



Hopedale Medical Foundation Hopedale Medical Complex Corporate Compliance Program

Regulatory Governance: US Department of Health and Human Services-Office of the Inspector General (OIG) Guidelines.

PROGRAM OVERVIEW

In recent years, there has been significant concern about “fraud and abuse” in healthcare. Considering this, the Office of Inspector General (OIG) has issued a document entitled “Compliance Program Guidance for Hospitals.”

The OIG has recommended that an effective compliance plan should contain the following seven elements:

1. The development and distribution of written standards of conduct, as well as written policies and procedures that promote the Hospital’s commitment to compliance and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals:
2. The designation of a chief compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body.
3. The development and implementation of regular, effective education and training programs for all affected employees.
4. The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation.
5. The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements.
6. The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and
7. The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

This manual outlines the process HMC will utilize to assure that it follows all the various laws and regulations established by both the Federal government as well as the State of Illinois. This manual is part of an ongoing process; it will be updated and expanded as the Program evolves.



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CODE OF ETHICS

It is the policy of Hopedale Medical Complex that the Corporate Compliance Program is considered as a guideline to be followed by all members of the Board of Directors, medical staff, administrative officers, directors, managers, and employees of this hospital. Hopedale Medical Complex requires that its board members, medical staff, administrative officers, managers, and employees maintain high standards of integrity, and business ethics. The Board of Directors, medical staff, administrative officers, directors, managers, and employees must avoid any actions that are or appear to be inconsistent with such standards.

The Corporate Compliance Program is an on-going process designed to prevent and detect violations of the law, particularly fraud and abuse. If a situation should arise where there is a question about whether a proposed action is following a law, regulation or policy, all individuals associated with HMC should contact the Corporate Compliance Officer or a member of the Corporate Compliance Committee.

Conflicts of interest must be avoided. Hopedale Medical Complex has policies concerning conflicts of interest, which must be followed. These include the Employment Conflict of Interest Policy, the Hospital Corporate Conflict of Interest Policy, and the Medical Staff Conflict of Interest Policy.



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FRAUD AND ABUSE LAWS

Relevant laws and regulations are continued in the Federal statutes enacting the Medicare and Medicaid programs and in various state laws. These statutes are collectively referred to as the “fraud and abuse” laws.

FRAUD:

Intentionally misrepresenting services (upcoding, miscoding, unbundling), billing for services not rendered, billing for services that are medically unnecessary, double billing, providing substandard care, falsifying records to obtain payment.

ABUSE:

Intentionally recording diagnosis and/or procedure codes improperly, granting waivers of copayments and similar sums improperly, adjusting bad debts improperly, recording dates and/or description of services improperly, and adjusting depreciation of assets that have been fully depreciated.

ANTI-KICKBACK:

These provisions, found in both Federal and State laws, prohibits the offer, solicitation, payment, or receipt of any remuneration, (cash goods and services or in kind), in return for or to induce the referral of any patient for any service that may be paid by any federal or state healthcare programs.

ANTI SELF-REFERRAL LAWS:

These laws prevent physicians and other health care providers from profiting from referrals for health care services made by the provider to another provider in which the referrer has a financial interest. These statutes are embodied at the Federal level in the “Stark” laws, and at the state level in the Illinois Health Care Worker’s Self-Referral Act. Note that usually the impact of these laws is on the individual health care provider and NOT on the hospital.

Therefore, corporate compliance with these laws for the hospital is usually achieved by being aware of restrictions and not promoting or participating in any action that might inadvertently result in a hospital-affiliated health care provider violating one of these laws.



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Among the Stark anti-self-referral laws are:

STARK 1:

Prevents physicians from referring patients who participate in a federal health program to clinical laboratories in which physicians or their families have a financial interest.

STARK II:

Now included eleven categories of designated health services, namely:

- Clinical lab services
- Physical therapy, occupational therapy, and speech-language pathology services
- Radiology and other imaging services (including nuclear medicine as of 01/01/07)
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Prosthetics, orthotics and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient hospital services
- Outpatient hospital services
- Parental and enteral nutrients, associated equipment, and supplies

ANTI-TRUST:

The following practices are forbidden:

1. Entering into agreements to fix prices, rig bids, share price or billing information with competitors
2. Entering into price discrimination agreements or engaging in bid-rigging unfair trade practices or other unethical activities.

EXCLUSION:

Federal law prohibits any person or entity from employing or contracting with an individual or entity that has been excluded from participation in any federal health care program, including Medicare and Medicaid.



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STANDARDS OF CONDUCT RELATING TO ANTITRUST COMPLIANCE

The following standards will be observed relative to compliance with the antitrust laws, specifically with respect to activities, negotiations, and interactions with competitors.

1. No employee, director, board member or agent of HMC has authority to enter into any activity, agreement or contract that would have the effect of reducing or eliminating competition, controlling prices, allocating markets, or excluding competitors. This includes not only formal written agreements but also so-called “gentlemen’s agreements” or “understandings”.
2. Examples of potentially anticompetitive arrangements include but are not limited to those that limit admissions or capacity, allocate patients, markets or territories, boycott or refuse to deal with third party payers, restrict advertising or marketing efforts, or suppress technological developments.
3. No employee, director, board member or agent of HMC may enter any discussion, communication, or agreement with any representative of any other organization providing the same services concerning prices or charges, pricing policies, discounts or allowances, other pricing terms and conditions, or wage and salary information. Requests for such information in the form of third-party surveys and questionnaires shall be reviewed by the Chief Operating Officer.
4. Any agreement with any other organization that provides the same services as this organization must be reviewed by the Corporate Compliance Officer and/or legal counsel and approved by the Chief Operating Officer, Chief Executive Officer, or Board of Trustees.
5. Any employee, director or board member who suspects that a particular activity, communication agreement or situation involving employees, agents or trustees violates these standards or state or federal antitrust laws, or appears to do so, should report those concerns to his or her supervisor, the Corporate Compliance Officer, or the Chief Operating Officer.



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STANDARDS OF CONDUCT TO MAINTAIN THE TAX-EXEMPT STATUS OF HMC

HMC, a tax-exempt organization, must act in an ethical manner and engage in activities in furtherance of its charitable purpose. HMC, its employees, Board members, medical staff and agents cannot engage in activities that benefit the personal interests of any individual. Such activities are not only ethical violations; they could result in the loss of HMC's tax-exempt status.

A tax-exempt organization must meet certain requirements in the following areas:

- 1. Community benefit-** The organization must have a conflict-of-interest policy and an Emergency Department open to all regardless of payment.
- 2. Lobbying-**only for legislation.
- 3. Political contributions-**cannot use assets for political purposes.
- 4. Private inurement-**no private benefit passes to individuals or corporations doing business with the organization.
- 5. Reporting requirements-**annual information returns and public inspection of specific tax documents.

Tax-exempt status is granted under both federal and state laws. Violations of these laws by HMC employees, agents, Board members, and medical staff may result in loss of this status.

If an employee becomes aware of a violation, or possible violation, in this area, the employee must contact his/her supervisor, Corporate Compliance Officer or call the Hotline.



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STANDARDS OF CONDUCT RELATING TO GIFTS FROM VENDOR

Many gifts are given to physicians and other health care professionals by companies in the pharmaceutical, device, and medical equipment industries serve as an important and socially beneficial function. For example, drug companies have long provided funds for educational seminars and conferences. Some gifts that reflect customary practices may not be consistent with the principles of medical ethics. To avoid the acceptance of inappropriate gifts, all physicians and other employees of Hopedale Medical Complex shall observe the following standards of conduct:

1. Any gifts accepted by individuals should primarily entail a benefit to patients and should not be of substantial value, not to exceed \$100.00 annually. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments may not be accepted. Individual gifts of minimal value are permissible if the gifts are related to the individual's work (e.g., pens and notepads).
2. Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy by a company's sales representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor, who, in turn, can use the money to reduce the conference registration fee. Payments to defray the costs of a conference may not be accepted directly from the company by individuals who are attending the conference.
3. Subsidies from vendors may not be accepted directly or indirectly to pay for the costs of travel, lodging, or personal expenses, nor may subsidies be accepted to compensate for the individual's time. Subsidies for hospitality may not be accepted outside of modest meals or social events that are held as part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of individuals for their time or their travel, lodging, and other out-of-pocket expenses.
4. No gifts may be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite conferences, or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and material should belong to the organizers of the conferences or lectures.



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STANDARDS OF CONDUCT RELATING TO BUSINESS ETHICS

1. No employee, Board member or medical staff appointee may make improper use of the HMC property or permit others to do so. Examples of improper use include the unauthorized appropriation or personal use of services, equipment, technology and patents, software, and computer and copying equipment and the alteration, destruction, or disclosure of data. The occasional use of telephones, copying machines, and office supplies, when the cost is insignificant, is permitted.
2. Seeking, accepting, offering, or making any payment, gift, or other thing of value to or from any subcontractor, vendor, supplier or potential contractor for the purpose of obtaining or acknowledging favorable treatment under a private or government contract or subcontract is strictly forbidden. Ordinary business courtesies or de minimis gifts when not solicited may be accepted.
3. All entries in books and records, including financial records, clinical records, and expense accounts shall be accurate and complete and conform with applicable policies.
4. Employees shall use their best efforts to avoid violations of federal copyright laws, including, but not limited to laws pertaining to computer software.
5. Required time records shall be completed in a timely and accurate manner. No cost should be allocated which is unallowable, misallocated, contrary to a contract provisions, or otherwise improper.
6. All Board members, employees and medical staff appointees shall refrain from any conduct during the performance of their duties that has the appearance of impropriety or that could reasonable be construed as contrary to the interests and mission of the organization.



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STATEMENT CONCERNING POSSIBLE CONFLICTS OF INTEREST

GENERAL

Key employees of HOPEDALE MEDICAL COMPLEX, must conduct their personal affairs in such a manner as to avoid a conflict of interest with their duties and responsibilities as key employees of HOPEDALE MEDICAL COMPLEX. For the purposes of this policy, key employees are defined as all officers of the corporation, employees who function as directors and above levels of administration, all employed physicians and consultants who function as interims in any of the above defined roles.

SPECIFIC

Any duality of interest on the part of any key employee shall be disclosed to the CEO and made a matter of record through an annual procedure, and when the interest becomes the matter of that employee action. The definition of duality of interest for consultants acting in the roles of key employees shall be limited to third party vendor and arrangements with other healthcare organizations in which their roles could weaken Hopedale Medical Complex's market share or have a negative impact on Hopedale Medical Complex's net income. All remaining duality of interests listed below under SPECIFIC APPLICATION OF STATEMENT, must be disclosed by consultants holding the positions at issue.

Conflicts regarding officers of the corporation shall be disclosed to the Finance and Audit Committee of the Board of Trustees.

Any employee having a duality of interest shall not use his/her personal influence on the matter.

This statement shall also be applicable to any member of one's immediate family or any person acting on his/her behalf.

Employees will be required to attest annually to the familiarity with HOPEDALE MEDICAL COMPLEX'S statement in this regard and to provide information concerning any possible conflict of interest so that disclosure may, if necessary, be made.

Whenever there exists a conflict, the matter in question shall be made public by disclosure to the Board of Directors.



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SPECIFIC APPLICATION OF STATEMENT

1. **Financial Interests:** “Financial Interest” for this purpose shall mean beneficiary. A possible conflict of interest arises when a key employee holds a financial interest in or receives any personal benefit from a business firm furnishing services, materials, or supplies to HOPEDALE MEDICAL COMPLEX. If the amount of business done by HOPEDALE MEDICAL COMPLEX with any publicly held company has virtually no effect on the total results of such a company, “financial interest” shall not include the ownership of shares in a publicly held corporation.
2. **Use of HOPEDALE MEDICAL COMPLEX’S Services, Property, or Facilities:** Another area of potential conflict involves the use of HOPEDALE MEDICAL COMPLEX’S services or facilities. A key employee seeking staff assistance or the use of HOPEDALE MEDICAL COMPLEX property or facilities to the extent that extraordinary assistance is provided, there should be a clear understanding of how this assistance will benefit HOPEDALE MEDICAL COMPLEX.
3. **Privileged Information:** A key employee must never use information received while an employee of HOPEDALE MEDICAL COMPLEX if personal use of such information would be detrimental in any way to HOPEDALE MEDICAL COMPLEX. Any actions which might impair the reputation of HOPEDALE MEDICAL COMPLEX must also be avoided.
4. **Employment of Relatives:** Employment or the use of relatives as independent contractors, who would be directly or indirectly supervised by a relative will not be permitted without the express written consent of the Vice President of Human Resources and the President/CEO. Relatives are defined by HR Policy as spouses, children, parents, siblings, grandparents, grandchildren, adopted children, stepchildren, mothers-in-law, fathers-in-law, brothers-in-law, daughters-in-law, sons-in-law, aunts, uncles, nieces, nephews and first cousins.



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PROCEDURE FOR COMPLIANCE REFERRALS

(NOTE: This list is a general reference only. The ultimate responsibility for Compliance activities rests with the Board of the Hospital, and therefore the Board may assign any compliance-related task to any person as it chooses. Generally, compliance activities will be overseen by the relevant department with the technical assistance of the Compliance Officer and his or her staff.)

A. ISSUES MANAGED BY COMPLIANCE OFFICER/COMPLIANCE COMMITTEE

1. Disclosure of confidential information
2. Allegations of fraudulent activities
3. Allegations of falsification of records
4. Allegations of non-compliance with sponsored research requirements
5. Allegations of misuse of assets
6. Allegations of non-compliance with policies, procedures, standards of conduct or law by any Hospital officer, director, board member, affiliated physician, employee or agent
7. Alleged instances of billing fraud
8. Allegations of financial misdealings, fraud, theft or embezzlement
9. Allegations of improper, unbundled, or incorrect billings
10. Allegations contained in sections (B), (C) or (D) below which the Hospital Board directs be investigated concurrently by the department specified below and the Compliance Officer/Compliance Committee.

B. ISSUES MANAGED BY HUMAN RESOURCES

1. Americans with Disabilities Act Issues
2. Equal Employment Opportunity/Discrimination Issues



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3. Illegal Substance Use Issues and Issue involving allegations of impaired persons by reason of use of alcohol or legal or illegal drugs.
4. Management-Labor Issues
5. Sexual Harassment Issues
6. Workplace Safety Issues

C. ISSUES MANAGED BY MEDICAL STAFF

1. Questions regarding quality of care rendered by physicians or allied health professionals credentialed through Medical Affairs
2. Questions regarding professional conduct of physicians, nurses or other licensed health care providers
3. Disruptive/impaired physicians

D. ISSUES MANAGED BY RESPECTIVE DEPARTMENTS

1. All issues specific to area



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PROCEDURE TO RESPOND TO SEARCH WARRANTS

1. In the event that agents of the federal or state government present any agent, affiliate, director or employee of the Hospital with a search warrant seeking access to the organization's books, records or documents, that a person should immediately contact one or all of the President & Chief Executive Officer, Corporate Compliance Officer and/or legal counsel for the Hospital.
2. The employee receiving the warrant should ask to see the identification from each agent and get a business card from each agent present. The business cards should be immediately copied and transmitted by either fax or hand delivery to the President & Chief Executive Officer, the Corporate Compliance Officer and/or Legal Counsel.
3. A copy of the search warrant should also be obtained from the agent and either faxed or hand carried to the President & Chief Executive Officer, the Corporate Compliance Officer and/or legal counsel. The agents are required to provide a copy of the warrant.
4. The agents should also be asked for a copy of any affidavit supporting the search warrant. This must also be disclosed unless it is under seal. If the affidavit is obtained, it should be immediately faxed or hand carried to the President & Chief Executive Officer, the Corporate Compliance Officer and/or legal counsel. If the agents state that affidavit is under seal, the fact should also be immediately communicated to the President & Chief Executive Officer, the Corporate Compliance Officer and/or legal counsel.
5. The search warrant will include an attachment listing things that can be seized and places that may be searched. If the agents try to go into areas that are not listed in the warrant, ask them to wait until legal counsel can arrive. If they refuse to wait, do not interfere, but note which agents went into areas not specified in the warrant and exactly when that occurred.
6. The agents should be requested to provide an itemized list of any things taken away. They are required to give you a receipt.
7. If the agents take documents (including computer files), ask to make copies of those documents before they do. They are not required to allow copies to be made and may refuse to do so.
8. PERSONS ON THE PREMISES are NOT required to speak with agents during the search, even if they are served with a subpoena, and should not do so except to the extent that it is necessary to comply with the search warrant. ANY PERSON



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PRESENT MAY DECLINE TO ANSWER QUESTIONS ADDRESSED TO THEM BY AN AGENT.

9. The senior ranking employee(s) present should accompany the agents during the search and take careful notes of what they take, what they look at, who they talked to and what questions were asked.
10. It is critical that no employee interferes with the agents during the search or prevents them from accessing anything listed in the search warrant. To do so could constitute obstruction of justice, which is a criminal offense.



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CORRECTIVE ACTION PLAN FOR CONFIRMED VIOLATIONS

The Corporate Compliance Officer, with the assistance of the Compliance Committee, is responsible for implementing the corrective action plan needed to resolve confirmed compliance violations.

PROCEDURE:

1. A corrective action plan which is approved by the Compliance Committee will be overseen by either the Corporate Compliance Officer (CCO), Human Resources Manager, Chief Operating Officer, or Director/Manager appointed by the Compliance Committee. The CCO, HR Manager, COO, Director/Manager are responsible for submitting periodic status reports to the Compliance Committee.
2. Any compliance violation requiring disciplinary action against an employee is referred to Human Resources.
3. The CCO and/or the HR Manager, COO, Director/Manager are responsible for the following activities:
 - Providing the appropriate employees with programs to educate personnel to prevent a recurrence of a confirmed compliance violation
 - Developing an ongoing monitoring or auditing which should detect a potential recurrence of a confirmed compliance violation
4. The CCO, in consultation with the Compliance Committee, will propose to the Board of the Hospital modifications to the NAH Compliance Program, when a confirmed violation pinpoints problems or areas of omission.
5. The CCO is responsible for performing a timely follow-up review of all corrective action plans.



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HUMAN RESOURCES PROCEDURES CONCERNING CORPORATE COMPLIANCE

1. All employees, as a condition of their employment, are required to adhere to the Corporate Compliance Program.
2. To document efforts with respect to education and training in the Compliance Program, employees shall acknowledge in writing their acceptance and understanding of this Policy and its requirements.
3. Attendance at annual compliance training will be documented and maintained in the employee's personnel file.
4. Failure to adhere to the Compliance Program, violations of any applicable laws, rules and regulations, and failure to report misconduct are considered to be violations of hospital policy and may be grounds for disciplinary action by the Hospital, including termination of employment when warranted.
5. All employees will:
 - a. receive training regarding the Compliance Program within 30 days of employment.
 - b. receives, or has access through the Intranet, the Compliance Policy applicable to their position and any revisions thereto. An acknowledgement of receipt and agreement to adhere to the same will be signed and filed in the employee's personnel file.
 - c. attend and participate in compliance training as a condition of continued employment.
 - d. use candor and honesty in the performance of their responsibilities;
 - e. protect confidential and sensitive information to prevent unauthorized or unlawful disclosure of such information and will conduct all business activities to maintain their confidentiality of patient information.
 - f. report any actual or suspected compliance violations to the Compliance Officer, their immediate supervisor or the Chief Executive Officer.
 - g. cooperate with government officials as required by the Policy on Reporting to Outside Agencies.



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- h. not engage in any business practice prohibited by the Standards of Conduct, including, but not limited to, kickbacks or payments intended to induce or influence new and favorable decisions to those in a position to benefit the Hospital or the employee, in any way, including payments for referrals;
 - i. prepare and maintain all patient and business records and reports accurately and truthfully and report inaccurate documents promptly to their supervisor.
- 6. Prior to extending an offer of employment to any new hire, the Human Resources Department shall take reasonable steps to determine if the prospective employee has been excluded from any federal health program or otherwise sanctioned for violations of the law. These steps shall include, but not be limited to, checking the lists of persons excluded from Medicare and Medicaid, as well as the list of debarred contractors, and documenting the same. Individuals who appear on either list shall not be offered employment.



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DISCIPLINE AND ENFORCEMENT POLICY

Every employee, staff and agent must assist NAH in complying with the Compliance Program. Individuals who are responsible for the failure to detect a problem and report according to the Program, will be disciplined.

Discipline will be decided on a case-by-case basis through the Human Resources Department. All levels of employees will be held to the same penalty for the same offense. All disciplinary measures will be documented regardless of whether they are recorded in the employee's personnel file. All disciplinary measures will be reported to the Corporate Compliance Committee and the Corporate Compliance Officer.



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BACKGROUND CHECKS

HMC NEW HIRES

HMC follows all Federal and State laws and regulations that pertain to the hiring of personnel. HMC will conduct a criminal background investigation as well as checking the Medicare Sanctions Report prior to hiring any employee.

No candidate who has been convicted of a healthcare-related crime, or excluded from participation in federal healthcare program, will be hired for a position, which includes discretionary authority which would result in providing a service which would be billed to any federal healthcare program.

If any candidate appears on the Medicare Sanctions Report or has a criminal background, they will not be hired. Human Resources will notify the candidate and director/manager of their ineligibility.

When an individual has been denied employment due to a criminal background or appearance on the Medicare Sanctions Report, it will be reported to the Corporate Compliance Officer and the Corporate Compliance Committee.

MEDICAL STAFF

For all medical staff, the Medical Staff office will check the National Practitioner Data Bank (NPDB) and The Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) and any other resource required for granting privileges and reappointment form these compliance-related background checks will be forwarded to the Corporate Compliance Officer.



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CUMULATIVE SANCTIONS

The Cumulative Sanctions report is an OIG-produced report. It is updated on a regular basis to reflect the status of health care providers and individuals who have been excluded from participation in the Medicare and Medicaid programs.

Compliance Department Summary and Recommendations

The Officer of Inspector General's (OIG) Compliance Program Guidance for Hospitals has specific guidelines and recommendations in regards to cumulative sanctions. It states that the compliance committee should coordinate personnel issues with the hospital's Human Resources Department or Medical Staff Office to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been check with respect to all employees, medical staff and independent contractors.

Human Resources

- Each new employee is reviewed through the cumulative sanctions data base during the hiring process. In addition, based on state law requirements, each new employee goes through the verified criminal background check.
- There is a bi-annual review of all employees for cumulative sanctions and criminal background check during the final quarter of that given calendar year.
- Human Resources will refer employees found on the cumulative sanctions list to the Corporate Compliance Officer.
- All job descriptions contain a key result area relating to demonstrating understanding and adherence to corporate compliance plan.

Medical Staff

- Each physician applicant is check initially and then every two years at reappointment to the medical staff. The process used are: National Practitioner Data Bank, Illinois Department of Professional Regulations, IDPH (for Medicare and Medicaid sanctions).
- The OIG web site sanctions list is check on a monthly basis by the Corporate Compliance Department.



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- Medical Staff Office implements a policy for non-employed physicians on notification of sanctions or activity against a license. They are required to notify the medical director within 24 hours of any arrest, indictment, convictions or actions taken against their license such as suspension, refusal to renew, cancellation or other restrictions. This is in order to accomplish our obligation for due diligence.

Material Management

- Material Management utilizes Metropolitan Chicago Health Care Association's (MCHC) "Vendors Sanctions Report" disk.
- The current vendor list has been compared to MCHC's "Vendor Sanctions Report" and all new vendors have been compared to that report prior to doing business with them.



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DEPARTMENT SPECIFIC STANDARDS AND PROCEDURES

Each Department, Director/Manager will develop, with the assistance of the Corporate Compliance Officer, Corporate Compliance Committee, and NAH legal counsel, specific standards and procedures for that department when indicated.