



## Hopedale Medical Complex

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Applicable Department(s)      Complexwide      \_\_\_\_\_  
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### POLICY

Hopedale Medical Complex (HMC) will uphold its legal and moral duty to follow the applicable laws, regulations and guidelines in connection with conducting hospital business and delivering quality patient care through the establishment and enforcement of an effective Corporate Compliance Program (Program). HMC places particular emphasis on healthcare laws, regulations and guidelines governing healthcare programs as prescribed by the Office of Inspector General (OIG). Such programs are defined as any government, commercial, private or other payer which reimburses HMC for services provided to its patients.

While HMC recognizes that the Program may not entirely eliminate fraud, abuse and waste from HMC, it is believed a sincere effort (via the Program) to comply with the applicable laws, regulations and guidelines through the establishment of a compliance program significantly reduces the risk of unlawful improper conduct.

### PURPOSE & GOALS

The purpose and goals of the Program are to:

- I. Provide a framework for acceptable business practices, thereby minimizing any loss, financial or otherwise, to HMC from failure to follow the applicable laws, regulations and guidelines.
- II. Demonstrate HMC's commitment to conducting business practice in an honest and ethical manner and establishing a culture within HMC that promotes prevention, detection and resolution of conduct that does not conform to laws, regulations and guidelines applicable to HMC.
- III. Provide expectations of employees, Board members, physicians, independent contractors and covered persons (auxiliaries, volunteers and students of healthcare professions) (collectively, Hospital Representatives) regarding their behavior or business while acting as representatives of HMC.
- IV. Assist HMC in actualizing its fundamental care-giving missions to patients and the community.
- V. Identify, prevent, detect and resolve conduct that it is not in conformity with HMC policies and procedures or applicable laws, regulations and guidelines.
- VI. Educate Hospital Representatives on HMC's compliance initiatives as appropriate.

## **PROCEDURE**

The following content is based on the OIG's seven elements of an effective compliance program.

## **APPOINTMENT OF A COMPLIANCE OFFICER AND COMMITTEE**

- I. APPOINTMENT
  - A. The Program shall be directed by a Corporate Compliance Officer (CCO) who:
    1. Is appointed by the Chief Executive Officer (CEO) and approved by HMC's Governing Board (collectively, Board).

2. Reports directly to the CEO and the Governing Board, serving at their discretion.
  3. Is a high level HMC official.
- B. Any change in the person responsible for administering the Program shall be approved by the Board.

## II. DUTIES OF THE COMPLIANCE OFFICER

### A. The CCO shall:

1. Oversee and monitor HMC's compliance activities.
2. Act as HMC's Privacy Officer.
3. Act as Chair of HMC's Corporate Compliance Committee (CCC) and report to the Board on the progress of the Program.
4. Ensure that the Program has been properly implemented, periodically reviewed and revisions are made as appropriate.
5. Periodically review the Code of Conduct (Code) and compliance policies and recommend revisions as necessary to meet changes in the business and regulatory environment.
6. Coordinate the review, and updating and delivery of compliance education and training for all HMC employees, physicians and Board, including current laws, regulations and guidelines as they pertain to the Program.
7. Coordinate auditing and monitoring of activities within the scope of the Program.
8. Coordinate compliance activities in departments on a periodic basis and review the results of the compliance activities.
9. Coordinate the review of contracts with vendors and independent contractors as they relate to corporate compliance and ensure a Business Associate Agreement is in place when appropriate.

10. Ensure that the Program and the Code have been effectively communicated to Hospital Representatives through contractual agreements or by delivering a copy of the Program and the Code to them.
11. Receive and investigate reports of possible illegal conduct or other conduct that violates the Program, the Code, compliance policies and procedures, laws, regulations or guidelines.
12. Establish and administer a communication system that shall be available to employees to report any suspected illegal conduct or other conduct that violates the Program, the Code, compliance policies or procedures, laws, regulations or guidelines.
13. Notify the appropriate law enforcement agency of possible illegal misconduct, when required, and work with the agency through the investigative and corrective action processes.
14. Ensure consistent and appropriate sanctions are implemented in the event of violations of compliance policies and procedures, laws, regulations or guidelines.

### III. COMPLIANCE COMMITTEE

#### A. Membership and Appointment.

1. Compliance Committee members consist, at minimum, of the following key employees in addition to the CCO:
  - Medical Director
  - Corporate Compliance Officer/
  - HIPAA Privacy Officer
  - COO/President
  - CFO
  - Hospital DON
  - Nursing Home DON
  - Pharmacy Manager
  - Med Arts DON
  - Surgery DON
  - Physical Therapy Manager

- Radiology Manager
- Lab Manager
- Revenue Cycle Manager
- MAPBO Manager
- Quality Manager
- Risk Manager -
- HR Manager -
- Non-Clinical Manager -
- Non-Manager Employee -
- Non-Manager Employee -

2. Membership vacancies are filled by the Committee's review and selection of appropriate candidates.

B. Functions:

1. Reporting to, and coordinating with, the CCO with respect to compliance-related activities.
2. Analysis of business and legal requirements with which HMC must comply.
3. Regular review of the Program.
4. Assessment of policies and procedures and the Code of Conduct to determine their adequacy in meeting HMC's objectives and promoting compliance.
5. Coordinating compliance training, relaying compliance-related communications and monitoring compliance efforts.
6. Participation in periodic risk assessments and reviews of hospital department audit results and ensure that conclusive audit recommendations are carried out as appropriate.
7. Assist in developing Work Plans to address potential compliance issues uncovered in the course of conducting risk assessments or audits.

8. Participation in the determination of the appropriate approach/strategy to promote compliance with the Program and detection of any potential violation.
9. Participation in the maintenance of a system to solicit, evaluate and respond to complaints and problems.
10. Performance of such special projects as requested by the CCO.
11. Working together with managers and supervisors from other departments to ensure their participation in and compliance with the Program.

## **DEVELOPMENT AND DISTRIBUTION OF THE CODE/POLICIES/PROCEDURES**

### **I. CODE**

- A. HMC has developed a Code describing HMC's commitment to the conduct of its business in accordance with the laws, regulations and guidelines. The Code applies to all Hospital Representatives.
- B. The Code, or applicable portions, is made available to all employees, initially on hire and thereafter in the Policy & Procedure software. (When necessary, the Code will be translated into other languages and written at appropriate reading levels.)
  1. Employees sign a statement acknowledging receipt of the compliance materials and affirming their intention to abide by the Program.

### **II. POLICIES AND PROCEDURES**

- A. The Program shall support a collection of relevant policies and procedures which adequately cover the major, non-inclusive areas of compliance risk noted below and guide daily business and patient care operations:
  1. Documentation;
  2. Billing;
  3. Coding;
  4. Physician relationships;
  5. Contractual and vendor relationships;

6. Community Benefit and Charity Care;
7. Discipline and response to non-compliance;
8. Self-disclosure;
9. Record retention;
10. Conflicts of interest;
11. EMTALA;
12. Patient Safety;
13. Quality of care;
14. Information privacy and security;
15. Corrective action plans;
16. Auditing and monitoring;
17. Compliance reporting mechanisms;
18. Compliance oversight;
19. Process for Hospital Representative background and exclusion list checks, including use of OIG, GSA and other lists;
20. Compliance education and tracking.

## **DEVELOPMENT AND IMPLEMENTATION OF EMPLOYEE EDUCATION AND TRAINING**

### **I. GENERAL REQUIREMENTS**

- A. The proper education and training of Hospital Representatives is a significant element of the Program.
- B. HMC shall require employees to attend specific training upon hire and annually so they have a clear understanding of top management's expectations of behavior, employee responsibilities and their rights under the Program. The training shall emphasis HMC's commitment to compliance with laws, regulations and guidelines.
- C. It is not necessary, however, that every Hospital Representative be educated concerning every aspect of the Program. The CCO shall determine, in cooperation with the CCC, the materials and the training that each classification of Hospital Representative shall receive.
- D. Each employee shall receive a copy of the Code and other relevant compliance materials and sign a statement acknowledging receipt of the compliance materials and affirming their intention to abide by the

Program. The CCO shall promptly respond to any employees' questions regarding the Program.

## II. SPECIFIC EDUCATION AND TRAINING

- A. In addition to the distribution of compliance materials, the CCO or a designee shall provide for additional training (e.g., seminars, live or videotaped presentations or more detailed written materials) in targeted departments covering specific issues identified by the CCC. Such training shall utilize in-house personnel or outside experts when necessary.
- B. Government Compliance Alerts and Guidances.
  1. The OIG and other government agencies periodically publish fraud and abuse alerts, interpretations and compliance guidance regulations. The CCO or a designee shall distribute copies of this material to the CCC and to other affected employees as deemed appropriate. Of particular importance are the compliance guidance regulations that are published by the OIG, which includes HMC model compliance guidance and other model compliance guidances.
  2. In identifying potential risk areas and developing or revising compliance policies and procedures to strengthen controls over these areas, the CCO or a designee shall ensure that affected employees receive the Centers for Medicare and Medicaid Services (CMS), Intermediary, Carrier and other agency manual revisions, instructions, regulations, bulletins or other material, which is considered necessary to properly perform their job duties and responsibilities.
- C. Competency Assessment
  1. Education and training is part of HMC's competency assessment program. The CCO or designee shall enlist the assistance of the Director of Staff Education and others for education and training relating to compliance issues. The CCO, with the input of affected departments, shall develop an appropriate education competency assessment for affected employees.
  2. An employee's competency shall be evaluated in orientation and throughout employment. Documentation of the competency

validation shall be retained by HMC's Human Resources personnel in accordance with its record retention program.

D. Attendance

1. Attendance and participation in training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action in accordance with HMC's disciplinary policies, including possible termination.

E. Training and Education Records Retention

1. HMC shall maintain adequate records of its training and education programs for its employees, including attendance logs and copies of the materials distributed or covered at the training and education sessions.
2. Department supervisors shall be responsible for collecting attendance information for programs attended by their staff independent of those organized through the Compliance Department and forwarding such information to the CCO.

## **DEVELOPMENT OF EFFECTIVE LINES OF COMMUNICATION**

I. GOVERNANCE AND LEGAL COUNSEL COMMUNICATION

1. The CCO's position in the organizational structure shall allow direct, open communication between the CCO and members of the Board regarding compliance issues affecting the organization. In addition, the CCO shall have open access to organization's legal counsel when necessary.
2. This communication can be conducted independent of the regular Board reporting schedule and shall be privileged and confidential between the parties mentioned, as appropriate.

II. EMPLOYEE ACCESS TO THE COMPLIANCE OFFICER

- A. It is essential to the success of HMC's Program and the facility that HMC personnel understand the role of the CCO and an open line of communication be maintained between the CCO and HMC personnel.

### III. EMPLOYEE RESPONSIBILITY

A. Employees of HMC shall have the following responsibility with respect to this Program:

1. To report to HMC as truthfully and factually as possible violations of the law, regulations or guidelines occurring with HMC or involving HMC's assets, or any violations of this Program.
2. To obtain clarification of any questions the employees may have with their job duties, laws, regulations, guidelines or this Program.
3. To submit to the appropriate agency in writing any question which cannot be resolved internally regarding billing, coding, documentation or reimbursement matters. The documentation shall include dates, specific facts, names, etc., which are necessary to resolve the issue.
4. To cooperate fully with the Board and the CCO in their efforts to implement and maintain the Program.
5. To cooperate fully in any investigations or audits conducted in connection with this Program.

### IV. REPORTING MECHANISMS

A. A Hospital Representative shall report, in good faith, their belief of violations regarding the Program or applicable laws, or seek guidance regarding any questions he or she may have with regard to the Program or the carrying out of their job duties.

1. A reporting order, as listed below, shall be used in the attempt to successfully resolve issues during an internal investigative process. If using the order of reporting is not appropriate or the issue is not addressed satisfactorily at a particular level, the next level of contact can be initiated.
  - a. Contact the CCO or department supervisor to determine whether or not a compliance issue exists. If it is determined to be a compliance issue, the CCO should be promptly notified (see contact information below). A private meeting can be requested with the CCO.

- a. If the supervisor believes the violation involves the conduct of the CCO, the question or concern shall be delivered immediately to the Chief Executive Officer.
  - ii. If the complaint involves the reporting employee's supervisor, the employee should relay the issue to the CCO.
- b. Mail the written question/concern to:

Andie Halley, CCO  
Hopedale Medical Complex  
107 Tremont Street  
P. O. Box 267  
Hopedale, IL 61747

#### B. Retaliation

1. Any threat of retaliation against a person, who acts pursuant to their responsibilities under the Program, is in violation of the HMC employee handbook, and in some instances, may be a violation of the federal "whistleblower" laws. Retaliation, if proven, shall be subject to appropriate discipline.
2. Employees who report potential compliance issues in good faith shall not be retaliated against. However, employees who intentionally or through gross disregard for the facts, file false or misleading claims against another person shall be subject to disciplinary action, up to and including possible termination from employment. In addition, employees who voluntarily report acts of misconduct or violations they have committed shall not be immune from disciplinary but such voluntary reporting shall be a consideration in any disciplinary action taken.

#### C. False Report

1. Any attempt or act to harm or slander another through false accusations, malicious rumors or other irresponsible actions is a

violation of the HMC employee handbook. Such attempts, if proven, shall be subject to discipline up to and including possible termination.

D. Confidentiality

1. HMC, at the request of an employee making a report, shall provide such anonymity to the employee to the greatest extent possible under the circumstances provided such confidentiality is, in the judgment of the CCO, consistent with HMC's obligation to investigate employee concerns and take necessary corrective action. However, HMC cannot provide any assurances of anonymity if an external investigation is performed or when the law mandated reporting (e.g. child or elder abuse.)

**PROGRAM EVALUATION TECHNIQUES: AUDITING AND MONITORING**

I. PURPOSE

- A. An ongoing evaluation process to detect areas of potential non-compliance and improve the quality of the work product is critical to the success of HMC's Program.

II. RISK ASSESSMENT

- A. A Risk Assessment shall be conducted by the CCO on an annual basis to identify and prioritize those areas the CCC will consider for auditing and monitoring.

1. Risk Assessments will include general compliance as well as HIPAA Privacy/Security assessments.

B. Responsibility

1. The Risk Assessment shall be conducted collectively by members of the CCC and may utilize resources such as:
  - a. OIG's annual Work Plan;
  - b. OIG's model compliance guidance;
  - c. OIG's Supplemental Compliance Guidances for Hospitals, Ambulance Services, SNF's, and others as appropriate.

- d. OIG Advisory Opinions.
- e. National and Local Coverage Determinations.
- f. National fraud cases and initiatives;
- g. Other pertinent information in conducting the Risk Assessment.

### III. WORK PLAN

A. The Work Plan shall identify a list of prioritized items chosen from the Risk Assessment and include the following elements:

- 1. Name of auditing/monitoring project.
- 2. Assignment of project leader.
- 3. Description of the project to be studied.
- 4. Reporting requirements.
- 5. Projected start and completion dates.

B. Periodic Testing & Monitoring

- 1. HMC shall conduct the following testing and monitoring processes in connection with, but not limited to, the areas identified in the Work Plan.

C. External Program Review

- 1. On a periodic basis, the CCC shall consider retaining an experienced independent firm to review HMC's Compliance Program to determine whether the seven elements of an effective compliance program have been satisfied. The independent review shall include, but is not limited to a review of:
  - a. General Program;
  - b. Code;
  - c. Policies and procedures;
  - d. Records and reports, which are required to be maintained in accordance with the provisions of the Program;
  - e. Training and education processes;

- f. Dissemination of the Program to employees, physicians and independent contractors;
- g. Evaluation of the communication of complaints or violations and review of disciplinary actions taken in connection with the Program.

#### D. External Communications

1. Correspondence relating to audits, denials, surveys, complaints, investigations or inquiries from an agency administering a healthcare program shall be immediately copied and directed to the CCO (or designee) and the COO.
2. Upon review of the correspondence by the CCO or designee and the COO, the CCO with various CCC members as needed, shall determine the appropriate action or response to the correspondence.
3. The CCO and CCC may consider ongoing monitoring of certain risk areas identified in the above correspondences or the annual Risk Assessment. The ongoing monitoring procedures may include the use of benchmarking, ratio analysis, and other statistical measures to determine HMC's compliance with or risk associated with the risk area.

#### E. Investigations and Corrective Action

1. If an audit discloses potential violations or misconduct, the procedures outlined in this Program shall be followed. In addition, the CCO shall, with assistance of the CCC, ensure that policies and procedures are updated and additional training is provided where necessary to prevent continued non-compliance. The COO will be notified in writing by the CCO in writing when such corrective action is recommended or taken by the CCC.

#### F. Auditing/Monitoring Record Retention

1. HMC shall maintain documentation supporting the testing, monitoring and auditing of risk areas. The documentation shall include copies of the records reviewed, results of the review and any corrective action taken. The records shall be maintained in accordance with HMC's Corporate Record Retention policy.

## RESPONSE TO ALLEGATIONS OF IMPROPER/ILLEGAL ACTIVITIES

Upon receipt of audit results, reports or complaints suggesting possible non-compliance with laws, regulations, or guidelines, the CCO or designee shall follow the investigation policies and procedures set forth below.

### I. PURPOSE OF INVESTIGATION

- A. To identify those situations in which the laws, regulations or guidelines may not have been followed.
- B. To identify individuals who may have knowingly, willfully or inadvertently (but should have known) caused medical claims to be submitted or processed in a manner which violates applicable laws, rules or guidelines.
- C. To facilitate the correction of any practices not in compliance with the applicable laws, regulations or guidelines.
- D. To implement those procedures necessary to ensure future compliance.
- E. To protect and preserve HMC and its assets from, or in the event of, civil or criminal enforcement actions.

### II. CONTROL OF INVESTIGATIONS

- A. The CCO shall be responsible for directing the investigation of the alleged problem or incident.
  - 1. If the CCO is involved in the allegation directly through the performance of his/her own misconduct, HMC's CEO shall direct the investigation and temporarily withdraw the CCO from this role.
  - 2. If the CCO is not under investigation for wrongdoing but, for example, has a conflict of interest associated with the case, he/she may maintain oversight of the incident but not be directly involved in the investigation process.

- B. At the discretion of the CCO, the information or report received may be forwarded to legal counsel who may assist in the investigation of the alleged problem or incident.
- C. In conducting the investigation, the CCO or legal counsel may request the support of HMC staff, external counsel and auditors, consultants and other external resources with the technical expertise or knowledge to assist with the specific problem or incident.

### III. INVESTIGATIVE PROCESS

A. The following basic, non-inclusive investigation elements shall be initiated and documented.

#### B. Investigation Timing

1. The investigation of complaints shall be initiated within two business days of when the issue is reported to the CCO. Report of violations shall be taken seriously and follow-up with the reporting individual/entity will take place as soon as possible, but not later than 30 days after the report has been submitted.

#### C. Interviews

1. Interviewed of the persons who may have knowledge of the alleged issue and a review of the applicable laws and regulations that might be relevant to, or provide guidance with respect to, the appropriateness of the activity in question, are essential in determining whether or not a problem actually exists.
2. The purpose of interviewing the person(s) who appeared to play a role in the issue shall be to determine the facts related to the alleged problem or incident as opposed to making judgments and may include the following steps:
  - a. Understanding of the applicable laws, regulations or guidelines of the person or persons involved in the situation;
  - b. Identification of persons with supervisory or managerial responsibility in the process;

- c. Determining whether individuals are adequately trained to perform the process functions;
- d. Determining the extent to which any person knowingly or with reckless disregard or intentional indifference acted contrary to the applicable laws, regulations or guidelines.

#### D. Documentation Review

- 1. A review of representative documentation to determine the nature, duration, and potential magnitude of the problem. Examples of such documentation include:
  - a. Bills or claims submitted to or under the Medicare, Medicaid, other federal or state program or private health care program or contract.
  - b. Relevant contracts, cost reports, invoices, ledgers and other documents.

#### E. Conclusions

- 1. If the review results in conclusions or findings that the conduct is permitted under applicable laws, regulations or guidelines or that the alleged problem or incident did not occur, the investigation shall be closed.
  - a. An investigation demonstrating proper conduct took place must still be documented in the event subsequent details arise proving otherwise.
- 2. If the investigation concludes that there are improper practices occurring, that practices are occurring which are contrary to applicable law, regulations or guidelines or that inaccurate claims are being submitted, corrective action shall be taken in accordance with HMC's disciplinary policy.

#### F. Follow-Up

- 1. If the identity of the person or persons filing the complaint is known, the CCO shall, within 7 days of initiating an investigation, report to that person or persons that an investigation has been started. Upon

conclusion of the investigation, if appropriate, the corrective action that is taken may also be communicated to the reporting individual. There shall be no delay in taking corrective action without the COO written consent.

#### G. Preparation of a Summary Report

1. This report shall include:
  - a. Date and time of the report;
  - b. Date and time of the incident prompting an investigation;
  - c. A description of the incident;
  - d. A summary of the investigation process and positive or negative findings;
  - e. Identification of any person whom the investigator believes to have either acted deliberately or with reckless disregard or intentional indifference toward the applicable laws, regulations or guidelines;
  - f. Estimates, if possible, of the nature and extent of the resulting overpayment by the government, if any, or other damages;
  - g. Personnel sanctions or corrective actions implemented.

### CORRECTIVE ACTION

If, upon conclusion of an investigation, it appears that there are genuine compliance concerns, the CCO shall immediately formulate and implement a corrective action plan with the consent of the CCC and the COO. The CEO shall review a copy of said plan for comment before final adoption. The corrective action plan shall be designed to ensure that the specific issue is addressed and, to the extent possible, that similar problems do not occur in other departments or areas. The procedure for undertaking corrective action shall include, but need not be limited to, the following:

#### I. POSSIBLE CRIMINAL ACTIVITY

- A. If the investigation uncovers what appears to be criminal activity on the part of any employee or other party, HMC shall:
  1. Notify legal counsel, COO, CEO and the Chairman of the Governing Board.

2. Immediately suspend the activities related to the problem until such time as the offending practices are corrected.
3. Initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or with reckless disregard. Appropriate disciplinary action shall include, at a minimum, the removal of the person from any position with oversight for or involvement with the process and may include, in addition, reprimand, suspension, demotion or discharge.
4. Notify the appropriate law enforcement or regulatory authorities with the advice of legal counsel no later than 60 days after credible evidence has been obtained to confirm that a violation has occurred.
5. Modify the applicable policies and procedures.
6. Undertake an appropriate program of education to prevent similar noncompliance in the future.
7. Take any other action deemed appropriate under the circumstances.
8. Document actions taken and maintain documentation in accordance with HMC's policy, Corporate Record Retention.

## II. OTHER COMPLIANCE VIOLATIONS

If the investigation reveals a compliance concern, which does not appear to be the result of conduct that is intentional, willfully indifferent or with reckless disregard, HMC shall undertake the following steps.

### A. Improper Payments

1. If the concern results in duplicate payments by Medicare, Medicaid, other federal or state health care programs or private health care programs or contracts, coding or claims submission errors, payments for non-covered services or for services not rendered or provided other than as claimed or any other type of overpayment resulting from billing or payment errors, HMC shall:
  - a. Stop billing or conducting other activities, which are problematic until such time as the offending practice is corrected;

- b. Determine in consultation with legal counsel , COO and CFO, the need to calculate and repay the overpayments to the appropriate Fiscal Intermediary, Carrier or other payers;
- c. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, suspension, demotion or discharge;
- d. Promptly undertake an appropriate program of education to prevent future similar problems;
- e. Modify the applicable policies and procedures;
- f. Document actions taken and maintain documentation in accordance with HMC's Corporate Record Retention policy.

#### B. No Improper Payment

- 1. In the event the compliance concern does not result in an improper payment by Medicare, Medicaid, and other federal or state healthcare programs or a private healthcare Program or contract, HMC shall:
  - a. Correct the defective practice or procedure as quickly as possible by finding the real problem and resolving it with the proper solution;
  - b. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action shall be consistent with HMC guidelines;
  - c. Promptly undertake an appropriate program of education to prevent future similar problems;
  - d. Document actions taken and maintain documentation in accordance with HMC's policy, Corporate Record Retention.

### III. FUTURE ACTIONS

- A. Any issue for which a corrective action program is implemented shall be specifically targeted for monitoring and review in future audits of the affected department or area.
- B. The CCO shall regularly report, but not less than annually, to the Governing Board on the nature of any investigations that have been conducted, the findings, the corrective actions and the repayment, if applicable, of funds to Federal, State or other agencies.

### **ENFORCING STANDARDS THROUGH WELL PUBLICIZED DISCIPLINARY GUIDELINES**

Hospital Representatives who have failed to comply with HMC's Program, Code, policies and procedures, laws, regulations or guidelines or who have otherwise engaged in wrongdoing that has the potential of impairing HMC's status as a reliable, honest and trustworthy healthcare provider, shall also be subject to disciplinary action. Disciplinary action can involve up to and including termination of employment or termination of a contractual relationship with non-employed personnel or entities.

#### **I. PERSONS INVOLVED IN IMPROPER ACTIVITIES**

- A. Any employee, Board member, physician, independent contractor or covered person who violates the Program, the Code, HMC policies and procedures, laws, regulations or guidelines shall be appropriately disciplined or the contractual relationship terminated as outlined in HMC's personnel or other policies.
- B. Violations include the failure to report suspected improper activity. Disciplinary action may range from a warning to termination and may include mandatory training. Any disciplinary action shall be appropriately documented in the employee's personnel file, along with a statement of the reasons for imposing the discipline.

#### **II. PERSONS FAILING TO DETECT IMPROPER ACTIVITIES**

- A. Any Hospital Representative who fails to detect violations of the Program, the Code or laws, regulations or guidelines that should have been detected by a reasonable person shall be appropriately disciplined as provided by HMC's personnel or other policies.

### III. MANAGEMENT RESPONSIBLE FOR DISCIPLINE

- A. Human Resources personnel, in consultation with the CCO and the COO, shall establish procedures for the discipline of employees for violations of the Program, Code, policies and procedures, laws, regulations or guidelines.
- B. The CCO and CEO shall establish procedures for disciplinary actions for board members, physicians, independent contractors and covered persons for violations of the Program, Code, policies and procedures, laws, regulations or guidelines.
- C. All disciplinary action shall be taken on a fair and equitable basis and be applied in a consistent manner to these individuals.

### IV. DISCIPLINE RECORD RETENTION

- A. HMC shall maintain records documenting the enforcement of disciplinary standards in accordance with HMC's policy, Corporate Record Retention.

### V. BACKGROUND AND EXCLUSION LIST (BACKGROUND) CHECKS

- A. HMC shall conduct a reasonable and prudent background investigation as part of every employment application. In addition, HMC shall conduct a background investigation of physicians, independent contractors and covered persons providing direct patient care.
  - 1. HMC's background investigation shall vary depending on the individual mentioned above and/or job responsibilities, but a minimum, shall include:
    - a. A reference check;
    - b. An inquiry of the OIG's list of excluded individuals/entities;
    - c. An inquiry of the General Services Administration (GSA) excluded parties list system;
    - d. A criminal background check.
    - e. If the applicant is a physician or mid-level provider, HMC will perform an inquiry of the National Practitioners' Databank.
  - 2. HMC has the discretion to expand its background investigation as deemed necessary.

3. HMC's employment application specifically requires the applicant to disclose any criminal conviction, as defined by 42 U.S.C. 1320a-7(i) or exclusion action. Pursuant to HMC policies, HMC prohibits the employment of individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as debarred, excluded or otherwise ineligible for participation in federal health care programs (as defined in 42 U.S.C. 1320a-7b(f)).
4. In addition, pending the resolution of any criminal charges or proposed debarment or exclusion, such Hospital Representatives shall be removed from direct responsibility for or involvement in any Federal healthcare program. If resolution of the matter results in conviction, debarment or exclusion, HMC shall terminate its employment or other contractual arrangement with the individuals, board members, physicians, independent contractors or covered persons.
5. HMC shall conduct regular reviews of the OIG's list of excluded individuals/entities and the GSA's excluded list to check if existing employees have been added to the list.

## RECORD KEEPING AND RETENTION

### I. PURPOSE

- A. The purpose of the policy, Corporate Record Retention is to provide guidelines as to the creation, maintenance, retention and destruction of documents, and to establish a mechanism for periodic review of the retention periods and of HMC's compliance with the requirements of this policy and of applicable document retention periods specified by law or regulation.

### II. RECORDKEEPING

- A. All reports of compliance concerns, regardless of their origination, will be documented and maintained by the CCO.
  1. If the employee or other person was seeking information regarding the Code or some other matter such as their job duties, the CCO shall record the nature of the call or report and the information requested and shall respond to the employee as soon as possible, but not later than two business days, if their name is known.

2. HMC shall maintain documentation supporting the testing, monitoring and auditing of risk areas. The documentation shall include copies of the records reviewed, results of the review and any corrective action taken. The records shall be maintained in accordance with HMC's policy, Corporate Record Retention.
- B. Minutes of all Compliance Committee meetings shall be recorded by an appointed person and maintained by the CCO in accordance with HMC's Corporate Record Retention policy.

### III. RETENTION

- A. HMC shall follow record retention requirements required by applicable laws, regulations and contractual agreements. It is expressly prohibited to alter documents to deceive another person or entity, to conceal information to distort the truth, to destroy records to hide the facts or to obstruct an investigation in any way by tampering with HMC's records.

### IV. REPORTS TO THE BOARD

#### A. Frequency

1. The CCO shall report to the Governing Board regarding any ongoing compliance activities of HMC at each Governing Boarding meeting

#### B. Content

1. The CCO shall prepare written reports summarizing the compliance activities of HMC with a focus on the highest risk areas relevant to the seven elements of an effective compliance program. The reports may include summaries of HMC's activities regarding the Program's Risk Assessment, Work Plan, education and training, auditing and monitoring, violations, disciplinary actions and other compliance information pertinent to the Board.
2. The full Governing Board report may contain summaries of the reports to the Corporate Compliance Committee.

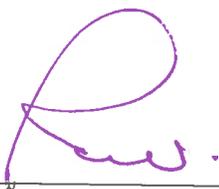
3. Where there is no activity, it shall be noted in the CCC meeting minutes.
4. The retention of these reports shall follow HMC's policy, Corporate Record Retention.

The signatures below represent an acceptance of the Corporate Compliance Program.

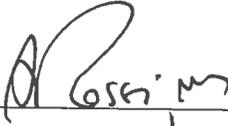
Date: 11/7/17

Administrator President/COO Approval: \_\_\_\_\_ 

Date: 11/9/17

Medical Director Approval (if applicable): \_\_\_\_\_ 

Date: 11-8-17

Governing Board Approval: \_\_\_\_\_ 

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