SANTA BARBARA COUNTY PUBLIC HEALTH DEPARTMENT

COMPLIANCE PLAN

September 2019

Approved: August 28, 2019 Health Center Board
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I. Introduction

A. Overview

Santa Barbara County Public Health Department (PHD) has adopted a Compliance Program that reflects its commitment to provide high quality of care and effective risk management. PHD is committed to preventing, detecting, and correcting any improper or unethical conduct or conduct that does not conform to federal and state law, payer program requirements and PHD’s business practices. This Plan describes PHD’s Compliance Program. The Program applies to: (1) medical necessity/quality of care and its associated documentation; (2) billings; (3) payments; (4) governance; (5) mandatory reporting; (6) credentialing; and (7) other risk areas that are identified by PHD.

PHD’s Compliance Program applies to all “Compliance Partners”. All Compliance Partners are expected to read, understand and comply with this Plan (including the Code of Conduct contained herein). In addition, all Compliance Partners are expected to report any conduct that they believe violates this Plan, PHD’s policies, or applicable laws and regulations to their supervisor, PHD’s Compliance Officer, or the Compliance Hotline.

Identity theft through illegal access to proprietary databases is occurring at levels and scopes never before encountered. An effective Compliance Program such as this one can substantially reduce potential liability for PHD and its Compliance Partners as well as protecting our client’s protected health and identifying information.

Federal and state government agencies have intensified their efforts to audit, investigate and prosecute Medicare and Medicaid fraud, waste, and abuse. Civil and criminal audits and investigations of the health care and human services industry are occurring at an unprecedented rate, resulting in large fines and criminal convictions. Even if the outcome of an audit or investigation is positive, a lengthy audit or investigation can be extremely intrusive and disrupt PHD’s ability to provide care and services.

Definitions:

Adverse event or incident: An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.
Conflict of Interest: for this Plan is defined as a situation in which financial or
other personal considerations have the potential to compromise or bias professional judgment and objectivity.

**Compliance Partners:** are (1) individuals employed by PHD; (2) individuals, contractors, clients, volunteers, and other entities providing services and supplies to PHD; and/or (3) members of the Health Center (HC) Board

**Claims management:** Activities undertaken by the risk manager to exert control over potential or filed claims against the organization and/or its providers. These activities include;

- identifying potential claims early,
- notifying the organization’s liability insurance carrier and/or defense counsel of potential claims and lawsuits,
- evaluating liability and associated costs,
- identifying and mitigating potential damages,
- assisting with the defense of claims by scheduling individuals for deposition,
- providing documents or answers to written interrogatories,
- implementing alternate dispute-resolution tactics, and
- investigating adverse events or incidents.

**Federally Qualified Health Center (FQHC):** An FQHC is a system of primary care as defined in the Public Health Services Act as administered by the Federal government Health Resources and Services Administration (HRSA). PHD, through its Health Care Centers, Homeless Program and Ryan White Program are grantees and is defined as a Community Health Center as a FQHC.

**Harm:** A deleterious outcome for a patient, staff member, practice or organization.

**Harm Reduction:** A systematic process to evaluate policies and operations to eliminate or minimize harm.

**Health Center Board:** The Health Center Board is an advisory board that together with the County Board of Supervisors provides oversight for all PHD FQHC activities.

**Loss control/loss reduction:** The minimization of the severity of losses through methods such as claims investigation and administration, early identification and management of events, and minimization of potential loss of reputation.

**Loss prevention:** The minimization of the likelihood (probability) of a loss through risk assessment and identification; staff and volunteer education, credentialing, and development; policy and procedure implementation, review, and revision; preventive maintenance; quality/performance review and improvement; root-cause analysis; and others.

**Near miss:** Through either chance or through timely intervention, an event or situation that could have resulted in an accident, injury, or illness but did not, (e.g., a procedure almost performed on the wrong patient due to lapse in verification of patient identification but caught at the last minute by chance). Near misses are opportunities for learning and afford the chance to develop
preventive strategies and actions. Near misses receive the same level of scrutiny as adverse events that result in actual injury.

**Patient Safety Goals:** National Patient Safety Goals (NPSGs) for ambulatory care are established by the Joint Commission. The purpose of NPSGs is to improve patient safety by focusing on problems in healthcare safety and how to solve them. Goals include:

- Identify patients correctly.
- Use medicines safely by labeling them appropriately and taking precautions with anticoagulants.
- Review patient medications; communicate and educate about current medication regimens.
- Prevent infections.

**Potentially compensable event (PCE):** An unusual occurrence or serious injury for which there is neither an active claim nor institution of formal legal action but that, in the organization’s judgment, is reportable to the party (or parties) providing the medical malpractice insurance. Examples include a fall with injuries, delay or failure in diagnosing a patient’s condition, an adverse reaction to treatment, significant complaints from a patient or family regarding care or treatment, and an attorney request for medical records.

**Red Flag:** A term used to describe a condition or set of conditions that warrant additional attention and review such as unusually diagnostic laboratory test results for a patient, evidence of potential fraud, waste and abuse, etc.

**Risk analysis:** Determination of the causes, potential probability or potential harm of an identified risk and alternatives for dealing with the risk.

**Risk assessment:** Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.

**Risk avoidance:** Avoidance of engaging in practices or of hazards that expose the organization to liability.

**Risk control:** Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event.

**Risk financing:** Analysis of the cost associated with quantifying risk and funding for it.

**Risk identification:** The process used to identify situations, policies, or practices that could result in the risk of patient harm and/or financial loss. Sources of information include proactive risk assessments, closed claims data, adverse event reports, past accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.

**Risk management:** Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to patients, staff, visitors, volunteers, and others and to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out
decisions that will prevent or minimize clinical, business, and operational risks.

**Root-cause analysis:** A process for identifying the basic or causal factor(s) that underlie the occurrence of an adverse event.

**Unsafe and/or hazardous condition:** Any set of circumstances (exclusive of a patient’s own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

**B. Program Elements**

PHD’s Compliance Program consists of eight elements.

1. Written compliance **policies** and **procedures** that describe PHD’s Compliance Program, including a Risk Management Plan and the Code of Conduct contained herein;

2. Appointment of a **Compliance Officer** who is responsible for the day-to-day operation of the Compliance Program and a Compliance Committee to assist the Compliance Officer;

3. **Training** and education of all affected Compliance Partners on the Compliance Program;

4. Mechanisms to **report** compliance concerns;

5. **Disciplinary** policies to encourage good faith participation in the Compliance Program;

6. System for **identifying** compliance risk areas, including monitoring and auditing;

7. System for **responding** to, investigating, and correcting compliance problems; and

8. A policy of **non-intimidation** and **non-retaliation** for good faith participation in the Program.

PHD’s development and implementation of these eight elements will require the full cooperation and participation of all Compliance Partners. Such cooperation and participation will insure that PHD maintains a high level of honest and ethical behavior in the delivery of its services.
II. **Code of Conduct**

It is PHD's policy that all Compliance Partners will comply with laws, regulations, and ethical standards applicable to their duties. The following standards of conduct apply to all Compliance Partners. The PHD does not condone unethical business dealings, such as illegal acts, indirect contributions, rebates, kickbacks and bribery.

A. **This Code of Conduct contained herein applies to all:** (1) individuals employed by PHD; (2) individuals and entities providing services and supplies to PHD; and (3) members of the PHD Health Center Board. **General Employee Conduct:**

**Honesty and Lawful Conduct:** Compliance Partners must be honest and truthful in all of their dealings. Compliance Partners must avoid doing anything that is, or might be, against the law.

**Respect for Individuals Served:** Compliance Partners must fully respect the rights of the individuals served including their right to privacy, respect, dignified existence, self-determination, participation in their own care and treatment, freedom of choice, ability to voice grievances, and reasonable accommodation of individual needs. The PHD expects its employees to conduct themselves in a businesslike and professional manner. Drinking, gambling, fighting, swearing, illegal drug usage and similar unprofessional activities are strictly prohibited while on the job.

**Non-Discrimination:** Compliance Partners shall not discriminate based on sex, gender, race, sexual preference, religion, creed, military status, national origin, marital status, disability, status as a victim of domestic violence, or source of payment or sponsorship. Employees must not engage in harassment, use inappropriate language, post or access inappropriate materials in their work area.

**Business Information:** Compliance Partners may not disclose or release any confidential information relating to PHD's operations, pending or contemplated business transactions, and confidential information without proper authorization. All confidential information is to be used for the benefit of PHD and the individuals it serves, and is not to be used for the personal benefit of Compliance Partners, their families, or friends. Employees uncertain about the application or interpretation of any legal requirements should refer the matter to their supervisor, who should seek consultation with the Deputy Director who may seek legal advice.

B. **Conflicts of Interest:**

We must always exercise our best skill, care and judgment for the benefit of the
County and our clients. We must refrain from being influenced by personal considerations of any kind in the performance of our duties. Failure to adhere to this Policy may be considered a breach of the person's obligation to the County, and may result in disciplinary action.

The County has established Conflict of Interest controls in its procurement procedures (see Santa Barbara County Online Purchasing Manual).

Furthermore, the County has established an annual process whereby decision makers in the County that have authority to grant or withhold public benefits such as licenses, permit, contract awards, etc. are required to complete and submit an annual declaration (Form 700 Conflict of Interest Statement) of all private holdings. These declarations are reviewed for any potential conflict of interests by the County Administration. These decision-makers within the Public Health Department must examine their own and their immediate family's activities, and promptly report the existence of any enterprises in which they or their immediate family has an "interest," and/or which the person knows is engaged, or is reasonably likely to engage, in transactions with the County. A person's immediate family includes his or her spouse, siblings, children, in-law of any of them, and parents. (redundant). A person is deemed to have an "interest" in an enterprise when he or she, or a member of his or her immediate family, has some relationship with the enterprise that could be viewed as possibly compromising the personnel's loyalty to the County or its client's interests. Such a relationship includes being employed by, having a contractual relationship with, being a member, owner, director, or officer of, or having a financial interest in an enterprise from which the County (Public Health) purchases, leases, negotiates, or otherwise does business with.

Whenever a conflict of interest or even a possible conflict of interest exists, that conflict must be fully disclosed per the Policy, and the personnel involved must refrain from participating in the consideration or determination of the matter.

PHD's Health Center Board members may have conflicts of interest associated with their oversight of FQHC operations and their professional or personal activities, holdings, interests, etc. The must abide by the Health Center Bylaws and the Health Center Board Conflict of Interest Policy.

Conflicts can be complicated. Please consult the Compliance Officer for guidance.

C. **Relationships with Patients/Clients and Suppliers:**

Employees should not invest in or acquire a financial interest in any business for which PHD has a contractual relationship or that provides
goods or services to PHD.

In all matters relevant to customers, suppliers, government authorities, the public and others in the PHD, employees must make every effort to achieve complete, accurate, and timely communications - responding promptly and courteously to proper requests for information and to all complaints. Employees should document compliments and complaints in the PHD database.

D. Gifts, Entertainment, and Favors:

Employees must not accept entertainment, gifts, or personal favors that could, in any way, influence, or appear to influence, business decisions in favor of any person with which the PHD has business dealings. Similarly, employees must not accept preferential treatment offered because of their positions with the PHD. Please review the County Acceptance of Gifts, Personal Policy and the PHD Policy on Acceptance of Gifts and Donations.

E. Kickbacks and Secret Commissions:

Employees may not receive payment or compensation except as authorized under County policy. The PHD strictly prohibits the acceptance of kickbacks and secret commissions from suppliers or others. Please review the County's Online Procurement Manual for specifics on avoidance of such conflict of interest.

F. Public Health Department Funds and Other Assets:

Employees who have access to PHD funds in any form must follow the prescribed procedures for cash handling as detailed in the PHD's policies and procedures. The PHD maintains strict standards to prevent fraud and dishonesty. If employees become aware of any evidence of fraud and dishonesty, they should immediately advise their supervisor or the Compliance Officer. Please review the PHD Cash Handling Guidelines Policy.

When an employee's position requires spending PHD funds or incurring any reimbursable personal expenses, that individual must follow all appropriate PHD policies such as the PHD Training and Travel Expenses Reimbursement policy, etc.

If PHD incurs any loss or theft of County property or assets, these must be reported to the Auditor-Controller in alignment with their Reporting Loss or Theft Policy. These reports should be coordinated through the PHD Chief Financial Officer.
G. **Records and Associated Communication:**

The PHD's records must accurately reflect all clinical and business transactions and these records must be posted, updated and or stored in a timely manner. The employees responsible for accounting and recordkeeping must fully disclose and record assets, liabilities, or both, and must exercise diligence in enforcing these requirements.

Compliance Partners must not create false records or communications (see County Reporting Loss or Theft Policy above) including,

- False clinical documentation, false expense, attendance, production, financial, or similar reports and statements
- False advertising, deceptive marketing practices, or other misleading representations

H. **Dealing With Those Outside The Public Health Department:**

Employees must not use PHD identification, stationery, supplies, and equipment for personal or political matters. When communicating publicly on matters that involve PHD business, employees should not speak for the department on any topic, unless given approval in accordance with PHD's current policies.

When dealing with anyone outside the PHD, including public officials, employees must take care not to compromise the integrity or damage the reputation of the department or any individual, business, or government body.

Employees should direct the media inquiries and other questions from individuals from the community to the PHD's Public Information Officer (PIO).

I. **Privacy and Confidentiality:**

Employees must comply with the Confidentiality of Information agreement signed upon hire. Records must be handled in a confidential manner. When handling financial and personal information about customers or others with whom the PHD has dealings, observe the following principles:

- Collect, use, and retain only the personal information necessary for the PHD's business. Whenever possible, obtain any relevant information directly from the person concerned. Use only reputable and reliable sources to supplement this information.
- Retain information only for as long as necessary or as required by law. Protect the physical security of this information.
- Limit internal access to personal information to those with a legitimate business reason for seeking that information. Use only personal
information for the purposes for which it was originally obtained. Obtain the consent of the person concerned before externally disclosing any personal information, unless legal process or contractual obligation provides otherwise.

☐ Follow the PHD's policies on Health Insurance Portability and Accountability Act (HIPAA) and the Heath Information Technology, Economic and Clinical Health (HITECH) act requirements.

III. Compliance Standards

A. Medical Necessity and Quality of Care and Services

Delivery of Care and Services: Individuals served by PHD will be afforded the care and service levels necessary to attain or maintain the highest possible quality of care within available resources to improve or maintain their health and well-being. Clinical staff will be trained to evaluate and provide appropriate services and are encouraged to seek guidance, when necessary, from the Supervising Physician, Medical Director, management or other senior staff members.

Ability to Provide: PHD will refer individuals and their families to appropriate providers when it cannot provide for the individual's needs.

Medical Necessity: Medical care and services shall be based on medical need and professionally recognized standards of care.

Appropriate Treatment: PHD shall provide appropriate and sufficient treatment and services to address individual clinical conditions in accordance with their plans of care and professional standards of practice. Employees shall be informed of and protect and preserve the basic rights of Individuals served by PHD. Employees must interact with individuals in an honest and ethical manner. Employees shall provide services respectful to an Individual's cultural, religious, or ethnic background.

Quality Improvement: PHD shall have processes to measure and improve the quality of its care, services and the safety of patients. PHD's quality assurance program and improvement processes shall be coordinated with its Compliance Program.

Accountability: Employees shall be responsible for being knowledgeable, balancing individual needs, allowable benefits, and limited resources in carrying out services, supervision, and case management.

Survey Performance: PHD will regularly survey its clients for input on quality
and service levels. Current and past surveys shall be reviewed in order to identify specific risk areas and where appropriate, incorporate corrective action into the program's policies, procedures, training and monitoring.

B. Billing For Services

Verification of Coverage: The Office Professional staff is responsible for verifying insurance coverage and benefits at every client office visit. Employees shall maintain familiarity with current policies that describe the programs and insurance products which are appropriate and acceptable for the Health Care Centers. Employees should understand the requirements of the Indigent Care Program (ICP) and Tobacco Settlement funding since the PHD administers them and resources are limited.

Accurate and Truthful Claims and Reports: Claims submitted for payment must be accurate, truthful, and reflect only those services and supplies which were ordered and provided. Expense reports, cost reports, reimbursement requests, and financial statements must be prepared accurately and adequate documentation must exist to support information provided in the report. No individual shall willfully or purposefully misrepresent any financial reports or reimbursement requests. Non-allowable costs must be appropriately identified and removed and related party transactions must be treated consistent with applicable laws and regulations.

Coding: Coding of services by all staff, including Physicians, Health Care Practitioners (HCPs), PHNs, RNs, LVNs, RDs, Health Educators, Medical Assistants (MAs) and Office Professionals (OPs), shall accurately reflect the services rendered (see PHD Coding and Billing Compliance Plan).

Adequate Documentation: Billing of services and supplies must be based on accurate documentation to support the services and supplies, and in accordance with applicable laws and regulations and third party payor requirements. Documentation of services must be completed by employees at the time of service or as soon thereafter as practical in accordance with existing policies and procedures.

Ordered Services: Medically necessary services that are ordered, provided, documented, and billed must be appropriate to the quantity and type of service provided.

Inadequate or Substandard Care or Services: Claims shall not be knowingly submitted for payment for inadequate or substandard care or services.
Excluded Providers: Claims for services or supplies furnished by an individual or entity that has been excluded from participation in a federal or state health care program shall not knowingly be submitted for payment.

Record Retention: Records that demonstrate the right to receive payment, including medical records, will be retained in accordance with California State regulations, the PHD Medical Record Retention Policy, and Medicare/Medi-Cal record retention policies.

C. Payment

Credit Balances: A "credit balance" is typically the result of an excess or improper payment from billing or claims processing errors. If a department or program knows that it has received payments for which it was not entitled from a governmental or private payor or a recipient, the payments will be refunded to the appropriate payor or recipient.

Payment of Items or Gifts: Employees should not give anything of value, including bribes, kickbacks, or payoffs, to any government representative, fiscal intermediary, carrier, contractor, vendor, or any other person in a position to benefit PHD (see previous reference in Section II Code of Conduct, B Conflict of Interest).

Exception for Nominal Value: Employees may provide or receive ordinary and reasonable business entertainment and gifts of nominal value, if those gifts are not given for the purpose of influencing the business behavior of the recipient. Employees are expected to be in compliance with all applicable County policies as specified in the PHD Policy for on Acceptance of Gifts and Donations and the PHD’s Conflict of Interest Policy (See Section II B).

D. Professional Practices

Behavior of Employees: Employees shall model appropriate and acceptable behavior to the individuals served and shall maintain professional boundaries with individuals served, both in and out of the office.

Prohibited Activities: Employees shall not engage in any activity that constitutes abuse or neglect and shall refrain from working under the influence of alcohol, illegal substances, or prescription/non-prescription medications which may impair their functionality or in conflict with the directions of their medical provider or while appearing impaired (significant odor, impaired speech or judgment). Employees are not allowed to possess a firearm of any type at
any PHD location or satellite site. Employees are prohibited from the illegal sale of drugs (prescription or otherwise), alcohol, or other illegal substances to any Individual receiving services from PHD.

**Abusive Practices:** Employees shall not intentionally prescribe or administer improper medications or have any intentional physical contact with or engage in psychological abuse of an Individual that causes or has the potential to cause harm. Employees must also refrain from any activity that could constitute sexual harassment and may not engage in sexual contact or allow or encourage sexual contact with any patient/client receiving services from PHD. New employees are required to review and acknowledge the County Anti-Harassment Policy.

**E. Governance**

**Board Oversight:** The PHD Director and HC Board shall approve the Compliance Program and ensure that they receive appropriate information and updates in a timely manner. The PHD HC Board has a duty to make reasonable inquiry when presented with facts or circumstances of a material nature (i.e. indications of financial improprieties, self-dealing, or fraud) or a major governmental investigation.

**Conflict of Interest:** In accordance with the PHDs Conflict of Interest Policy identified in Section II B, any actual or potential conflict of interest for HC Board members or employees must be disclosed to ensure that the integrity of PHD’s operations is not compromised. Employees must disclose to the Compliance Officer any financial interest that they or a member of their family have in any entity that does business with PHD.

**F. Mandatory Reporting**

**Abuse, Neglect, Mistreatment:** Individuals receiving services from PHD will be free from abuse, neglect and mistreatment from any Compliance Partners. Any allegations of abuse, neglect or mistreatment must be immediately reported to the appropriate supervisor and other officials as required by law and investigated in accordance with applicable policies, rules, and regulations. New employees are required to review and acknowledge the review of the PHDs policies for reporting Elder and Dependent Adult Abuse and Child Abuse and Statutory Rape Reporting Policies.

**G. Credentialing**

**Background Checks:** As specified in the PHD Credentialing and Privileging
Policy, PHD and/or its contracted Credentialing Verification Organization will screen prospective Compliance Partners against websites which provide information on excluded individuals and entities, criminal backgrounds, and professional licensure and certification. Screening is done monthly (or more frequently if mandated by another 3rd party payer) to ensure such individuals and entities have not been excluded, convicted of a disqualifying criminal offense, or had their licensure or certification suspended, revoked or terminated since the initial screening.

Physicians: For physicians and other healthcare practitioners, PHD shall consult the National Practitioner Data Bank and verify the individual's license.

Other Compliance Partners: For applicable Compliance Partners and contractors, PHD shall consult the Office of Inspector General’s Exclusion Database for Individuals and Entities; the General Services' System for Award Management Exclusion List and the California Medi-Cal Suspended and Ineligible Provider List. In addition, contractors are required to perform their own routine exclusion list monitoring for themselves, their staff and any subcontractors to ensure adherence to the PHD Compliance Plan.

Employee, Member, and Contractor Certifications: PHD shall require potential Compliance Partners to certify that they have not been convicted of an offense that would preclude employment, PHD HC Board membership, or a contractual relationship with PHD and that they have not been excluded from participation in any federal or state health care program.

H. Business Practices

Improper and Illegal Means: PHD will forego any business transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to anyone to induce the use of PHD’s services.

Business Records: Business records must be accurate and truthful, with no material omissions. PHD’s assets and liabilities must be accounted for properly in compliance with all tax and financial reporting requirements.

Computer Resources and Internet Use: Compliance Partners who use PHD computer hardware and information systems assume the responsibility for using these resources in an appropriate manner and in accordance with Santa Barbara County's Acceptable (Computer) Use Policy. PHD owns all information communicated or stored via computer.

Purchasing: Purchasing decisions must be made with the purpose of obtaining
the highest quality product or service for PHD at the most reasonable price and in compliance with County policy (see County Procurement Manual). No purchasing decision may be made based on considerations from which employees, or their family member or friend, will benefit.

**Grants:** Individuals associated with grants shall conduct their activity in accordance with grant approval guidelines and documentation must be maintained by grant coordinators/administrators.

**Marketing and Referrals:** Employees must refrain from improper or high pressure individual solicitation or marketing. Employees must be truthful in the representations they make in marketing PHD’s services, and never agree to offer anything of value in return for referrals.

**Relationships with Other Providers:** Contracts, leases, and other financial relationships with hospitals, physicians, hospices, other medical providers and suppliers who have a referral relationship with PHD will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties. Free or discounted services or items will not be accepted or provided in return for referrals.

**I. Scope and Application of Standards to Compliance Partners**

**Responsibility of Compliance Partners:** Compliance Partners are expected to be familiar with and comply with all federal and state laws, regulations, and rules that govern their activities. Compliance Partners are also expected to adhere to this Compliance Plan Program and any applicable departmental and other compliance policies and procedures.

**Departmental Executives, Managers and Supervisors:** Departmental Executives, managers and supervisors have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that the employees they supervise understand the importance of the Compliance Plan.

**Departmental Compliance Policies and Procedures:** In addition to the Compliance Plan many of the programs have specific compliance policies and procedures. These additional policies and procedures are an integral part of the Compliance Program and are designed to complement the standards set forth in this Plan.

**IV. Compliance Officer**
A. **Authority and Duties:** PHD’s Compliance Officer has been appointed to run the day-to-day operations of the Compliance Program and is responsible for receiving, investigating, and responding to all reports, complaints, and questions.

The Compliance Officer shall:

- Develop and implement policies, procedures, and practices; integrate these compliance policies with current County policies.
- Develop and coordinate educational and training programs and materials;
- Conduct and facilitate internal audits to evaluate compliance and assess internal controls;
- Investigate compliance inquiries and Compliance hotline complaints and if appropriate develop corrective action plans;
- Ensure that screening prospective Compliance Partners is in accordance with this Plan;
- Ensure that physicians, independent contractors, suppliers, and other agents who furnish medical, nursing, or other healthcare or personal care services to PHD are aware of the Program’s requirements;
- Disseminate information on PHD’s Compliance Program to independent contractors of PHD;
- Review and modify the Plan including the Code of Conduct, and the Compliance Program, to reflect the evolving nature of applicable laws and regulations and the priorities of PHD;
- Assist management in review of PHD’s contracts for compliance with applicable laws and regulations and qualified status of contractors;
- Coordinate and oversee the: (1) compliance initiatives of PHD’s programs; and (2) audits and investigations conducted by government agencies;
- Maintain documentation of the following: internal and external audit and investigation results, logs of hotline calls and their resolution, corrective action plans, due diligence efforts with regard to business transactions, records of compliance training, and modification and distribution of policies and procedures; and
- Coordinate with Risk Management and the PHD Quality Improvement committees to obtain data from incident reports and patient satisfaction survey results.

B. **Distribution Responsibility:** The Compliance Officer shall develop a system that distributes the responsibilities described in this Plan. Compliance concerns are to be reported to PHD’s Compliance Officer. Depending on the findings, issues will be brought to the attention of PHD’s Director, the Compliance Committee, and the PHD HC Board.
C. Reporting: The Compliance Officer shall report semi-annually to the PHD Director and the HC Board.

V. Compliance Committee:

A. Appointment and Authority: The PHD Director or designee shall appoint a Committee to assist in the implementation of the Compliance Program. The Committee shall include the Compliance Officer and members of the department, representing different programs, (i.e.: clinical, finance, coding, information technology, and operations.)

B. Authority and Duties: The scope of the Committee's authority and duties shall be determined by the PHD Director and the HC Board and modified as the Compliance Program is evaluated. The Committee's primary duties are:

- Identification of specific risks areas,
- Assessing existing policies and procedures that address these risk areas and modifying them as needed,
- Working with programs to develop or modify standards of conduct, and policies and procedures to promote compliance with legal and ethical requirements,
- Developing and evaluating appropriate strategies to promote compliance with the Compliance Program and detection of any potential violations,
- Evaluation and approval of Compliance Program initiatives, processes and documentation, and
- Receiving, reviewing, and recommending appropriate responses to reports of actual or potential non-compliance with applicable laws, regulations,
- Enforcing the Code of Conduct, and policies and procedures in coordination with the Compliance Officer and with the assistance of counsel as necessary.

C. Meetings: The Compliance Committee shall meet at least quarterly.

VI. Compliance Training and Education

A. Applicability: Employees shall participate in training and education on the Compliance Program, including the Code of Conduct and the PHD Risk Management Plan. Training programs should include sessions summarizing fraud and abuse laws and federal health care program and private payor requirements.

B. Frequency: Such mandatory training shall occur periodically and shall
be made a part of the orientation for all new employees and HC Board members.

C. **Targeted Training:** In addition to general compliance training and education, face to face training and targeted compliance training that is tailored to particular individuals, programs and identified risk areas may be offered. Such training is mandatory.

D. **Records of Training:** The Compliance Officer shall ensure that records are maintained, including copies of training materials, the types of training program offered, dates offered, and the individuals in attendance for a period of ten (10) years from the date of training.

E. **Periodic Review of Training:** The Compliance Committee shall periodically monitor, evaluate and assess the effectiveness of PHD's training and education programs and shall revise such programs as necessary.

F. **Distribution of Compliance Information:** In addition to periodic training the Compliance Officer will distribute relevant new compliance information to affected Compliance Partners. Such information may include fraud alerts, advisory opinions, newsletters, bulletins and email alerts.

G. **Distribution and Certification of Plan:** This Compliance Plan will be made accessible to Compliance Partners in whatever format is deemed appropriate, including posting on the PHD's Intranet and Website. Compliance Partners will be required to examine the Compliance Plan and certify their examination within sixty (60) days of receipt of the Plan. New Compliance Partners must certify their receipt and examination of the Plan within sixty (60) days after their commencement date. Subsequent to the initial certification, each employee or member shall annually repeat the procedure of examining and certifying the contents of the Plan. The certifications will be distributed by, and returned to, the Compliance Officer or delegate.

VII. **Reporting Compliance Issues**

A. **Required Reporting:** If any employee believes that fraud, waste, abuse or other improper conduct has occurred, the individual is strongly encouraged to report such information internally (see PHD Fraud Waste and Abuse Health Care Center Policy and the reporting of Coding Fraud Waste and Abuse Reporting Policy). Individuals who report such conduct in good faith shall not be retaliated against or intimidated for making such a report. PHD shall maintain the confidentiality of reports to the extent feasible and permitted by law. An individual may report a concern:
• Confidentially to their Supervisor, Manager, Deputy Director or the Compliance Officer. The Compliance Officer can be reached at (805) 681-5173 or via email at dan.reid@sbcphd.org.
• Confidentially or Anonymously through the PHD’s Compliance Reporting Hotline. The number is: (844)-351-0659.
• Confidentially or Anonymously through the PHD’s Compliance Reporting Fax number: (805) 681-5200.
• Confidentially or Anonymously in writing through the PHD Compliance Reporting Email box (phdcompliancereporting@sbcphd.org).

While PHD requires such individuals to report fraud, waste, abuse or other improper conduct to PHD, certain laws provide that individuals may also bring their concerns directly to the government. Compliance Partners and contractors may also contact the Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

B. Confidentiality: Any individual who reports a compliance concern in good faith will have the right to do so anonymously. The information provided by the individual will be treated as confidential and privileged to the extent feasible and permitted by applicable laws. However, individuals who report compliance concerns are encouraged to identify themselves when making such reports so that an investigation can be conducted with a full factual background and without any delay.

C. Non-Retaliation and Non-Intimidation Any individual who reports a compliance concern in good faith will be protected against retaliation and intimidation.

In such an instance, retaliation is itself a violation of the Code of Conduct and unlawful. However, if the individual who reports the compliance issue has participated in a violation of law, the Code of Conduct or a PHD policy, PHD retains the right to take appropriate disciplinary action.

VIII. Responding to Compliance Problems.

A. Investigation of Reports Upon receiving a credible report of suspected or actual fraud, waste, abuse or other improper conduct or upon the identification of a potential or actual compliance problem in the course of self-evaluation and audits, the Compliance Officer will investigate such report or problem through internal compliance processes, and involve County Counsel, auditors, or other experts to assist in an investigation, as appropriate and necessary. PHD requires that all Compliance Partners fully cooperate in any such investigations. The investigative file should contain documentation of the alleged violation, a description of the investigative process, copies of
interview notes and key documents, a log of the witnesses interviewed, documents reviewed, the results of the investigation, and any disciplinary and/or corrective action plan.

**B. Corrective Action:** After appropriate investigation, if the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Code of Conduct, Compliance Program, PHD's policies and procedures, and any applicable laws or regulations, the Compliance Officer shall institute corrective action. Any problems identified shall be corrected promptly and thoroughly, and procedures, policies, and systems shall be implemented as necessary to reduce the potential for reoccurrence. Such action may include: additional training for Compliance Partners, modification or improvement of PHD's business practices; and modification or improvement of the Compliance Program itself to better ensure continuing compliance with applicable federal and state laws and regulations; disclosure to appropriate government agencies and/or third party payers; and repayment of funds that were improperly paid.

**C. Disciplinary Action** After appropriate investigation, if the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Code of Conduct, Compliance Program, PHD's policies and procedures, and any applicable laws or regulations, the Compliance Officer will report findings to PHD Administration and work with County Human Resources or the County Purchasing Division to impose sanctions against those individuals involved. Sanctions shall be imposed against any Compliance Partners for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; and (3) encouraging, directing, facilitating or permitting non-compliant behavior. Sanctions shall be imposed subject to the due process requirements of any applicable employment contracts, civil service rules, organizational bylaws, or contracts or agreements. Sanctions shall be fairly and consistently applied and enforced in accordance with any written standards of disciplinary action.

- Employee sanctions can range from an oral warning to, in the most extreme cases, termination.
- HC Board Member sanctions can range from written admonition to, in the most extreme cases, removal from the HC Board.
- Contractor sanctions shall range from written admonition, financial penalties, and in the most extreme cases, termination of the contractor's relationship with PHD.
- In some instances, as per current County policies as a local government entity, investigation results may be released to law enforcement for potential criminal prosecutions.

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IX. **Risk Management Plan**

A. **Patient Safety and Risk Management Program Purpose:** The Risk Management Plan is designed to support the mission and vision of the Public Health Department (PHD) as it pertains to clinical risk patient, visitor, volunteer, and employee safety and potential business, operational, and property risks.

B. **Guiding Principles:** The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives.

The Patient Safety and Risk Management Program supports the PHD’s philosophy that patient safety and risk management is everyone’s responsibility. Teamwork and participation among managers, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program.

PHD supports the establishment of a culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback. Unsafe conditions and hazards should be readily and proactively identified, medical or patient care errors will be reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are held accountable for compliance with patient safety and risk management practices.

The PHD’s Risk Management Plan stimulates the development, review, and revision of the organization’s practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Provider and staff education, competency validation, and credentialing requirements
- Claims management
- Confidentiality and release of information
- Event investigation, root-cause analysis, and follow-up
- Complaint resolution
- Reporting and management of adverse events
- Trend analysis of events

C. **Governing Body Leadership:** The success of the Patient Safety and Risk Management Program requires top-level commitment and support. The Santa Barbara County Board of Supervisors and Health Center(HC) board authorize
the formal program and adoption of this Plan through a resolution documented in board meeting minutes.

The HC Board is committed to promoting the safety of patients, visitors, employees, volunteers, and other individuals involved in organizational operations. The Patient Safety and Risk Management Program is designed to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety. The HC Board empowers the organizational leadership with the responsibility for implementing performance improvement and risk management strategies.

D. **Program Goals and Objectives:** The Patient Safety and Risk Management Program goals and objectives are to:

- Continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns.
- Minimize losses to the organization by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate regulatory and legal compliance, (e.g., HRSA).
- Protect human and intangible resources (e.g., reputation).

F. **Scope and Functions of the Risk Management Program:** The PHD's Patient Safety and Risk Management Program is designed to interface with all programs and services throughout the organization.

1. **Functional Interfaces:**

Functional interfaces with the patient safety and risk management program include the following: Provider documentation and appropriateness of medical care

- Buildings and grounds
- Claims management
- Regulatory compliance
- Credentialing of providers
- Disaster preparation and management
- Employee health
- Event/incident/accident reporting and investigation
2. Patient Safety and Risk Management Program Functions:

Risk management functional responsibilities include:

a) Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event-reporting policies and procedures.

b) Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., preventive screening, diagnostic testing, medication use processes, perinatal care). Proactive risk assessment can include the use of failure mode and effects analysis, system analysis, and other tools.

c) Overseeing the data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events, claims, finances, and effectiveness of the risk management program.

This system may utilize and include, but is not limited to, the following:

- Attorney requests for medical records, x-rays, laboratory reports
- Committee reports and minutes
- Criteria-based outcome studies
• Event, incident, or near miss reports
• Medical record reviews
• Monitoring systems based on objective criteria
• Notice letters, lawsuits
• Nursing reports
• Patient complaints & surveys
• Provider input
• Root-cause analyses of sentinel events

d) Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such events.

e) Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.

f) Facilitating and ensuring the implementation of patient safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, and prevention programs.

g) Facilitating and ensuring provider and staff participation in educational programs on patient safety and risk management.

h) Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution. This ordinarily involves performing safety culture surveys and assessments and modeling appropriate behavior and program support by administration and executives.

i) Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, staff, and volunteers.

j) Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., biomedical equipment maintenance, fire prevention, etc.).

k) Preventing and minimizing the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization.
l) Decreasing the likelihood of claims and lawsuits by developing a patient and family communication and education plan. This includes communicating and disclosing errors and events that occur in the course of patient care with a plan to manage any adverse effects or complications.

m) Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.

n) Reporting claims to the County's Risk Manager in accordance with policy.

o) Supporting quality assessment and improvement programs throughout the organization.

p) Implementing programs that fulfill regulatory, legal, and accreditation requirements.

q) Establishing an ongoing patient safety/risk management committee composed of representatives from key clinical and administrative departments and services.

r) Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:

- Claims and claim trends
- Culture of safety surveys
- Event trending data
- Ongoing risk assessment information
- Patient survey results
- Quality performance data
- Research data

s) Completing insurance and deeming applications.

t) Developing and monitoring effective handoff processes (such as Patient Centered Medical Home models) for continuity of patient care.

G. **Administrative and Committee Structure and Mechanisms for Coordination:**

The Patient Safety and Risk Management Program is administered through the Compliance Officer, who reports to the Deputy Director. The Compliance
Officer interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The Compliance Officer chairs the Compliance Committee. The committee meets regularly and includes representatives from key clinical and administration areas. The composition of the Compliance Committee is designed to facilitate the sharing of risk management knowledge and practices across multiple disciplines and to optimize the use of key findings from risk management activities in making recommendations to reduce the overall likelihood of adverse events and improve patient safety. The Committee’s activities are an integral part of a patient safety and quality improvement and evaluation system.

Documentation of the designation of the Compliance Officer is contained in the Patient Safety and Risk Management Plan. The Compliance Officer is responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating and reporting to the County’s Risk Manager actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to County policy. The Compliance Officer serves as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. The risk manager oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

H. **Monitoring and Continuous Improvement:** The Patient Safety/Risk Management Committee reviews risk management activities regularly. The Compliance Officer reports activities and outcomes (e.g., claims activity, risk and safety assessment results, event report summaries and trends) regularly to the governing board. This report informs the governing board of efforts made to identify and reduce risks and the success of these activities and communicates outstanding issues that need input and/or support for action or resolution. Data reporting may include event trends, claims analysis, frequency and severity data, credentialing activity, relevant provider and staff education, and risk management/patient safety activities. In accordance with the organization’s policies and protocols, recommendations from the Patient Safety/Risk Management Committee are submitted as needed to the HC Board.

I. **Confidentiality:** Documents and records that are part of the patient safety and risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, attorney work product, and peer review protections.
X. Monitoring and Auditing

A. System for Identifying Risks: The Compliance Committee shall develop a system for routine identification and evaluation of compliance risk areas. Such a monitoring and auditing system shall include the Risk Management Plan (see Section IX above and also referred to as the Annual Risk Reduction Work Plan), performance of regular, periodic compliance audits by internal or external auditors and designated Compliance Partners. Such audits will include reviews of PHD's business and billing practices, including pre-billing audits, and measures to identify, anticipate, and respond to quality of care risk areas. In addition, such System shall include a periodic review of the Compliance Program to determine whether the elements of the Program have been satisfied and the effectiveness of the Program has been determined or evaluated.

PHD shall have an annual financial audit and a single audit conducted by the County Auditor/Controller and/or an independent Certified Public Accountant Firm to examine, on a test basis, evidence supporting the proper handling and reporting of amounts and disclosures relating to the financial activity of PHD. PHD shall also conduct annual reviews of business and contractual agreements and relationships as well as billing practices to reasonably ensure that all activities are in compliance with its Code of Conduct, standards, and procedures. PHD shall also maintain a disclosure listing of all individuals associated with PHD who have identified outside party interests that represent potential conflicts of interest. Results of audits related to the FQHC operations and the Public Health Department will be shared with the Health Center Board on an annual basis.

The Compliance Officer and/or Committee shall establish and implement standard operating procedures for conducting internal reviews. These procedures shall establish specific schedules for the frequency of each type of review activity. Sampling shall be conducted in a manner consistent with generally accepted statistical standards. The results of such reviews shall be documented on a standardized form and retained for a minimum of ten years.

B. Corrective Action Plans: The Compliance Officer and/or Committee shall receive and review the results of such reviews, develop a corrective action plan to remedy any deficiencies identified in the results, and provide the corrective action plan to those individuals who will be charged with the responsibility of implementing it. If periodic review and monitoring activities identify substantial deviation from acceptable norms, the Compliance Officer, Committee, and HC Board shall take prompt steps to address such deviations. Where additional investigation of such deviations is appropriate, the Compliance Officer, in consultation with the Committee, shall retain the
services of such independent advisors as shall be necessary to address such deviations.

C. **Government Inquiries.** If contacted by a government (i.e.: Medicare, Medi-Cal, Federal Bureau of Investigation (FBI), Office of Inspector General (OIG), Health Resources Services Administration (HRSA)) official, employees are required to obtain the official's identification and immediately inform their supervisor and the Compliance Officer of the contact. While employees may voluntarily speak with such officials, they are strongly encouraged that before they speak to such officials, they first contact their supervisor and the Compliance Officer.

Employees may not respond to a request to disclose PHD’s documents without first obtaining approval from their supervisor, HIPAA Privacy Officer, and/or Compliance Officer.

XI. **Laws Regarding the Prevention of Fraud, Waste and Abuse.**

A. **Federal Laws**

**Federal False Claims Act:** Any employee who submits a claim to the federal government that is false is subject to civil penalties of $5000-$10,000 per false claim.

**Administrative Remedies for False Claims and Statements:** If a person submits a claim that the employee knows is false, contains false information or omits material information, the employee may be subject to a $5,000-$10,000 penalty per claim and triple damages (see Federal False Claims Act).

**Federal Anti-Kickback Law:** Employees may not knowingly offer, pay, solicit, or receive remuneration in exchange for referring, furnishing, purchasing, leasing or ordering a service or item paid for by Medicare, Medicaid, or other federal health care program. Criminal or civil penalties include repayment of damages, fines, imprisonment, and exclusion from participation in federal health care programs.

B. **State Laws**

California has the following similar laws: these include the California False Claims Act, False Statements Law, Anti-Kickback Law, Self-Referral Prohibition Law, Health Care and Insurance Fraud Penal Law. Individuals may be entitled to bring an action under the State False Claims Act, and share in a percentage of any recovery. However, if the action has no merit and is for the purpose of harassing PHD, the individual may have to pay PHD for its legal fees and costs.
C. Whistleblower Protections

Federal Whistleblower Protection: An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against because of their lawful acts conducted in furtherance of a False Claims Act action may bring an action against the employer. However, if the employee's action has no basis in law or fact or is primarily for harassment of the employer, the employee may have to pay the employer its fees and costs.

California State Whistleblower Protection: Compliance Partners who, in good faith, report a false claim are protected against discharge, demotion, suspension, threats, harassment, and other discrimination by their employer. Remedies include reinstatement, double back pay plus interest, and litigation costs and attorneys' fees.

*These are summaries of very complex laws. The Compliance Officer can provide you with more information about these laws, or their application to any situation you may encounter. These laws all serve the important function of protecting the Federal and State health care programs from fraud, waste, and abuse and allow those funds to protect the beneficiaries of these programs. PHD supports the goals of these laws and requires all Compliance Partners, to comply with these laws as part of our mission of providing services to individuals.

XII. Program Evaluation

The Compliance Officer will oversee an annual review of the PHD Compliance Program, which may include the following:

- Randomly survey staff as to their knowledge and understanding of the Program.
- Will make a report to the PHD Director and the HC Board annually on the activities and the effectiveness of the Program.
- Examine employee certifications of compliance and filing with the applicable government regulatory agency, if necessary.
- Coordinate with PHD Supervisors and Managers to evaluate adherence to the employee elements of the Compliance Program and Code of Conduct for PHD employees through the existing annual employee performance review (EPR) and the annual individual performance plan (IDP) evaluation processes.

XIII. Summary

PHD is proud of its reputation for consistently providing high quality care, practicing the values of professionalism, integrity and trust. Select this link to review the Public Health Department Mission, Vision and Values.
The signatures below represent an acceptance of the Compliance Program and the Code of Conduct.

PHD Director Approval: [Signature]
Date: 8/30/2019

HC Board Approval: [Signature]
Date: 8-28-19