

**Sequoyah County – City of Sallisaw Hospital Authority
d/b/a Sequoyah Memorial Hospital**

Corporate Compliance Program

Revised April 2009

**Sequoyah County – City of Sallisaw Hospital Authority
d/b/a Sequoyah Memorial Hospital**

Corporate Compliance Program

Revised April 2009

Contents

Section I: Purpose

2

Section II: Standards of Conduct

2

Section III: Compliance Officer and Committee

A. Appointment of a Compliance Officer

3

B. Duties of the Compliance Officer

3

C. Appointment of a Compliance Committee

4

Section IV: Training and Education

5

Section V: Developing Effective Lines of Communication

A. Access to the Compliance Officer

6

Section VI: Auditing and Monitoring

8

Section VII: Investigations of Potential Noncompliance

10

Section VIII: Hospital Response

11

**Section IX: Enforcing Standards through Well Publicized
Disciplinary Guidelines**

13

Section X: Reports to the Board of Directors

15

Section XI: Record Retention

15

Section I: Purpose

The purpose of Sequoyah County - City of Sallisaw Hospital Authority d/b/a Sequoyah Memorial Hospital's (the Hospital) Corporate Compliance Program (Program) is to provide a framework for acceptable business practices to be conducted in conformity with applicable laws and regulations in connection with conducting the business of the Hospital. The Program will be the foundation for conducting business in an honest and ethical manner and establishing a culture within the Hospital that promotes prevention, detection and resolution of conduct that does not conform to the applicable laws, regulations and guidelines applicable to the Hospital.

It is the Hospital's intent to follow the applicable laws, regulations and guidelines in connection with conducting Hospital business. The Hospital places particular emphasis on the health care laws, regulations and guidelines governing health care programs as prescribed by the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG) and other regulatory authorities. A health care program is defined as any governmental, commercial, private or other payer that reimburses the Hospital for services provided to its patients.

In addition to fulfilling a legal duty to follow the applicable laws, regulations and guidelines, the Program will assist the Hospital to meet its mission to patients and the community. Other important intended goals of the Program are to:

Demonstrate the Hospital's commitment to honest and ethical conduct;

Provide expectations of employees, board members, physicians, independent contractors (independent contractors are defined as individuals or companies providing direct patient care or impacting claim submission and/or payments) and covered persons (covered persons are defined as members of the auxiliary, volunteers and students of health care professions) regarding their behavior relating to conducting business as a representative of the Hospital;

Identify, prevent, detect and resolve conduct that is not in conformity with Hospital policies and procedures or applicable laws, regulations and guidelines;

Educate employees, board members, physicians, independent contractors and covered persons on the Hospital's compliance program; and

Minimize any loss to the Hospital from failure to follow the applicable laws, regulations or guidelines.

The Hospital recognizes that an effective compliance program is a sound investment and that the implementation of a compliance program may not entirely eliminate fraud, abuse and waste from the Hospital. However, the Hospital believes that a sincere effort to comply with the applicable laws, regulations and guidelines through the establishment of an effective compliance program, significantly reduces the risk of unlawful or improper conduct.

The Hospital shall review the contents of the Program on an annual basis. The Board of Directors shall approve any revisions to the Program.

Section II: Standards of Conduct

As part of the Program, the Hospital has developed Standards of Conduct that describe the Hospital's commitment to conducting its business in accordance with the laws, regulations and guidelines in connection with conducting Hospital business. The Standards of Conduct apply to all employees, board members, physicians, independent contractors and covered persons.

The Standards of Conduct, or applicable portions, will be distributed to all employees, board members, physicians, independent contractors and covered persons. (When necessary, the Standards of Conduct will be translated into other languages and written at appropriate reading levels.) The Standards of Conduct will be reviewed on an annual basis.

Section III: Compliance Officer and Committee

A. Appointment of a Compliance Officer

The Program shall be directed by a Compliance Officer. The Compliance Officer shall be appointed by the Chief Executive Officer (CEO) and approved by the Board of Directors of the Hospital and shall serve at its discretion. The Compliance Officer shall be a high level official of the Hospital. The Compliance Officer shall report directly to the CEO and Board of Directors. Any change in the person responsible for administering this Program shall be approved by the Board of Directors.

B. Duties of the Compliance Officer

The Compliance Officer's duties shall include the following:

Oversee and monitor the Hospital's compliance activities.

Meet periodically with the Compliance Committee and report to the Board of Directors at least semi-annually on the activities of the Program.

Oversee that the Program has been properly implemented and that revisions are made as appropriate.

Periodically review the Compliance Program document, Standards of Conduct and compliance policies and recommend revisions as necessary to meet changes in the Hospital's business and regulatory environment.

Coordinate compliance training and related educational activities for the Hospital.

Coordinate the review and updating of compliance education or training materials to reflect current laws, regulations and guidelines applicable to Hospital business.

Coordinate auditing and monitoring of activities within the scope of the Compliance Program.

Coordinate compliance activities in departments on a periodic basis and review the results of the compliance activities.

Ensure that the Program and Standards of Conduct have been effectively communicated to present and new employees of the Hospital.

Ensure that the Program and Standards of Conduct have been effectively communicated to physicians, independent contractors and covered persons through contractual agreements or by delivering a copy of the Program and Standards of Conduct to them.

Receive and coordinate investigations of reports of possible illegal conduct or other conduct that violates the Program, Standards of Conduct, compliance policies and procedures, laws, regulations or guidelines applicable to Hospital business.

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, Standards of Conduct, compliance policies or procedures, laws, regulations or guidelines applicable to Hospital business.

Notify the appropriate law enforcement agency of possible illegal misconduct, when required, and work with the agency through the investigative and corrective action processes.

Act as the Chair of the Compliance Committee for this Program.

C. Appointment of a Compliance Committee

The Compliance Officer shall appoint a Compliance Committee comprised of selected employees from various departments of the Hospital.

The Compliance Committee (Committee) members shall assist the Compliance Officer in the design, implementation and ongoing review of the Program. Committee members may participate in reviews or audits of department activities and assist in developing specific standards of conduct and compliance policies and procedures. In connection with the Compliance Officer, the Committee members shall coordinate compliance training, relay compliance related communications and monitor compliance efforts in their department or other departments as requested. The Committee members shall report to, and coordinate with, the Compliance Officer with respect to compliance related activities in their department and other departments as requested. The Compliance Officer and Committee shall be responsible to work with the managers and supervisors from other departments to ensure their participation in and compliance with the Program.

To assure proper coordination of the compliance effort, the Compliance Committee shall meet periodically to discuss, review and resolve compliance issues in coordination with the Compliance Officer. The Compliance Committee's functions shall include, but not be limited to:

Analyze business and legal requirements with which the Hospital must comply.

Assess policies and procedures to determine their adequacy in meeting the Hospital's objectives.

Participate in periodic risk assessments and reviews of audit results.

Participate in developing standards of conduct, policies and procedures and recommend and monitor the development of internal systems and controls to promote compliance.

Assist in developing work programs to address potential compliance issues uncovered in the course of conducting risk assessments or audits.

Participation in the determination of the appropriate approach/strategy to promote compliance with the Program and detection of any potential violation.

Participate in the maintenance of a system to solicit, evaluate and respond to complaints and problems.

Perform such special projects as requested by the Compliance Officer.

Section IV: Training and Education

The proper education and training of employees, board members, physicians, independent contractors and covered persons is a significant element of an effective compliance program. The Hospital shall require employees, board members, physicians and covered persons to attend compliance training on an annual basis so they have a clear understanding of their responsibilities and rights under the Program. Independent contractors may be required to attend compliance training on an annual basis if required by the contract and there are no other provisions for compliance training described in the contract that act as an equivalent to the annual training. The training and education shall emphasize the Hospital's commitment to compliance with laws, regulations and guidelines applicable to Hospital business.

It is not necessary; however, that every employee, board member, physician, independent contractor or covered persons be educated concerning every aspect of the Program. The Compliance Officer shall determine, in cooperation with the Compliance Committee, the materials and the training that each classification of employee, board member, physician, independent contractor or covered person shall receive.

Employees, physicians, independent contractors or covered persons shall receive a copy of the Standards of Conduct and relevant portions of the Program (compliance materials). The Compliance Officer or a designee shall ensure that each employee signs a statement acknowledging receipt of the compliance materials and affirming their intention to abide by the Program.

The Compliance Officer or designee shall promptly respond to any questions of employees, physicians, independent contractors or covered persons regarding the Program.

A. Specific Training and Education

Employees, physicians, independent contractors or covered persons may be required to attend specific training and education. Specific training and education may be focused on emerging issues, department or job specific functions. The Compliance Officer may use different forms of training and education, including the distribution of compliance articles or periodicals, requesting attendance at seminars, live or videotaped presentations or more detailed written materials. Such training may be conducted by in-house personnel or outside experts.

B. Government Compliance Alerts and Guidance

The OIG and other government agencies periodically publish fraud and abuse alerts, interpretations and compliance guidance regulations. The Compliance Officer, or a designee, may distribute copies of this material to the Compliance Committee and other employees, physicians, independent contractors or covered persons as deemed appropriate. Of particular importance, are the compliance guidance regulations that are published by the OIG, which includes the Hospital model compliance guidance and other model compliance guidance for other services.

In identifying potential risk areas and developing or revising compliance policies and procedures to strengthen controls over these areas, the Compliance Officer, or a designee, shall provide that employees, physicians, independent contractors or covered persons receive the Centers for Medicare and Medicaid Services (CMS), Medicare Administrative Contractors 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

Education and training is part of the Hospital's competency assessment program. The Compliance Officer, or designee, shall enlist the assistance of the appropriate persons for conducting education and training relating to compliance matters. With the input of the affected departments, the Compliance Officer, designee and appropriate persons shall develop an appropriate education competency assessment for employees, physicians, independent contractors or covered persons. An employee's competency shall be evaluated in orientation and throughout employment. A physician, independent contractor or covered person's competency shall be evaluated by the appropriate oversight body, department or in accordance with the contractual agreement. Documentation of the competency validation shall be retained by the Hospital's human resources department or other oversight body or affected department in accordance with its record retention program.

D. New Employee, Physician, Independent Contractor or Covered Persons Orientation

During orientation, new employees, physicians, independent contractors or covered persons shall receive the compliance materials relative to their job duties as a part of their orientation.

E. Attendance

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 the Hospital's disciplinary policies, including possible termination.

G. Training and Education Materials Retention

The Hospital shall maintain adequate records of its training and education programs for its employees, physicians, independent contractors or covered persons, including attendance logs and copies of the materials distributed or covered at the training and education sessions.

Section V: Developing Effective Lines of Communication

A. Access to the Compliance Officer

An open line of communication between the Compliance Officer and Hospital employees, physicians, independent contractors or covered persons is essential to the success of the Hospital's Program.

1. Employee, Physician, Independent Contractors and Covered Person's Responsibility

Employees, physicians, independent contractors or covered persons of the Hospital shall have the following responsibility with respect to this Program:

To report to the Hospital as truthfully and factually as possible violations of the law, regulations, guidelines or Program occurring within the Hospital or involving the Hospital's assets.

To obtain clarification of any questions they may have with their job duties, laws, regulations, guidelines or Program.

For questions that cannot be resolved internally, and with the guidance of the Compliance Officer and others, to submit to the appropriate agency in writing requesting clarification of any question involving billing, coding, documentation or reimbursement matters. The documentation to be maintained from this process shall include dates, specific facts, names, etc., which are necessary to resolve the question.

To cooperate fully with the Board of Directors and the Compliance Officer in their efforts to implement and maintain the Program.

To cooperate fully in any investigations or audits conducted in connection with this Program.

2. Reporting Mechanisms

An employee, board member, physician, independent contractor or covered person shall report in good faith their belief of violations of the Program or applicable laws, or seek guidance regarding any questions they may have with regard to the Program or the carrying out of their job duties, as follows:

By contacting the employees, physicians, independent contractors or covered person's supervisor to determine if it is a compliance issue or not. If it is determined that it is a compliance issue, the Compliance Officer should be promptly notified. If the complaint involves the employee's supervisor, the employee should report the issue to the Compliance Officer.

By calling the Compliance Officer, Beth Fair Medical Imaging Director .

By requesting a private meeting with the Compliance Officer.

By mailing the written question/concern to:

Sequoyah Memorial Hospital
Corporate Compliance Officer
PO Box 505
Sallisaw, OK 74955-0505

By calling the compliance hotline at 918-775-1601. The hotline number shall be posted on bulletin boards throughout the Hospital. Such calls may be made anonymously. The hotline shall be checked daily Monday through Friday, except for holidays.

The investigation of reported complaints shall be initiated within two business days. Reported complaints shall be taken seriously and shall be responded to as soon as possible, but not later than 60 days after the reported complaint.

A log will be maintained by the Compliance Officer of all complaints reported in person, through the mail or received on the hotline.

3. Questions or Concerns

Upon receipt of a question or concern about a compliance related issue, the employees, physicians, independent contractors or covered persons supervisor or the department manager shall promptly deliver a report of the question or concern to the Compliance Officer. However, if the supervisor or the department manager believes that the question or concern involves an allegation of a violation

of the law, regulations, guidelines or the Program by the Compliance Officer, the question or concern shall be delivered immediately to the CEO.

4. Record-Keeping

A record shall be made of each report received by the Compliance Officer on a form prepared for this purpose. The Compliance Officer shall record information pertaining to the report, which is necessary to conduct an appropriate investigation. This information shall include pertinent details relating to the reported incident, including the time and date, person or persons involved in the incident, description of the incident, results of the investigation and final disposition of the complaint or inquiry. If the employee or other person was seeking information regarding the Standards of Conduct or some other matter such as their job duties, the Compliance Officer 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.

5. Retaliation

Any threat of retaliation against an employee, physician, independent contractor or covered person, who acts pursuant to their responsibilities under the Program, is not only against Hospital policy, but also in some instances, may be a violation of the law. Retaliation, if proven, shall be subject to appropriate discipline. Employees, physicians, independent contractors or covered persons who report potential compliance issues in good faith shall not be retaliated against. However, employees, physicians, independent contractors or covered persons who file false or misleading claims shall be subject to disciplinary action. In addition, employees, physicians, independent contractors or covered persons who report acts of misconduct or violations they have committed shall not be immune from disciplinary action.

6. False Report

Any attempt by an employee, physician, independent contractor or covered person to harm or slander another employee, physician, independent contractor or covered person through false accusations, malicious rumors or other irresponsible actions is a violation of Hospital policy. Such attempts, if proven, shall be subject to discipline.

7. Confidentiality

The Hospital, at the request of an employee, physician, independent contractor or covered person making a report, shall provide such anonymity to the employee, physician, independent contractor or covered person as is possible under the circumstances provided such confidentiality is, in the judgment of the Compliance Officer, consistent with the Hospital's obligation to investigate the concerns and take necessary corrective action. However, the Hospital cannot provide any assurances of anonymity if an external investigation is performed.

Section VI: Auditing and Monitoring

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 the Hospital's Program.

To identify the areas the Hospital will consider to audit or monitor, the Hospital shall conduct a risk assessment on an annual basis. The risk assessment shall be conducted by the Compliance Officer or designee and may consider such resources as the OIG's annual Work Program, OIG's model compliance guidance and supplemental compliance guidance for hospitals, OIG advisory opinions, national and local coverage determinations, national fraud cases and initiatives and other pertinent information in conducting the risk assessment. The risk assessment shall be conducted with members of the Compliance Committee and other appropriate personnel as determined by the Compliance Officer.

At the conclusion of the risk assessment, the Hospital shall develop a Work Plan that it shall follow during the course of the next twelve months to monitor its progress in completing the items identified in the risk assessment.

The Hospital shall conduct the following testing and monitoring process in connection with, but not limited to, the areas identified in the Work Plan:

A. Periodic Testing and Monitoring

The Hospital shall have an annual financial audit conducted by an independent public accounting firm.

The Hospital shall schedule periodic testing or monitoring of targeted risk areas to determine if it is in compliance with the procedures and standards of conduct established in this Program. Such testing shall be coordinated by the Compliance Officer or a designee. Such testing shall be either conducted by in-house personnel or by outside auditors or consultants. The Compliance Officer shall consult with the CEO to determine if legal counsel or outside auditors are needed to assist with the project and if it should be conducted under attorney client privilege.

Testing Techniques

The Compliance Officer, staff or external auditors shall consider techniques such as the following:

Interviews of employees, physicians, independent contractors or covered persons involved in management, operations, billing and other related activities

Reviews of written policies and procedures prepared by the different departments of the Hospital

Analytical or comparative reviews

Examinations of supporting documents and records

Surveys or questionnaires of employees, physicians, independent contractors or covered persons

C. Annual Review

On an annual basis, the Compliance Officer and others, as identified by the Compliance Officer and Committee, shall review the Hospital's Compliance Program to determine whether the seven elements of an effective compliance program have been satisfied. Every third year, the Compliance Officer, with the approval of the CEO and Board of Directors, shall retain an independent firm to review the Compliance Program. The independent review shall include, but is not limited to, reviewing the compliance program and standards of conduct, reviewing records and reports, which are required to be maintained in accordance with the provisions of the Program, reviewing training and education processes, dissemination of the Program to employees, physicians, independent contractors and covered persons, evaluating the communication of complaints or violations and review of disciplinary actions taken in connection with the Program.

D. Other Monitoring

Correspondence relating to audits, denials, surveys, complaints, investigations or inquiries from an agency administering a health care program shall be directed to the Compliance Officer or designee. Upon review of the correspondence by the Compliance Officer or designee and the appropriate Hospital personnel, the Compliance Officer shall determine the appropriate action or response to the correspondence.

The Compliance Officer and Committee may consider ongoing monitoring of certain risk areas identified in the Hospital's annual risk assessment. The ongoing monitoring procedures may include the use of benchmarking, ratio analysis, and other statistical measures to determine the Hospital's compliance with or risk associated with the risk area.

E. Investigations and Corrective Action

If an audit discloses potential violations or misconduct, the procedures outlined in Sections VIII and IX of this Program shall be followed. In addition, the Compliance Officer shall, with assistance of the Compliance Committee, ensure that policies and procedures are updated and additional training is provided where necessary to prevent continued non-compliance.

Record Retention

The Hospital 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 the Hospital's record retention policy.

Section VII: Investigations of Potential Noncompliance

Upon receipt of audit results, reports or complaints suggesting possible noncompliance with laws, regulations or guidelines, the Hospital shall follow the investigation policies and procedures set forth below:

- A. **Purpose of Investigation.** The purpose of the investigation shall be to identify those situations in which the laws, regulations or guidelines may not have been followed; to identify individuals who may have knowingly or inadvertently caused claims to be submitted or processed in a manner which violates applicable laws, rules or guidelines; to facilitate the correction of any practices not in compliance with the applicable laws, regulations or guidelines; to implement those procedures necessary to ensure future compliance; to protect the Hospital in the event of civil or criminal enforcement actions and to preserve and protect the Hospital's assets.
- B. **Control of Investigations.** The Compliance Officer shall be responsible for directing the investigation of the alleged problem or incident. At the discretion of the Compliance Officer, and through discussions with the CEO, unless it involves the CEO, the information or report received may be forwarded to legal counsel who may assist in the investigation of the alleged problem or incident.

In conducting an investigation, the Compliance Officer or legal counsel may request the support of Hospital staff, other counsel, auditors, consultants or other external resources with the technical expertise or knowledge to assist with the specific problem or incident. This group shall function under the direction of the Compliance Officer or legal counsel and shall be required to submit relevant evidence, notes, findings and conclusions to the Compliance Officer or legal counsel depending upon who is directing the investigation.

- C. **Investigative Process.** The following steps are not all inclusive, but are the basic procedures to be under taken:

Interviews of the employees, physicians, independent contractors or covered persons who may have knowledge of the alleged problem or process 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, to determine whether or not a problem actually exists.

A review of representative documentation, including for example, bills or claims submitted to or under the Medicare, Medicaid, other federal or state program or private health care program or contract, and/or relevant contracts, cost reports, invoices, ledgers and other documents, to determine the nature of the problem, the duration of the problem and the potential financial magnitude of the problem.

Interviews of the employees, physicians, independent contractors or covered persons who appeared to play a role in the process. Interviews shall be to determine the facts related to the alleged problem or incident as opposed to making judgments and may include the following steps:

The understanding of the applicable laws, regulations or guidelines of the employees, physicians, independent contractors or covered persons involved in the situation;

The identification of employees, physicians, independent contractors or covered persons with supervisory or managerial responsibility in the process;

The adequacy of the training of the employees, physicians, independent contractors or covered persons performing the functions within the process; and

The extent of which any employees, physicians, independent contractors or covered persons knowingly or with reckless disregard or intentional indifference acted contrary to the applicable laws, regulations or guidelines.

Preparation of a summary report, which (i) defines the nature of the problem, (ii) summarizes the investigation process, (iii) identifies any employees, physicians, independent contractors or covered persons whom the investigator believes to have either acted deliberately or with reckless disregard or intentional indifference toward the applicable laws, regulations or guidelines and (iv) if possible, estimates the nature and extent of the resulting overpayment by the government, if any.

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.

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 Section VI.

If the identity of the employee, physician, independent contractor or covered person filing the complaint is known, the Compliance Officer shall report to that employee, physician, independent contractor or covered person that an investigation has been completed and, if appropriate, the corrective action that shall be taken.

Section VIII: Hospital Response

If, upon conclusion of an investigation, it appears that there are genuine compliance concerns, the Compliance Officer shall immediately formulate and implement a corrective action program. The corrective action program 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 in the Hospital.

The procedure for undertaking corrective action shall include, but need not be limited to the following:

- A. Possible Criminal Activity.** If the investigation uncovers what appears to be criminal activity on the part of any employee, physician, independent contractor or covered person, the Hospital shall:

Notify CEO, legal counsel and the Chairman of the Board;

Immediately suspend the activities related to the problem until such time as the offending practices are corrected;

Initiate appropriate disciplinary action against the employee, physician, independent contractor, or covered person or employee, physician, independent contractor, or covered person 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 employee, physician, independent contractor or covered person from any position with oversight for or involvement with the process and may include, in addition, reprimand, suspension, demotion or discharge;

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;

Modify the applicable policies and procedures;

Undertake an appropriate program of education to prevent similar noncompliance in the future;

Take any other action deemed appropriate under the circumstances; and

Document actions taken and maintain documentation in accordance with the Hospital's record retention policy.

- B. Other Noncompliance.** 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, the Hospital shall undertake the following steps.

1. **Improper Payments.** If the concern results in improper 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 improper payment resulting from billing or payment errors, the Hospital shall:

Stop billing or conducting other activities, which are problematic until such time as the offending practice is corrected;

Determine in consultation with CEO, legal counsel, and the Chairman of the Board, the need to calculate and repay the overpayments to the appropriate Medicare Administrative Contractor or other payers;

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;

Undertake an appropriate program of education to prevent future similar problems;

Modify the applicable policies and procedures; and

Document actions taken and maintain documentation in accordance with the Hospital's record retention policy.

2. No Improper Payment. In the event the compliance concern does not result in an improper payment by Medicare, Medicaid and other federal or state health care programs or a private health care program or contract, the Hospital shall:

Correct the defective practice or procedure as quickly as possible by finding the problem and resolving it with a proper solution;

Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action shall be consistent with Hospital guidelines;

Undertake an appropriate program of education to prevent future similar problems; and

Document actions taken and maintain documentation in accordance with the Hospital's record retention policy.

3. Future Actions

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. The Compliance Officer shall periodically report to the Board of Directors on the nature of the investigations that have been conducted, the findings, the corrective actions and the repayment, if applicable, of funds to Federal, State or other payers.

Section IX: Enforcing Standards through Well Publicized Disciplinary Guidelines

Employees, board members, physicians, independent contractors and covered persons who have failed to comply with the Hospital's Program, Standards of Conduct, laws, regulations or guidelines shall be disciplined. Employees, board members, physicians, independent contractors and covered persons who have otherwise engaged in wrongdoing that has the potential of impairing the Hospital's status as a reliable, honest and trustworthy health care provider shall also be subject to disciplinary action.

A. Management Responsible for Discipline

Human Resources personnel, in consultation with the Compliance Officer and the CEO, shall establish procedures for the discipline of employees for violations of the Program, Standards of Conduct, laws, regulations or guidelines.

The Compliance Officer and CEO shall establish procedures for disciplinary actions for board members, physicians, independent contractors and covered persons for violations of the Program, Standards of Conduct, laws, regulations or guidelines.

The disciplinary action shall be taken on a fair and equitable basis and be applied in a consistent manner to employees, board members, physicians, independent contractors and covered persons.

B. Persons Involved in Improper Activities

Any employee, board member, physician, independent contractor or covered person who violates the Program, the Standards of Conduct or laws, regulations or guidelines shall be appropriately disciplined as provided by the Hospital's personnel or other policies. 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 such discipline.

C. Persons Failing to Detect Improper Activities

Any employee, board member, physician, independent contractor or covered person who fails to detect violations of the Program, the Standards of Conduct or laws, regulations or guidelines that should have been detected by a reasonable person shall be appropriately disciplined as provided by the Hospital's personnel or other policies.

D. Record Retention

The Hospital shall maintain records documenting the enforcement of disciplinary standards in accordance with the Hospital's record retention policy.

E. Background Checks

For all new employees, the Hospital shall conduct a reasonable and prudent background investigation as part of every employment application. In addition, the Hospital shall conduct a background investigation of physicians, independent contractors and covered persons providing direct patient care.

The Hospital's background investigation shall vary depending on the job responsibilities, but at a minimum, shall include a reference check, an inquiry of the Office of Inspector General's list of excluded individuals/entities, inquiry of the General Services Administration excluded parties list system and a criminal check. If the applicant is a physician or midlevel provider, the Hospital will perform an inquiry of the National Practitioners Databank. The Hospital has the discretion to expand its background investigation as deemed necessary.

The Hospital'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 the Hospital's policies, the Hospital prohibits the employment of individuals who have been recently convicted of a criminal offense related to health care 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)).

In addition, pending the resolution of any criminal charges or proposed debarment or exclusion, such employees, board member, physicians, independent contractors or covered persons shall be removed from direct responsibility for or involvement in any Federal health care program. If resolution of the matter results in conviction, debarment or exclusion, the Hospital shall terminate its employment or other contractual arrangement with the individuals, board members, physicians, independent contractors or covered persons.

The Hospital shall conduct periodic reviews of the Office of Inspector General's list of excluded individuals/entities and the General Services Administration's excluded list during the year to check if existing employees are on the lists.

Section X: Reports to the Board of Directors

The Compliance Officer shall report semiannually to the Board of Directors regarding the compliance activities of the Hospital. The Compliance Officer shall prepare written reports summarizing the compliance activities of the Hospital. The semiannual reports may include summaries of the Hospital's activities regarding the risk assessment, work plan, education and training, auditing and monitoring, disciplinary actions and other compliance information pertinent to the Hospital.

Section XI: Record Retention

The purpose of the record retention policy 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 the Hospital's compliance with the requirements of this policy and of applicable document retention periods specified by law or regulation. The Hospital shall follow the 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 the Hospital's records.