Bartlett Regional Hospital

Board Compliance & Audit Committee Agenda
Date: August 19, 2022 Time: 12:00 Noon
Zoom videoconference

Public, staff and Board members may access the meeting via the following link
https://bartletthospital.zoom.us/j/99468455767
or call
1-877-853-5247 and enter webinar ID 994 6845 5767

Mission Statement
Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

CALL TO ORDER
APPROVAL OF AGENDA
APPROVAL OF THE MINUTES – BOD Compliance & Audit Committee meeting – June 24th
INFORMATIONAL – Hospital Compliance Committee draft meeting minutes – August 3rd

TRAINING

Hospital Code of Conduct	10 minutes Nathan Overson, CO

NEW BUSINESS

A. Compliance Officer Report	10 minutes
1. Compliance dashboard	Committee Discussion

OLD BUSINESS

A. Compliance initiatives update	25 minutes
1. New Service Line Committee update Nate Rumsey, MBA, PE, PMP | Business Development Strategist	Committee Discussion
2. 340B Oversight Committee update	
3. Compliance staff recruitment update	
4. Certificate of Need update	
B. Discuss section 1.2, 2.2 and 6 of the 2022 BRH "Strategic Goals and Key Initiatives" document created by the Board	10 minutes Committee Discussion

FUTURE AGENDA ITEMS 5 minutes
A. Next Committee Education and Training

COMMITTEE MEMBER COMMENTS

ADJOURN - Next scheduled meeting: November

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Board Compliance & Audit Committee Meeting
Draft Minutes
June 24, 2022

Called to order at 12:00 PM., by Board Compliance Committee Chair, Iola Young

Compliance Committee and Board Members:
**Board Members: ***Iola Young, Committee Chair; *Brenda Knapp; *Deborah Johnston, Kenny Solomon-Gross, Hal Geiger

Staff/Other: Nathan Overson, Compliance Officer; Jerel Humphrey, CEO; Kim McDowell, CCO; Dallas Hargrave, HR Director; Bob Tyk, CFO; Tracy Dompeling, CBHO

Previous Board Compliance Meeting Minutes Approval: ***Ms. Knapp made a MOTION to approve the February 15th 2022 Board Compliance and Audit Committee Meeting minutes as submitted. Ms. Johnston seconded the motion, and hearing no objection, Ms. Young approved the meeting minutes without change.***

Board Annual Compliance Training Meeting Minutes Approval: ***Ms. Johnston made a MOTION to approve the March 2nd 2022 Board Annual Compliance Training Meeting minutes as submitted. Ms. Knapp seconded the motion, and hearing no objection, Ms. Young approved the meeting minutes without change.***

Committee Compliance Training:
Mr. Overson gave an overview of whistleblower protections and qui tam actions, and how they relate to the Bartlett's Compliance Program. Mr. Overson reviewed how qui tam actions work. He also gave hypothetical endings to scenarios that are possible at Bartlett. He stated that how we respond to concerns directly correlates with the reduction of risk of a whistleblower or qui tam action. Ms. Johnston asked whether we should have a third-party anonymous hotline for employees to call. Mr. Overson said that we do have an anonymous hotline, but it is not managed by a third-party vendor. Mr. Overson also mentioned that having an employee survey that askes about compliance topics is recommended as a periodic practice to get a sense of the Hospital's compliance culture and will be working to put together a survey in the near future.

Compliance Officer Report:
Mr. Overson reviewed new compliance dashboard and the data metrics with the Committee. Mr. Solomon-Gross asked whether the committee felt it met the informational need for the Board. Mr. Tyk and Mr. Humphrey agreed that it was similar to what they have seen used at other hospitals. Mr. Overson stated that the new format was more inclusive of a broader scope of compliance topics than the former method.

Compliance Initiatives Update:
Mr. Overson gave an update on the Service Line Workgroup which has been able to review three new service line since it started reviewing new service line requests. The Certificate of Need process should be ready to have applications ready to submit by the end of the week. This will kick off a 30-day clarification period where additional information can be requested or clarified.

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The new compliance position will be reposted after an unsuccessful initial recruitment campaign. The 340B Oversight Committee is working to finalize the data analysis from the contract pharmacies and continues to implement best practice compliance initiatives.

Board Strategic Goals and Key Initiatives:
The Committee discussed section 6 of the "Board Strategic Goals and Key Initiatives" document. The goal is to "continuously improve a robust, proactive compliance program at all levels while maintaining our strategic goals." The initiative is to "maintain a robust education and training program at all levels to assure compliance goals are achieved." Mr. Solomon-Gross described the intent of the Board when the goals and initiatives were developed were to have an outlined education program in place for all levels of the organization to be trained on a regular basis and have documented measures in place for the Board to review. Mr. Overson stated that he would take that direction and incorporate it into the Compliance Work Plan and the quarterly dashboard that goes to the Board.

Next Training Topic:
It was decided that the training topic for the next meeting would be the Hospital's Code of Conduct.

Meeting Adjourned: 1:16 PM

Next Meeting: August 19th Noon

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Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Hospital Compliance Committee Meeting
Draft Minutes
August 03, 2022

Called to order at 2:00 PM., by Compliance Committee Chair, Nathan Overson, CO

Hospital Compliance Committee Meeting Attendees: Nathan Overson, Beth Mow, Scott Chille, Rachael Stark, Angelita Rivera, Dallas Hargrave, Sara Dodd, Ursula Iha, Tami Lawson-Churchill, Robert Tyk, Nate Rumsey, Tracy Dompeling, Anita Moffitt

Education and Training:
Mr. Overson discussed the Code of Conduct. There was some discussion about the best way to approach an annual attestation for BRH employees and physicians, which is a best practice. The Code of Conduct attestation is covered in new hire orientation and the onboarding process for physicians, however the ongoing periodic review and annual attestation of the code of conduct is currently not tracked. It is anticipated that with the onboarding of a new hire for the Compliance Department the additional resource will allow for full implementation of this initiative within the next several months.

Compliance Program Activities Update:
Ms. Iha gave an overview of the three current activities: 340B internal audits, 340B Oversite Committee and 340B Contract Pharmacy. Monthly audits are going well and being covered by Ms. Iha since her 340B program manager is out on FMLA. The 340B Oversite Committee has almost completed the recommendation from 340B program review. The decision to either permanently stop or restart the 340B contract pharmacies has still not been made. Senior Leadership has tasked the new Business Development Strategist to review the contract pharmacy portion of the 340B program and make recommendations. The 340B Oversite Committee has recommended that if the contract pharmacy portion of the 340B program is to restart, the Committee would like to see it completely rebuilt before it starts up again.

Ms. Stark gave the HIPAA Privacy Officer update. She indicated that BRH remains lower than average on "cases" flagged by the Fair Warning software. These flagged cases require additional review for possible unauthorized records access. If in the review process an unauthorized access event is identified, the cases are referred to the manager and HR, and the Hospital's Patient Privacy Violation Sanction Policy is followed.

Mr. Chille gave the HIPAA Security Officer update on BRH's cyber security program. He reported that Security Awareness Month is in October and IT will be increasing the depth of the Hospital's security training as BRH has been "graduating on the Security Awareness Maturity Model." Mr. Chille reported that the recent penetration test results showed BRH in "pretty good shape and that we have a strong security posture both internal and external." IT is also working on rolling out multifactor authentication for employees who want to access the BRH network remotely.

Ms. Lawson-Churchill gave an overview of some of the new requirements enacted by BRH to comply with the new surprise billing rules and reported that BRH has transitioned to our new

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contractor, PARA, to utilize their price transparency software system. Starting in January BRH is required by the Surprise Billing Act (SBA) to provide a good faith estimate for services offered at BRH for all self-pay and uninsured patients. BRH is looking for an outside vendor to offer education to local providers since the hospital would be considered the convening provider for all services *at* BRH, not necessarily *by* BRH, even if the patients are billed by non-Bartlett providers. This education would be an effort to help coordinate billing information to allow BRH to provide these good faith estimates.

Mr. Overson discussed the new services that the Service Line Advisory Workgroup. He reported that the workgroup has paused to bring Nate Rumsey in as the Business Development Strategist for input on the scope, design of how the new committee would run. The Committee is looking forward to his expertise and guidance as his position will be an integral part of The New Service Line Committee.

Compliance Officer Report:

Mr. Overson mentioned the dashboard report was email out to the committee and asked if anyone had concerns or questions. There was some discussion of the Hospital Compliance Workplan and how the initiatives we have been working on are part of the Workplan and are prioritized based on compliance risk. Mr. Overson asked if there was anything on the horizon that needed to be added or adjusted on the Workplan. After some discussion the SBA good faith estimates would be added as well as continuing to watch the movement on the new patient privacy rules that are currently out for public comment that could result in some changes to our privacy procedures. Mr. Overson also expressed that he is looking forward to the additional staff resource that will give the Compliance Program better coverage and allow it to be more proactive.

Meeting Adjourned: 3:00 PM
Next Meeting Scheduled: November 2nd at 2:00 PM

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Definition

In Good Faith: Having a sincere belief or motive without any malice or desire to defraud others.

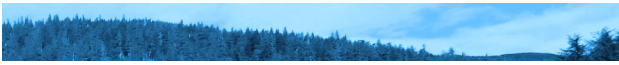
Opening Comments

How do we know the right thing to do? Do we include personal values into our work? Do we apply ethical standards in all our interactions here at BRH? These are questions that all employees will have to address some point while employed at Bartlett. Not because of a policy or procedure, but because it is the right way to conduct business.

This booklet will help you conduct everyday business by providing the basic policies under which Bartlett operates. Its handy small size makes it easy to keep in your pocket, coat, or purse- wherever is convenient.

The most important thing to remember about this booklet is to use it often. Its sole purpose is to help you do what's right.

In our business it is critical that we follow every applicable law and avoid even the *appearance* of improper actions. Simply said, use good judgment and high ethical standards in all your business dealings.



Bartlett Regional Hospital is committed to making sure that the communities of Northern Southeast Alaska can depend on us for their health care needs. The conduct of all Bartlett employees contributes to our success in providing quality service with access to all.

Conduct yourself with honesty, fairness and integrity. Treat others as you wish to be treated. Honesty is the best policy.

Sincerely **David Keith**
CEO

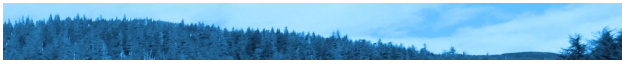
Nathan Overson
Compliance Officer

Reporting Suspected Violations

As an employee of Bartlett you have an obligation to report any concerns you have about possible illegal or unethical conduct at Bartlett. We are committed as an organization to investigating any suspected illegal or unethical conduct and to taking actions necessary to address such conduct and any harm that it may have caused. We would like you to feel comfortable reporting unethical or illegal conduct. If you're ever faced with an ethical question or dilemma, here are recommended steps:

1. Speak with your immediate supervisor or department manager.

2. If your supervisor or manager is not available or if you're not comfortable discussing your concern with them, contact the Bartlett Hospital Compliance Officer in person or at 796-8578. You may also choose to contact the compliance officer via email at noverson@bartletthospital.org send a letter via USPS, or place a written document under the Compliance Office door.



Finally, you may also use the Bartlett HOTLINE to report your concerns (1-907-796-8618). You don't have to give your name, and it's there for you 24 hours a day.

Remember, all your concerns - large or small - will be treated confidentially, if that is your desire, and you will not be disciplined for making a good faith report or asking a question.

General Policy

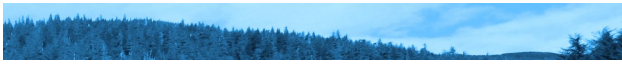
It is the policy of Bartlett Regional Hospital (the Hospital) to provide services in compliance with all state and federal laws governing its operations, and consistent with the highest standards of business and professional ethics. This policy is a solemn commitment to our patients, to our community, to those government agencies that regulate the Hospital, and to ourselves.

In order to ensure that the Hospital's compliance policies are consistently applied, the Hospital's Board of Directors has established a Compliance Program. As part of the Compliance Program the Hospital has designated a Compliance Officer and Compliance Committee who share responsibility for implementing and overseeing the Compliance Program.

All Hospital employees, contractors, as well as those professionals who enjoy professional staff membership, must carry out duties for the Hospital, in accordance with this Code of Conduct. Any violation of applicable law or deviation from appropriate ethical standards is subject to disciplinary action. Questions should be presented to a supervisor, Human Resources, or the Compliance Officer.

All employees should review this manual, attend mandatory training and sign a Certification and Agreement of Compliance statement.

If, at any time, any employee, contractor or professional staff member becomes aware of any apparent violation law or of the Hospital's policies, they MUST report the concern to their supervisor, to the Compliance Officer, or to the HOTLINE at 1-907-796-8618. ALL persons making such reports are assured that such reports will be shared only on a genuine need-to-know basis. The Hospital will take no adverse action against persons making such reports in good faith, whether or not the report ultimately proves to be well-founded. Bartlett will not tolerate retaliation against anyone that makes a good faith report about a possible legal or ethical violation.



Improper Inducements, Physician Financial Relationships

Federal healthcare Anti-kickback Statute makes it illegal for the Hospital to give or receive any "remuneration" that is intended to induce referrals of patients or other healthcare business that will be paid for by Medicare or Medicaid and other federal healthcare programs. The Stark law and regulations impose strict limitations and requirements on Bartlett's financial arrangements with physicians, and on gifts and other things of value that Bartlett may provide to physicians who refer patients to Bartlett for care.

These laws, termed "fraud and abuse," "anti-kickback" or "self-referral", are designed to prevent fraud in the Medicare and Medicaid programs and abuse of the public funds supporting the programs.

Anti - Kickback Law

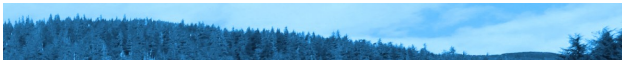
The federal Anti-kickback Statute prohibits giving or receiving anything of value (payments of money and in-kind benefits or gifts) in exchange for or to induce patient referrals and other federal healthcare program business. There are many activities that may violate the Anti-kickback Statute.

Examples of possible violations include activities such as offering gifts, loans, rebates, services, or payments to a physician who refers patients to the Hospital; accepting discounts or rebates from a vendor that are not properly structured and reported to the federal government; paying less than fair market value for an ownership interest in a healthcare joint venture; and giving gifts to a patient or waiving a patient's copayment or deductible amount to induce the patient to receive medical care.

Anti-kickback violations are punishable by up to five years in prison, with the potential for additional criminal fines up to $25,000 per violation, and administrative civil money penalties reaching as much as $50,000. Violation of the Anti-kickback statute may also result in exclusion from participation in federal healthcare programs.

Stark Law and Regulations

The federal Stark Law and regulations limit the Hospital's ability to pay or provide anything of value to physicians who are in a position to refer patients to the Hospital for care. Under Stark, no payment may be made to a physician for their services (e.g., medical director services; patient services) unless the payment is made pursuant to a written agreement (a contract) that meets all necessary requirements of an applicable Stark Law exception.



The Hospital is also limited in its ability to provide referring physicians with any gifts, gratuities, or other items or services that have value (e.g., lunch, gifts, transportation, office management services, etc.), and must track and retain records of all items and services it does provide to physician. Hospital employees should review applicable Hospital policies and/or discuss any proposed payments or gifting activities for referring physicians with the Compliance Officer before the payments or gratuities are given.

Conflicts of Interest: Gifts, Gratuities & Entertainment

Conflicts of Interest

Hospital personnel must ensure that decisions they make for the Hospital are made solely on the basis of what is best for the Hospital and its patients – not on the basis their own personal interest that may be benefited by the decision. A conflict of interest exists when an individual to whom the Hospital's Conflict of Interest Policy applies (e.g., employees, board members, physicians), or any friend, relative, or business associate of such individual might personally, directly or indirectly, benefit from a decision made on behalf of the Hospital by the benefitting individual.

Conflicts of interest must be managed in accordance with Bartlett's Conflict of Interest policy which generally requires the individual with the conflict of interest to both (1) disclose the conflict to the Hospital; and (2) refrain from participating in any decisions about the matter where the conflict exists. Other requirements may apply depending on the nature of the conflict in question.

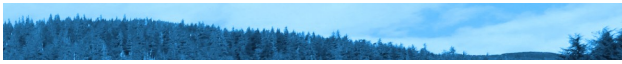
Hospital employees may not be employed by, act as a consultant to, or have an independent business relationship with any of the Hospital's service providers, competitors, or third party payers without disclosure to Human Resources.

Employees should not have other outside employment or business interests that place them in the position of

(i) appearing to represent the Hospital,

(ii) providing goods or services substantially similar to those the Hospital provides or is considering making

(iii) Lessening their efficiency, productivity, or dedication to the Hospital in performing their everyday duties.



Gifts, Entertainment & Other Items or Services of Value

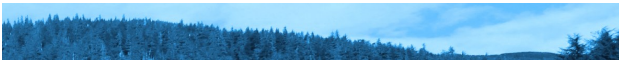
Gifts, entertainment and other items or services of value may only be accepted by Hospital staff when they are of such limited value that they could not reasonably be perceived by anyone as an attempt to affect the judgment of the recipient. Gifts of cash, whether from patients or from an organization or person with which the Hospital does business, may never be accepted.

Billing & Claims

The Hospital is committed to maintaining the accuracy of every claim it processes and submits. Many people throughout the Hospital have responsibility for initiating charges or for entering charge and procedure codes, and are expected to understand and follow coding and billing rules that apply to services for which they enter or initiate charges. Any false, inaccurate, or questionable claims should be reported immediately to a supervisor or to the Compliance Officer.

Federal and state laws prohibit filing false or fraudulent claims for payment from federal, state and commercial health care payment programs. Examples of billing practices that are or may lead to false or fraudulent claims include:

- Claiming reimbursement for services that have not been rendered;
- Filing duplicate claims;
- Filing claims for services that are not supported by necessary documentation
- "Up coding" to more complex procedures than were actually performed;
- Including inappropriate or inaccurate costs on Hospital cost reports;
- Billing for services using a provider number that is not assigned to the provider of the services; and
- Billing for a procedure or visit administered by a mid-level provider, but billed as a physician.
- The Hospital carefully follows the Medicare rules on assignment and reassignment of billing rights. If there is any question whether the Hospital may bill for a particular service, either on behalf of a physician or on its own behalf, the question should be directed to the Compliance Officer or the Director of Patient Financial Services for review.



A provider or supplier who files a false or fraudulent claim may be guilty of a felony, and may be subject to criminal prosecution. Civil fines and penalties equaling up to three times the programs' loss plus up to $23,607 per claim may also result.

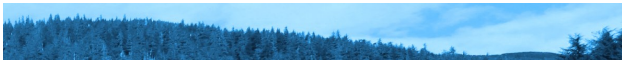
Patient Referrals and Patient Choice

Patients or their legal representatives may select health care providers and suppliers subject to the requirements of their health insurance plans. The choice of hospital, a skilled nursing facility, home care provider, or supplier should be made by the patient, with guidance from their physician and discharge planner as to which providers are qualified and medically appropriate. The Hospital is required by federal law to provide patients with a list of all home health agencies and skilled nursing facilities that are Medicare certified, provide services in the patient's geographic area, and have requested to be on the list.

Patient Transfers

The federal "anti-dumping" law (EMTALA) ensures that patients who come to a hospital with an emergency medical condition or in labor receive appropriate screening and stabilization. Prompt and effective delivery of emergency care may not be delayed in order to determine a patient's insurance or financial status. Patients with emergency medical conditions, and patients in labor, must be cared for and receive an appropriate Medical Screening Examination in the Hospital's Emergency Department. Transfer or discharge may not occur until the patient's emergency medical condition is deemed stable or when transfer must occur in order to provide the appropriate level of care. On call physicians may also violate EMTALA if they refuse to provide medically necessary screening examinations.

Under EMTALA, the Hospital is required to report any violations of EMTALA requirements to the federal government. Any employee who believes that an emergency patient has been transferred improperly, prior to receiving appropriate medical screening and stabilizing treatment, or did not receive an appropriate medical screening evaluation must report the incident to the Compliance Officer (907-796-8578) or call the Bartlett Compliance Hotline (907-796-8618)



Antitrust Laws

Antitrust laws in the United States prohibit any activity that is seen by the law as a restraint on competition or trade. Activities like price fixing; boycotts and agreements about the division of markets have been found to violate the federal antitrust laws. These laws apply to all segments of the health care services market (e.g., hospitals, physicians and other provider professions and organizations are subject to these laws.)

Discounts with Competitors

Hospital employees should avoid oral or written communications with any competitor about prices, pricing policies, pricing formulas, bids, bid formulas, or concerning discounts, credit arrangements, or related terms of sale or service. Hospital policy prohibits **any** consultation or discussion with competitors relating to prices or terms which the Hospital or any competitor charges or intends to charge.

- The following types of discussion with competitors are strictly prohibited:

- Information about the Hospital's business plans including plans to grow or down-size a service line;

- Current information or future plans regarding individual salaries or salary levels;

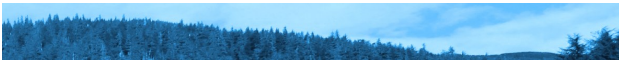
- Information about current or future pricing of services, or about contractual agreements with payer organizations.

Tax-Exempt Organizations

As a not-for-profit hospital serving charitable purposes, the Hospital holds federal tax-exempt status as an enterprise fund of the City and Borough of Juneau. That is, the Hospital is exempt from paying federal income tax on most of its revenue. Loss of exempt status would result in penalties, interest, and significant cost.

In order to qualify for tax exemption, the Hospital must be operated exclusively for charitable purposes. The Hospital must provide a community benefit, such as the promotion of health and the operation of an Emergency Department open to all. None of its earnings may be used to directly or indirectly benefit an individual that has a close relationship with the Hospital.

Because the Hospital is dedicated to its charitable purposes, all contracts and agreements must be negotiated at arm's length and approved through Executive leadership. Compensation provided to health professionals for recruitment, retention, employment, and personal services must be reasonable in the context of the services provided and the need for them.



Waste Disposal

The Hospital is committed to safe and responsible disposal of biomedical waste and other waste products. Compliance with applicable federal and state environmental regulations requires on-going monitoring and care.

The Hospital complies with the Clean Air Act, the Clean Water Act, the Resource Conservation and Recovery Act, and other federal and state laws and regulations governing the incineration, treatment, storage, disposal, and discharge of Hospital waste. If an employee suspects non-compliance or violation of any of these requirements, the circumstances should be reported to a supervisor, or to the Compliance Officer.

Controlled Substances

The Hospital requires that its employees comply with the terms of the Hospital's controlled substances registration and with federal and state laws regulating controlled substances. Under Hospital policy, access to controlled substances is limited to persons who are properly licensed and who have express authority to handle them.

Any employee who knows of unauthorized handling of controlled substances is to provide the information immediately to their supervisor, the Compliance Officer, Human Resources, or the BRH Hotline (907-796-8618).

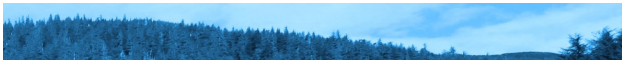
Privacy & Security of Confidential Information

Patient Information

Federal and state laws protect the privacy and security of a patient's protected health information (PHI). Hospital employees may only use, disclose or discuss patient-specific information with others when it is necessary for treatment, payment or healthcare operations as those terms are defined by HIPAA and in Bartlett's policies, or when disclosure is otherwise authorized by the patient or is required or authorized by the law. No employee is permitted access to the medical record of any patient without a legitimate, hospital-related reason for doing so. Employees should not discuss patients outside the Hospital or with their families.

Under no circumstances should an employee ever share confidential patient information on a social media site.

A violation of this policy can subject an employee to discipline, including immediate termination. Medical records should not be physically removed from the Hospital. Medical Records should not be altered or destroyed, except by authorized personnel.



Confidential Business & Employee Information

Information about the Hospital's business operations, business strategies, and operations should also be treated as confidential and only shared with outsiders when permitted by the Hospital. Information about individual employee salaries, benefits, payroll, personnel files and disciplinary matters should also be treated as confidential. The Hospital prohibits unauthorized access to its computer system either directly or by network or telephone.

Discrimination

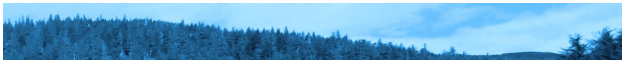
The Hospital is committed to a policy of non-discrimination and equal opportunity for all qualified applicants and employees, without regard to race, color, age, religion, sex, familial status, disability, sexual orientation, gender identity, gender expression or national origin. Our policy of non-discrimination extends to the care of patients, regardless of diagnosis.

If an employee feels they or any patient has been discriminated against or harassed on the basis of their race, color, gender, or other protected category, he or she should contact the Human Resources Director.

Purchasing

The Hospital is committed to a fair and objective procurement system which results in the acquisition of quality goods and services for the Hospital at fair market value.

Purchasing decisions must, in all instances, be free from any conflicts of interest that could affect the outcome.



Fund Raising

The Hospital does not authorize any employee or other individual to use the Hospital's name in any fund-raising activities not approved or supervised by the Bartlett Regional Hospital Foundation or CEO.

Intimidating & Disruptive Behavior

Safety and quality of patient care is dependent on teamwork, communication and a collaborative work environment. To assure quality and to promote a culture of safety, BRH has established a policy of non-tolerance of intimidating or disruptive behaviors by BRH employees and medical staff.

INTIMIDATING AND DISRUPTIVE BEHAVIORS INCLUDE OVERT ACTS SUCH AS:

- Verbal outbursts
- Physical threats

AS WELL AS PASSIVE ACTS SUCH AS:

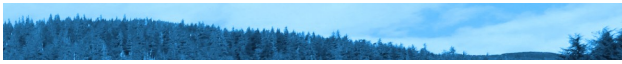
- Refusing to perform assigned tasks;
- Exhibiting uncooperative attitudes during routine activities;
- Reluctance or refusal to answer questions or return phone calls;
- Condescending language or voice intonation; or
- Impatience with questions.

All intimidating and disruptive behavior is unprofessional and will not be tolerated. Staff is urged to report incidents to their manager, Human Resource Director, the Director of Quality, Risk Manager or Compliance Officer with the assurance that retaliation is unlawful, counter to BRH policy, and will not be tolerated.

Response to Investigations

The Hospital will comply with subpoenas and cooperate with governmental investigations to the full extent required by law. The Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Clinical Officer (CCO), Chief Behavioral Health Officer (CBHO), Human Resource Director (collectively SLT) and the Compliance Officer are responsible for coordinating the Hospital's response to investigations and the release of any information.

If a department, an employee, or a professional staff member receives an investigative demand, subpoena, or search warrant involving the Hospital, it should be brought immediately to the Compliance Officer (907-796-8578). Do not release or copy any documents without authorization from the Compliance Officer.



If an investigator, inspector, agent, or government auditor comes to the Hospital, contact the SLT "Administrator on-call" and the Compliance Officer or a member of the Compliance Committee (for Joint Commission Surveyors contact the Quality Improvement Director). Ask the investigator to wait until one of the above listed officers arrives before reviewing any documents or conducting any interviews. If Hospital employees are approached by government investigators and agents, the employee has the right to insist on being interviewed only at the Hospital, during business hours and with counsel or a management representative present.

Hospital employees are not permitted to alter, remove, or destroy documents or records of the Hospital. This includes paper, tape, digital/electronic, and computer records.

REPORTING

If a question arises as to whether any action complies with Hospital policies or applicable law, staff should present that question to the CEO, their supervisor, to a member of the Compliance Committee, or to the Compliance Officer at:

1-907-796-8578

or the BRH HOTLINE at:

1-907-796-8618

Such reports may be made in person, by phone, by e-mail or letter. Disclosure of the identity of the reporting party is not required. Report may be made anonymously.

This booklet is meant to be a brief overview of our compliance program and does not cover every policy or situation.

For specific questions on any potential compliance issue or concern, please consult the specific compliance policy, the policy or procedure related to your department, or the Compliance Officer.

Compliance Officer	Nathan Overson
As of Date	8.3.2022
Date Reviewed with Compliance Committee	8.3.2023
Date Reviewed with Board	

Element/Metric	Q1	Q2	Q3	Q4	YTD
Oversight					
% Completion of annual Board members compliance training	100%	100%			100%
% Quarterly reports to Board	100%	100%			100%
Compliance concerns/questions addressed as an outcome of education	38	32			35
Code of Conduct/Policies and Procedures					
% Completion of CoC attestation: physicians	N/A	N/A			
% Completion of CoC attestation: employees	N/A	N/A			
% Policy and procedure training: new employees	100%	100%			100%
% Compliance policies and procedures reviewed per schedule	4%	15%			10%
Policies: new or revised	2	1			3
Exclusion Screening					
% LEIE/SAM physician screening: prior to hire/contract	100%	100%			100%
% LEIE/SAM employee screening: prior to hire/contract	100%	100%			100%
% LEIE/SAM physician screening: monthly	100%	100%			100%
% LEIE/SAM employee screening: monthly	100%	100%			100%
% LEIE/SAM vendor screening: monthly	100%	100%			100%
Education					
% Completion of new hire compliance training within 30 days of hire	100%	100%			100%
% Completion of annual compliance training	100%	100%			100%
% Completion of new hire HIPAA training within 30 days of hire	100%	100%			100%
% Completion of annual HIPAA training	100%	100%			100%
Compliance Investigations					
Number of hotline calls	0	0			0
Number of issues requiring compliance review	9	7			8
Number of issues closed	8	9			9
Number of issues pending	3	2			3
Average days to initiate compliance review	2	1			2
Average days to complete compliance review	14	14			14
Top three topics of concern reported: #1	340B	Unit Calculation			
Top three topics of concern reported: #2	HIPAA	HIPAA			
Top three topics of concern reported: #3	Billing	Documentation			
Departmental Monitoring and Auditing					
% Denied claims requiring resubmission	15%	13%			14%
Average % of billing accuracy	85%	87%			86%
Number of potentially inappropriate IS access or login flags	6	9			8
Number of employees referred to HR for a compliance infraction	2	1			2

Element/Metric	Q1	Q2	Q3	Q4	YTD
Repayments/Overpayments					
Discovered by internal audits					
Number of claims reviewed by the audit committee		10			
Number of claims requireing resubmission		1			
Repayment amount	0	0			0
Paid within 60 days	0	0			0
Discovered by internal monitoring					
Number of claims	201	169			370
Repayment amount	$100,247	$181,967			$282,215
Paid within 60 days	147	132			279
Government audits					
Number of claims	3	0			2
Repayment amount	$41,010	$0			$20,505
Paid within 60 days	3	0			3

Comments/Suggested Action Items

N/A's represent areas where the process still needs to be developed.

Definitions

Oversight	Definitions
% Completion of annual Board members compliance training	The percentage of board members who have received annual compliance training for a rolling four quarters. In the event of a new appointment to an unexpired term, this percentage will reflect the first full quarter following the new appointment.
% Quarterly reports to Board	The percentage of quarterly reports given to the Board Compliance and Audit Committee by the Compliance Officer or designee.
Compliance concerns/questions addressed as an outcome of education	Number of compliance consults with management or education sessions with staff (e.g. Compliance education at a staff meeting specifically addressing a concern or question).
Code of Conduct/Policies and Procedures	**Definitions**
% Completion of CoC attestation: physicians	The percentage of completed annual attestations for the Code of Conduct by medical staff for a rolling four quarters.
% Completion of CoC attestation: employees	The percentage of completed annual attestations for the Code of Conduct by employees for a rolling four quarters.
% Policy and procedure training: new employees	The percentage of new employees who have received policy and procedure training.
% Compliance policies and procedures reviewed per schedule	The percentage of policies and procedures that have been reviewed, and are within the periodic document review schedule.
Policies: new or revised	Number of new or materially revised compliance policies
Exclusion Screening	**Definitions**
% LEIE/SAM physician screening: prior to hire/contract	The percentage of physicians screened through the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE), and General Services Administration's (GSA) System for Award Management (SAM) prior to starting at Bartlett.

% LEIE/SAM employee screening: prior to hire/contract	The percentage of employees screened through the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE), and General Services Administration's (GSA) System for Award Management (SAM) prior to starting at Bartlett.
% LEIE/SAM physician screening: monthly	The percentage of physicians screened through the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE), and General Services Administration's (GSA) System for Award Management (SAM) monthly.
% LEIE/SAM employee screening: monthly	The percentage of employees screened through the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE), and General Services Administration's (GSA) System for Award Management (SAM) monthly.
% LEIE/SAM vendor screening: monthly	The percentage of vendors screened through the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE), and General Services Administration's (GSA) System for Award Management (SAM) monthly.
Education	Definitions
% Completion of new hire compliance training within 30 days of hire	The percentage of employees completing new hire compliance training within 30 days of hire
% Completion of annual compliance training	The percentage of employees who received annual compliance training
% Completion of new hire HIPAA training within 30 days of hire	The percentage of employees completing HIPAA training within 30 days of hire
% Completion of annual HIPAA training	The percentage of employees who received annual HIPAA training
Compliance Investigations	Definitions
Number of hotline calls	Number of hotline calls received
Number of issues requiring compliance review	Number of compliance issues requiring review
Number of issues closed	Number of compliance issues closed
Number of issues pending	Number of compliance issues pending
Average time to initiate compliance review	Average time to initiate compliance review measured in days

Average time to complete compliance review	Average time to complete compliance review measured in days
Top three topics of concern reported: #1	First of top three topics of concern reported to compliance
Top three topics of concern reported: #2	Second of top three topics of concern reported to compliance
Top three topics of concern reported: #3	Third of top three topics of concern reported to compliance
Departmental Monitoring and Auditing	Definitions
% Denied claims requiring resubmission	Percentage of denied billing claims requiring resubmission
Average % of billing accuracy	Average percentage of billing accuracy
Number of potentially inappropriate IS access or login flags	Number of flags identified by monitoring software of potential inappropriate IS access into medical records requiring additional review.
Number of employees referred to HR for a compliance infraction	Number of employees referred to HR for a compliance infraction
Repayments/Overpayments	Definitions
Discovered by internal audits	Discovered by internal auditing
Number of claims reviewed by the audit committee	Number of claims reviewed by the audit committee
Number of claims requireing resubmission	Number of claims requireing resubmission
Repayment amount	Repayment amount
Paid within 60 days	Number of claims where the amount was paid back within 60 days
Discovered by internal monitoring	Discovered by Bartlett's regular internal processes
Number of claims	Number of claims identified for overpayment by internal processes
Repayment amount	Repayment amount
Paid within 60 days	Number of claims where the amount was paid back within 60 days
Government audits	Any outside audit preformed under regulatory authority or by a government agency
Number of claims	Number of claims identified for overpayment by an outside audit
Repayment amount	Repayment amount
Paid within 60 days	Number of claims where the amount was paid back within 60 days

1. Services: Develop, maintain, and grow a sustainable service portfolio that is responsive to community needs.		
	Initiative	**Owner**
1.1	Evaluate and expand affiliations and partnerships with other healthcare organizations.	Planning Committee
1.2	Develop a comprehensive telehealth department at Bartlett Regional Hospital to help develop new service lines.	Planning Committee
1.3	Recruit needed medical specialists.	Physician Recruitment Committee

2. Facility: Maintain a comprehensive campus. Address major replacement needs and options for future service lines and revenue growth.		
	Initiative	**Owner**
2.1	Develop a facility plan that provides for the efficient delivery of clinical services.	Planning Committee
2.2	Develop proformas for additional service lines, change of use, and acquisitions to properly evaluate return on investment so the board can move decisively.	1. Planning Committee 2. Governance Committee
2.3	Evaluate current Bartlett Regional Hospital technology and industry best practices to prioritize replacement and identify new equipment needs.	Governance Committee

3. People: Create an atmosphere that enhances employee, physician, and stakeholder satisfaction to improve our ability to recruit and retain. Improve strategic alliances and communication to maintain a community continuum of care.		
	Initiative	**Owner**
3.1	Resolve electronic medical record system concerns.	1. Finance Committee 2. Quality Committee
3.2	Expand workforce development programs.	1. Planning Committee 2. Quality Committee
3.3	Explore feasibility of hospital run clinics and hospital employed providers.	1. Planning Committee 2. Finance Committee

4. Financial: Develop a revenue and net income stream that maintains cash reserves while facilitating above goals and objectives.		
	Initiative	**Owner**
4.1	Evaluate current guidelines to identify the number of days of unrestricted cash on hand that are required.	Finance Committee
4.2	Ensure Bartlett Regional Hospital has the proper executive team to manage finances and assure adequate financial controls.	Finance Committee
4.3	Monitor inflation, provider shortages, and labor shortages impact on budget.	Finance Committee
4.4	Evaluate service line impact on revenues.	Finance Committee

5. Quality and Safety: Provide excellent community centered care that improves outcomes, maximizes safety, improves access and affordability and is in compliance with national and state regulations.		
	Initiative	**Owner**
5.1	Stay current on technology and resources to facilitate risk management, data security, and employee safety.	Quality Committee
5.2	Develop quality initiatives that exceed accreditation and regulation requirements.	Quality Committee

6. Compliance: Continuously improve a robust, proactive compliance program at all levels while maintaining our strategic goals.		
	Initiative	**Owner**
6.1	Maintain a robust education and training program at all levels to assure compliance goals are achieved.	Compliance Committee