulgate such a rule is clearly set forth in Minn. Stat. § 144.691, subd. 3(b), which directs the Board (now, the Commissioner) to promulgate, by rule, "a list of patient complaints which may be processed through a complaint or grievance mechanism". In response to that mandate, the Board used the Patient's Bill of Rights "as the genesis for a concomitant list of complaints..." (Statement of Need, p. 10). Because of the controversy the Board's proposed list has generated, the Statement of Need is worth repeating at this point to understand the Board's reasoning:

> Subd. 3(b) of the grievance mechanism statute requires the establishment, by rule, of a list of patient complaints which are capable of being processed through a grievance mechanism. Since most complaints are arguably related to the alleged breach of a duty owed to the complainant by the party against whom the complaint is made, and since the existence of such a duty derives from a right or a privilege belonging to the complainant, a list of complaints can be developed by an examination of the rights and privileges accorded such complainants. There is already a list of patient rights which are recognized by the Legislature (Minnesota Statutes 144.651; Exhibit VII). It seems reasonable to use this list of statutorily-recognized rights as the genesis for a concomitant list of complaints of the type intended by the Legislature. Hence, the Patient Bill of Rights, as amended, serves as the basis for the list of complaints set forth in this rule. Some provisions of that statute which do not appear to apply to patients, as opposed to residents in long-term care settings were considered inappropriate for these purposes (e.g., provisions relating to the right of residents to manage personal finances, with a quarterly accounting by the facility of transactions made in the residents behalf). On the other hand, other provisions of that statute, which were not expressly applied to patients, do seem appropriate in this context because they relate to complaints which might well be voiced by patients (e.g., provisions relating to the right of residents to be free from medically unjustifiable discharge can also be related to the potential similar problem of premature release of emergency room patients from an acute care facility). Two other sections of the Bill of Rights [(6), (21)] were not used in the generation of the complaint list because they seem to be adequately addressed through the patient notification rule [MHD 524(H)]. The remaining sections of the Bill of Rights are couched here in negative terms in order to make clear the situations in which such rights may be abrogated. For example, if

a patient is guaranteed the right to considerate and respectful care, then a violation of that right (or a breach of the duty to observe that right) is characterizable as a failure to provide or lack of, considerate and respectful care. The complaint related to the abrogation of that right, which would be made by a patient, would be to the effect that he or she was not being afforded considerate and respectful care. The list of rights from which the list of complaints is culled often includes rights of varying degrees of magnitude in the same section [e.g., the coupling of the right to participate in the planning of medical treatment with the right to refuse to participate in experimental research in Minnesota Statutes 144.651, S. (10)]. The replication of this technique in these rules is inappropriate because of the attempt to set differing times for response under proposed MHD 524(c). It seems reasonable to require a faster response time when the complaint relates to medical issues than when the complaint relates to psycho-social issues. Hence, where sections of the Bill of Rights include both medical and psycho-social rights, the list of complaints derived from those sections separates the medical components from the psycho-social components; in this fashion, the listing of complaint response times in proposed MHD 524(c) more clearly reflects the magnitude of a particular type of complaint. Finally, since patient dissatification resulting from perceptions of billing practices arguably has an impact upon the subsequent incidence of suit, it appears appropriate to include a reference to billing concerns in this complaint list.

Prior to the hearing, two facilities (Golden Valley Health Clinic and St. Mary's Hospital and Home of Winsted) submitted criticisms of the Board's proposal. They can be summarized as follows:

1. The list is not all inclusive, allowing significant leeway for a facility in dealing with complaints which don't fit into any of the specified categories.

2. The list is vague--how can a facility know if it is providing "understandable" information about diagnosis? What steps will satisfy a complaint that a patient has not been "afforded an opportunity to participate" in the planning of his treatment? How should mentally ill or chemically dependent patients be treated?

3. Some are responsibility of the physician, not the hospital [MHD 525(b), (j), (l) and (q)].

4. Some are a matter of judgment based upon the condition of the patient, hospital rules, and the medical knowledge of the individuals involved.

5. Were malpractice insurance carriers consulted to determine the correlation between the proposed list and malpractice claims?

The Board did not propose any changes to the original list.

At the Hearing, a number of complaints were voiced regarding the Board's proposed list:

1. The Board has presented no evidence to demonstrate that these areas have any relationship to malpractice (U. of M.; T. p. 28).

2. The Board has taken some "rights" granted to residents of nursing homes, but not patients in hospitals, in the Patient's Bill of Rights, and had arbitrarily granted them to patients (U. of M.; T. p. 29 and MHA; T. p. 56).

3. The Board should be consistent with the Patient's Bill of Rights and either incorporate it by reference or repeat it verbatim (MHA; T. p. 56), and add to it, at some later date, other categories of complaints which have been found to result in malpractice claims (U. of M.; T. p. 31).

4. Lack of consistency with the Patient's Bill of Rights makes it difficult for the legislature or a facility to use the grievance mechanism reports as a information-gathering tool to assist it in deciding whether to change the Bill of Rights or amend its procedures (U. of M.; T. pp. 35-36).

In an attempt to determine how these rules would impact on its existing grievance mechanism, the University of Minnesota Hospitals conducted a one week study. Of the 106 complaints raised during the week, 59 would have been included in the Board's proposed list, while 47 would not have been (T. pp. 37-38). This was used by opponents of the Board's proposal to argue that the adoption of the Board's list would place undue emphasis on those classes of complaints that fell within the list, and might result in a detrimental change in the operation of complaint resolution mechanisms in those facilities which already had them in operation (40 of the 184 members of MHA). At present, at least in the three facilities which presented testimony about their existing mechanisms, all types of complaints are handled. But all three representatives supported MHA's proposal that the Board's list be replaced with either a reference to the Patient's Bill of Rights or a list taken, verbatim, from that statute.

After the hearing, criticism of the Board's list continued. Summarized, those criticisms argued:

1. The list should be eliminated since it has not been shown to be related to malpractice claims.

2. The list is too vague. It would require responses to complaints about room temperature, improperly drawn drapes, a loud television, a nurse's dressing habits.

3. The proposal of MHA should be adopted.

In response to the University of Minnesota's criticisms raised at the hearing, the Board, in its post-hearing submission argued:

1. Mr. Diehl's statement that the non-delegation doctrine requires a proven nexus between the list of complaints enumerated in rule and the incidence of claim or suit is without merit. Subdivision 1 of the grievance mechanism

statute (Laws 1976, Ch. 325, Section 8, Subdivision 1) indicates that the Legislature, not the agency, has made a determination that grievances related to billing and inadequacies of treatment may impact on the incidence of claim or suit. Hence, insofar as the list of complaints specified in rule relates to these things, there is no delegation problem. Those things specified in the list of complaints which do not relate to billing or inadequacies of treatment can still be included without the agency acting ultra vires since the language of the statute (subdivision 1) permits the inclusion of other factors which, although not proven, may have an impact on the incidence of claim or suit.

2. Mr. Diehl's testimony questioning the appropriateness of including complaints which derive from the rights of residents (as opposed to patients) as expressed in the Patient Bill of Rights overlooks the recent expansion of hospital services to provide care to persons who would formerly be considered "residents," not "patients" - e.g., chemical dependency and detoxification units, rehabilitation services, etc.

3. Lastly, Mr. Diehl's suggestion that the Patient Bill of Rights be referenced in the rules is not appropriate. First, the legislation [subd. 3(b)] commands the development of a "list" of complaints in rule. Secondly, it would be impossible to tie the Patient Bill of Rights statute, as it stands, into the specified time limits for response which are proposed to be promulgated.

4. With regard to whether post-discharge complaints are covered by the rules, it is clear that they may, indeed, be processed through such a mechanism. The statute, however, is arguably directed at ameliorating potential problems while the individual is in the institution, i.e., while he is a "patient." Once discharged the individual is no longer a "patient;" hence the main thrust of the proposed rules is directed toward the former situation.

5. Ms. Countryman's criticism that some types of complaints were not mentioned is not really tenable because she offered no examples and because the list is specifically described as not being all-inclusive.

Beyond that, there are really two major criticisms which must be overcome if the Board's proposal can be deemed to meet the statutory standards of Section 15.0412, subdivision 4. The first allegation is that the Board has not demonstrated any relationship between its proposed list and malpractice claims. The second is that the Board's "tinkering" with the Patient's Bill of Rights is improper.

With respect to the first of these, very little evidence was presented at the hearing, or otherwise, regarding the actual history of malpractice claims in the state, presumably because such evidence is not readily available. Really, the only relevant evidence is contained in a dialogue at the hearing between J. Breviu, representing the Board and K. Countryman, from the University of Minnesota Hospitals:

MR. BREVIU: Do you feel the program at University Hospital in any way has reduced or kept the incidents of malpractice claims from climbing?

MRS. COUNTRYMAN: I think that factually that would be very difficult to assess, because we were covered under governmental immunity until the 1st of August. I think, however, in terms of patients satisfaction with the care delivered, or understanding of the care delivered, it's definitely increased the satisfaction, which would be my impression would decrease the claims or suits generated out of frustration and anger and misunderstanding. I don't believe it can or should address suits, valid suits generated for valid reasons.

MR. BREVIU: Would you feel that the patients' satisfaction is a result of the existence of the program rather than your ability to attempt to look into certain specific areas of patient complaints? It seems to me you've described a program which increases staff satisfaction in ability to deal with certain frustrations and which has increased patient satisfaction with the staff as a result. Is it this general, the type of atmosphere that has been created that has what you -- that has resulted in decrease in -- has resulted in some patients not bringing malpractice claims when they might otherwise have?

MRS. COUNTRYMAN: I think that's an assumption that could be made, most definitely. I think that's probably one of the reasons that hospitals are looking to funding these types of programs, that people who are satisfied are less inclined to sue or more inclined to evaluate the appropriateness of suit.

(Transcript, pp. 47-48)

Mrs. Countryman has articulated, in her last response, the logical conclusion that can be drawn regarding legislative intent: That by establishing a grievance mechanism, the incidence of malpractice suits will be decreased.

The puzzle presented by the critics of the Board's list is that in one breath, they argue that the Board has failed to meet its statutory burden to demonstrate the reasonableness of its proposed list, but in the next breath, they recommend adopting the Patient's Bill of Rights verbatim. It seems as if they are hard pressed to find any better list than that in the Patient's Bill of Rights. Indeed, apart from one recommendation that there be no list at all, none of the critics proposed anything but the Patient's Bill of Rights.

The repeated argument of the Board that it is reasonable to use the rights from the Patient's Bill of Rights as the basis of the list since malpractice claims are arguably related to an alleged breach of a duty owed by the facility to the complaint, and since such a duty arises from some right of the complainant, and since the Patient's Bill of Rights spells out a list of such rights, is not as sophistic as it may appear at first blush. There is no statutory definition of malpractice. Rather, a malpractice

action is just one form of a negligence action. Indeed, in a 1966 medical malpractice case, the Minnesota court has quoted from Professor Prosser's Torts Treatise to lay the conceptual framework for analyzing the merits of the specific case. Miller v. Raaen, 273 Minn. 109, 139 N.W.2d 877 (1966). And the first three sentences which the Court quoted from Prosser are:

> The traditional formula for the elements necessary to such a cause of action may be stated briefly as follows:
>
> 1. A duty, or obligation, recognized by the law, requiring the action to conform to a certain standard of conduct, for the protection of others against unreasonable risks.
>
> 2. A failure on his part to conform to the standard required.

These are really the basis for the Board's logic. While it is admitted that the best support for a list would be data from actual malpractice claims, it is the finding of the Commissioner that the conceptual approach of the Board--looking to the Patient's Bill of Rights--is an adequate response to the legislative mandate that the Board adopt a list.

The second complaint was that the Board should not have modified the Patient's Bill of Rights at all, but rather should incorporate it by reference or adopt it verbatim. Obviously, it would have been easy for the legislature to direct, by statute, that the grievances to be processed shall be those arising from the Patient's Bill of Rights. This they did not do, but rather directed the Board to come up with its own list. In this statutory setting, the Board had statutory authority to do what it did. But is it reasonable to have altered the list in the way that it did? A rereading of the Statement of Need and a companion of the list as proposed by the Board with the Patient's Bill of Rights indicates that there was a reasonable basis for each of the changes made by the Board.

For example, which "rights" guaranteed to residents of nursing homes were transferred to patients in facilities? They are MHD 525(I), (L-O), and (Q-U):

> I. failure to provide requested information, prior to or at the time of admission and during the period spent in the facility, relating to charges for care;
>
> L. retaliatory, arbitrary, or otherwise medically unjustifiable discharge;
>
> M. interference with or retaliation for the free exercise of any legally prescribed rights;
>
> N. mental and/or physical abuse;

O. medically unjustifiable physical and/or chemical restraints;

Q. requiring the performance of services not included for therapeutic purposes in the plan of care;

R. restriction of the right to associate and communicate privately with others;

S. interference with the sending and receipt of personal mail;

T. restriction of the rights to meet with representatives and to participate in commercial, religious and community activities;

U. restriction of the right to retain and use personal clothing and possessions, to the extent that space permits.

While some appear to be more reasonably related to malpractice claims than others (I, L, N and O as opposed to S, T, and U), it would be impossible to predict (except in light of past, and presently unavailable, data) that even the most unlikely of them might not be the real motivating factor for a suit.

The argument that verbatim repetition of the Patient's Bill of Rights is preferable, because it will enable to the legislature, the Board, or a facility to use data from the complaint mechanism in evaluating proposed changes to the Patient's Bill of Rights, is a sensible point. But the primary purpose of having a list of complaints in a rule is not to facilitate evaluation of the Patient's Bill of Rights. For that reason, this argument against the Board's proposal cannot sustain a finding of unreasonableness.

In summary, it is found that the Commissioner has statutory authority to adopt proposed MHD 525, and that it has demonstrated the need for, and reasonableness of its proposal.

Proposed MHD 526

32. That proposed MHD 526 would set forth the information required to be filed with the Commissioner annually by each hospital and outpatient surgery center relating to the experience of its grievance mechanism.

The authority for such a rule is clear. Minn. Stat. § 144.691, subd. 4 states that the reports shall be filed, and goes on to state that the "frequency, form, and content of each report shall be as prescribed by rule of the state board of health (now, the Commissioner)."

Prior to the hearing, Golden Valley Health Center criticized the proposal as being "too bureaucratic" and questioned its efficacy.

At the hearing, the Board made two suggestions for changes. First,

it suggested that the section of the report which would require the reporting of the total number of complaints "received by" a facility be changed to the total number of complaints "filed with" the facility "pursuant to MHD 524B.1." The purpose of this change was to clarify that the Board wanted only information relating to the operation of the formal grievance mechanism, not all complaints of whatever nature. This was supported by MHA.

The second change comes in the section which would require the facility to report the number of complaints resolved "to the patient's satisfaction". The Board proposed to insert the word "apparent" so that it would require a report of the number of complaints resolved "to the patient's apparent satisfaction". This proposal was justified by the Board on the basis that whether a patient is, or is not, satisfied is somewhat of a "judgment call" (T. p. 20) and that the Board was interested only is a rough estimate. This reasoning, and the proposed change, was supported by the University of Minnesota Hospitals and MHA (T. pp. 37 and 57, respectively).

MHA proposed that the section of the rule which would require a facility to report the total complaints "according to classification under MHD 525" be modified, to be consistent with their proposal that the Patient's Bill of Rights be substituted for the list in 525. In light of the previous finding, there would be no point in making this change.

After the hearing, the Minnesota Mental Health Association supported a non-controversial Board proposal that the facility have to report the number of patients making multiple complaints. It went on to suggest that the facility have to report the number of complaints against a single service or department. It argued that such information will enable the institution and the Board to identify areas where improvements may be needed. While such information may, indeed be helpful, the Commissioner does not have enough evidence to find that the insertion ought to be made. It would be better for the Association to petition the Board, pursuant to Minn. Stat. § 15.0415 (1976) for such a change, in order that all affected persons have an opportunity to comment on the merits and demerits of the proposal.

In summary, the original proposal, as proposed to be amended by the Board, is based on adequate statutory authority, is needed, and is reasonable.

Proposed MHD 527

33. That proposed MHD 527 is a penalty section, imposing automatic

fines for some enumerated violations and empowering the Commissioner to issue correction orders for other enumerated violations.

The statutory basis for such a rule is Minn. Stat. § 144.691, subd. 3(d), which directs the Board to promulgate by rule:

> A schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of this section.

The threshold question, raised by MHA in its written testimony, is whether the Commissioner's statutory authority extends to promulgating a rule providing for a schedule of fines for violation of another rule, as opposed to a violation of the statute. In effect, MHA is focusing on the last three words of the statute quoted above. The Hearing Examiner found that this position was well taken. Stating that there are a limited number of acts required of facilities by the statute:

1. that every hospital and outpatient surgery center establish a mechanism (Subd. 1);
2. that each patient receiving treatment be notified of the mechanism (Subd. 2); and
3. that each facility submit a report on the operation of its mechanism (Subd. 4);

he found that, absent some other authority, those were the only acts for which fines may be imposed if they are violated. This is an unduly strained and rigid interpretation of the statute. The statute directs the Board (now, the Commissioner) to develop a schedule of fines in rule (Minn. Stat. 144.691, subd. 3(d)). This schedule of fines must be directed toward penalizing the failure of certain health facilities to comply with "the provisions of this section" (subd. 3(d)). The words "this section" refer to the grievance mechanism statute in toto. Hence, as the hearing examiner indicates, any violation of any provision of the statute constitutes activity which can be subjected to a schedule of fines. However, the statute also commands the Board (now, the Commissioner) to develop standards in rule, (Subd. 3(a), (b), (c)), which standards make specific the impact of the law. Such rules, properly promulgated, would be as much a part of "this section" as the statutory language itself; here the legislature is directing the agency to "fill in the details" of measuring compliance left open by the law. Hence, failure to comply with such properly promulgated rules would be failure to comply with the "provisions of this section" and would be subject to sanctions specified in a schedule of fines. To hold otherwise would be construing the statute so narrowly as to vitiate the utility of the enforcement tool given

the Commissioner by the Legislature to determine compliance with the law and to execute its mandated data gathering and analysis functions (subd. 4).

It was the position of MHA and numerous others that there be no provision for automatic fines at all (even for a violation of the statute). Rather, they urged that the correction order process be the sole method of penalizing violations. This suggestion, however, would be contrary to the legislative language quoted at the beginning of this Finding. Therefore, the Commissioner has the statutory authority and has demonstrated the need for such a rule. However, because of Finding 24, above, the language of 527 A.1.b. would have to be changed to eliminate the reference to specific time limits. Therefore, this section will be rewritten to indicate that failure to respond to a complaint "as soon as possible" is subject to a fine.

Finally, with regard to the automatic fine issue, did the Board demonstrate the reasonableness of its automatic fine proposal? The Board's justification was that failure to give an individual the required notice is a past violation, rather than an ongoing one, and the use of a correction order is inappropriate because the effect of such an order would merely be the granting of "one free bite" for a type of violation that is not susceptible to reinspection to determine whether the correction order has been acted upon. In light of the amount of the fine ($50) and in light of the right to a hearing to protect the unjustly accused facility, the Board's automatic fine proposal is justified.

MHA also made a number of other proposals regarding the schedule of fines. Some were mere "housekeeping" to make this rule consistent with charges in other rules proposed by MHA (which were, in many cases, adopted as Board proposals at the hearing). But other MHA suggestions were more substantive. The substantive will be discussed first.

The Board had proposed that there be a 60-day time limit for correction of any violation for which an order had been issued. MHA agreed with the 60-day "outside" limit, but suggested that there be a 20-day "inside" limit to give facilities at least 20 days to correct violations. Under this MHA proposal, proposed MHD 527(B)(2) would read:

> In no case may the allowable period for correction of any of the violations [in MHD 527(B)(1)] be less than 20 days nor more than 60 days.

In justification of this proposal, the MHA representative raised the specter,

at the hearing, of a correction order being issued one day, requiring the reprinting of the patient notice, for example, and the time for correction being only two days, with an immediate reinspection and fine being assessed for failure to correct, in what MHA felt was an unreasonably short time span. He stated "I guess what we're trying, obviously, is to protect ourselves against a potential problem. I can't say that that specifically is going to happen." (T. p. 59).

The Board responded, at the hearing, in opposition to this proposal, by pointing out that while some violations could be reasonably anticipated to take longer than a few days to cure (reprinting notices, resubmission of an annual report, reordering of a facility's filing system), other violations (which would also be subject to the 20 day minimum) were those which could be cured more quickly, and to permit a 20 day minimum correction time would defeat the intent of the statute. Examples cited by the Board were failure to post the notice and failure to have any mechanism at all. The MHA representative agreed with the Board that failure to have any mechanism at all should be cured immediately (T. p. 61), but the two disagreed over whether there should be a 20 day minimum, with a few exceptions (MHA); or whether there should be no minimum, with a few exceptions (Board). While either would be reasonable, the Examiner recommended that there be no minimum, except for a 20 day minimum in the case of MHD 527(B)(1)(d), (e), (f) and (g). The Commissioner will adopt the Examiner's recommendation, with the exception of its applicability to 527(B)(1)(e) ("failure to post notice") since necessary changes in a posted notice can be accomplished with ease in less than 20 days, merely by typing a new notice.

The next substantive change proposed by MHA was in the amount of the fines. The Association proposed that in no event should the fine exceed $50 per violation, except that in the case of multiple violations, the amounts originally proposed by the Board as maximum per violation amounts be retained. No justification for this proposal was offered by the Association. The Board's desire for flexibility--tailoring the amount of the fine to the seriousness of the violation--seems eminently logical, and the adoption of the Association's proposal would remove that flexibility.

The final "substantive" change proposed by the Association is arguably merely a matter of clarity or convenience. The proposal would add a section to the rule which would specify that all hearings provided for in the rule be

conducted in accordance with Minnesota Statutes Section 15.0411. The Board had assumed that any person who is given automatic fine or a correction order which leads to a fine is entitled to a hearing. Its proposed rule specifies, in both cases, that the fines are payable within 30 days of assessment "unless there is a facility request for a hearing within that period". The Commissioner cannot conceive of a situation in which such a hearing would not be a "contested case" within Minn. Stat. § 15.0411, nor can he conceive of a situation in which the affected facility would not know that.

The "housekeeping" changes relate to the descriptions of violations in MHD 527(B)(1). They will be changed in order to be consistent with the changes recommended in earlier findings. These changes need not be spelled out beyond referencing the affected subsection of MHD 527(B)(1) in which they must be made, which are (b), (c), and (d).

34. In summary, statutory authority, the need for, and the reasonableness of, proposed MHD 527 have been demonstrated, and the rule, as modified will be adopted.

Proposed MHD 370(g)

35. That the final rule proposed by the Board relates solely to health maintenance organizations (hereinafter "HMO"), and for ease in reference, it is placed in the Department's rules for HMOs. The rule would require each HMO to make an annual report to the Board (now, the Commissioner) on the operation of its grievance mechanism.

The statutory authority for the rule is contained in Minn. Stat. § 144.691, subd. 4 (1976), which places HMOs in the same status as other facilities in requiring such reports and authorizing the Board (now, the Commissioner) to adopt rules relating to the "frequency, form and content" of such reports.

Prior to the hearing, a number of changes were proposed by Group Health Plan, Inc., Group Health Association of Northeastern Minnesota, Inc., and MedCenter Health Plan. All three recommended that the filing date of the report be changed to April 1, so as to be consistent with a different Annual Report that must be filed by HMOs on that date. The Board, at the hearing, adopted this proposal because "...it was felt more appropriate and more streamline (sic) to require the submission of this [grievance mechanism] data along with the annual report..." (T. p. 24).

Another prehearing comment was that proposed MHD 370(g)(5), which required a copy of written summaries of actions taken pursuant to complaints be included in the HMO's report, raised a problem of patient confidentiality. The Board agreed with this, and at the hearing, proposed to modify the rule to state that the identity of specific individuals should not be disclosed.

Other prehearing criticisms, however, were not responded to by the Board. Group Health Association of Northeastern Minnesota, Inc. (hereinafter "GHANM") proposed that MHD 370(g)(4), which required HMOs to include in their report "the total number of complaints received", be modified to require a report of the total number of written complaints received. The Board's proposal (covering both written and oral) is consistent with MHD 526(D) for other facilities, and appears to be consistent with the malpractice-reduction orientation of the Act. It is inconsistent, however, with the existing HMO rules, which relate solely to written complaints [see Minn. Rule MHD 370(d)-(f)]. It is especially noteworthy that the record-keeping rule for HMOs, MHD 370(f), requires that records be kept solely for written complaints. The adoption of the Board's proposal, in its present form, therefore, would require that HMOs either keep two sets of records or else that they expand their present records to include oral complaints. The rule, as then proposed by the Board, can be justified in light of the statutory purpose. However, because of the inconsistencies noted above, the hearing examiner recommended that the Board (now, the Commissioner) give consideration to whether or not the limitation proposed by GHPNM should be adopted. The same reasoning would lead to the same result in MHD 370(g)(6) and (g)(7). The Commissioner adopts these recommendations, and the rules will be rewritten accordingly.

One change the Board did propose at the hearing would decrease the reporting requirements of HMOs. That change is in MHD 370(g)(5), already discussed, and would permit HMOs to include in their report synopses of actions taken as a result of complaints, rather than copies of summaries of such actions.

Another change proposed by the Board at the hearing would be to modify the requirement that HMOs report the number of complaints "resolved to the enrollee's satisfaction". The Board, as in MHD 526(H), proposed to modify the rule so that it would require the reporting of the number of complaints "resolved to the enrollee's apparent satisfaction". The logic for the change is the same as that in MHD 526(H).

After the hearing, Physician's Health Plan recommended that proposed MHD 370(g)(5) be deleted in toto. A similar suggestion came from MedCenter Health Plan before the hearing. Both argued that this rule (which, if adopted with the Board's proposed changes noted above, would require HMOs to include in their reports synopses of actions taken in response to complaints) was too burdensome, and Physician's went on to say that is was unreasonable to require the reports to be so extensive "as to serve as an investigative tool of the [Board] in understanding the nature of complaints".

The hearing examiner found that the board offered no justification for this section of the proposed rule; however, he apparently overlooked relevant language in the Board's combined Statement of Need and Evidence. On page 15 of that document, the reasons for MHD 370(g)(5) are identified as the same as those stated for MHD 526E. Those reasons (at p. 11 of the Statement of Need and Evidence) highlighted the Board's need for information which would reveal frequently occurring problems. In the area of HMOs a classification of complaints along the lines of the Patient's Bill of Rights was felt (albeit tacitly) to be inappropriate, because of the obvious differences between HMO's and health facilities. Hence, synopses of such complaints were thought to be more revealing than classification according to the Patient's Bill of Rights. The reasoning which was persuasive in the case of MHD 526E failed to persuade the hearing examiner when applied to MHD 370(g)(5). The Commissioner finds such reasoning persuasive in both cases. However, in recognition of the apparent administrative burden this would place upon HMOs, the Commissioner will adopt an alternative provision, directed at the same end. The rule will be modified to require the HMO to report the total number of written complaints received by the HMO according to a classification most suited to the needs of the particular HMO (e.g.: coverage, billing and similar complaints; patient care complaints; and psycho-social complaints), if such classification is not unduly burdensome.

36. In summary, the Board has shown the authority, need and reasonableness of proposed MHD 370(g), and, with the modification to MHD 370(g)(7) relating to "apparent," will require the reporting of only written complaints.

Based on the foregoing Findings of Fact, the Commissioner hereby makes the following:

CONCLUSIONS

1. That the Board gave due, timely and proper notice of the hearing herein. All other substantive and procedural requirements of the statute and applicable rules have been fulfilled.

2. The Commissioner has statutory authority to adopt the proposed rules.

3, With the exceptions noted in the Findings, the Board has demonstrated the need for and reasonableness of the proposed rules.

4. The Board offered a number of changes and modifications to the proposed rules both at the hearing and in its post-hearing submission. Except as expressly found otherwise above, the changes are reasonable, necessary, and non-substantial.

DATE: July 12, 1977

WARREN R. LAWSON, M.D.
Commissioner of Health

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ST PAUL MN
55155

ANTHONY DICK WDSM RADIO
230 E SUPR ST
DULUTH MN
55102

ANTI-TRUST DIV.ATTY GEN.
160 STATE OFF BLDG
ST PAUL MN
55155

ARNOLD ROBERT MESPA
41 SHERBURNE
ST PAUL MN
55103

ARROWHEAD REG. DEV COMM.
211 W 2ND ST
DULUTH MN
55802

ARROWHEAD REGIONAL DEV COMM
200 ARROWHEAD PLACE
DULUTH MN
55802

ARVER JOHN A
2467 COHANCY
ST PAUL MN
55113

ASMUSSEN,DENNIS,MPIRG
3036 UNIV AVE SE
MPLS MN
55414

ASSOCIATION OF COUNTRY INT
48 E 8TH STREET
ST PAUL MN
55101

ASSN OF MINN COUNTIES
55 SHERBURNE AVE #203
ST PAUL MN
55103

ASSN RESIDENCES FOR RETARDED
459 RICE SUITE 301
ST PAUL MN
55103

AUTOMOBILE MFRS ASSN INC
55 SHERBURNE AVE
ST PAUL MN
55103

BABCOCK LOCHER NELSON ET AL
118 E MAIN ST
ANOKA MN
55303

BADALICH JOHN P
2025 THOMPSON AVE
SO ST PAUL MN
55075

BARRETT FRED
ST LOUIS CO COURT HOUSE
DULUTH MN

BARTHOLOW HAROLD E FIRE CHF
2600 109 AVE N W
COON RAPIDS MN
55433

BATES DENNIS
446 STATE OFF BLDG
ST PAUL MN
55155

BECK PAT
953 HYACINTH AVE
ST PAUL MN
55106

BEECHER EVERETT
10 10 1ST ST SO
HOPKINS MN

BEGALKA D REV
212 N ELK ST
BELLE PLAINE MN
56011

BEMIDJI STATE COLLEGE
PLACEMENT BUR.J.C.BRADY
BEMIDJI MN
56601

BENSONI PETER USW OF AM.
609 PROVIDENCE BLDG.
DULUTH MN

BERGERUD ALF
300 ROANOKE BLDG
MPLS MN
55402

BERGSETH THOMAS
1011 NICOLLET MALL
MPLS MN
55403

BERGUSON & LOFGREN
MN GAS 700 LINDEN W
MPLS MN
55403

BEST FLANAGAN ET AL
4040 IDS CENTER
MPLS MN
55402

BEUTEL ROBERT
2200 SILVER LAKE RD
NEW BRIGHTON MN
55112

BLADIN PAPER CO W J LICKE
115 1ST ST SW
GRAND RAPIDS MN
55744

BLOMQUIST BARRY L

NORTH BRANCH MN
55056

BLOOMINGTON CITY CLERK
2215 W OLD SHAKOPEE RD#
BLOOMINGTON MN
55431

BOLTON MALCOLM
422 ALDRICH AVE NO
MPLS MN
55405

BOWMAN & BRUNS ATTN P MASON
1616 PIONEER BLDG
ST PAUL MN
55101

BREHL JAMES W
332 HAMM BLDG
ST PAUL MN
55102

BRICK PHILIP D
807 SELLWOOD BLDG
DULUTH MN
55802

BRIGGS & MORGAN - B F FRI
2200 W 1ST NATL BK BLDG
ST PAUL MN
55101

BRIGHAM E M III
RR4
RED WING MN
55066

BROEKER JOHN
2850METRO DR. SUITE 504
BLOOMINGTON MN
55420

BROOKS WILLIAM F JR
854 MIDLAND BK BLDG
MPLS MN
55401

BROWN C M GOODRIDGE PUB S
IND DIST #561
GOODRIDGE MN
56725

BROWN H D
4961 KINGSBERRY LANE
MINNETONKA MN
55343

BRUBACHER RICHARD COMM ADM
208 ADM BLDG
ST PAUL MN
55101

BRUNING C.R.DEPT.CLINIC.EXP.
BURTON HALL
MPLS. MN
55455

BUSCH NOEL
SUITE 705 510 MARQUETTE
MPLS MN
55402

BUCHHOLTZ CHARLES
5544 BRENT AVE E
INV GRV HTS MN
55075

BURGER ALBERT
600 DEGREE OF HONOR BLD
ST PAUL MN
55101

BUR.ENGR.IND.DIV. MR.KIBIGER
219 N. 2ND ST.
MPLS. MN

BUR NATL AFFAIRS INC
1231 25TH ST NW
WASHINGTON DC
20037

CABLE COMM SYST-H SARRAZIN
BOX 777
HECTOR MN
55342

CAIN RUTH
730 E 38TH ST
MPLS MN
55407

CAIRNS JOHN A
47TH FLR IDS CENTER
MPLS MN
55402

CARLSON CARL L
7516 80TH ST S
COTTAGE GROVE MN
55016

CARLSON VERNE E
BOX 755 CITY HALL
WILLMAR MN
56201

CARRISON DALE K
MANKATO STATE COLLEGE
MANKATO MN
56001

CARTER LOCEY & ASSOC
2353 N RICE ST
ST PAUL MN
55113

CENTRAL BUSINESS DATA
BENSON RADIO ARCADE BLD
BENSON MN
56215

CENTRAL MN REG DEV COMM
1139 FRANKLIN AVE
SAUK RAPIDS MN
56379

CHAMBER OF COMMERCE
30 SO 1ST AVE EAST
ELY MN
55731

CHAMBERLAIN JOHN L
PO BOX 241
MPLS MN
55440

CHERCHES CHRIS CITY MGR
5005 MTKA BLVD
ST LOUIS PARK MN
55416

CHRISTIAN SCI COMM ON PUB
1821 UNIV AVE SUITE 271
ST PAUL MN
55104

CHRISTIANSEN FREDRIK
RM 505 CAPITOL SQ BLDG
ST PAUL MN
55155

CHRYSALIS CENTER FOR WOME
2104 STEVENS AVE S
MPLS MN
55404

CITY CLERK
386 CITY HALL
ST PAUL MN
55102

CITIZENS LEAGUE
530 SYNDICATE BLDG
MPLS MN
55402

CITY OF ROBBINSDALE
C LARSON 4221 LAKE RD
ROBBINSDALE MN
55422

CLARKSON J.B.
2350 I.D.S. CENTER
MINNEAPOLIS MN
55402

CLAUSEN PHILLIP
2307 STANDISH ST
ST PAUL MN
55108

CLAWSON CONNIE
HELP CT 317-17TH AV SE
MPLS MN

COLEMAN NICHOLAS
208 STATE CAPITOL
ST PAUL MN
55155

COLLIN LAURENCE
RT 2
ISANTI MN
55040

COMMUNITY DESIGN CENTER
118 E 26TH ST
MPLS MN
55404

CONCORDIA COLLEGE
DEAN
MOORHEAD MN
56560

CONSUMER SERVICES DEPT COMM
5TH FLR METRO SQ BLDG
ST PAUL MN
55101

COUNTY ATTYS COUNCIL
95 SHERBURNE AVE S203
ST PAUL MN
55103

CRAVEN NORMAN
10537 THOMAS AVE S
BLOOMINGTON MN
55431

CROW WING CO PLANNING & ADV
COURT HOUSE
BRAINERD MN
56401

CUSHMAN J S DAYTON HUDSON
700 NICOLLET MALL
MPLS MN
55402

DAHLKE LOIS M
115 S EAGLE ST
BELLE PLAINE MN
56011

DAILEY THOMAS ECONOMICS LAB
370 WABASHA ST
ST PAUL MN
55102

DANKERS,KENNETH
1200 WEST FOURTH STREET
RED WING MN
55066

DANIELSON RODNEY L
418 AUDITORIUM
ST PAUL MN
55102

DAYTON CHAS SIERRA CLUB
800 MIDLAND BANK BLDG
MPLS MN
55401

DEVELOP DISABILITIES PROGRAM
STATE PLAN 101 CAP SQ
ST PAUL MN
55155

DICKINSON MRS JOANNE
BOX 1065
MARSHALL MN
56258

DIEHL JOHN
26 KENWOOD PKWY
ST PAUL MN
55105

DISPATCH PIONEER PRESS
PRESS RM STATE CAPITOL
ST PAUL MN
55101

DORSEY MARQUART
2400 1ST NATL BANK BLDG
MPLS MN
55402

DOUGLAS BELL ET AL
2212 AM.NATL BK BLDG
ST PAUL MN
55102

DOW CHEMICAL
47 BLDG
MIDLAND MI
48640

DUDLEY E P
RT 7 BOX 122
EXCELSIOR MN
55331

DUNN OLIVER PLUMBERS LOC 15
708 SO 10TH ST
MPLS MN
55404

DUGAN KEN ST PAUL PLANNING
421 WABASHA ST
ST PAUL MN
55102

E CENTRAL REG. DEV. COMM
COURTHOUSE 18 N VINE ST
MORA MN
55051

EBELING EDWARD H.
161 W. MAIN
PERHAM MN
56573

EICHTEN DANIEL
3794 HAZEL
WHITE BEAR LK MN
55110

ELDER DR JAMES B
11140 WASHBURN AVE SO
BLOOMINGTON MN
55431

ELDRED R W ARMOUR & CO
UNION STOCK YARDS
SO ST PAUL MN
55075

ELMER EDWIN W
2901 PLEASANT AVE
MPLS MN
55408

EMERICK RICHARD A
1908 IDS CENTER
MPLS MN
55402

ENGELBRECHT DOUGLAS
809 RANGE ST
NO MANKATO MN
56001

ENNIS A F BOISE CASCADE
PO BOX 713
INTL FALLS MN
56649

ENV SERV-GEN RESOURCE CORP
6340 INDUSTRIAL DR
HOPKINS MN
55343

ERDMAN ROGER TENNANT CO
701 N LILAC DR
MPLS MN
55441

ERNEST K LEHMANN & ASSOC.
1409 WILLOW ST.
MPLS MN
55403

ESSE KENNETH
4801 W 50TH ST
EDINA MN
55424

ETHICS COMM
RM 410 STATE OFF BLDG
ST PAUL MN
55155

EVANS CHAS.L. PRENTICE-HALL
ENGELWOOD CLIFFS
NEW JERSEY

EWALD DOUGLAS MINN HOSP A
2333 UNIV AVE SE
MPLS MN
55414

EWING MRS WM
42 ASTAR RD
BABBITT MN
55706

FAEGRE & BENSON ATTN LIBR
1300 NW BANK BLDG
MPLS MN
55402

FARMERS ELEVATOR ASSN
852 GRAIN EXCH BLDG
MPLS MN
55415

FARRELL FRANK BUR NOR
RM 1180 176 E 5TH ST
ST PAUL MN
55101

FELHABER R S
W 1ST NATL BANK BLDG
ST PAUL MN
55101

FILTER LOREN
BOX 36
BRITT MN
55701

FINLEY JAMES F
920 MINN BLDG
ST PAUL MN
55101

FINNEGAN J.R.
55 E. 4TH
ST.PAUL MN
55101

FITZGERALD DR BOB
3007 LYNDALE AVE SO
MPLS MN
55408

FLEMING FREDERICK A
1860 HIGHLAND PARKWAY
ST PAUL MN
55116

FLADLAND CLINT MN LEP BUR
795 RAYMOND AVE
ST PAUL MN
55114

FORBES GORDON MINN RRS ASSN
203 HANOVER 480 CEDAR
ST PAUL MN
55101

FORSBERG AGR SERV
518 SUMMIT AVE
NEW ULM MN
56073

FOX W.E. LINDQUIST & VENNUM
4200 IDSCTR 80 S.8TH ST
MINNEAPOLIS MN
55402

FRANKLIN ROBERT B MPLS TR
426 PORTLAND
MPLS MN
55415

FREDIN CONRAD M
811 FIRST NATL BK BLDG
DULUTH MN
55802

FREDLUND MRS PHYLLIS
RR 4 BOX 37
CANBY MN
56220

FREDRIKSON BYRON ET AL
47TH FLR IDS CENTER M
PLS MN
55402

FRISON FRANK NECA
RM 305 200 SO ROBERT
ST PAUL MN
55107

GALVIN M J JR
W2162 1ST NATL BK BLDG
ST PAUL MN
55101

GARDNER HOW - R A JOHNSON
515 WASHINGTON AVE N
MPLS MN
55401

GEBERT K L
220 GRAIN EXCH
MPLS MN
55415

GEO A HORMEL & CO LAW DEPT
PO BOX 800
AUSTIN MN
55912

GIEL DAVID
RM B-28 STATE CAPITOL
ST PAUL MN
55155

GLEESON MICHAEL
909 SOC SC BLDG U OF M
MPLS MN
55455

GLEN. HILLS HOSP.R.VAN HA
3901 GOLDEN VALLEY RD.
MPLS. MN
55422

GODIN RALPH J
3824 47TH AVE SO
MPLS MN
55406

GOODMAN DF TEL CABLE TV
302 E SUPERIOR
DULUTH MN
55802

GRAHAM THOS H
854 MIDLAND BK BLDG
MPLS MN
55401

GRANATH MARVIN -HONEYWELL
2701 4TH AVE SO
MPLS MN
55408

GREATER MET AREA HOSPITALITY
5152 CEDAR AVE S
MPLS MN
55417

GREEN DEL CITY MGR
BLOOMINGTON CITY HALL
BLOOMINGTON MN
55431

GREEN GARY J
41 SHERBURNE AVE
ST PAUL MN
55102

GREEN JANET
9773 N SHORE DR
DULUTH MN
55804

GRUMMERT REV DONALD
1435 ADAMS ST
MPLS MN
55413

GUSTAFSON DAN-LABOR TEMPLE
312 CENTRAL
MPLS MN
55414

GUSTAFSON WALLACE
BOX 567
WILLMAR MN
56201

H B FULLER CO
2400 KASOTA AVE
ST PAUL MN
55108

HAFNER DR A J
BOX393 MAYO U OF M
MPLS MN
55455

HANFT PHILIP M
1200 ALWORTH BLDG
DULUTH MN
55802

HANSON ETHEL
2813 85TH AVE N
MPLS MN
55444

HAROLD J WESTIN CONSTRUCTORS
45 E 8TH ST
ST PAUL MN
55101

HALLBERG LEE & MCCABE
4927 34TH AVE S
MPLS MN
55417

HAUN DR J W CEN MILLS
PO BOX 1113
MPLS MN
55440

HAYES, THOMAS W
700 SELLWOOD BLG
DULUTH MN
55812

HEALTH MANPOWER C LARSON
717 DELAWARE ST SE
MPLS MN
55440

HART PATRICK V
112 E LIBERTY BOX 3271
MANKATO MN
56001

HARTFELDT WILL
434 HAMM BLDG
ST PAUL MN
55102

HAVEN ROBT TWIN TN TREATM
1706 UNIV AVE
ST PAUL MN
55104

HEAD & TRUHN
1007 SOO LINE BLDG
MPLS MN
55402

HEADWATERS REG DEV. COMM
BOX 584 MENTAL HEALTH
BEMIDJI MN
56601

HEANEY BILL
30 W SUPERIOR ST
DULUTH MN
55802

HEARING EX.OFF. M GREENBE
1745 UNIV AVE
ST PAUL MN
55104

HEIM PAUL M
3944 IDS CENTER 80 S 8
MPLS MN
55402

HEINTZ MARY ELLEN
PO BOX 599
CINCINNATI OH
45201

HEISENFELT WM
BOX 516
BEMIDJI MN
56601

HELTZER JAMES DAYTON HUDS
777 NICOLLET MALL
MPLS MN
55402

HENDRICKSON A WM
100 FREEMAN DRIVE
ST PETER MN
56082

HENDRICKSON MRS VIRGINIA
3324 COUNTRY WOOD DR
BURNSVILLE MN
55337

HILL JIM ASSOC.MILK PROD.
7850 METRO PARKWAY
MINNEAPOLIS MN
55420

HINRICHSEN PATRICK
MANKATO FREE PRESS
MANKATO MN
56001

HOLCAHL SCOTT
380 N BLDG GRAIN EXCH
MPLS MN
55415

HOLEY GEO AERONAUTICS
DOWNTOWN AIRPORT
ST PAUL MN
55107

HOLMES EUSTIS ET AL
4610 IDS CENTER
MPLS MN
55402

HOPKINS WM.B. DIR.MISCCA
3915 GOLDEN VALLEY ROAD
GOLDEN VALLEY MN
55422

HORNER WALDORF - KAZIUKENICZ
PO BOX 3260
ST PAUL MN
55165

HOULE MELVIN
881 W HWY 96
SHOREVIEW MN
55112

HOUSE APPROPRIATIONS COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HULSTRAND ANDERSON & LARS
PO BOX 130
WILLMAR MN
56201

HUMAN RIGHTS
300 CAPITOL SQ BLDG
ST PAUL MN
55101

HUMAN SERVICES
414 LAFFAYETTE RD 5THFL
ST PAUL MN
55101

HUSEBYE, CRAIG J.
5036 FRANCE S.
EDINA MN
55410

HUTCHISON R.M. ANOKA CO.C
COURT HOUSE
ANOKA MN
55303

HYDROLOGIST
CHIPPEWA NATL FOREST
CASS LAKE MN
56633

HYLAND DEAN
1501 W 50TH ST
MPLS MN
55419

ILLINGWORTH ROBERT C
6750 FRANCE AVE S RM290
MPLS MN

INGERRIGTSEN DR K H
23 SE 4TH ST
MPLS MN
55414

INGVALSON VERN MN.FARM BUR.
3110 WOODDALE DR PO 337
OST PAUL MN
55165

INS FED OF MINN
902 SOO LINE BLDG
MPLS MN
55402

INTERSTATE POWER RW STEEL
1000 MAIN ST
DUBUQUE IA
52001

IUOE LOC 49 CHAS SWENSON
2580 UNIV AVE
ST PAUL MN
55101

IVERSON DR JOS DEPT ED
ST OLAF COLLEGE
NORTHFIELD MN
55057

IZAAK WALTON MN DIV
111 E FRANKLIN RM-210
MPLS MN
55404

JACKMAN DONALD G
4023 E LAKE ST
MPLS MN
55406

JAIN NIRMAL ENIV PROCESS
1220 GLENWOOD AVE
MPLS MN
55405

JENUS INC
525 LAKE AVE SO
DULUTH MN
55801

JENSEN ARTHUR,CITY CLK
2215 W OLD SHAKOPEE RD
BLOOMINGTON MN
55431

JENSEN CARL A
127 E MAIN ST
SLEEPY EYE MN
56085

JENSEN MRS GAYNOLD
111 WEST 107TH ST
MPLS MN
55420

JOHANSEN BUS SERV INC
19 DAYTON RD
CHAMPLIN MN
55316

JOHNSON & SANDERSON
ST MARYS HOSPITAL
ROCHESTER MN
55901

JOHNSON CLARENCE IBEW LU 292
3615 37TH AVE S
MPLS MN
55406

JOHNSON G ROBERT
4344 IDS CENTER
MPLS MN
55402

JOHNSON LEROY
9939 BLUEBIRD ST NW
COON RAPIDS MN
55433

JOHNSON M.D. FRUNDT & FRU

BLUE EARTH MN
56013

JOHNSON LANCE J
265 S LAFAYETTE RD
ST PAUL MN
55107

KABLE RICHARD W

BETHEL MN
55006

KAVANEY RICHARD
1220 NORTHERN FED BLDG
ST PAUL MN
55102

KEABLE MIKE
909 6TH AVE N
ST CLOUD MN
56301

KEENAN RICHARD J
4444 IDS BLDG
MPLS MN
55402

KEILY DANILE
3549 W2 PLEASANT AVE
MPLS MN
55408

KIMBALL ROBERT
647 CAPITOL SQ BLDG
ST PAUL MN
55101

KJERVIK DIANE
4302 POWEL HALL U OF M
MPLS MN

KLOSTER MARION PEAVEY CO
730 2ND AVE S
MPLS MN
55402

KLUZ STEVEN J
1910 1ST NATL BK BLDG
MPLS MN
55402

KNAPP J A
RM 3 CAPITOL
ST PAUL MN
55155

KNOPP TIMOTHY
COLLEGE FORESTRY U OF M
ST PAUL MN
55108

KNUTSON DR KEITH,BIOLOGY DPT
ST CLOUD STATE
ST CLOUD MN
56301

KNUTSON R N GRANNIS ETAL
F J SCHULT BLDG
ST ST PAUL MN
55075

KNUDSON ROBT
4375 BROWNDALE AVE
MPLS MN
55424

KOLLER MR & MRS ERWIN A
1565 DULUTH ST
ST PAUL MN
55108

KOPP MRS VERNON
2050 65TH ST E
INVER GR HGHT MN
55075

KRAMER ERNEST W
717 DELAWARE ST SE
MPLS MN
55440

KROEGER CHARLES
122 NW 7TH STREET
FARIBAULT MN
55021

KRONLOKKEN J E
10048 NORD RD
BLOOMINGTON MN
55437

KROON H CLIFTON
210 E WALNUT
MANKATO MN
56001

KUHL CARL
4421 4TH ST NE
COL HEIGHTS MN
55421

KVB ENGINEERING INC
600 S CO RD 18
MPLS MN
55426

LABELLE JUANITA MRS
5816 AQUILA AVE NO
NEW HOPE MN
55428

LAKE SUPERIOR INDUSTRIAL BUR
828 FIRST AM. BK. BLDG.
DULUTH MN
55802

LANAHAN E F - SIBLEY CO
184 E 6TH ST
ST PAUL MN
55101

LANGVIN DAVID
7500 80TH ST S
COTTAGE GROVE MN
55016

LANSING & OAKES
400 SIBLEY ST
ST PAUL MN
55101

LAPP LAZAR LAURIE ET AL
1200 BUILDERS EXCHANGE
MINNEAPOLIS MN
55402

LARSON C L
3800 MINNEHAHA AVE SO
MPLS MN
55406

LARSON HANS P CIV HOSP SERV
717 DELAWARE ST SE
MPLS MN
55440

LEAGUE MN MUNIC
300 HANOVER 480 CEDAR
ST PAUL MN
55101

LEAGUE WOMEN VOTERS OF MINN
555 WABASHA
ST PAUL MN
55102

LEG.REF.LIB-Z. DEWITT
RM 111 STATE CAPITOL
ST PAUL MN
55155

LEWIS DR.G.M JR.
ABBOTT 110 E 18TH ST
MPLS MN
55403

LIBBEY LEONARD
BOX 17011 NOKOMIS STA
MPLS MN
55417

LINDALL & JONATHAN DEVELOP.
VILLAGE ONE CENTER
CHASKA MN
55318

LOCKNER GARY
R R 1 BOX 23
BAUDETTE MN
56623

LOOS CALVIN J
6809 LYNDALE AVE SO
MPLS MN
55423

LOWE DOUG
2701 N LEXINGTON AVE
ROSEVILLE MN
55113

LUTH SOC SERVICE OF MN
2414 PARK AVE
MPLS MN
55404

LYNCH DONALD SIBLEY CO
184 E 6TH ST
ST PAUL MN
55102

MALONE E I COMM LABOR & INDU
444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

MANKATO STAT STUDENT SENA
CENTENNIAL STUDENT UN
MANKATO MN
56001

MANKATO STATE STUDENT ASSN
BOX 58 MANKATO COLLEGE
MANKATO MN
56001

MANSFIELD LARRY HCARC
1800 CHICAGO AVE S
MPLS MN
55404

MANTHEY T J PICKANDS MATHER
1100 SUPERIOR AVE
CLEVELAND OH
44114

MARRINAN MARGARET M
1117 COMMERCE BLDG
ST PAUL MN
55101

MASTOR & MATTSON LTD
315 PEAVEY BLDG
MPLS MN
55402

MAUL WARREN E
320 S 4TH ST
MPLS MN
55415

MAYO FOUNDATION G CRWOLL
200 FIRST AVE NW
ROCHESTER MN
55901

MCDONALD PHILIP M
2077 SELBY AVE
ST PAUL MN
55104

MCFADDEN G H DISPATCH-PRESS
55 E 4TH ST
ST PAUL MN
55101

MCKIBBON MRS SHIRLEY
11 EVERGREEN LN
BABBITT MN
55706

MCLELLAN LARKIN
215 ADM BLDG ST CAPITOL
ST PAUL MN
55101

MECCA
867 GRAND AVE
ST PAUL MN
55105

MET. WASTE CONTOL COMM.
350 METRO SQ BLG
ST PAUL MN
55101

MEIEROTTO, JOAN
1794 SO LEXINGTON
ST PAUL MN
55118

MET TER MEN ASSN A ROSENTHAL
1821 UNIV AVE
ST PAUL MN
55104

METROPOLITAN COUNCIL LIBR
300 METRO SQUARE
ST PAUL MN
55155

MEYER HERBERT
10524 ZENITH AVE S
BLOOMINGTON MN
55431

MEYERLE KATHLEEN
1528 GRAND AVE APT 4
ST PAUL MN
55105

MIDLAND GLASS-MD SPURLING
PO BOX 69
SHAKOPEE MN
55379

MILLER PAUL J PHARMACY SE
ST MARYS HOSP
ROCHESTER MN
55901

MILLER RICHARD A
1020 PLYMOUTH BLDG
MPLS MN
55402

MILLER TOM
2311 PILLSBURY AVE S
MPLS MN
55404

MINN APT ASSN
GRIGGS-MIDWAY BLDG
ST PAUL MN
55104

MINN ASPHALT PAVEMENT ASS
555 WABASHA RM 209
ST PAUL MN
55102

MINN ASSN COOPERATIVES
55 SHERBURNE AVE
ST PAUL MN
55103

MINN ASSN ELEC COOPERATIVES
4901 W 77TH ST
MPLS MN
55435

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN ASSN VOL SOC SERVICE
1821 UNIV SUITE 389
ST PAUL MN
55114

MINN ASSN WATERSHED DIST'S

ADA MN
56510

MINN AUTOMOBILE DEALERS ASSN
GRIGGS MIDWAY BLDG
ST PAUL MN
55104

MINN CHAP ASSOC BLDRS-CONTRS
7204 W 27TH ST
MPLS MN
55426

MINN COMM FOR HANDICAPPED
METRO SQ 492 7TH C ROBT
ST PAUL MN
55101

MINN COMMUNITY DEVELOP SERV
512 ROSSMOR BLDG
ST PAUL MN
55101

MINN COUNCIL STATE EMP NO 6
475 RICE ST
ST PAUL MN
55103

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINN FARMERS UNION PRES C
1275 UNIV AVE
ST PAUL MN
55104

MINN FOOD RETAILERS ASSN
555 WABASHA
ST PAUL MN
55101

MINN GOV ENG COUNCIL
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MINNETONKA MN
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MINN HEREFORD-LJ SCHAFER

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55314

MINN. HOTEL & MTR. ASSN
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MINN HOUSING INST N T CARTER
7801 METRO PKWY
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55420

MINN HWYS MANAGEMENT SERVICE
407 HWY BLDG
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MINN LAND USE COMMITTEE
4344 IDS CENTER
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55402

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINNE MINE CREDIT UNION
3000 HUDSON PK S 100
ST PAUL MN
55119

MINN.MTR.TRANSP. .J.N.DENN
1821 UNIV.
ST.PAUL MN
55104

MINN PETROLEUM COUNCIL
1020 NORTHERN FED BLDG
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55102

MINN POLLUTION CONTROL AG
1935 W CO RD B2
ROSEVILLE MN
55113

MINN POULTRY & HATCHERY ASSN
BOX 158
MADELIA MN
56062

MN REP STATE CENTRAL COMM
555 WABASHA AVE
ST PAUL MN
55102

MINN RESTAURANT ASSN
2001 UNIVERSITY AVE.
ST PAUL MN
55104

MINN RETAIL FED INS
131 METRO SP
ST PAUL MN
55101

MINN RETAIL HARDWARE ASSN
3033 EXCELSIOR BLVD 313
MPLS MN
55416

MINN SOCIETY ARCHITECTS AIA
NW NATL BK BLDG
ST PAUL MN
55101

MINN SOC CERTIFIED PUB ACCTS
1102 WESLEY TEMPLE BLDG
MPLS MN
55403

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

MINN STATE BD PHARMACY
717 DELAWARE ST SE #351
MPLS MN
55414

MINN STATE MED ASSN
375 JACKSON ST
ST PAUL MN
55101

MINN STATE RETIREMENT SYSTEM
529 JACKSON ST
ST PAUL MN
55101

MINN TEAMSTERS CREDIT UNI
2021 HENN AVE E
MPLS MN
55413

MINN TBR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

MINN.TURKEY GROWERS ASSN
2303 UNIV AVE
ST PAUL MN
55114

MINN VETERANS MED ASSN
2175 W HWY 36
ROSEVILLE MN
55113

MINN WATER RESOURCES BD
RM 200 555 WABASHA ST
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55102

MINN-WISC BOUNDARY AREA COMM
600 2ND ST
HUDSON WI
54016

MN. ASN.C&IND H.D.PETERSON
480 CEDAR ST.
ST.PAUL MN
55101

MN AFL-CIO L.O. LASHOMB
175 AURORA
ST PAUL MN
55103

MN.BD OF NURSING
717 DELAWARE ST SE
MPLS MN
55414

MN ELECTRICAL ASSN
3100 HUMBOLT SO
MPLS MN
55408

MN PUB INT RESEARCH GROUP
3036 UNIV AVE SE
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MN SOC SERV ASS J HOOD
614 PORTLAND
ST PAUL MN
55102

MN STATE SER BLIND-K NATA
1745 UNIVERSITY AVE
ST PAUL MN
55104

MOFFITT R C
RM 301 M MPLS CITYHALL
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55415

MOOD R BLOOMINGTON HLTH DEPT
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BLOOMINGTON MN
55431

MORTON BUILDINGS INC
R #1
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56329

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BOX 45 ST MARYS COLLEGE
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MPLS ASSN RETARDED CITIZENS
3100 W LAKE ST
MPLS MN
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MPLS CITY ATTORNEY
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MPLS STAR PRESS ROOM
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MPLS MN
55437

NCEC INC C/O DR DAHLBERG
CONCORDIA COLLEGE
MOORHEAD MN
56560

NIELSEN STOCK & BLACKBURN
415 730 BLDG
MPLS MN

NW COUNTRY ELEVATOR ASSN
802 GRAIN EXCH BLDG
MPLS MN
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NW BELL TEL CO LEGAL DEPT
224 S 5TH ST RM 2000
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55101

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55430

PULSCHER ROBT SPRINGSTED INC
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55429

OLD COLONY GAS & OIL COMPANY
17TH AVE N AT 2ND ST
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OTTER TAIL POWER CO.
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PROCTOR&GAMBLE L THECHAR
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55431

REAGAN MICHAEL
% MINN LEARNING CTR
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56401

REARDON MRS HELEN
1125 S E 6TH ST
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56201

REID DAVID H
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RED OWL STORES INC
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HOPKINS MN
55343

REGION FIVE REG. DEV. COMM.
102 6TH ST N
STAPLES MN
56479

REGION NINE DEV. COMM.
709 N FRONT ST
MANKATO MN
56001

REIERSON G
1335 WHITE BEAR AVE
ST PAUL MN
55106

REINO C LAINE 3M COMPANY
3M CENTER
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55101

RENNER R.H. ST PAUL AREA CC
300 OSBORN BLDG.
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55102

RENQUIST ARTHUR NSP CO
414 NICOLLET MALL
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RICHARDSON THOS
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RICHARDS MONTGOMERY ET AL
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55014

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55355

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SAN SIMEON DEVELOP CORP
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SANFORD S M
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SATHRE, HARVEY
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55103

SAX DOVE & STENSON
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SE MN REG DEV COMM
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SCHMIDT LARRY WCCO-TV NEWS
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SCHMIDT WARREN WELLCOME M
GARDEN CITY MN
56034

SCHNEIDER MAHLON
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SCHUTZ LINDA
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STATE CAPITOL
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SENATE FINANCE COMMITTEE
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SENATE GOV OP COMM
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MPLS MN
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TIMESAVERS INC ATT R S VOLD
5270 HANSON COURT
MPLS MN
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TOUCHE ROSS & CO K H STOCKE
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TWIN CITIES PIPING INC AS
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MPLS MN
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TWIN CITY RETAIL DRUGGIST AS
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UNION STOCK YARDS
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HOTELS, RESORTS, RESTAURANTS

U.S. Soil Conservation Serv., 517 Red Courts Bldg., St. Paul (Trailer Parks,

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10/4/77

- MHD 521 - 527; MHD 370

MINNESOTA DEPARTMENT OF HEALTH RULES

CHAPTER 29

RULES

Relating to the Operation of

Health Facilities Grievance Mechanisms

MHD 521 Applicability. These rules apply to hospitals and outpatient surgery centers.

MHD 522 Definitions. Definitions for these rules are as follows:

A. "grievance mechanism" means grievance and/or complaint procedures.

B. "hospital" means any entity licensed as such pursuant to Minn. Stat. §§ 144.50 to 144.56.

C. "outpatient surgery center" means a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

D. "patient" means an individual in or admitted to a hospital or outpatient surgery center for the purpose of prevention of disease, medical diagnosis or medical treatment. The term "patient" includes inpatient, outpatient and emergency room patient.

E. "representative" means a person designated by the patient as a responsible party, a parent of a minor, a guardian, or one who is in loco parentis to a patient unable to act for himself.

MHD 523 Minimum Standard. Every hospital and every outpatient surgery center shall establish, operate and maintain a grievance mechanism designed to process and resolve patient grievances in accordance with these rules.

MHD 524 Procedural Requirements.

A. Designated Person. Every hospital and every outpatient surgery center, shall designate an individual, by name or by title, to be accountable for the operation of a grievance mechanism.

B. Complaints, Generally.

1. Any patient, or his representative, may initiate any oral or written complaint related to those subjects specified in MHD 525.

2. Such complaints may be made to a person designated by the facility under MHD 524 A., or to any other person authorized to receive complaints by the facility. A person authorized to receive complaints shall be physically within the facility and able to receive complaints during ordinary business hours. Persons authorized to receive complaints, other than a person designated under MHD 524 A., shall, in all complaint cases, report any response or resolution, or refer the complaint, to a person designated under MHD 524 A.

C. Time for Response. Response to a complaint, or notice of the resolution of a complaint, shall be provided to the complainant as soon as possible. Such responses, or notices of resolution, shall be in writing, if requested by the complainant.

D. Notice of Time Limit. The authorized individual to whom any oral complaint is made shall, upon receipt of the complaint, inform the complainant of his best estimate of when the facility could respond to the complaint.

E. Complaint Records. The following complaint records shall be maintained by the facility for at least one year:

1. an annotation of the date, time and substance of each complaint made by, or in behalf of, any patient;
2. a reference to any previous complaints made by, or in behalf of, the same patient during his current stay in the facility; and,
3. an annotation of the date, time and substance of any response to, denial of, or resolution of, the complaint.

The arrangement of such records shall be such that identification of particular patients and complainants is possible.

F. Patient Notice.

1. Notice of Mechanism. Written notice of the existence and availability of the grievance mechanism shall be posted conspiciously in all facilities, along with the notice required under Minn. Stat. § 144.652, and furnished, unless an emergency prevents such furnishing, to the patient or his representative if and when the former is actually admitted to the facility. If an individual patient notice is required to be furnished to the patient or his representative under Minn. Stat. § 144.652, written notice under these rules shall be furnished at the same time.
2. Content of the Notice. Such written notice shall include the following:
   a. a statement that complaints or grievances related to rights expressed in the Patients' Bill of Rights (Minn. Stat. § 144.651), or to any other rights, may be able to be resolved within the facility;

b. a statement that the facility maintains a grievance mechanism for this purpose;

c. a statement specifying an individual or type of individual to whom such complaints or grievances can be directed; and

d. a statement that any complainant has the right to request and to receive a written response to any complaint.

MHD 525 Patient Complaints. Complaints relating to at least the following shall be subject to being processed through a grievance mechanism;

A. lack of considerate or respectful care;

B. failure to provide complete, current and understandable information concerning diagnosis, treatment or prognosis;

C. failure to provide the name and specialty, if any, of the physician responsible for coordination of care;

D. failure to afford consideration of privacy;

E. failure to afford consideration of individual social, religious and psychological well-being;

F. failure to preserve the confidentiality of the medical care program;

G. failure to provide, upon request, information bearing on the individual case with respect to any relationship of the facility to other health services facilities, medical groups or other similar entities;

H. failure to afford continuity of care;

I. failure to provide requested information, prior to or at the time of admission and during the period spent in the facility, relating to charges for care;

J. failure to afford the opportunity to participate in the planning of medical treatment;

K. failure to inform of, or to offer an opportunity to refuse to participate in, experimental research;

L. retaliatory, arbitrary, or otherwise medically unjustifiable discharge;

M. interference with or retaliation for the free exercise of any legally prescribed rights;

N. mental and/or physical abuse;

O. medically unjustifiable physical and/or chemical restraints;

P. failure to comply with lawful requests to release or to withhold medical records;

Q. requiring the performance of services not included for therapeutic purposes in the plan of care;

R. restriction of the right to associate and communicate privately with others;

S. interference with the sending and receipt of personal mail;

T. restriction of the rights to meet with representatives and to participate in commercial, religious and community activities;

U. restriction of the right to retain and use personal clothing and possessions, to the extent that space permits; and,

V. failure to respond to questions concerning billing practices, the amount of a specific bill, and the like.

MHD 526 Reports. Every hospital and every outpatient surgery center, shall, on or before each February first, submit to the commissioner of health a report on the experience of their respective grievance mechanisms during the immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting institution;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the grievance mechanism;

D. the total number of complaints filed with the facility pursuant to MHD 524 B.1.;

E. the total number of complaints, according to classification under MHD 525;

F. the total number of any other complaints;

G. the number of patients by whom or for whom more than one complaint was made and the total number of such complaints; and,

H. the total number of complaints resolved to the patient's apparent satisfaction.

MHD 527 Schedule of Fines.

A. Patient Notification and Complaint Mishandling.

1. Grounds; Fine Amounts. The following violations of these rules shall constitute grounds for the automatic assessment of a per violation $50 fine:

a. failure to give individual patient notice, as required under MHD 524 H.; and,

b. failure to respond to a patient complaint as soon as possible, as required under MHD 524 C.

Multiple violations with respect to the current stay of a particular patient shall result in fines which in no case exceed $200. Such fines are payable within 30 days of the automatic assessment, unless there is a facility request for a hearing. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.

B. Inadequate or Improperly Functioning Mechanism.

1. Grounds. The following violations of these rules shall constitute grounds for the issuance of a correction order:

   a. failure to have a grievance mechanism, as required under MHD 523;

   b. failure to designate an individual, by name or title, to be responsible for the operation of a grievance mechanism, as required under MHD 524 A.;

   c. failure to have an individual within the facility and able to receive complaints during ordinary business hours, as required under MHD 524 B.2.;

   d. failure to maintain complaint records, as required by MHD 524 E.;

   e. failure to post notice, as required by MHD 524 F.;

   f. failure to submit an annual report, as required by MHD 526; and,

   g. failure to fulfill the criteria for content of the annual report, as required by MHD 526 A.

2. Time Periods for Correction. In no case may the allowable period for correction of any of the violations in MHD 527 B.1. exceed 60 days. In no case may the allowable period for correction of violations in MHD 527 B.1.d., f., or g. be less than 20 days.

3. Fine Amounts. The amounts which shall be assessed in the event that the facility does not comply with correction orders within the allocated period of time are as follows:

   a. violations as described in MHD 527 B.1.a. - up to $200 per violation;

b. violations as described in MHD 527 B.1.b. - up to $100 per violation;

c. violations as described in MHD 527 B.1.c. - up to $150 per violation;

d. violations as described in MHD 527 B.1.d. - up to $50 per violation;

e. violations as described in MHD 527 B.1.e. - up to $100 per violation;

f. violations as described in MHD 527 B.1.f. - up to $200 per violation;

g. violations as described in MHD 527 B.1.g. - up to $100 per violation;

Such fines are payable within 30 days of the assessment, unless there is a facility request for a hearing within that period. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.

MHD 528-535: Reserved for future use.

MHD 370 GOVERNING BODY; CONSUMER MEMBERS;
ENROLLEE PARTICIPATION; COMPLAINT SYSTEM

(g) Complaint Reports. Every health maintenance organization shall submit to the commissioner of health, along with its annual report, a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

(1) the name and location of the reporting health maintenance organization;

(2) the reporting period in question;

(3) the name of the individual(s) responsible for the operation of the complaint system;

(4) the total number of written complaints received by the health maintenance organization;

(5) the total number of written complaints received, classified as to whether they were principally medical care, psychosocial, or coverage-related in nature, or classified according to a classification most suited to the characteristics of the particular health maintenance organization, unless unduly burdensome;

(6) the number of enrollees by whom or for whom more than one written complaint was made and the total number of such complaints; and,

(7) the total number of written complaints resolved to the enrollee's apparent satisfaction.

APPROVED AS TO FORM AND LEGALITY

OCT 4 1977 19

WARREN SPANNAUS, ATTORNEY GENERAL

BY /s/ Michael B. Miller

SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE :
FILED
OCT 4 1977
Joan Anderson Growe
Secretary of State

4:05 P.M.

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : Michael Miller
Special Assistant
Attorney General
G-19-k Administration

DATE: Sept. 1, 1977

FROM : John A. Breviu
Special Assistant
Attorney General

PHONE: 5402

SUBJECT: Rules Relating to the Operation of Health Facilities
Grievance Mechanisms

Enclosed for your review please find the entire record in the above-entitled matter. I am also enclosing two copies of the record as well as five copies of the rules as adopted.

Please call me if you have any questions or problems.

JAB:ss
enclosures

MINNESOTA DEPARTMENT OF HEALTH RULES

CHAPTER 29

Proposed Rules

Relating to the Operation of

Health Facilities Grievance Mechanisms

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MHD 521 Applicability. These rules apply to hospitals and outpatient surgery centers.

MHD 522 Definitions. Definitions for these rules are as follows:

A. "grievance mechanism" means grievance and/or complaint procedures.

B. "hospital" means any entity licensed as such pursuant to Minnesota Statutes 144.50 to 144.56.

C. "outpatient surgery center" means a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

MHD 523 Minimum Standard. Every hospital and every outpatient surgery center shall establish, operate and maintain a grievance mechanism designed to process and resolve patient grievances in accordance with these rules.

MHD 524 Procedural Requirements.

A. Designated Person. Every hospital and every outpatient surgery center, shall, through their respective governing authorities, designate an individual to be accountable for the operation of a grievance mechanism.

B. Complaints, Generally.

1. Any patient, or his representative, may initiate any oral or written complaint related to those subjects specified in MHD 525.

2. Such complaints may be made to the person designated by the facility under MHD 524 A,, or to any other person authorized to receive complaints by the facility. A person authorized to receive complaints shall be physically within the facility and able to receive complaints during ordinary business and visiting hours. Persons authorized to receive complaints, other than the person designated under MHD 524 A,, shall, in all complaint cases, report any response or resolution, or refer the complaint, to the person designated under MHD 524 A.

C. Time Limits for Response. When such complaints are made while the patient is in the facility, written response to them, or written notice of the resolution of the complaint, shall be provided to the complainant within the following time periods:

1. 24 hours for complaints relating to the following provisions of MHD 525: A.; B.; C.; G.; I.; K.; L.; M.; N.; O.; Q.; and T.
2. 72 hours for complaints relating to the following provisions of MHD 525: D.; E.; F.; H.; J.; R.; S.; and U.
3. 30 days for complaints relating to the following provisions of MHD 525: P.; and V.

D. Notice of Time Limit. The authorized individual to whom the complaint is made shall, within 4 hours, inform the complainant of the applicable time limit, in his best judgement, for response or resolution under MHD 524 C.1., 2., or 3.

E. Exception. If the condition of the patient in question presents an emergency situation preventing timely response to, or the resolution of, a complaint, the time limits specified in MHD 524 C.1. and 2. shall extend an additional 48 hours. In all such cases, a dated annotation of the existence of such an emergency situation shall be placed in the

record required to be kept under MHD 524 G. and signed by the person asserting them in behalf of the facility.

F. Denials. The grounds on which denial of the action requested by the complainant can be based include the following:

1. the action sought by the claimant is medically and/or therapeutically contraindicated;
2. the action sought by the claimant would be violative of any of the rights, as prescribed in Minnesota Statutes 144.651, of other facility patients; or,
3. the action sought by the claimant would violate a written policy, approved by the facility's governing authority.

A dated annotation of any of the above grounds shall be placed in the patient's record and signed by the person asserting them.

G. Patient Complaint Records. The following complaint records shall be maintained according to patient by the facility for periods of time determined in a written policy approved by the facility's governing authority:

1. an annotation of the date, time and substance of each complaint made by, or in behalf of, any patient;
2. a reference to any previous complaints made by, or in behalf of, the same patient during his current stay in the facility; and,
3. an annotation of the date, time and substance of any response to, or resolution of, the complaint.

H. Patient Notice.

1. Notice of Mechanism. Written notice of the existence and availability of the grievance mechanism shall be posted conspicuously in all facilities, along with the notice required under Minnesota

Statutes 144.652, and furnished, along with the notice required under Minnesota Statutes 144.652, to the patient or his representative upon admittance to the facility.

2. Content of the Notice. Such written notice shall include the following:

   a. a statement that complaints or grievances related to rights expressed in the Patients' Bill of Rights (Minnesota Statutes 144.651), or to any other rights, may be able to be resolved within the facility;

   b. a statement that the facility maintains a grievance mechanism for this purpose; and,

   c. a statement specifying an individual or type of individual to whom such complaints or grievances can be directed.

MHD 525 Patient Complaints. Complaints relating to at least the following shall be subject to being processed through a grievance mechanism;

A. lack of considerate or respectful care;

B. failure to provide complete, current and understandable information concerning diagnosis, treatment or prognosis;

C. failure to provide the name and specialty, if any, of the physician responsible for coordination of care;

D. failure to afford consideration of privacy;

E. failure to afford consideration of individual social, religious and psychological well-being;

F. failure to preserve the confidentiality of the medical care program;

G. failure to provide, upon request, information bearing on the individual case with respect to any relationship of the facility to other health services facilities, medical groups or other similar entities;

H. failure to afford continuity of care;

I. failure to provide requested information, prior to or at the time of admission and during the period spent in the facility, relating to charges for care;

J. failure to afford the opportunity to participate in the planning of medical treatment;

K. failure to inform of, or to offer an opportunity to refuse to participate in, experimental research;

L. retaliatory, arbitrary, or otherwise medically unjustifiable discharge;

M. interference with or retaliation for the free exercise of any legally prescribed rights;

N. mental and/or physical abuse;

O. medically unjustifiable physical and/or chemical restraints;

P. failure to comply with lawful requests to release or to withhold medical records;

Q. requiring the performance of services not included for therapeutic purposes in the plan of care;

R. restriction of the right to associate and communicate privately with others;

S. interference with the sending and receipt of personal mail;

T. restriction of the rights to meet with representatives and to participate in commercial, religious and community activities;

U. restriction of the right to retain and use personal clothing and possessions, to the extent that space permits; and,

V. failure to respond to questions concerning billing practices, the amount of a specific bill, and the like.

MHD 526 Reports. Every hospital and every outpatient surgery center, shall, on or before each February first, submit to the state board of health a report on the experience of their respective grievance mechanisms during the

immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting institution;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the grievance mechanism;

D. the total number of complaints received by the facility;

E. the total number of complaints, according to classification under MHD 525;

F. the total number of any other complaints;

G. the number of patients by whom or for whom more than one complaint was made and the total number of such complaints; and,

H. the total number of complaints resolved to the patient's satisfaction.

MHD 527 Schedule of Fines.

A. Patient Notification and Complaint Mishandling.

1. Grounds; Fine Amounts. The following violations of these rules shall constitute grounds for the automatic assessment of a per violation $50 fine:

a. failure to given individual patient notice, as required under MHD 524 H.; and,

b. failure to respond to a patient complaint within the applicable time limits, as required under MHD 524 C.

Multiple violations with respect to the current stay of a particular patient shall result in fines which in no case exceed $200. Such fines are payable within 30 days of the automatic assessment, unless there is a facility request for a hearing. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.

B. Inadequate or Improperly Functioning Mechanism.

1. Grounds. The following violations of these rules shall constitute grounds for the issuance of a correction order:

   a. failure to have a grievance mechanism, as required under MHD 523;

   b. failure to designate a person to be responsible for the operation of a grievance mechanism, as required under MHD 524 A.;

   c. failure to have an individual within the facility and able to receive complaints during ordinary business and visiting hours, as required under MHD 524 B.2.;

   d. failure to maintain patient complaint records, as required by MHD 524 G.;

   e. failure to post notice, as required by MHD 524 H.;

   f. failure to submit an annual report, as required by MHD 526; and,

   g. failure to fulfill the criteria for content of the annual report, as required by MHD 526 A.

2. Time Periods for Correction. In no case may the allowable period for correction of any of the violations in MHD 527 B.1. exceed 60 days.

3. Fine Amounts. The amounts which shall be assessed in the event that the facility does not comply with correction orders within the allocated period of time are as follows:

   a. violations as described in MHD 527 B.1.a. - up to $200 per violation;

   b. violations as described in MHD 527 B.1.b. - up to $100 per violation;

c. violations as described in MHD 527 B.1.c. - up to $150 per violation;

d. violations as described in MHD 527 B.1.d. - up to $50 per violation;

e. violations as described in MHD 527 B.1.e. - up to $100 per violation;

f. violations as described in MHD 527 B.1.f. - up to $200 per violation; and,

g. violations as described in MHD 527 B.1.g. - up to $100 per violation.

Such fines are payable within 30 days of the assessment, unless there is a facility request for a hearing within that period. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.

MHD 528-535: Reserved for future use.

MHD 370 GOVERNING BODY; CONSUMER MEMBERS;
ENROLLEE PARTICIPATION; COMPLAINT SYSTEM

(g) Complaint Reports. Every health maintenance organization shall, on or before each February first, submit to the state board of health a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

(1) the name and location of the reporting health maintenance organization;

(2) the reporting period in question;

(3) the name of the individual(s) responsible for the operation of the complaint system;

(4) the total number of complaints received by the health maintenance organization;

(5) a copy of the written summaries of informal discussions, consultations and conferences required to be kept for each complaint under (f)(2) of this rule;

(6) the number of enrollees by whom or for whom more than one complaint was made and the total number of such complaints; and,

(7) the total number of complaints resolved to the enrollee's satisfaction.

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STATE OF MINNESOTA

BOARD OF HEALTH

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE MINNESOTA STATE BOARD OF HEALTH RELATING TO THE OPERATION OF HEALTH FACILITIES GRIEVANCE MECHANISMS

ORDER FOR HEARING

IT IS HEREBY ORDERED that a public hearing on the above-captioned rules be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Tuesday, January 18, 1977, commencing at 9:00 A.M., and continuing until all persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that a Notice of Hearing be mailed to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose.

IT IS FURTHER ORDERED that the Notice of Hearing be published in the State Register.

Dated: November 17, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

for Ellen Z Fifer

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

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OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE MINNESOTA STATE BOARD OF HEALTH RELATING TO THE OPERATION OF HEALTH FACILITIES GRIEVANCE MECHANISMS

NOTICE OF HEARING

NOTICE IS HEREBY GIVEN that a public hearing in the above-entitled matter will be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Tuesday, January 18, 1977, commencing at 9:00 A.M., and continuing until all persons have had an opportunity to be heard.

All interested or affected persons will have an opportunity to participate. Statements may be made orally and written materials may be submitted at the hearing. In addition, written materials may be submitted by mail to Allan Klein, Hearing Examiner, Room 300, 1745 University Avenue, St. Paul, Minnesota, (612)296-8112, either before the hearing or within 20 days after the close of the hearing.

The proposed rules, if adopted, would implement the requirements of Minn. Laws 1976, ch. 325, § 8, including:

1. The delineation of minimum standards and procedural requirements for grievance mechanisms;

2. The presentation of a list of patient complaints which may be processed through such a mechanism;

3. The description of the form and manner in which patient notices are to be made;

4. The specification of a schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of the statute; and

5. Requiring the submission of at least an annual report on the operation of such mechanisms by hospitals, outpatient surgery centers and health maintenance organizations.

Copies of the proposed rules are now available and one free copy may be obtained by writing to Daniel J. McInerney, Jr., Room 212, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of the hearing. The authority to promulgate the proposed rules is contained in Minn. Laws 1976, ch. 325, § 8. A "statement of need" explaining why the agency feels the proposed rules are necessary and a "statement of evidence" outlining the testimony the Board of Health will introduce at the hearing, will be filed with the Office of Hearing Examiners at least 25 days prior to the hearing and will be available there for public inspection.

Please be advised that pursuant to Minn. Stat. § 10A.01 subd. 11 (1974), any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. The State Ethics Commission is located at 410 State Office Building, St. Paul, Minnesota, 55155.

It is suggested that, to save time and avoid duplication, those organizations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests.

Dated: November 17, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

for Allen J. Fiss

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of promulgating rules of the Board of Health relating to Health Facility Grievance Mechanisms as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing and notice of hearing as well as acting as or appointing a presiding officer for all hearings.

This resolution was adopted by the Board of Health at its meeting held on October 14, 1976.

CERTIFICATE OF BOARD OF HEALTH'S

AUTHORIZING RESOLUTION

I, Warren R. Lawson, M.D., do hereby certify that I am the Commissioner of Health and that I was, on October 14, 1976, the Secretary and Executive Officer of the Minnesota State Board of Health, a board then duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the said Board duly and properly called and held on the 14th day of October, 1976, that a quorum was present at said meeting; that a majority of those present voted for the resolution; that said resolution is set forth in the minutes of said meeting and has not been rescinded or modified.

> RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of promulgating rules of the Board relating to Health Facility Grievance Mechanisms as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing and notice of hearing as well as acting as or appointing a presiding officer for all hearings.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 19th day of July, 1977.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH



WARREN R. LAWSON, M.D.

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Adoption of Rules of the Minnesota State Board of Health Relating to the Operation of Health Facilities Grievance Mechanisms

AFFIDAVIT OF RECEIPT OF THE SECRETARY OF STATE'S LIST

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

Judy Hoffman, being duly sworn upon oath, deposes and says:

1. That she is an employee of the Minnesota Department of Health, Division of Health Facilities.

2. That on the 22nd day of November, she went to the Secretary of State's office for the State of Minnesota and requested a current list of all representatives of associations or other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearing relating to the promulgation of rules pursuant to Minn. Stat. § 15.0412.

3. That on the 22nd day of November, 1976, in response to the above request, the Secretary of State provided her with such a list, a copy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Judy Hoffman

Subscribed and sworn to before me this
23rd day of December, 1976.

Marie B. Tromiczak

MARIE B. TROMICZAK
NOTARY PUBLIC - MINNESOTA
HENNEPIN COUNTY
My Commission Expires D.E.C. 2, 1980

STATE OF MINNESOTA

COUNTY OF HENNEPIN

In the Matter of the Proposed Rules
Relating to the Operation of Health
Facilities Grievance Mechanisms

AFFIDAVIT OF MAILING

Judy Hoffman, being first duly sworn,

deposes and says:

That on the 30 day of November, 1976, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof, as well as to all members of the Minnesota Legislature as of the date of mailing.

Judy Hoffman

Subscribed and sworn to before
me this 30th day of Nov, 1976.

MILDRETH OLSON
Notary Public, Ramsey Co. Mn.
MY COMMISION EXPIRES
October 31, 1980

Mildreth Olson

STATE OF MINNESOTA

COUNTY OF RAMSEY

In the Matter of the Proposed Rules
Relating to the Operation of Health
Facilities Grievance Mechanisms

CERTIFICATE

I hereby certify that the 502 general labels and 6 lists for the Minnesota Department of Health all of which are attached and made a part hereof, constitute the complete list of persons, associations, and other interested groups who as of 8:45 o'clock A .M., this 22nd day of November, 1976, have requested pursuant to Minn. Stat. §15.0412 subd. 4 (1971), that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

SECRETARY OF STATE

JOAN ANDERSON GROWE

by Virginia Daniels

STATE OF MINNESOTA

COUNTY OF HENNEPIN

In the Matter of the Proposed Adoption of Rules of the Minnesota State Board of Health Relating to the Operation of Health Facilities Grievance Mechanisms

COMBINED STATEMENT OF NEED AND STATEMENT OF EVIDENCE

The above-captioned rules are not amendments to existing rules of the Minnesota Board of Health.

For its combined statements of need and evidence herein, the Board submits the attached document entitled, "Statutory Authority and Statement of Need." This document constitutes the agency statement supporting the need for and reasonableness of the proposed rules. It further constitutes all of the documentary evidence the Board of Health intends to submit at the hearing herein to support the reasonableness of the proposed rules.

The Board will cite the following statutory authority for these rules:

Minn. Laws 1976, ch. 325 §8;

Minn. Stat. § 15.0412 (Supp. 1975);

Minn. Stat. § 62D.01 et seq. (1974) as amended;

Minn. Stat. §§ 144.50-144.56 (1974) as amended:

Minn. Laws 1976, ch. 274.

Dated: December 22, 1976.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed
Adoption of Rules of the Minnesota
State Board of Health Relating to
the Operation of Health Facilities
Grievance Mechanisms

STATEMENT OF AGENCY
PERSONNEL AT HEARING

The Minnesota Board of Health will be represented at the hearing by Daniel McInerney. He is the only witness expected to offer testimony on behalf of the Board. John Breviu, Special Assistant Attorney General, will also appear on behalf of the Board of Health at this hearing.

Dated: December 22, 1976.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

mental health association of minnesota, inc.

4510 w. 77th street - room 100 • minneapolis, minnesota 55435 (612) 835-3424

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4 February 1977

Mr. Allen Klein
Hearing Examiner, Room 300
1745 University Avenue
St. Paul, Minnesota 55104

Subject: Proposed Rules of the Minnesota State Board of Health Relating to the Operation of Health Facilities Grievance Mechanisms

Reference: 1) Minnesota Dept. of Health Rules Chapter 29

2) Additions and Deletions Prepared Before Hearing of January 18, 1977

3) Minnesota Laws 1976, Ch. 325, S8

Gentlemen:

The Public Affairs Committee of the Mental Health Association has reviewed the proposed rules and the authorizing legislation. We offer the following comments and recommendations.

1. The legislation applies to "grievances by patients or their representatives" (144.691 Subd. 1) and, therefore, applies to all patients, including mental health patients. We assume this is understood by the institutions that will be affected and that the Board of Health will, through its review procedures, make certain that all groups of patients are included.

2. The filing and reporting of grievances (MHD 524E and 526) provides that instances of multiple complaints by individual patients be identified. We believe this will provide needed and useful information. We also believe, however, that the number of complaints against a single service or department should be incorporated into the filing and reporting system. Specifically, we recommend that the data be filed so that the total number of complaints and number of complainants in each service or department be identifiable and be reported. This would require additions to MHD 524E, 526 and 370.

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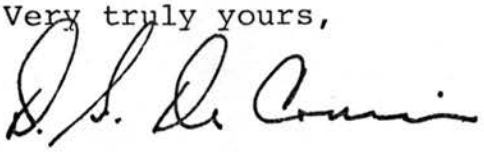
We believe this information will enable the institution to identify situations where improvements in patient care may be needed. This information will also enable the Board of Health to identify areas where several institutions may have common problems and needs.

3. We are concerned that MHD 524A does not provide guidelines on the selection of the "designated person" who is to be accountable for the operation of the grievance mechanism. We believe this person must have ready access to all levels of authority within the institution. Access to the upper levels will require selection of a person at a sufficiently high level within the hierarchy. This will also be necessary to give the entire grievance mechanism credibility in the eyes of the patients and staff.

We appreciate this opportunity to offer our recommendations and we ask that this letter be made a part of the hearing record.

Very truly yours,



David G. DeCoursin
Public Affairs Committee

DGD/lk

cc: Paul Messplay
Mary Howey
Ann Graves

Golden Valley
Health Center

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JAN 11 1977
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EXAMINERS

January 6, 1977

Allan Klein, Hearing Examiner
Room 300
1745 University Avenue
St. Paul, Minnesota

Dear Mr. Klein:

The comments in this letter are made in response to the Minnesota Health Department Chapter 29 Proposed Rules Relating to the Operation of Health Facilities Grievance Mechanisms. Golden Valley Health Center is a 377 bed general acute hospital with about half of our beds directed to mental health and chemical dependency needs.

The Health Center is supportive of the basic objective that hospitals and other service organizations should have methods for responding to complaints. The proposed rules have so many stipulations about response time and report writing that what has been accomplished in an informal way must now be formalized into its own bureaucracy. The rules appear to be detailed beyond reason and in fact somewhat of an over control. Do not other processes of review, whether conducted voluntarily by the hospitals (Joint Commission on Accreditation of Hospitals) or by legislative action, address the quality of care provided in the hospital setting? I doubt whether the forced imposition of a reporting process will in fact significantly improve treatment provided.

The anticipated volume of complaints is hard for anyone to predict. Since the rules do not differentiate complaints, it must be assumed that every displeasure of a patient must have a formal response. This is a major concern in our setting. Treatment of the mentally ill and chemically dependent involves changes in behavior which has associated with it certain resistance to change, thus complaints. If the rules are administered as defined, one must ask who is the patient and who is doing the treating. It's not difficult to envision the system being bogged down in spending an inordinate amount of time formally answering complaints instead of treating the patient. There must be specific consideration given to those programs such as in mental health and chemical dependency.

Implementation of the rules in the general medical-surgical part of the Health Center will be difficult. It will be even more difficult and extensive in other areas of our hospital. Time and effort must be extended to <u>each</u> complaint. This means money and can only mean the patient must pay for the service. The increase in cost - is it worth it? Is it cost-effective? Estimating the cost to the total health system is difficult, however, there is perhaps one comparison. The cost of producing a letter has been conservatively estimated at $5.00 per letter. Some estimate higher. If this can be compared to the processing requirements for each complaint, each complaint may cost $15 plus to process. Is it worth it? Will all who pay the hospital bill feel the added cost is worth paying? What will be the position of the Minnesota Rate Review?

Golden Valley
Health Center

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The proposed rules are very process oriented. There is little identified about the "quality" of a response. Will the next step for the State be to check the validity of every complaint? Are patients so dissatisfied with the service provided in hospitals that exhaustive rules are required to handle complaints? Perhaps the health care dollar can be put to more appropriate use in other ways.

It is interesting to note a reason for denial of action requested is that a written policy of the board would be violated. In many hospitals the board delegates to the chief executive officer the authority to establish operating policies. This section should be amended to reflect actual practice.

The rules do not differentiate between age of patients. Do the complaints of a five-year old get addressed the same as an adult in the proposed rules? As they are written now, they would. Is this intended?

The list of individual complaints in the rules are not all inclusive, which allows significant leeway for others that cannot fit the description of those itemized. Interpretation is needed for those already identified. If an objective of the law is to satisfy patients, then how can "good" or "bad" food be measured when tastes differ. How is "understandable" measured? How does an institution "afford" something to occur? These are all nebulous terms, ones that are based on opinion, not fact.

In representing the Health Center and patients served by it, I am greatly concerned about the impact of this and similar legislation of the health care system. The cost/effectiveness of the rules is questionable, as is the ability to enforce such legislation. Will the cost of administering such a program outweigh the benefits or improve the health status of the patient we are trying to serve? Is it the best use of the patient's dollar? The Department of Health should consider these factors in reviewing the proposed rules and comments of others. The rules are inappropriate and should be revised.

Sincerely,

Cris A. Stang
Executive Vice President

FEL/pe

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MR ALLEN W. KLEIN
STATE OFFICE OF HEARING EXAMINERS
1745 UNIVERSITY AVE
ST PAUL MN 55104

THIS IS A CONFIRMATION COPY OF A PREVIOUSLY PHONE-DELIVERED TELEGRAM

RE: THE HEALTH DEPARTMENT ADDENDUM TO THE GRIEVANCE PROCEDURE REGULATIONS PURSUANT TO CHAPTER 325 MHD 524 F.1. "ENTRY" SHOULD BE CHANGED TO "UPON ADMITTANCE OR INITIATION OF SERVICES" TO REDUCE ADMINISTRATIVE BURDEN AND PROVIDE EFFECTIVE NOTICE TO THE APPROPRIATE PARTIES.
MHA

18:43 EST

MGMCOMP MGM

STATE OF MINNESOTA

DEPARTMENT of Public Welfare

Office Memorandum

RECEIVED
JAN 25 1977
OFFICE OF HEARING EXAMINERS

TO : Allan Klein, Hearing Officer
1745 University Avenue, Room 300
St. Paul, Minnesota 55104

DATE: January 17, 1977

FROM : Vera Likins
Commissioner

PHONE: 2701

SUBJECT: Rule Relating to Operation of Health Facilities Grievance Procedure

In accordance with provisions of the Administrative Procedures Act a formal Public Hearing is to be held on January 18th pertaining to the above. As a Department we wish to advise you as the Hearing Officer and the Department of Health generally that we support the concept and the general intent of the proposed Rule. We are, however, voicing our opposition in regard to certain specifics called for by the proposed Rule. Our specific concerns, suggested amendments and reasons for the suggested amendments are reflected in the following paragraphs:

PROPOSED AMENDMENTS:

MHD 524 (b) (1)	delete the words . . . related to those subjects specified in MHD 525.
MHD 524 (b) (2)	delete the words . . . a person authorized to receive complaints shall be physically within the facility and able to receive complaints during ordinary business and visiting hours. . .
MHD 524 (c) (d) and (e)	delete and substitute the following:

(c) The individual accountable for the operation of the facility's grievance mechanism shall acknowledge the receipt of a grievance within 24 hours (excluding weekends and holidays).

(d) Resolution of the complaint shall be provided to the person making the complaint within seven working days. If the grievance cannot be resolved within seven working days, the individual responsible for the grievance process will provide the patient with the anticipated date the grievance will be resolved.

(e) If the patient is still in the facility, response to the grievance must be given orally, unless specifically requested in writing by the patient. If the patient has left the facility, the response must be provided in writing.

REASON (S) FOR PROPOSING THE AMENDMENTS:

The Department of Public Welfare supports the philosophy of patient advocacy, and supports the Minnesota Health Department's requirement that every hospital and out-patient surgery center develop and implement a grievance mechanism. It is the concern of this Department, however, that the requirements imposed by MHD 524 (b), (c), and (d) may actually work to the detriment of quality patient care in our state hospitals. It has been the philosophy of this department that every employee within our Department is charged with the responsibility to serve as an advocate for our clients, and as such, is responsible to receive and act upon complaints of our clients. In addition, each of the state hospitals employs an individual identified as a patient advocate. This individual serves in an "ombudsman" role, and is responsible to assist the patients, depending upon their needs. This would also be the individual we would most likely see as the individual authorized to receive complaints as specified by the proposed rules (MHD 524).

It appears that MHD 524 (b) (2) as proposed, places an unusual emphasis on requiring the employee receiving complaints be physically present in the hospital, rather than holding that person accountable for seeking a resolution of the problem. Due to the length of visiting hours in our state institutions, we may be forced to add three to five full time positions at each facility just to receive complaints if the Rule is adopted as proposed (MHD 524 (b) (2). Requiring this number of staff to be physically present would not, however guarantee that the complaints received would be resolved. It is the Department's feeling that the regulations should emphasize that a single person be identified to coordinate the receiving, processing and resolution of grievances and complaints. Regulations should not spell out how this person is utilized, i.e., specific hours of work on duty.

The proposed regulations dealing with time limits for response, MHD 524 (c), (d), and (e) also appear to place an unusual emphasis on responding to the receipt of a complaint, rather than on the complaint itself. The Department agrees that the hospital should acknowledge the receipt of the complaint by the individual who

will be trying to resolve it. We believe that this can be done informally, and does not require a written or lengthy process. The Department, however, feels that emphasis should be placed on resolving the complaint and there should be adequate time allowed for this. This is our rationale for a seven day requirement. It is our feeling that the responsible individual should be able to respond within this time frame, or he should be able to provide the patient with a specific time frame.

In line with the proposed regulations, I hope that the board will realize that these regulations will effect facilities licensed as psychiatric hospitals. Thus, such complaints as identified by MHD 525 (a), (e), (g), (m), (n), (o), (r), (s), (t), and (u) may have special implications for patients committed under the Minnesota Hospitalization and Commitment Act, 253A.01 - .21. Since these complaints may involve district and probate courts, as well as county welfare agencies, the facility must be provided with adequate time to prepare a properly detailed response to the patient's complaint.

In summary, I would say that the Department of Public Welfare supports the intent of the proposed rules. We envision that the rule to be promulgated will stimulate the development of effective grievance mechanisms in all hospitals. We believe, however, that the interests of all parties will be better served -- thinking specifically of state hospitals -- if the Rule were more flexible and minimizing the mandating of unnecessary detail.

VJL:WGR:mhv

CC: Dr. Warren Lawson, Commissioner
Health Department
717 Delaware

Janet Brodahl, Health Department

Dan McInerney, Health Department

SAINT CLOUD HOSPITAL
TELEPHONE 251-2700
ST. CLOUD, MINNESOTA 56301
1406 SIXTH AVENUE NORTH

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OFFICE OF HEARING EXAMINERS

February 2, 1977

Mr. Allen Klein
Room 300
1745 University Avenue
St. Paul, MN 55104

Dear Mr. Klein:

Members of the Saint Cloud Hospital staff have had an opportunity to review the revised regulations relating to the grievance procedures mandated by statutes of the 1976 session of the Minnesota State Legislature. A public hearing was held regarding these proposed regulations on January 18, 1977. It is our understanding that written testimony will be accepted until February 7, 1977.

We support the revisions to the original regulations as presented by the Minnesota Health Department to the extent they are offered.

However, we strongly urge additional revisions in sections 524C and 525. The combination of these two requirements in the existing regulations has the potential of creating a nightmare of inappropriate documentation.

Because of the vague and general categorical list of grievances outlined in section 525, the person or office designated to handle patient grievances could be held accountable (according to section 524C) to respond to such things as an uncomfortable room temperature, improperly drawn drapes, a loud television in another patient's room, the way a nurse dresses, the attending or consulting physician's ability to effectively communicate ..., the list goes on and on and could easily get to the point where the resolution of one patient's grievance could result in the disruption of what other patients feel to be their rights.

Additionally, the statute, (Chapter 325, section 8, subdivision one) indicates this legislation has been enacted to have an "impact on the incidence of malpractice claims and suits." It is our belief that section 524C and section 525 do not meet or relate to the statutes' requirement to "impact" malpractice in the hospital setting.

We recommend that section 524C be amended to read:

> When such complaints are made while the patient is in the facility, response to them, or notice of the resolution of the complaint shall be provided to the complainant within a reasonable time period not to exceed 72 hours.

We also recommend that section 525 be eliminated in total since it does not carry out the intent of the legislation and has no relevance to the issue of addressing the incidence of malpractice claims.

Sincerely yours,

Gene S. Bakke
Executive Vice President

GSB:pl

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MINNESOTA STATE MEDICAL ASSOCIATION

101 E. FIFTH STREET • ST. PAUL, MINNESOTA 55101 • AREA 612 PHONE 222-6366

OFFICE OF THE PRESIDENT • RICHARD E. ANONSEN, M.D. • 5250 WAYZATA BOULEVARD • MINNEAPOLIS, MINNESOTA 55416

February 4, 1977

Mr. Allan Klein
Office of Hearing Examiners
Room 300 - 1745 University Avenue
St. Paul, Minnesota 55104

Dear Mr. Klein:

This letter is in regard to the rules relating to the operation of Health Facilities Grievance Mechanisms as proposed by the Minnesota State Board of Health and which went to public hearing on January 18, 1977.

The Minnesota State Medical Association supports the concept of grievance procedures for patients within hospitals and nursing homes. However, upon reviewing the proposed grievance procedures for patients in hospitals and surgery centers, the Minnesota State Medical Association finds these grievance mechanisms to be unduly cumbersome and too intensive, and thus this Association supports the amendments recommended by the Minnesota Hospital Association to these proposed rules.

We were most encouraged to see that the Minnesota Department of Health had adopted many of the proposed amendments prior to this hearing which had been recommended by the Minnesota Hospital Association and also the Minnesota State Medical Association.

Specifically, we strongly recommend that you accept the amendments proposed by the Minnesota Hospital Association relating to sections MHD 524 (c) (1) dealing with time frames for response to complaints, MHD 525, patient complaints, and MHD 527 (b) (3) pertaining to the amounts which a facility may be fined.

Again, we strongly recommend the adoption of the proposed amendments as submitted by the Minnesota Hospital Association to Sections 524, 525, and 527. It is our opinion that the adoption of these amendments will greatly improve the grievance process for the patient within each facility, and will allow the physician, the nurse, and all allied health personnel the opportunity to provide the highest quality care to the patient while at

the same time not becoming inundated with unnecessary paper work.

The Minnesota State Medical Association thanks you for the opportunity to provide these comments regarding the proposed rules relating to the operation of Health Facilities Grievance Mechanisms and looks forward to working with the Minnesota Department of Health and the Minnesota Hospital Association in the implementation of these rules.

Sincerely yours,

Richard E. Anonsen, M.D.
President, Minnesota State Medical Association

cc: Warren Lawson, M.D., Commission, Minnesota Department of Health
Minnesota Hospital Association

REA:ds

MOUNT SINAI HOSPITAL
of Minneapolis

SUSAN HOFFMAN
Patient Representative Coordinator

2215 PARK AVENUE • MINNEAPOLIS, MINNESOTA 55404 • (612) 871-3700



RECEIVED
FEB 1 1977
OFFICE OF HEARING
EXAMINERS

January 27, 1977

Mr. Allen Klein
Officer of Hearing Examiners
Room 300
1745 University Ave.
St. Paul, Minnesota 55104

Dear Mr. Klein:

I am writing in response to the hearing that I attended on Tuesday, January 17th concerning the proposed adoption of rules of the Minnesota State Board of Health relating to the operation of Health Facilities Grievance Mechanisms.

The Mount Sinai Hospital staff completely agrees with the intent of the law and the mandatory implementation of a grievance procedure for hospitals. We are concerned, however, that certain limitations could restrict the continued progress and effectiveness of our patient representative program.

Enclosed is a job description of our program. Because of its length let me briefly review how our department functions. Upon admission, ten specially trained volunteer patient representatives visit all in-hospital patients, talk with them and give them our department's card (copy enclosed). If a patient has a concern, or needs assistance of any kind, he or she contacts our office and we see the patient as soon as possible, respond to their concern and deal with the issue.

We are working very hard to humanize our institution and to provide the best possible patient care. By remaining informal, we have been able to respond to patient complaints, as well as visit with patients and explain hospital policy. Our record keeping system records sufficiently compliments, complaints and responses to those complaints.

We strongly urge you to adopt the proposed changes offered by the Minnesota Hospital Association, as we fully endorse their proposals. Specifically, we feel very stongly that MHD 524 C, time limits for response, as proposed at the hearing is unrealistic and MHD 525, patient complaints, should be the Patient Bill of Rights rather than the proposed separate list.

At your convenience, please familiarize yourself with our hospital's patient representative job description, as we are proud of our program's development and its success. If you have any further questions, I invite you to contact me for further discussion, or if you prefer to come and see how our department is functioning.

Thank you very much for your attention.

Sincerely yours,

Susan Hoffman
Patient Representatives
Co-ordinator

SH/jp

Enc: 3

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PATIENT REPRESENTATIVE

DESCRIPTION

I. INTRODUCTION

Dr. Francis Weld Peabody, Professor of Medicine at Harvard, once wrote: "The secret of the care of the patient is in caring for the patient." While these words were originally directed toward the medical student and the physician in an effort to emphasize the human needs of the patient, they have become increasingly and vitally relevant to the broader spectrum of workers involved in the delivery of health care. The institution within which the physician operates has become so large, potent, complex and, to the patient, so confusing and alienating, that the responsibility for caring for the patient now falls upon all hospital personnel.

In an effort to humanize and personalize the hospital environment to improve the continuum of patient care, the Mount Sinai Hospital has designated an Office of Patient Representatives, to respond to the problems, requests, complaints and unmet needs of patients and their families. In effect, to act as liaison between the patient and the institution.

The Patient Representative Department provides a specific channel through which patients can seek solutions to problems, concerns and unmet needs. The Patient Representative interprets the hospital's philosophy, policies, procedures, and services to patients, their families and visitors.

II. OBJECTIVES OF DEPARTMENT

1.) Keeping patients in a positive frame of mind by providing emotional support while in the institution.
2.) To develop a system whereby each patient is personally contacted by a Patient Representative for the express purpose of demonstrating a personal interest in the patient's welfare.
3.) To insure that the patient is aware of his rights and responsibilities in the hospital setting.
4.) To work with inservice education in the development of methods to increase staff awareness of the patient's perception of the hospital experience.
5.) Meet with departments, if necessary, and recommend alternative policies and procedures to improve service to patients.
6.) To insure that patients, families, and visitors have access to an unbiased individual who can represent their needs to the hospital.
7.) To provide a mechanism within the hospital to deal with health-related consumer questions, comments, concerns, compliments and complaints.
8.) To expand, improve and expedite the delivery of services to patients, families and visitors by providing direct and immediate access to a hospital representative who has problem-solving skills and authority.
9.) To gather information on the quality of care and publicize this information to the appropriate departments.
10.) To be responsive to the special or unique needs of various constituencies who utilize Mount Sinai Hospital.
11.) To use this program as a public relations tool in various communities by publicizing the implementation and success of the program.

12.) To enhance the hospital's public image by increasing patient satisfaction.
13.) To develop a system which will facilitate the timely identification and solution of patient problems.
14.) To provide a means for handling special situations for which no mechanism has been established.
15.) To provide a grievance mechanism that will allow for timely review and action regarding patient complaints.
16.) To develop a process which will enable the Patient Representative Coordinator to effect policy and procedual change aimed at improving service to those who utilize the hospital.
17.) To develop a system directed at corrective problem solving for individuals and preventive problem solving aimed at system improvement.
18.) To develop a training program for Patient Representatives so that they are adequately prepared to discharge the functions and responsibilities of this position.
19.) To educate hospital staff regarding the Patient Representative Program so that all concerned have a clear understanding of what is to be accomplished.

III. COVERAGE

The Patient Representative Office has the authority and jurisdiction to deal with all referrals. Its volunteer staff makes daily visits to patients on floors 2 SOUTH, 3,4,5 and 6, excluding the I.C.U., C.C.U. and 5 WEST units. The Surgicial Waiting Room, I.C.U., C.C.U., 5 WEST, ambulatory care and emergency units will operate on a referral basis from nursing and staff, until time when the coordinator and assistant director feel it is time to expand the program. Floor personnel are encouraged to deal with any problems and issues arising which they feel can be answered on that primary level, so that contact is not always provided by the Patient Representative staff. Even in cases of referral, contact may be made by the staff of existing departments who can best resolve the particular issue. The Patient Representative department thus serves both as a back-up to the everyday problems resolution process, and as a coordination and orchestration point for the resolution of cases that come specificifically to its attention.

Upon admission to the Hospital, each patient receives an information booklet which describes the general operation of the hospital and contains information pertinent to the patient's stay. Also included is a statement of Patient Rights and Responsibilities and the availability of the Patient Representative Office for assistance.

The Patient Representative Office will be open and the coordinator present from 8:30 a.m. to 4:00 p.m. Monday through Friday. After 4:00 p.m. and on week-ends, the P.B.X. telephone operator will take messages which the Patient Representative Coordinator will pick up daily. In an emergency situation, the P.B.X. operator may contact the night supervisor.

IV. SOURCES OF REFERRAL

Patient needs are communicated to the Patient Representative office in the following kinds of ways:

1.) Direct patient contacts during systematized floor visits by patient representatives.
2.) Direct patient phone calls, from inpatients, outpatients and former patients. The telephone operators are aware of the availability and function of the office, and channel the appropriate calls to it.
3.) Re

3.) Referrals from staff at the professional and non-professional levels.
4.) Referrals from family, visitors or community members.
5.) Letters, mailed either directly to the office or to the Administration office and subsequently referred to the Patient Representative Office.

V. COMPLAINT RESOLUTION PROCESS

The key to the office's effectiveness is the manner in which it receives complaints and requests, assembles the facts and opinions relevant to them, investigates them, and finally takes or recommends the appropriate action. The steps of the investigative process are outlined as follows:

1.) Investigate the substance of the complaint by:
   a.) interviewing the patient to identify the sources of difficulty.
   b.) collecting other relevant information.
   c.) reviewing the files of similar problems to see what course was pursued previously.
   d.) interviewing and discussing thesituation with the staff involved.
   e.) if appropriate, inspecting the premises or monitoring the process during normal operation.

2.) Determine if the claim is meritorious, and, if so, report it to the Head of the Department or the Head Norse involved. Take independent action where empowered to do so with respect to meritorious complaints. Act as the patient's representative before the various levels of authority involved in the problem, negotiating institutional red tape on behalf of individual's. Assure the patient that corrective action has been taken, and express appreciation for bringing the matter to the attention of the office. Document findings and provide these along with recommendations. Monitor and evaluate the corrective actions, continuing to visit the patient if necessary. Effective follow-up is extremely important.

3.) Return non-meritiorious complaints to the ~~the~~ patient, explaining the investigation, results, conclusions and those situations which exist that preclude further action. Refer the patient to the proper authority if unsatisfied with the action taken.

4.) File a written report on all cases, both complaints and requests, which includes an evaluation of the situation, the action taken or recommended, and any follow-up done. These reports extrapolate a profile of the experiences of patients, pinpoint unfavorable trends and areas or attitudes which may need review, and after recommend corrective action.

VI. POSITION DESCRIPTION: PATIENT REPRESENTATIVE COORDINATOR

I. Position Summary:

The Patient Representative Coordinator is a staff member who is subject to the general direction of the Assistant Director and has overall responsibility for program development and for the direction and supervision of Patient Representative Volunteers. He or she participates in the selection and training of all Volunteer Patient Representatives. This individual will serve as liaison between the hospital and the patient in matters pertaining to health related consumer questions, comments, compliments and complaints.

This person will also provide feedback to members of the Management Supervisory Group regarding the patients perception of the hospital experience. He/she is further responsible for facilitating communication between the patient and the hospital and for recommending change as appropriate to improve the overall delivery of service to the patient.

This person must be very cognizant of the human rights of the individual patient and communicate those rights to the patient or, if necessary, to the hospital on behalf of the patient.

II. Qualifications:

1.) Education
   a. High school graduate or equivalent; college desirable.
   b. Prefer communications, human relations or public relations background.

2.) Knowledge and Abilities
   a. Well groomed and mature in action and appearance.
   b. Strong written and oral communication skills.
   c. Quietly aggressive, friendly and able to sustain self-control.
   d. Must have the ability to approach highly trained professional personnel in a tactful and effective manner when problems present themselves which demand resolution.
   e. Must be aware of his or her own personal biases and be able to control negative feelings which relate to those biases.
   f. Must have a strong desire to show care and concern for all people, regardless of racial, social or religious background.
   g. Self-initiative.
   h. Ability to teach, organize and direct the activities of others.
   i. Possess problem solving and decision making skills.

III. Duties and Responsibilities:

1.) Participates in program development and implementation.
2.) Serves in a staff capacity to the Patient Representative Advisory Board.
3.) Works with hospital staff and various hospital constituencies toward improving the delivery of hospital services and attempting to convince them that each is the resource to humanize the hospital.
4.) Represents the patient to the hospital in matters of concern to the patient.
5.) Interprets hospital philosophy, policies and procedures to patients, their families and visitors.
6.) Compiles statistical information regarding patient seen, questions, comments, compliments, complaints, follow-up, etc.
7.) Document reports and keep files of activities of the department.
8.) Coordinates the selection and training of Patient Representative Volunteers.
9.) Supervises and directs the activities of the Patient Representative Volunteer.
10.) Facilitates the efficient movement of patients through the hospital system.
11.) Assure that the patient is aware of his rights and responsiblities in the hospital setting.
12.) Makes referrals as appropriate to various resource programs and services within the hospital.
13.) Sets and reviews program and personal objectives with the Assistant Director at regular intervals.
14.) Makes recommendations for change of present hospital policies, procedures, and systems as indicated.
15.) Develops a working relationship with members of the Management/Supervisory Groups as necessary to carry out assigned responsibilities.
16.) Assume responsibility for patient questionnaires.
17.) Generally responsible for assuring that the hospital is cognizant of and responsive to the needs of patients, families and visitors whenever possible.
18.) Periodically make rounds with volunteers.
19.) Communicate with other departments; as appropriate to identify problems and coordinate their resolution.
20.) Meet and discuss concerns with hospital staff as needed.

21.) Communicate compliments to appropriate departments.
22.) Serve on committees.

III. Responsibilities to Assistant Director :
1.) Keep him/her informed of pertinent developments.
2.) Receive from him/her supervision and work performance review.
3.) Utilize as a resource person.
4.) Consult for assistance in problem-solving.
5.) Submit written quarterly reports.

VII. PATIENT REPRESENTATIVE VOLUNTEER: JOB DESCRIPTION

Job Summary - The patient representative volunteer serves as a representative and friend to patients, their families and visitors. She or he visits and explains general hospital information and assists with non-medical questions, needs and suggestions; confers with the Patient Representative coordinator. The volunteer is able to facilitate meaningful communication among hospital staff and patients.

Job Responsibilities

1.) Preparation for initial visitation:
a.) Wear name tag with name and patient representative volunteer on it.
b.) Obtain listing of all new admissions by name, room, bed.
c.) Have enough calling cards, brochures, etc. availiable to distribute.
d.) Carry writing materials.
e.) Check with each head nurse or ward secretary before visiting any patient.
f.) Check patient's room and bed assignment.

2.) Visitation:
a.) Verify name verbally and/or by name band.
b.) Introduce self by name and title of patient representative.
c.) Whenever possible sit on chair when talking to patient.
d.) Checkif patient has received, read, or has any questions concerning brochure, patient rights and responsibilities.
e.) Answer any questions concerning rights, responsibilities, or any other concerns.
f.) Give the patient your patient representative calling card.
g.) Remind patient to fill out questionnaire, tell of its newness and importance if patient wants views known.
h.) Remind patient that patient representative program is a resource for family and friends.
i.) Whenever necessary include the roommate.
j.) Always be willing to listen, constantly stay open to responses and remember, common sense, not drastic action.

3.) Immediately After Visit:
a.) Write notes, concerns, compliments, complaints and questions.
b.) Note if return visit has to be made.
c.) If patient is out of room return later or put name on list for following day.
d.) Resolve problems as appropriate within the scope of defined responsibilities.
e.) After completing rounds write report in daily report book.
f.) Write compliments and complaints on appropriate sheets in office.
g.) Serious concerns are referred to patient representative coordinator.

4.) Responsibilities to Patient Representative Coordinator:
a.) Keep Coordinator informed of patient's needs.
b.) Utilize coordinator as a resource person.
c.) Consult coordinator for assistance in problem solving.

d.) Make suggestions to coordinator and discuss any concerns openly.

e.) Check with coordinator for briefing and de-briefing sessions before and after seeing patients.

f.) Attend monthly department meetings, as called by coordinator.

VIII. CONCLUSION

The rise in patient advocary seems to have paralleled the increasing scientific complexity of medicine, the widening communication gulf between patient, family and physician, and the multiplication of the number of doctors attending a patient. Hospitals have become frightening places for many patients. It is our hope that with the development of the Patient Representative Program at Mount Sinai Hospital we are taking the time to understand and care, to communicate that caring to the patient, and in so doing, providing the patient with relief from isolation.



RECEIVED
FEB 7 1977
OFFICE OF HEARING EXAMINERS

February 4, 1977

Mr. Allan Klein, Hearing Examiner
Office of Hearing Examiners
Room 300
1745 University Avenue
Saint Paul, Minnesota 55104

In the matter of the proposed adoption of rules of the Minnesota State Board of Health relating to the operation of Health Facilities Grievance Mechanisms

Dear Mr. Klein:

Saint Marys Hospital and Rochester Methodist Hospital, both affiliated with the Mayo Clinic, Rochester, Minnesota, wish to submit the following comments for your consideration regarding proposed Minnesota Department of Health rules pertaining to Minnesota Laws 1976, Chapter 325, s.8.

Our institutions strongly concur with and support the written amendments and oral testimony offered by Mr. Gordon Springer on behalf of the Minnesota Hospital Association at the hearing of January 18, 1977. Specifically, we urge your consideration of MHA suggested revisions of proposed rules regarding:

1. Time Limits (MDH 524c) which, as proposed, are inefficient and unnecessary for reasons stated by MHA; and

2. List of Grievances (MDH 525 a-v) which far exceed the intent of the statute (to provide a mechanism for dealing with grievances that may have an impact on the incidence of malpractice claims and suits) and which should therefore be revised and limited to those rights contained in the Patient Bill of Rights which are applicable to hospital patients (as opposed to nursing home residents), as defined in Minnesota Statute 144.652; and

3. Automatic Assessment of Fines (MDH 527, inclusive) which we believe constitutes a serious compromise of the right to due process.

Further, we are also concerned that MDH 524f, regarding Patient Notice, may be interpreted to require posting and handout in the emergency room setting of hospitals. At the time of the January 18, 1977 hearing, Mr. Daniel J. McInerney stated during an informal conversation that, in his opinion, the "Patient Notice" requirements proposed are basically the same as those contained in the Patient Bill of Rights, Minnesota Statute 144.652, and that it would be inappropriate to apply them to emergency or outpatient visits. This point may need clarification in Section 524f.

In conclusion, we emphasize our primary concern stems from the apparent inconsistencies between the proposed MDH rules and the corresponding Patient Bill of Rights. The close relationship of these two laws is very obvious. We believe a more effective patient grievance procedure will result if the proposed MDH rules are made more compatible with the Patient Bill of Rights, particularly in MDH 525 a-v.

Sincerely,

James Anderson

James Anderson, Administrator
Rochester Methodist Hospital

Sister Generose Gervais

Sister Generose Gervais, Administrator
Saint Marys Hospital

JA/SGG:md

cc: Mr. Daniel J. McInerney
Minnesota Department of Health

Mr. Benjamin R. Hippe
Mayo Clinic Legal Section

SAINT MARY'S HOSPITAL AND HOME
551 Fourth Street North
Winsted, Minnesota 55395

RECEIVED
DEC 17 1976
OFFICE OF HEARING
EXAMINERS

December 15, 1976

Mr. Allan Klein, Examiner
Room 300
1745 University Avenue
St. Paul, Minnesota

Dear Mr. Klein:

This communication regarding the proposed Patient Grievance Regulations is being submitted as requested by the Board of Health notice of November 17, 1976.

I can recognize that there may be a relationship between patients' grievances and the incidence of malpractice claims. I also recognize this program as an attempt to secure information relating the number of claims. However there is no doubt in my mind this type of information cannot be secured without directly increasing costs to the patients and taxpayers. Certainly the Health Department will have to employ a staff to carry out the regulations and enforce them. Large metropolitan hospitals will no doubt have to employ additional staff for soliciting complaints and grievances will generate more than the normal number. No doubt insurance carriers will also have to increase their labor hours. Smaller rural hospitals will probably absorb the added work load but have less time to do other important work.

If we are to assume that to secure this information the cost is economically acceptable, I wonder how long it is to continue? It would appear to me that the program should be evaluated after two years and terminated if the cost is not out-weighed by the savings.

In reviewing the patients complaints (a) through (v), it appears some of them are the responsibility of the physician not the hospital, (b,j,l,q). Others could certainly be a matter of judgement based on the condition of the patient, hospital rules, and the medical knowledge of the individuals involved.

In reviewing the regulations I have the feeling all complaints must be resolved to the patients' satisfaction and the hospital is doing something wrong if this is not the case. Although everyone would like to resolve all grievances in a manner satisfactory to the complaintant we know this is not practical in all cases.

In the development of the list of patient complaints, were the insurance carriers consulted to determine the correlation between malpractice claims and the type of complaints listed?

Thank you for your time and consideration spent reviewing these comments. Hopefully the end result of this program will not prove costly to the consumer, it is designed to protect and will be simple in its operation.

Respectfully yours,

Ed Evans

Edward J. Evans
Administrator

EJE/mn

THE physicians HEALTH PLAN

RECEIVED
JAN 21 1977
OFFICE OF HEARING EXAMINERS

January 19, 1977

Allan Klein
Hearing Examiner
Room 300
1745 University Avenue
St. Paul, Minn.

Dear Mr. Klein:

I am writing in regard to the public hearing held on January 18, 1977 concerning the proposed adoption of rules relating to the operation of grievance mechanisms by health facilities and health maintenance organizations. My specific comments relate to the proposed amendment of MHD 370 concerning reporting requirements of health maintenance organizations on the experience of its complaint system.

We concur with the general change made in the proposed rule, as presented at the hearing, that all reporting to the Minnesota Board of Health be done in conjunction with the HMO Annual Report. There certainly is no need to fragment or further confuse an already complex reporting system.

With respect to the specific items of information to be included in the report, we would respectfully suggest that the requirements, as now presented, appear unduly extensive. Specifically, we would suggest that item (g)(5) be stricken from the proposed rules. This item would require that a copy of the written summaries of informal discussions, consultations, etc. be filed with the report.

It is our interpretation that it is the legislative intent that such reporting should serve as an indicator of the extent to which problems may exist with a health maintenance organization. It would not seem reasonable that the items reported be so extensive as to serve as an investigative tool by the Health Department in understanding the nature of complaints. The deletion of this proposed provision should not encumber the Minnesota Board of Health in performing its duties, in that if the report filed indicates that some investigation is necessary, Minnesota Statute 62D.11, Subdivision 2 requires that health maintenance organizations must maintain a complete record of each complaint filed with it for a period of 3 years.

Suite 401 20 South Washington Avenue, Minneapolis, Minnesota 55401 / Phone: (612) 332-7541

Since reporting requirements ultimately translate into time and dollars which must be spent by the regulated organization in assuring compliance with such requirements, we feel that a careful documentation of need be made before additional requirements are cast in stone (e.g. become rules). This documentation was not included in the presentation made by the Department of Health staff members at the public hearing.

Sincerely,

Douglas A. Shaw

Douglas A. Shaw
Associate Director

DAS:jm
cc:Kent Peterson
Supervisor, HMO Unit

Group Health Association of Northeastern Minnesota, Inc.
307 First Street North, Virginia, Minnesota 55792, Phone 218/749-5890

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

DEC 23 1976

December 21, 1976

Mr. Allan Klein
Hearing Examiner
Room 300
1745 University Avenue
St. Paul, MN 55101

Dear Mr. Klein:

As per the notice of a hearing in the matter of the proposed adoption of rules of the Minnesota State Board of Health relating to the operation of Health Facilities Grievance Mechanisms, I wish to provide written testimony concerning MHD 370:

(g) I believe that this should be April 1 to coincide with the Annual Report that each HMO has to file with the State.

(g-1) I have no objection.

(g-2) I have no objection with the change in (g).

(g-3) I have no objection.

(g-4) This should read:

"the total number of written complaints received by the health maintenance organization"

(g-5) I believe this should be detailed as to actually what is meant by "written summaries" as we do approach a problem in the confidentiality of a persons medical records.

(g-6) This should read:

"the number of enrollees by whom or for whom more than one written complaint was made and the total number of such written complaints; and,"

(g-7) This should read:

"the total number of written complaints resolved to the enrollee's satisfaction."

I appreciate your consideration in this matter.

Sincerely,

Ronald J. Daigle
Operations Director

RJD:mr

cc: Kent Peterson
HMO Unit
Minnesota Department of Health

Group Health Plan, Inc.

2500 COMO AVENUE, ST. PAUL, MN 55108
(612) 646-9461

RECEIVED
NOV 17 1976
HMO Unit
Minn. Dept. of Health

November 17,1976

Mr. Kent Peterson
Supervisor, HMO Unit
Minnesota State Board of Health
Minnesota Department of Health Building
Minneapolis, Minnesota 55440

Dear Mr. Peterson:

As you know HF 2538 became Sections 8, 9, and 10 of Chapter 325, Laws of Minnesota (1976). You may not know that the author of the bill asked Group Health Plan for some advice regarding the text of the bill when it was in draft form.

At that time the draft required HMO's to establish a complaint mechanism, to notify patients of such system "upon admission to the facility," etc. We pointed out that such language was unnecessary in light of the language of 62D and the rules thereunder regarding complaint procedure. We pointed out that the only new thing the proposed draft would accomplish would be to require complaint procedure data in our annual report to the MDH.

These observations were heeded, appropriate amendments were made in the bill, and the bill was passed into law fully reflecting our input.

The foregoing is recorded to explain why we object to the language you propose for MHD 370 (g). Such language does not tie the complaint procedure report into the annual report and contains irrelevant matters. We propose the following language instead which we know to be completely in the spirit of the law and relevant to its purpose:

> "(g) Every health maintenance organization shall include the following information in its annual report to the Board:
>
> (1) The name of the individual(s) responsible for the operation of the complaint system;
>
> (2) The total number of complaints received in the reporting period; and
>
> (3) A copy of the written summary required by (f)(2), of this rule, except that the participation acknowledgment signatures need not be included in the copy as long as they are maintained in the permanent files of the health maintenance organization."

Very truly yours,

John E. Thames

John E. Thames
Assistant to the General Manager

/kw

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JAN 14 1978
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EXAMINERS



MedCenter
Health Plan

January 12, 1977

Mr. Allen Klein
Hearing Examiner
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

re: Minnesota Department of Health Rules, Chapter 29 Proposed Rules Relating to the Operation of Health Facilities Grievance Mechanisms. Specifically, MHD 370 -- Governing Body; Consumer Members, Enrollee Participation Complaint System, proposed (g), Complaint Reports

These rules, as proposed, place an undue and unncessary burden on the HMO for two reasons. These are as follows:

1) The rules require that every health maintenance organization shall, on or before each February first, submit to the State Board of Health . . . . This requirement is inconsistent with all other annual HMO reporting requirements which are due on April first of each year.

2) MHD 370 (g)(5) requires that each HMO provide the Board of Health "a copy of the written summaries of informal discussions, consultations, and conferences required to be kept for each complaint under (f)(2) of this rule." This rule does nothing more than to create an unnecessary flow of paper which adds to the costs of the HMO and accomplishes nothing. I ask, who is going to sit and read all of the pages of copy submitted and who is going to pay for the Department of Health paper storage costs?

Therefore, I suggest that MHD 370 (g) be changed to read as follows:

5000 West 39th Street St. Louis Park, Minnesota 55416 (927-3185)

(g) Complaint Reports. Every health maintenance organization shall, on or before each ~~February first~~ April first, submit to the state board of health a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

(1) the name and location of the reporting health maintenance organization;

(2) the reporting period in question;

(3) the name of the individual(s) responsible for the operation of the complaint system;

(4) the total number of complaints received by the health maintenance organization;

~~(5) a copy of the written summaries of informal discussions, conclusions/and/conferences required to be kept for each complaint/under (f)(2)/of this rule;~~

~~(6)~~(5) the number of enrollees by whom or for whom more than one complaint was made and the total number of such complaints; and,

~~(7)~~(6) the total number of complaints resolved to the enrollee's satisfaction.

Sincerely,

Stephen K. Goldstone
Executive Director

Public Ex 1

Minnesota Hospital Association Testimony

Minnesota Health Department Hearing
on the Establishment of Grievance
Procedures for Patients in Hospitals
and Surgery Centers

January 18, 1977

Minnesota Hospital Association
2333 University Avenue S.E.
Minneapolis, Minnesota 55414

General Comments on Proposed Regulations for Grievance Procedures

The Minnesota Hospital Association strongly supports the intent of the legislation requiring that hospitals set up grievance procedures. Hospitals want to minimize problems between the institution and the patients served -- not because this is required by law, but in order to provide the best service to patients. At least 40 hospitals were already operating formal patient grievance mechanisms before Chapter 325 was passed. However, the regulations as proposed present a number of problems:

1) They are inappropriate because they go beyond the intent and the authority of the law;
2) They will have a negative effect on the ability of hospitals to respond to patient complaints;
3) They will greatly increase hospitals' costs and, correspondingly, patients' health care bills.

Inappropriateness of the proposed regulations. The legislature authorized the State Board of Health to promulgate minimum standards and procedures which hospitals must meet in establishing and operating their grievance mechanisms. The Minnesota Hospital Association believes that the proposed regulations being heard today go far beyond establishing minimum standards and procedures. They go beyond ensuring that hospitals be accountable to patients and the State Board of Health in responding to patient complaints. The regulations mandate a very specific and rigid procedure for response which, although the drafters deny this is so, may even

extend to requiring resolution of the complaint in some cases (eg. if a denial is not allowable under MHD 524 F., 1,2 or 3 of the proposed regs.).

Ineffectiveness of the proposed regulations. The proposed regulations will actually minimize the ability of hospitals to effectively respond to patient complaints and to provide better care in general. The rigidity of the procedure contained in the proposed regulations fails to account for the unique character of both the facility and particularly the patient who has a complaint. It will result in a very impersonal response to the patient.

One facility reports that the written responses and requirement that patients be notified of the facility's time limit for response will extend the period of time that it currently takes to respond to a patient's complaint. Another facility states that if the times for response remain as short as in the proposed regulations, and if complaints must be received during visiting hours, these duties will fall to persons who are directly responsible for patient care. As a result, in busy times it is possible that patient care may become a second priority to filling out reports, maintaining files and giving the appropriate notices.

Costliness of the proposed regulations. At a time when health care costs are a major concern of the legislature, it is difficult to believe that the legislature would have wanted these regulations to be as costly as they will be to facilities and, ultimately, to patients.

Since a significant number of hospitals are already offering patients a forum for complaints which they believe fulfills the intent of

Chapter 325, the regulations should be more flexible. The rigidity of the proposed regulations will necessitate changes in virtually every grievance mechanism operating in the state. This will be very costly, and there is no evidence that there will be a corresponding benefit to patients. Simpler regulations which would improve existing grievance mechanisms without replacing them completely would be more appropriate and less expensive than the regulations as proposed.

The cost of operating a grievance procedure, once established, under the proposed regulations will be very expensive because of the complexity and scope of the requirements. The administrative burden which will result from the required notifications of time limits, written responses and reporting requirements will necessitate hiring additional employees to carry out administrative duties. One hospital which already has a grievance mechanism in operation during business hours reports that to extend it to cover visiting hours with the same type of employees, specially trained for such duties, will require an additional 2800 staff hours, which will cost approximately $15,000 per year. Multiplied by 184 hospitals, this would be $2,760,000.

The Minnesota Hospital Association is offering several amendments which we view as essential to enabling hospitals to comply with the proposed regulations.

MHA Amendments to the Proposed Regs for Grievance Procedures

Rules as Proposed

MHD 521 Applicability. These rules apply to hospitals and outpatient surgery centers.

MHD 522 Definitions. Definitions for these rules are as follows:

A. "grievance mechanism" means grievance and/or complaint procedures.

B. "hospital" means any entity licensed as such pursuant to Minn. Stat. §§ 144.50 to 144.56.

C. "outpatient surgery center" means a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

MHD 522 is amended to add a section:

E. "Representative" means a parent of a minor child, a guardian or other person designated by the patient as a responsible party or one who is in loco parentis to a patient unable to act for himself.

Explanation: This definition is needed to clarify who may initiate complaints. It limits such persons to those who might reasonably be concerned over the patient's welfare (including spouses, children and counsel, as described in the agency's statement of need under 524(b)(1)). By requiring a representative other than parent or guardian to be specifically designated, the

hospital is not put in the position of having to deal with a number of persons who consider themselves to be the patient's representative, but who may have conflicting opinions on the care involved.

MHD 523 Minimum standard. Every hospital and every outpatient surgery center shall establish, operate and maintain a grievance mechanism designed to process and resolve patient grievances in accordance with these rules.

MHD 524 Procedural requirements.

MHD 524 is amended to read:

A. Designated ~~person~~ individual or type of individual. Every hospital and every out-patient surgery center, shall~~, through their respective governing authorities,~~ designate an individual or type of individual to be accountable for the operation of a grievance mechanism.

Explanation: The phrase "through their respective governing authorities" is deleted because a grievance procedure could be more flexible and responsive to the patient if organized by the chief administrative officer of the hospital than by a board which meets only periodically. Specifics of a facility's procedure is a management decision based on policies in

the law and in the regulations promulgated by the board of health.

The phrase "individual or type of individual" is substituted for the word "person" in order to save the cost of printing new notices because of changes in personnel.

B. Complaints, generally.

1. Any patient, or his representative, may initiate any oral or written complaint related to those subjects specified in MHD 525.

2. Such complaints may be made to the ~~person~~ individual or type of individual designated by the facility under MHD 524 A., or to any ~~other~~ person authorized to receive complaints by the facility. A person authorized to receive complaints shall be physically within the facility and able to receive complaints during ordinary business ~~and visiting~~ hours. Persons authorized to receive complaints, other than the individual or type of individual designated under MHD 524 A., shall, in all complaint cases, report any response or resolution, or refer the complaint, to the ~~person~~ individual or type of individual designated under MHD 524 A.

Explanation: The first sentence is amended to agree with the change in MHD 524 A. "Visiting" hours is deleted because this seriously reduces the facility's flexibility in implementing its system without any significant benefit to patients. For example, small hospitals might be forced to delegate the responsibility for taking complaints during visiting hours to persons who are also in charge of the patient's care, and this may discourage patients from complaining about care. Also, some facilities, in order to have the best trained and qualified person handling all patient complaints, would like to assign only one person to this task. Since visiting and business hours in all facilities would amount to much more than 40 hours per week, it would be impossible for one person to do all of the work. If the reason for allowing complaints during visiting hours is to enable a patient's representative to make complaints (as stated in the agency's statement of need under MHD 524(b)(2),) this can be accomplished in other ways. For example, the representative could

leave a complaint in writing for the designated individual or type of individual. Also, most representatives could call the designated individual during business hours.

C. Time limits for response. When such complaints are made while the patient is in the facility, ~~written~~ response to them, or ~~written~~ notice of the resolution of the complaint, shall be provided to the complainant in writing if requested within ~~the following time periods:~~

~~1. 24 hours for complaints relating to the following provisions of MHD 525: A.; B.; C.; G.; I.; K.; L.; M.; N.; O.; Q.; and T.~~

~~2. 72 hours for complaints relating to the following provisions of MHD 525: D.; E.; F.; H.; J.; R.; S.; and U.~~

~~3. 30 days for complaints relating to the following provisions of MHD 525: P.; and V.~~

a reasonable time, not to exceed 72 hours after the complaint is received.

Explanation: The requirement that hospitals make a written response is deleted because it is too cumbersome, too expensive, and too impersonal when included for all complaints. The requirement that responses be in writing may actually hinder the original intent of the legislature to establish a procedure "to resolve promptly and effectively

grievances by patients." (Minnesota Statutes 144.691, subd.1, Chapter 325, Laws 1976.) The requirement may actually delay responses. Also, written responses may be less adequate and even inappropriate. Hospitals should not be required to provide them unless requested by patients. Some hospitals which already have grievance procedures state that they have found that in the sensitive and complex situations involving patients' complaints, face to face dialogue with patients and their families is more effective in resolving problems. The time limits are simplified for a number of reasons:

1) Confusion of the part of hospital employees and patients will be reduced by having one time period for all complaints.

2) *Since each patient has an individualized medical care plan geared to his particular problem, it also seems appropriate that he should receive a personalized resolution of his complaints on an individual time basis consistent with the problem and within the broad guidelines of this amendment.*

3) *The 24 hour time period would often be an unrealistic one in view of the many daily extenuating circumstances (eg. difficulty in locating staff or physicians who were present at the time the problem occurred, or patient care emergencies which are more crucial). If this limit is left in the regulations, many of the responses made within that time will not be satisfactory to the patient and will only exacerbate the problems that the legislation was intended to solve.*

4) *The legislature did not prioritize the patient bill of rights which forms the basis for*

complaints. Therefore a single time period for response to all complaints is most consistent with the legislative intent of the patient bill of rights.

D. Notice of Time Limit. The authorized individual to whom the complaint is made shall, ~~within 4 hours,~~ <u>upon receipt of the complaint</u>, inform the complainant of the applicable time limit, in his best judgment, for response or resolution under MHD 524 C. ~~1,2,3.~~

<u>Explanation</u>: These changes bring the section into agreement with previous amendments which limit complaints to business hours and simplify the times for response. The authorized individual is required to inform the patient of the time for response upon receipt of the complaint because:

1) this should be preferable to the patient, and

2) because it will be easy for the authorized

person to do under MHA's proposed amendments since there will be only one time limit. These changes also solve potential problems which could arise under the proposed regulations. If a patient could make a formal complaint in the evening during visiting hours, it may be necessary to wake the patient in order to comply with the requirement to notify the patient of the time limit for response within 4 hours. Under these amendments the patient would be notified upon receipt of the complaint by the authorized person, which would be during business hours.

~~E. Exception. If the condition of the patient in question presents an emergency situation preventing timely response to, or the resolution of, a complaint, the time limits specified in MHD 524 C.1. and 2. shall extend an additional 48 hours. In all such cases, a dated annotation of the existence of such an emergency situation shall be placed in the record required to be kept under MHD 524 G. and signed by the person asserting them in behalf of the facility.~~

Explanation: Although this section appears to be intended to ease the burden of response, it is ambiguous and unnecessary. Since the patient's physician is the only person who can provide accurate, appropriate medical information dealing with the patient's condition, it would always be necessary to contact the physician to determine if an emergency exists. The section also appears less necessary with the amendment of the time limits to allow 72 hours for response to all complaints. In addition, patients in this condition are unlikely to complain in the first place.

~~E. Denials. The grounds on which denial of the action requested by the complainant can be based include the followings.~~

~~1. the action sought by the claimant is medically and/or therapeutically contraindicated;~~

~~2. the action sought by the claimant would be violative of any of the rights, as prescribed in Minn. Stat. § 144.651, of other facility patients; or,~~

~~3. the action sought by the claimant would violate a written policy, approved by the facility's governing authority.~~

A dated annotation of ~~any of the~~ a denial and the grounds for the denial shall be placed in the ~~patient's~~ complaint record. ~~and signed by the person asserting them.~~

Explanations: This section has been simplified for a number of reasons:

1) The proposed regulations go beyond the intent of the law which is to require facilities to set up a procedure for response to complaints. The regs state in substance when the facility can deny requested action by patients. This approaches a requirement to resolve, not merely to respond to complaints, and the agency in its statement of need (MHD 524(c) admits that this was not the apparent intent

of the legislature. ("In specifying that a conduit for low-level resolution of claims be present in all facilities, it refrained from requiring that such complaints be formally resolved at that level.")

2) Subpoints one and two of the proposed regulation would require the involvement of a physician and an attorney to interpret circumstances, which would be very expensive.

3) Subpoint three is too narrow, since if neither subpoint one or two was relevant a facility would be required to grant any patient's request, no matter how ridiculous or inappropriate. It would be impossible for the governing board to document in writing, in advance, every conceivable patient request which should be denied.

4) Finally, it should be made clear that the record of the denial belongs in the complaint record, not the medical record.

G. ~~Patient~~ complaint records. ~~The following complaint records shall be maintained according to patient by the facility for periods of time determined in a written policy approved by the facility's governing authority:~~

~~1. an annotation of the date, time and substance of each complaint made by, or in behalf of, any patient;~~

~~2. a reference to any previous complaints made by, or in behalf of, the same patient during his current stay in the facility; and~~

~~3. an annotation of the date, time and substance of any response to, or resolution of, the complaint.~~

The facility shall maintain records of the operation of its grievance mechanism sufficient to complete the annual report required by MHD 526. Such records shall be retained as long as necessary for reporting purposes.

Explanation: This section is simplified to allow facilities flexibility in recordkeeping as long as they are able to meet the reporting requirement (which appears to be the major reason for keeping such records in the first place). A facility might, for example, wish to keep its records by type of complaint or chronologically, and only index by patient. The purpose of the statute would not be thwarted by allowing this flexibility.

H. Patient notice.

1. Notice of mechanism. Written notice of the existence and availability of the grievance mechanism shall be posted conspicuously in all facilities, along with the notice required under Minn. Stat. § 144.652, and furnished, along with the notice required under Minn. Stat. § 144.652, to the patient or his representative upon admittance to the facility.

2. Content of the notice. Such written notice shall include the following:

a. a statement that complaints or grievances related to rights expressed in the Patients' Bill of Rights (Minn. Stat. § 144.651), or to any other rights, may be able to be resolved within the facility;

b. a statement that the facility maintains a grievance mechanism for this purpose; ~~and,~~

c. a statement specifying an individual or type of individual to whom such complaints or grievances can be directed./ ; and,

d. a statement that the patient may request a response in writing.

Explanation: This amendment is necessary to implement the change in 524 C. Otherwise the patient would not be aware of tis right to request a written response.

MHD 525 Patient complaints. Complaints relating to at least ~~the following~~ billing and the rights described in the patient bill of rights (Minnesota Statutes § 144.651) shall be subject to being processed through a grievance mechanism.

~~A. lack of considerate or respectful care;~~

~~B. failure to provide complete, current and understandable information concerning diagnosis, treatment or prognosis;~~

~~C. failure to provide the name and specialty, if any, of the physician responsible for coordination of care;~~

~~D. failure to afford consideration or privacy;~~

~~E. failure to afford consideration of individual social, religious and psychological well-being;~~

~~F. failure to preserve the confidentiality of the medical care program;~~

~~G. failure to provide, upon request, information bearing on the individual case with respect to any relationship of the facility to other health services facilities, medical groups and other similar entities;~~

~~H. failure to afford continuity of care;~~

~~I. failure to provide requested information, prior to or at the time of admission and during the period spent in the facility, relating to charges for care;~~

~~J. failure to afford the opportunity to participate in the planning of medical treatment;~~

~~K. failure to inform of, or to offer an opportunity to refuse to participate in, experimental research;~~

~~L. retaliatory, arbitrary, or otherwise medically unjustifiable discharge;~~

~~M. interference with or retaliation for the free exercise of any legally prescribed rights;~~

~~N. mental and/or physical abuse;~~

~~O. medically unjustifiable physical and/or chemical restraints;~~

~~P. failure to comply with lawful requests to release or to withhold medical records;~~

~~Q. requiring the performance of services not included for therapeutic purposes in the plan of care;~~

~~R. restriction of the right to associate and communicate privately with others;~~

~~S. interference with the sending and receipt of personal mail;~~

~~T. restriction of the rights to meet with representatives and to participate in commercial, religious and community activities;~~

~~U. restriction of the right to retain and use personal clothing and possessions, to the extent that space permits; and,~~

~~V. failure to respond to questions concerning billing practices, the amount of a specific bill, and the like.~~

Explanation: This section has been simplified to correct ambiguities. The complaints listed in the proposed regs paraphrase § 144.651. It is preferable to use the exact language of the statute because some of the rights are vague and since they may be interpreted by the courts, those interpretations could be applied here. Also, the proposed regulations which do not apply to nursing homes incorporate some rights which the legislature attributed only to nursing homes (eg. 525 T.), and this attempt to expand the rights of hospital patients through amendment by rulemaking is inappropriate. Incorporation of the statute by reference would alleviate these problems.

MHD 526 Reports. Every hospital and every outpatient surgery center, shall, on or before each February first, submit to the state board of health a report on the experience of their respective grievance mechanisms during the immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting institution;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the grievance mechanism;

D. the total number of complaints ~~received by the facility~~ filed with the facility pursuant to MHD 524 (B)(1);

E. the total number of complaints, according to classification under ~~MHD 525~~ Minnesota Stat. § 144.651;

F. the total number of any other complaints;

G. the number of patients by whom or for whom more than one complaint was made and the total number of such complaints; and,

H. the total number of complaints resolved to the patient's apparent satisfaction.

Explanation: These amendments are made to make it clear that only complaints going through the formal mechanism need be reported; to bring the section into agreement with the amendments to MHD 525; and to clarify that

personnel need only observe patients' apparent satisfaction rather than initiate procedures to document patient reaction. The change in (H) above also makes clear that response, not resolution is required by these regulations.

MHD 527 Schedule of fines.

~~A. Patient notification and complaint mishandling.~~

~~1. Grounds; fine amounts. The following violations of these rules shall constitute grounds for the automatic assessment of a per violation $50 fine:~~

~~a. failure to given individual patient notice, as required under MHD 524 H.; and,~~

~~b. failure to respond to a patient complaint within the applicable time limits, as required under MHD 524 G.~~

~~Multiple violations with respect to the current stay of a particular patient shall result in fines which in no case exceed $200. Such fines are payable within 30 days of the automatic assessment, unless there is a facility request for a hearing. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.~~

~~B. Inadequate or improperly functioning mechanism.~~

A. ~~1.~~ Grounds. The following violations of these rules shall constitute grounds for the issuance of a correction order:

A. 1. Patient notification and complaint mishandling.

a. failure to give an individual patient notice, ~~as~~ required under MHD H.; and

b. failure to respond to a patient complaint within the applicable time limits, as required under MHD 524 C.

B/ 2. Inadequate or Improperly Functioning Mechanism.

a. Failure to have a grievance mechanism, as required under MHD 523;

b. Failure to designate a ~~person~~ an individual or type of individual to be responsible for the operation of a grievance mechanism, as required under MHD 524 A.;

c. Failure to have an individual within the facility and able to receive complaints during ordinary business ~~and visiting~~ hours, as required under MHD 524 B.2;

d. Failure to maintain ~~patient~~ complaint records, as required by MHD 524 G.;

e. Failure to post notice, as required by MHD 524 H.;

f. Failure to submit an annual report, as required by MHD 526; and,

g. Failure to fulfill the criteria for content of the annual report, as required by 526 A

Explanation: Part A and B have been consolidated to eliminate the automatic assessment of fines under the proposed section A of the regs. The agency's statement of need argues that automatic fines are imposed because "the mechanism has demonstrated its failure in the past to comply with these proposed

rules as they related to particular patients." However, the statute (Chap. 325) gives the agency rulemaking authority to promulgate a "schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of this section, "(144.691, subd 3, d.) Since timelimits are not a part of the section of the statute itself, it is reasonable to assume that the concern was to ensure a working process (a prospective concern) not to require adjudication on individual matters. Therefore, it seems logical to enforce the law in a way that encourages establishment of an effective process, not to attempt to adjudicate individual matters.

In addition, where a fine is automatically assessed, the only remedy for the facility is an administrative hearing, which is costly to the state and the facility. It is possible that a misinterpretation of the degree of notice required or the time limit allowed is involved, and with a period for correction, the facility could adjust its policies.

A final argument against automatic assessment of fines is that it may not afford facilities due process of law as required by the Minnesota and

U.S. Constitutions.

B. ~~2.~~ Time Periods for correction. In no case may the allowable period for correction of any violation in ~~MHD-527-B.1~~ MHD 527 A. ~~exeeed~~ be less than 20 days nor more than 60 days.

Explanation: If facilities' compliance with 527 A is inadequate in the opinion of inspectors, it may be necessary to have new notices printed, rewrite the annual report, or create a new filing system. In light of this, a minimum 20 day period seems reasonable.

C. ~~3.~~ Fine amounts. The amounts which shall be assessed in the event that the facility does not comply with correction orders within the allocated period of time are as follows:

1. violations described in 527 A.1 -- $50 dollars per violation, except that multiple violations with respect to the current stay of a particular patient shall result in fines which in no case exceed $200.

2. ~~a.~~ violations as described in MHD ~~527 B.1.a~~ 527A.2.a. -- up to $200 per violation;

3. ~~b.~~ violations as described in MHD ~~527 B.1.b.~~ 527A.2.b. -- up to $100 per violation;

4. ~~c.~~ violations as described in MHD ~~527 B.1.c.~~ 527 A.2.c. -- up to $150 per violation;

5. ~~d.~~ violations as described in MHD ~~527 B.1.d.~~ 527 A.2.d. -- up to $50 per violation;

6. ~~e.~~ violations as described in MHD ~~527 B.1.e.~~ 527 A.2.e. -- up to $100 per violation;

7. ~~f.~~ violations as described in MHD ~~527 B.1.f.~~ 527 A.2.f. -- up to $200 per violation; and,

8. ~~g.~~ violations as described in MHD ~~527 B.1.g.~~ 527 A.2.g.-- up to $100 per violation.

Such fines are payable within 30 days of the assessment unless there is a facility request for a hearing within that period. Such a request shall stay the collection of the assessed fines, pending the outcome of the hearing.

Explanation: *The changes in this section are not substantive, but are merely necessary to bring the section into agreement with earlier changes.*

D. Hearings. All hearings provided for in MHD 527 will be conducted in accordance with Minnesota Statutes § 15.0411.

Explanation: *This section is added to inform persons where the rules of administrative contested cases can be found.*

STATE OF MINNESOTA

DEPARTMENT HEALTH

Office Memorandum

TO : Allan Klein
Hearing Examiner

DATE: 2/7/77

FROM : Dan McInerney
Health Law Consultant

PHONE: 5511

RECEIVED
FEB 7 1977
OFFICE OF HEARING EXAMINERS

SUBJECT: Proposed Rules for the Operation of Health Facilities Grievance Mechanisms

Please find attached some additional testimony and non-substantive changes to the rules as proposed, which we would like placed in the record.

DJM:jh
Attachment

Read
3:25 pm
2/7/77

RECEIVED
FEB 7 1977
OFFICE OF HEARING
EXAMINERS

I. Testimony of John Diehl (University Hospitals and Clinics)

Mr. Diehl's statement that the non-delegation doctrine requires a proven nexus between the list of complaints enumerated in rule and the incidence of claim or suit is without merit. Subdivision 1 of the grievance mechanism statute (Laws 1976, Ch. 325, Section 8, Subdivision 1) indicates that the Legislature, not the agency, has made a determination that grievances related to billing and inadequacies of treatment may impact on the incidence of claim or suit. Hence, insofar as the list of complaints specified in rule relates to these things, there is no delegation problem. Those things specified in the list of complaints which do not relate to billing or inadequacies of treatment can still be included without the agency acting ultra vires since the language of the statute (subdivision 1) permits the inclusion of other factors which, although not proven, may have an impact on the incidence of claim or suit.

Mr. Diehl's testimony questioning the appropriateness of including complaints which derive from the rights of residents (as opposed to patients) as expressed in the Patient Bill of Rights overlooks the recent expansion of hospital services to provide care to persons who would formerly be considered "residents," not "patients" - e.g., chemical dependency and detoxification units, rehabilitation services, etc.

As to whether a great and onerous increase in costs would result from the implementation of the rules, Mr. Diehl offered no supporting evidence. It is clear, however, that record-keeping requirements of every new regulatory effort cost something. Further, the Minnesota Supreme Court has held that property rights are subject to such restrictions as government may require for the common good. Although the exercise of a police power may be costly to an individual or group, if the measure reasonably tends to accomplish the purpose of its enactment without unreasonably or arbitrarily exceeding the needs of the occasion, it is a valid exercise of a police power. City of Minneapolis v. Krebes, ___Minn___, 326 N.W 2nd 617 (1975); Lee v. Delmont, 228 Minn 101, 36 N.W. 2nd 530 (1949).

Lastly, Mr. Diehl's suggestion that the Patient Bill of Rights be referenced in the rules is not appropriate. First, the legislation (subd. 3.(b)) commands the development of a "list" of complaints in rule. Secondly, it would be impossible to tie the Patient Bill of Rights statute, as it stands, into the specified time limits for response which are proposed to be promulgated.

II. Testimony of Cathy Countryman (University Hospitals and Clinics)

Ms. Countryman's statement that the rules as posposed would force the resolution of grievances was not supported by any testimony indicating how this would be so.

With regard to whether post-discharge complaints are covered by the rules, it is clear that they may, indeed, be processed through such a mechanism. The statute, however, is arguably directed at ameliorating potential problems while the individual is in the institution, i.e., while he is a "patient." Once discharged the individual is no longer a "patient;" hence the main thrust of the proposed rules is directed toward the former situation.

Ms. Countryman's criticism that some types of complaints were not mentioned is not really tenable because she offered no examples and because the list is specifically described as not being all-inclusive.

With respect to Ms. Countryman's urging of the adoption of an overall 72-hour limit, it must be pointed out that three days to respond to a complaint is an extremely long time when the complaint relates to the quality of medical care. This would be the kind of unacceptable situation which would obtain if a complaint were made on a Friday and to which response were not made until the following Monday. If the Health Department were to consider consolidating the 24 and 72 hour time limits into one, it could not support a time limit of more than 48 hours.

[Comments about referencing the Patient Bill of Rights are discussed above in I.]

III. Testimony of Gordon Sprenger (Minnesota Hospital Association)

The written testimony of the Hospital Association concerning the inappropriateness, ineffectiveness and costliness of the proposed rules fails to make specific criticisms. There is no reference to an overall alternative approach. The costliness data provided is speculative, since there is no longer a proposed staffing requirement with regard to visiting hours, since there is no requirement that additional persons be employed exclusively to operate the mechanism, and since the extrapolation of the unsupported figures from hospital X to other hospitals of varying sizes, service mix and service intensity is questionable. Testimony recommending altering the portion of the schedule of fines which includes automatic assessment in certain circumstances fails to take notice of the operation of the regulatory process. Correction orders are directed at remedying existing deficiencies. The deficiencies in question would have occurred in the past; hence the application of a correction order technique would be inappropriate. The actual effect of making the proposed changes would be to give the facility "one free shot" at violating the notice and response provisions, viz., should a correction order be issued because of the failure of a facility to, e.g., give the requisite patient notice, then any subsequent failure would be, in any case, automatically finable as a violation of the correction order. The ultimate effect of the change could be the same as if no change were made - automatic fining.

The argument that the schedule of fines could only apply to violations of the statute itself, and not to the time limits prescribed in rule (pp 21-22, Public Exhibit 1) is untenable. The schedule of fines must be developed in rule, according to the statute (subd. 3.(d)). It must apply to "failure ... to comply with the provisions of this section" (subd. 3.(d)). The "provisions of this section" include a mandate to the Board of Health to set standards in rule (subd. 3 (a), (b) and (c)). Hence, a failure to comply with properly promulgated rules is a failure to comply with "the provisions of this section" and is subject to the sanctions specified in the schedule of fines.

The Hospital Association's proposed time periods for correction orders are not reasonable. Placing a bottom limit of no less than twenty days on all correction orders defeats the stated purpose of the statute - to require an established, functional grievance mechanism in health facilities. To accept the approach proposed by the Hospital Association would effectively permit facilities to have no grievance mechanism at all, to have no one able to receive complaints, to fail to post notice, etc., and to have a three-week grace period without respect to both the importance of these violations and the relative ease with which they can be corrected.

[Comments about the MHA-recommended 72-hour overall time limit and about referencing the Patient Bill of Rights are addressed above in I. and II.]

Letter of Vera Likins, Commissioner of Public Welfare

The recommended changes in the proposed rules described in Commissioner Likins' letter are unacceptable and inappropriate. The deletion of the reference to the list of complaints in proposed MHD 525 would eliminate the tie-in with the provisions of the Patient Bill of Rights. The reasons for this tie-in were described in the Health Department's previously submitted written testimony.

The "special implications" for committed patients which are asserted as affecting state psychiatric hospitals are not identified. Since only response (and not resolution) is mandated, and not the character, content or completeness of such response (a recognition of the complexity of some problems), it is difficult to see an unduly onerous burden being placed upon the state psychiatric hospital system.

The remainder of the comments which are germane to the rules as proposed is adequately addressed in previous written Health Department testimony and eslewhere in this addendum.

Letter of James Anderson and Sister Generose Gervais

The comments in this letter are addressed in both previous written Health Department testimony and elsewhere in this addendum. The reference to an informal conversation with Mr. McInerney raises issues which are clarified in the attached non-substantive modification to proposed MHD 524 F.

Changes in the Rules as Proposed

MHD 522 D. "patient" means an individual in or admitted to a hospital or outpatient surgery center for the purpose of prevention of disease, medical diagnosis or medical treatment. The term "patient" includes inpatient, outpatient and emergency room patient.

[MHD 522 D is changed to MHD 522 E]

MHD 524 F.1. Notice of Mechanism. Written notice of the existence and availability of the grievance mechanism shall be posted conspiciously in all facilities, along with the notice required under Minnesota Statutes 144.652, and furnished, unless an emergency prevents such furnishing, ~~, along with the notice required under Minnesota Statutes 144.652,~~ to the patient or his representative upon ~~admittance~~ entry to the facility. If an individual patient notice is required to be furnished to the patient or his representative under Minnesota Statutes 144.652, written notice under these rules shall be furnished at the same time.

These first two changes are necessary because of a potential lack of clarity in the rules as currently proposed. Adding a definition of "patient" makes it clear that any person seen for the purpose of disease prevention, diagnosis or treatment is one of the types of individuals sought to be protected by the statute. The rules as initially drafted might possibly have been construed as not covering persons brought into emergency rooms or treated in outpatient departments. This possible lack of clarity could result from a requirement in the proposed rules (MHD 524 F.1.) that patients be furnished upon admission with the notice of the existence of a grievance mechanism along with their copy of the Patient Bill of Rights. The Patient Bill of Rights (Minnesota Statutes 144.651, et seq.), as amended (Laws 1976 Ch. 274) has a definition of "patient" (Section 1) which arguably excludes that law's applicability to persons treated and released in a period less than 24 hours. Hence, outpatients and emergency room patients, unless actually admitted to the facility, would not necessarily be receiving a copy of the Patient Bill of Rights, and, thus, might not be considered as persons who must receive notice of the grievance mechanism. Adding a definition of "patient" clarifies the rules. It is quite clear that the grievance mechanism statute intends to include such individuals within its scope of applicability. A similar misinterpretation would affect persons with the minor conditions which can be treated in outpatient surgery centers in the same way. First, it specifically applies to outpatient surgery centers; second, the requirement that outpatient surgery centers establish grievance mechanisms confirms an intent to benefit hospital outpatient and emergency room patients, since the type of individual treated in this former type of facility is precisely the type who

would be treated and released from hospital outpatient departments or emergency rooms. The addition of the definition of "patient" assures that an interpretation of the rules which limits their applicability to "inpatients" alone cannot be made.

Similarly, the change in MHD 524 F.1. eliminates the problematic word "admission," thereby removing a potential source of confusion which could result in a failure to consider patients not "admitted"-outpatients and emergency room patients - as beneficiaries of the statute. The deletion of the language requiring provision of the grievance mechanism notice along with the Patient Bill of Rights recognizes the possibility that outpatients, emergency room patients and outpatient surgery center patients arguably might not have to be furnished with the Bill of Rights (unless they are "admitted"). The additional sentence, however, makes it clear that, if the Bill of Rights is required to be given the patient, the notice of the grievance mechanism's existence be given to him at the same time. Finally the exception of "emergency" circumstances recognizes the fact that furnishing notice of the mechanism to an emergency patient may be a practical impossibility, unless or until the emergency condition is stabilized.

These changes would not substantially or fundamentally alter the rules as initially proposed since the subject matter of the rules remains the same. All they do is preclude a minimally possible post-promulgation interpretation of the rules which would conflict with their obvious intent. The individuals benefited by the rules would remain the same; the alterations only make it clearer that outpatients and emergency room patients, who were patently beneficiaries of the rules as they applied to outpatient surgery centers, are also beneficiaries of the rules as they apply to hospitals. The testimony elicited at the hearing evinced no such misinterpretation of the proposed rules (although subsequent comment may have); nonetheless, the changes proposed here will avoid any future misinterpretation. Finally, reaction to the applicability of the rules to outpatients and emergency room patients was invited by the rules as initially proposed, since, in the very least, these types of individuals were clearly covered in the outpatient surgery center area.

MHD 370 (g)(5) A <u>synopsis</u> ~~copy~~ of the written summaries of informal discussions, consultations and conferences required to be kept for each complaint under (f)(2) of this rule; the identity of specific individuals shall not be disclosed in such summaries;

[There would also be some concomitant renumbering or relettering changes in other parts of these rules]

This change eliminates the need for an HMO to submit a bulky package of summaries, while still requiring the submission of the information sought. The records from which such data are derived are open to health department inspection, in any case (under MHD 370 (f)(2)), and, in the event that the synopses

submitted seem inadequate, the summaries themselves are available. This does not appear to make a change which would substantially vary from the rules as initially proposed.

STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

In the Matter of the Proposed Rules)
of the State Health Department)
Governing the Operation of Health)
Facilities Grievance Mechanisms)

ORDER ADOPTING RULES

The above-entitled matter came on for hearing before the Minnesota State Board of Health on the 18th day of January, 1977, at 9:00 a.m. in the Board Room, Minnesota Department of Health Building, 717 Delaware Street S.E., Minneapolis, Minnesota 55440. Prior to the hearing, proper notice, required by Minn. Stat § 15.0412 (1976), was served upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

Having afforded interested persons an opportunity to present written and oral data, statements and arguments, having heard and considered all of the testimony and evidence adduced and upon the records, files and proceedings herein, having examined applicable statutory standards and criteria, and having confirmed the need for the above-entitled rules,

NOW, THEREFORE IT IS ORDERED THAT:

the attached rules, identified as "Rules Relating to the Operation of Health Facilities Grievance Mechanisms," are adopted this 12th day of July, 1977, pursuant to authority vested in me by Laws, 1977, Ch. 305 § 39, amending Minn. Stat. § 144.691 (1976).

STATE OF MINNESOTA
COMMISSIONER OF HEALTH

Warren R. Lawson, M.D.

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General John A. Breviu, do hereby declare that I have examined the proposed rules relating to the operation of health facilities grievance mechanisms and all related documents and that, based on them and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed.

Dated: Aug. 11, 1977

JOHN A. BREVIU
Special Assistant
Attorney General

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE MINNESOTA STATE BOARD OF HEALTH

IN THE MATTER OF THE PROPOSED)
ADOPTION OF RULES OF THE)
MINNESOTA STATE BOARD OF HEALTH) REPORT OF THE
RELATING TO THE OPERATION OF) CHIEF HEARING EXAMINER
HEALTH FACILITIES GRIEVANCE)
MECHANISMS)

WHEREAS, a hearing was held on January 18, 1977, before Allan W. Klein, a Hearing Examiner of the State Office of Hearing Examiners, on the above-entitled matter in compliance with Minn. Stat. § 15.0412, Subd. 4; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. § 15.052, Subd. 3, was issued to the State Board of Health on March 10, 1977; and

WHEREAS, the State Board of Health has now determined to adopt rules pursuant to Minn. Stat. § 15.0412, Subd. 4; and

WHEREAS, the State Board of Health has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. § 15.052, Subd. 4, and Rule HE 107; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the State Board of Health has met all requirements of Minn. Stat. § 15.0412, Subd. 4.

NOW, THEREFORE, upon receipt of this Report, the State Board of Health has the responsibility of submitting the complete hearing record and the rules as adopted by the Board to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. § 15.0412, Subd. 4.

Dated this 25th day
of August, 1977.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner