HUDSON HEADWATERS HEALTH NETWORK

Ethics & Compliance Program
2023

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Ethics & Compliance Program

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Definition of Ethics & Compliance

Hudson Headwaters Health Network (the Network) strives to maintain a reputation for conducting all fiscal and operational activities in accordance with the highest level of business and community ethics. As a healthcare provider, the Network is committed to operating under the highest ethical and moral standards, and ensures that the Network, in all of its activities, complies with applicable federal, state and local laws, regulations and guidelines.

The Network Ethics & Compliance Program (the Program) begins with the Network's organizational Mission, quality Vision and core Values. All compliance-related activities are designed to detect and prevent accidental or intentional noncompliance with applicable laws, throughout the organization. The Program contains organizational conduct requirements that are intended to address pertinent compliance issues and the overall scope of conduct; however, these requirements are not to be considered all-inclusive.

Purpose

The purpose of the Network's Ethics & Compliance Program is to:

1. Implement measures for detecting, correcting, and preventing fraud, waste and abuse;
2. Create a culture of non-retaliation and non-intimidation for reporting potential compliance and privacy breaches;
3. Ensure patients' rights to privacy and confidentiality of protected health information;
4. Facilitate compliance with regulatory, legal, and accrediting agency requirements; and
5. Protect human and intangible resources (e.g., reputation).

Scope of Program

The scope of the Program is comprehensive and includes all clinical and administrative departments and activities that have a direct or indirect influence on the quality and outcome of care delivered to all Network patients. This scope includes primary care, specialty care, behavioral health, dental, and imaging.

The Network performs all necessary "due diligence" for external services provided to Network patients through written agreement (specialists, radiology, etc.). Through this mechanism, the Network ensures that patients receive acceptable quality of care in these external settings.

Program Accountabilities and Responsibilities

Accountability

The Network's Board of Directors is ultimately accountable for the Ethics & Compliance Program. The Board holds the Chief Executive Officer accountable for the efficient and effective functioning of the Network and its Ethics & Compliance Program.

Responsible Individuals

A. The ***Chief Executive Officer (CEO)*** is accountable to the Board of Directors and holds ultimate responsibility for the implementation of the Ethics & Compliance Program. The ***CEO*** has oversight responsibility for Operations and Human Resources.

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B. The ***Chief Medical Officer (CMO)*** is accountable to the CEO and is responsible for leading and guiding the medical staff in performing their medical duties. The ***CMO*** is a member of the Network Quality, Risk & Compliance Committee and has oversight responsibility for all aspects of quality, risk management, patient safety and compliance from a clinical perspective. This position reports to the CEO and represents the committee at the Board of Director's meetings along with the Vice President of Compliance.
C. The Network's ***Chief Medical Informatics Officer (CMIO)*** has oversight responsibilities for Information Systems, Population Health, Quality and Patient Satisfaction. This position reports to the CEO.
D. The Network's ***Chief Compliance Officer*** has oversight responsibility for the Risk Management, Compliance, Privacy & Security, and Safety programs. This position reports to the Chief Medical Officer, Chief Operating Officer, Chief Executive Officer and the Board of Directors.
E. The Network's ***Executive Vice President of Finance/Chief Financial Officer (CFO)*** has oversight responsibility for all finance, billing and coding programs, and facilities management. This position reports to the Chief Executive Officer.
F. The Network's ***Executive Vice President of Human Resources*** has oversight responsibility for managing and directing all human resources practices, policies, and procedures. This position reports to the Chief Executive Officer.

Board of Directors

The Board of Directors takes an active role in the continual improvement of the Network. The Board reviews and approves the overall Ethics & Compliance Program annually, receives and acts upon reports presented by the Compliance Officer, and ensures the availability of resources and systems to support all Ethics and Compliance activities.

Network Quality, Risk & Compliance Committee (NQRCC)

The Network Quality, Risk & Compliance Committee has the responsibility to oversee all Quality Assessment and Quality Improvement, Compliance, Risk Management and Safety activities. This Committee also addresses all Network-wide issues that relate to quality, risk and compliance, including environmental center audits, patient/family/staff complaints, safety drills and incidents, clinical measures, customer service and overall unusual occurrences. The NQRCC reports its activities and findings to the CEO and the Board of Directors.

The NQRCC meets at least quarterly and is chaired by the Chief Compliance Officer and Chief Medical Officer. The Network recognizes the important role of leadership in its quality program. Accordingly, the Network Quality, Risk & Compliance Committee is comprised of:

- Chief Medical Officer;
- Chief Compliance Officer;
- Chief Financial Officer;
- Chief Operations Officer;
- Executive Vice President of Human Resources;
- Vice President of Population Health;
- Risk & Privacy Manager;
- Director of Nursing Practice and Ancillary Services; and the
- Infection Control Officer

Other staff may be requested to attend the NQRCC Committee Meeting depending on the material being discussed.

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Security & Safety Committee

Overseen by the Chief Compliance Officer and the Chief Financial Officer, the Security and Safety Committee is responsible for the overall privacy, safety and security throughout the Network. This includes both cyber security and physical plant/staff safety and security. The Security and Safety Committee is comprised of:

- Chief Medical Officer;
- Chief Compliance Officer;
- Chief Financial Officer;
- Chief Operations Officer;
- Chief Information Officer
- Director of Information Services;
- Director of Procurement and Facilities;
- Emergency Management Coordinator;
- Business Associate Compliance Manager;
- Infection Control Officer; and when applicable
- the Network's Legal Counsel.

Other staff may be requested to attend the Safety and Security Committee meeting depending on the material being discussed. When appropriate, subcommittee(s) are formed to address specific concerns.

Project-specific Workgroups

Multi-disciplinary ad-hoc workgroups are convened as new Network-wide initiatives are introduced and implemented. The groups meet at frequencies and for durations deemed necessary, depending on the complexity of the specific initiative.

Integration and Coordination

The Network's Ethics & Compliance Program is fully integrated into the Network's ongoing operations through participation of all departments, disciplines, and cross-functional groups/teams.

The Chief Executive Officer is responsible for the Program with active assistance from the Compliance Officer, the Network Quality, Risk & Compliance Committee and the Board of Directors.

Essential Components

Written Policies and Procedures

The Network has established policies that describe compliance expectations as embodied in a code of conduct, guide the implementation of the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved. Policies are to be followed by all Network employees, officers, and agents who are reasonably capable of reducing the prospect of criminal conduct. The Ethics & Compliance Program and related policies and procedures are specific to the mission, vision, organizational history, lines of business and corporate culture of the Network.

The Ethics & Compliance Program and related policies and procedures are developed in a collaborative fashion, incorporating all legal requirements with the business methodology embraced by the Network.

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The Program and related policies and procedures are reviewed and approved by Network Leadership and the Board of Directors.

Copies of the Ethics & Compliance Program and related policies and procedures are located on the Network's intranet site. Policies and procedures address specific areas of potential fraud, such as billing and claims processing. Any new or revised corporate compliance policies and procedures are disseminated to all staff members by the Risk & Compliance Department.

Designation of a Compliance Officer

The Chief Compliance Officer & Vice President of Compliance has been designated as the Network's Compliance Officer and has the responsibility to administer and manage all tasks related to establishing, monitoring and updating the Ethics & Compliance Program, with oversight from the Chief Executive Officer, the Board of Directors and the Network's Legal Counsel. The Compliance Officer reports directly to the Chief Executive Officer, Chief Medical Officer and the Board of Directors and periodically reports directly to the Board on the activities of the compliance program. Specifically, the Compliance Officer has the responsibility to:

- Oversee the completion of a compliance risk analysis to identify areas of risk specific to the Network.
- Supervise the implementation and maintenance of the Ethics & Compliance Program, coordinate existing compliance policies and procedures, develop new compliance policies and procedures and assure all revisions and new policies and procedures are disseminated as outlined in this program.
- Facilitate the review and revision, as necessary, of the Code of Conduct for all Network employees.
- Provide oversight for and evaluate monitoring and auditing of procedures related to compliance standards.
- Establish methods, such as periodic audits, to improve the Network's efficiency and quality of services, and to reduce the Network's vulnerability to fraud and abuse.
- Monitor that personnel receive training and education in the basic principles of corporate compliance and ethical business practices.
- Implement and maintain a means for anonymous communication for reporting noncompliance issues, and/or receiving help and assistance regarding potential violations and general information about corporate compliance.
- Establish and maintain open lines of communication with all departments, including the billing department and organizational personnel and agents to ensure effective and efficient compliance policies and procedures.
- Investigate any report or allegation concerning possible unethical or improper business practices and monitor subsequent corrective action and/or compliance.
- Work closely with regulatory body auditors where appropriate and be available as needed during annual Network audits.
- Prepare and forward compliance reports as required by the Network Quality, Risk & Compliance Committee, but no less than on a semi-annual basis. An annual summary and evaluation report are to be submitted to the CEO, Network Leadership and the Board of Directors.

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All questions and concerns regarding compliance with any of the directives set forth within this Program are to be directed to the Compliance Officer. All personnel and agents are required to fully cooperate with and assist the Compliance Officer as outlined in the performance of their duties. Any uncertainty regarding compliance issues on behalf of personnel or agents should be brought to the attention of the Compliance Officer for assistance and direction.

Effective Education & Training

The Network ensures that ethics and compliance training and education of all affected employees and associated persons, including officers and Board members, on compliance issues, expectations and compliance program operation is provided. Training occurs annually and is a part of the orientation for a new employees, officers and Board members. Education is provided through mandatory training programs and by disseminating publications that explain, in a practical manner, the requirements of the Ethics & Compliance Program. All employees receive training on how to perform their jobs in compliance with the standards of the Network and any applicable regulations, and each employee must understand that compliance is a condition of continued employment.

Coders, billers and coding managers are educated regularly on the following topics: Medicare reimbursement principles, billing Medicare and Medicaid for services not rendered, misrepresenting the nature of services rendered, alterations of medical records, billing in violation of the Medicare/Medicaid bundling regulations, medical necessity of services provided, contracts/conflict of interest, credit balance, failure to refund, and patients' freedom of choice.

Initial and annual training in compliance are conducted, both with respect to the Ethics & Compliance Program itself and applicable statutes and regulations. This training is a component of Board member, provider and staff orientation. Items to be included in compliance training include HIPAA, operation and importance of the Ethics & Compliance program, consequences of violating the standards and procedures set forth in the Program, and the role of each employee in the operation of the Program.

Training is provided in an understandable manner to assure all staff are aware and know the Network's code of conduct and steps to alert management and the Compliance Officer to concerns or problems. Training is modified to reflect the level of risk a staff member or agent possesses, or may encounter, with additional training for providers, managers, supervisors, Board members and those individuals working with billing and accounting processes.

Evaluation of management promotion and adherence to the Ethics & Compliance Program and any other compliance issues are a component of the individual's annual performance appraisal. Attendance records of personnel orientation and annual educational updates are maintained, with annual performance appraisals based, in part, on receipt of compliance information as offered by the Network.

Fraud, Waste & Abuse Program

Network employees or agents (via written or verbal contract and/or statement or representation of material fact in agreement), shall not knowingly and willfully make or cause to be made, any false claim or application for benefits under any federal, state or other healthcare program. Network personnel and agents shall not, with knowledge and fraudulent intent, retain federal, state or other healthcare benefit program funds, which have not been properly paid. The Ethics & Compliance Program includes activities to detect, correct and prevent fraud, waste, and abuse.

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Fraud: The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true, knowing that deception could result in some unauthorized benefit.

Waste: Acting with gross negligence or reckless disregard for the truth in a manner resulting in any unnecessary cost or consumption of health care resources.

Abuse: Incidents that are inconsistent with accepted medical or business practices, or that are improper or excessive.

Examples of Fraud, Waste & Abuse

1. Provider
   - Billing for Medicaid/Medicare services that were not provided;
   - Providing and/or billing for unnecessary services;
   - Selling prescriptions;
   - Ordering unnecessary tests; or
   - Giving money or presents to consumers in return for agreeing to get medical care from someone.

2. Patient
   - Lending a Medicaid identification card to another person;
   - Forging or altering a prescription or fiscal order;
   - Using multiple Medicaid ID cards;
   - Intentionally receiving duplicative, excessive, contraindicated, or conflicting health care services or supplies; or
   - Re-selling items provided by the Medicaid program.

Effective Lines of Communication

Communication lines to the Network Compliance Officer or designee are accessible to all employees, officers, agents, and Board members, to allow compliance issues to be reported. Communication lines include an anonymous "compliance hotline". Communication is confidential and good faith reporting of potential compliance issues as they are identified is expected. Standards of conduct are included in the terms and conditions of employment and are part of the Network's annual in-service for all employees, officers and Board members. Should staff, providers, or others question the integrity of any individual or department of the Network, they are expected to report their concerns, anonymously if so desired, through the compliance hotline without fear of retribution.

Individuals leaving an anonymous message are encouraged to provide as many details as possible in order for the Network to conduct a proper investigation. Individuals who report problems or concerns in good faith will be protected from retaliation, retribution or harassment. Employees who engage in retribution, harassment, or any other type of retaliatory action will be subject to disciplinary action up to and including termination of employment.

Posters containing information about the anonymous compliance hotline are posted in employee break rooms throughout the Network and on the intranet with compliance policies & procedures.

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Disciplinary Policies/Enforcement of Standards & Discipline

The Network encourages good faith participation in the Ethics & Compliance Program by all affected individuals. Policies outline expectations for reporting compliance issues and assisting in their resolution. The policies outline actions for failing to report suspected problems, participating in non-compliant behavior, and/or encouraging, directing, facilitating, or permitting, either actively or passively, non-compliant behavior. Such disciplinary policies shall be fairly and firmly enforced.

Through its systematic reporting, monitoring, and auditing systems, the Network investigates and remediates identified systematic and personnel problems. Discipline of an individual responsible for the failure to detect a violation and/or an individual who commits a violation is conducted. Upon determination that a personnel member has violated the conduct requirements as set forth in this plan, the individual case is handled per the Network's disciplinary processes.

Management personnel are made aware of their responsibility for compliance training and for the misconduct of subordinates.

- All personnel are informed that adherence to the Ethics & Compliance Program will be an element of annual performance evaluations and that willful violation or failure to comply with organizational policies/procedures and the Ethics & Compliance Program plan will be grounds for immediate termination.
- All disciplinary actions are conducted in such a manner that affords the personnel member confidentiality and due process.
- Self-disclosure of misconduct is encouraged, and personnel are advised that while self-reporting will not result in immunity from discipline, it will be considered as a strong mitigating factor when corrective action is required.
- No individual who has engaged in illegal or unethical behavior and/or who has been convicted of healthcare-related crimes is allowed to occupy any position within the Network which involves the exercise of discretionary authority.
- Any individual applying for a position of discretionary authority must have a background evaluation performed prior to hire. Upon discovery of any state or federal sanctions, the potential staff member will no longer be considered for hire.
- Any personnel in a position of discretionary authority who displays evidence that they are unwilling to comply with the Ethics & Compliance Program plan will be removed from that position.

Any personnel member who has been under federal or state sanctioning will be immediately terminated.

Internal Monitoring and Auditing

The Network has implemented a system for routine identification of compliance risk areas and for self-evaluation of such risk areas, including but not limited to internal audits and, as appropriate, external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care. The Network has taken reasonable steps to achieve compliance with its standards, i.e., by utilizing monitoring and auditing systems designed to detect actual or potential compliance issues by Network personnel or agents, and by having in place and publicizing a reporting system whereby staff and agents can report compliance issues without fear of retribution. The purpose

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of the ongoing auditing process is to identify actual or potential issues in a timely manner so that systemic checks and balances can be imposed quickly to prevent future recurrences.

A. Exclusions

- All current and prospective Network Board members, providers, employees, volunteers, vendors, suppliers, contractors, and any Business Associates are verified against the HHS/OIG Cumulative Sanctions List of excluded persons, the Systems for Award Management (SAM) database, and the NYS Office of the Medicaid Inspector General.
- Exclusion Monitoring is conducted monthly and reports are provided to the Network Quality, Risk & Compliance Committee quarterly if an exclusion is detected.

B. Auditing

- Coding and billing audits are conducted as outlined in the Compliance Policy & Procedure: Compliance Monitoring & Auditing: Billing & Claims.
- Assessments and changes must be documented clearly. Documentation must be consistent, timely, and authenticated.
- Should instances of potentially improper code assignments be identified, all pertinent policies/procedures, including official coding guidelines and billing manuals, are reviewed with the individual who incorrectly coded the encounter.
- A statistically valid, random sample of cases is reviewed to determine whether the problem is an isolated case, occurred during an isolated time period or is a widespread, ongoing problem.
- Staff are interviewed to obtain more information about how and why the particular billing or coding practice in question occurred. A trend analysis is conducted, and re-training is conducted as needs are identified.
- An annual financial audit is conducted to check for possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, limitations on certain physician referrals (the Stark Law), and the False Claims Act in any jurisdiction whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency (other than those disclosed or accrued in the financial statements).
- An independent audit of the Network's consolidated financial statements is conducted annually (including 330 Grant funds) to check for compliance for each major federal program and report on internal control over compliance required by the Uniform Guidance.
- An independent audit is conducted to check for compliance with the rules and regulations of the US Department of Health and Human Services Office of Pharmacy Affairs Drug Pricing Program ("Section 340B"). The audit is conducted in compliance with attestation standards established by the American Institute of Certified Public Accountants.

C. Monitoring

- Monitoring provides an ongoing system of internal coding and billing review. Monitoring is conducted on a regular basis and focuses on compliance to the Program and performance measures. The purpose of monitoring is to assure that policies and procedures have been properly followed.
- Monitoring techniques include, but are not limited to health center visits, interviewing staff members, interviewing management, review of operations, billing and related functions and trend analysis studies.

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Prompt Response to Detected Offenses

The Network encourages prompt reporting, at the earliest reasonable opportunity, by employees, Board members, independent contractors and vendors of any activity or conduct in violation of any Network compliance policy or any federal, state, or local laws or regulations pertaining to compliance-related matters.

The Compliance Officer promptly investigates any reports of potential violations or non-compliance and, when necessary and/or appropriate, available evidence is reviewed with the relevant supervisor, manager, director, or senior manager and the Board of Directors.

Policy of Non-Intimidation & Non-Retaliation

The Network has established a policy of non-intimidation and non-retaliation for good faith participation in the Ethics & Compliance Program including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials.

Regulatory Compliance

The Network's definition and resulting application of compliance at all times remains consistent with the Office of Inspector General (OIG), Office of Medicaid Inspector General (OMIG), Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) Program Expectations, HRSA BPHC Compliance Manual, appropriate guidelines of the Federal Tort Claims Act (FTCA), all applicable accrediting entities and federal and state laws, rules, and regulations.

Federal Regulations

The False Claims Act

The False Claims Act (the Act) imposes liability only when the claimant acts "knowingly". It does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information also can be found liable under the Act. The False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false.

The Anti-Kickback Statute

The Anti-Kickback Statute is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business.

The Physician Self-Referral Law (Stark Law)

The Stark Law Prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. The Stark Law also prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third-party payer) for those referred services.

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The Exclusion Authorities

The effect of an OIG exclusion from federal health care programs is that no federal health care program payment may be made for any items or services (1) furnished by an excluded individual or entity, or (2) directed or prescribed by an excluded physician. This payment ban applies to all methods of federal program reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system (PPS). Any items and services furnished by an excluded individual or entity are not reimbursable under federal health care programs. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the federal payment itself is made to another provider, practitioner or supplier that is not excluded.

The Civil Monetary Penalties Law

The Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to: (1) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (3) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; or (6) using a payment intended for a federal health care program beneficiary for another use.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to defraud any health care benefit program; or obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

HIPAA Requirements

Patient Rights, Responsibilities, & Privacy Practices

The Network is committed to ensuring patient rights and responsibilities by educating staff and providers. The Network's Patient Rights, Responsibilities & Privacy Practices are available to every patient of the Network through the following channels:

- New Patient Packets;
- Network's website;
- Posted in prominent locations throughout the Health Centers and the exam rooms;
- Printed handouts are available to patients in waiting room areas.

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Privacy & Security

The Network restricts access to all patient protected health information (PHI), including electronic information, to individuals who have a need to know and permission for access. Confidentiality must be safeguarded by the restrictive use of PHI obtained from and about a patient. Information from the patient's medical record shall be secured by departmental policies regarding authorized users and authorized release of patient and clinical data. PHI is not allowed off the premises unless in an encrypted electronic form.

The Network has identified a Privacy and Security Officer as required by the Health Insurance Portability and Accountability Act (HIPAA) who has the responsibility to oversee all ongoing activities related to the development, implementation, and maintenance of the Network's privacy and security policies in accordance with applicable federal and state laws.

Release of Information

Adherence to all governing rules and regulations in relation to the release and disclosure of medical records while ensuring continuity of care and patient confidentiality is maintained. Medical records are secure when the Network is responding to requests for release of confidential information.

New York State Regulations

New York Social Services Law (SOS Article 5, Title 11, Section 363-d)

Every provider of medical assistance program items and services that is subject to subdivision four of this section shall adopt and implement a compliance program or, in the case of the Network, the Ethics & Compliance Program. Such program shall at a minimum be applicable to billings to and payments from the medical assistance program but need not be confined to such matters. The compliance program required may be a component of more comprehensive compliance activities by the medical assistance provider so long as the requirements of this section are met. A compliance program shall include the following elements: written policies and procedures, training and education, designated employee(s), communication lines, disciplinary actions, a system for routine identification, a system for responding, and a policy of non-intimidation and non-retaliation.

New York Labor Law (LAB Article 20-c, Section 740)

An employer shall not take any retaliatory personnel action against an employee because such employee does any of the following: (a) discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation when such violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud; (b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or (c) objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

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Employee Whistleblower Protections

The Network is prohibited from discharging, demoting, or otherwise discriminating against an employee as a reprisal for disclosing to government entities information that the employee reasonably believes is evidence of gross mismanagement of a federal contract, a gross waste of federal funds, an abuse of authority relating to a federal contract, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a federal contract (including the competition for or negotiation of a contract). A reprisal is prohibited even if it is undertaken at the request of an executive branch official, unless the request takes the form of a non-discretionary directive and is within the authority of the executive branch official making the request.

An employee who believes that he or she has been discharged, demoted, or otherwise discriminated against contrary to this policy may submit a complaint with the Inspector General of the agency concerned. Procedures for submitting fraud, waste, abuse, and whistleblower complaints are generally accessible on agency Office of Inspector General Hotline or Whistleblower Internet sites.

Health Information Management

The Network achieves continued excellence with respect to its medical records. These records are maintained in a manner that is current, detailed, secure, and enabling of effective, confidential patient care and quality review. Medical records reflect all aspects of care and are complete, accurate, systematically organized, legible, authenticated, and readily available to all appropriate health care practitioners and other necessary parties, in strict accordance with HIPAA guidelines.

Conflict of Interest and Code of Conduct

It is the policy of the Network to outline the standard of conduct expected of all employees, officers, Board directors and appropriate agents. It is expected that during the performance of duties on behalf of the Network, conflicts of interest will be avoided. In the event that a covered individual is involved in a conflict of interest, it is expected that the conflict will be disclosed so that resolution of the conflict may occur.

Board members, Network employees, agents, consultants, volunteers, and others who act on the Network's behalf have a responsibility to patients, federal and state governments, other Network funders and the communities served by the Network to conduct themselves prudently, responsibly, in furtherance of, and consistent with the Network's charitable purposes and non-profit, tax-exempt status, and in the best interests of the Network's patients.

The Ethics & Compliance Program is implemented in such a manner as to ensure organizational compliance with appropriate policies concerning confidentiality and conflict of interest, as well as with all HIPAA requirements concerning patient/staff confidentiality and privacy issues.

Record Creation and Retention

A permanent written record of any communication (verbal, written or electronic) reporting a real or potential noncompliance issue, must be generated.

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All records regarding corporate compliance and any of the issues outlined in this Ethics & Compliance Program are kept in a locked file cabinet. Records must be available upon request for any authorized state or federal official requesting review.

Reports, as outlined earlier in this Plan, are forwarded to the Board of Directors. The Compliance Officer keeps an original copy of all reports. All copies of reports disseminated for review are collected and disposed of in a confidential manner.

All documentation related to the corporate compliance issues as outlined in the Ethics & Compliance Program are retained for a period of seven years, (or as required by state and federal mandates).

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