

COMPLIANCE MANUAL

CODE OF CONDUCT

COMPLIANCE PROGRAM STRUCTURE & GUIDELINES

COMPLIANCE POLICIES AND PROCEDURES

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A Message from the President

Our Mission

The “Hospital”¹ is dedicated to improving the health and quality of life of children in an ethical and professional manner. We change the lives of children with complex medical illnesses and disabling conditions through superb multi-disciplinary care, teaching, research and advocacy programs.

We are the only specialty children’s hospital in New York State that provides the highest level of multidisciplinary medical care and rehabilitation for children with complex medical illnesses and conditions.

Working collaboratively in an environment that fosters excellence, our goal is to improve each patient’s overall health, independence and quality of life, as well as provide hope to patients and families through superior outcomes — without regard to religion, race, color, national origin, age, disability, sex or ability to pay.

Our Vision

We are relentless in the pursuit of excellence in everything we do. We are innovators. We constantly challenge ourselves to find better treatment modalities and more effective ways of organizing and delivering services. We act with compassion and respect toward our patients and their families.

We are dedicated to interdisciplinary teamwork which is centered on providing first-class care and service.

We value all those who work for and with us, as they have built the Hospital’s reputation. We provide a work environment that is respectful and fair, allows management to listen to and communicate with Personnel (defined below) regularly; educates and trains those with whom we work on a regular basis so that they can effectively carry out their responsibilities; and compensates our Personnel fairly. Honesty and integrity characterize all of our actions and decisions.

Our Compliance Program

The Hospital has designed and implemented a comprehensive Compliance Program that sets forth the standards of conduct that all Personnel are expected to follow in their employment or course of dealings with the Hospital. “Personnel” includes all employees, executives, governing body members, and any other person or affiliate who is associated with the Hospital includes, for example, independent contractors, interns, volunteers, vendors and others. One significant element of the Compliance Program is this Code of Conduct (the “Code of Conduct” or “Code”), which has been approved by the Hospital’s Board of Trustees (the “Board”). This Code is designed to be consistent with the principles set forth in

¹ As used throughout this document, the term “Hospital” includes all areas.

our Mission Statement, as well as applicable laws and regulations. It is a sign of our commitment to ensuring that our actions reflect our words. In this spirit, we expect all Personnel to adhere, without exception, to these standards.

This Compliance Manual, in addition to setting forth the Hospital's Code of Conduct, highlights some of the key elements at the core of the Hospital's Compliance Program. The Code of Conduct is supplemented by the more detailed Hospital Program Structure & Guidelines and a comprehensive listing of Compliance Policies and Procedures. Specific Departments within the Hospital have their own specific policies and procedures that apply in addition to this Compliance Manual. Please familiarize yourself with the contents of this Manual, any applicable Department policies and procedures and continue to uphold the Hospital's legal and ethical principles without exception.

Our Compliance Program will continue to operate effectively only if everyone takes the time to be aware of what our Code of Conduct states, abides by its requirements and works to support our dedication to maintaining the highest standard of care in compliance with all applicable laws, rules and standards. In short, we are committed to "doing the right thing."

Thank you for your commitment to providing an ethical and lawful environment in which we can serve our patients. If you have any questions regarding the Hospital's Compliance Program, please refer to the Code of Conduct or speak with the Hospital's Compliance Officer. Remember that violations of legal or ethical requirements jeopardize the welfare of our Hospital, our employees and patients, and the community we serve. Remember too, that standards of conduct mean little without personal commitment. Ultimately, the responsibility for ethical behavior – and thus for our reputation – rests largely in your hands.

Sincerely,

President and CEO

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INTRODUCTION

The Hospital designed and implemented a comprehensive Compliance Program that sets forth the standards of conduct, policies and procedures that all "Affected Individuals" (as defined below) are expected to follow. Our Compliance Program consists of the following:

(A) Compliance Program Code of Conduct. The Code of Conduct sets forth the general standards of conduct to which all Affected Individuals associated with the Hospital must adhere.

(B) Compliance Program Structure and Guidelines. The Compliance Program Structure and Guidelines set forth the structure of the Compliance Program and describes its day-to-day operation.

(C) Compliance Policies and Procedures. Certain compliance issues require further detail and instruction. To that end, the Hospital has adopted specific Compliance Policies and Procedures covering certain areas. *If you have specific responsibilities that are addressed by a Compliance Policy and Procedure, you must ensure that you are familiar with its requirements.* The Compliance Policies and Procedures may be accessed on intranet under policies and procedures. They are also available upon request to the Compliance Officer at any time.

The Code of Conduct, the Compliance Program Structure and Guidelines, and our Compliance Policies and Procedures are collectively referred to as the Hospital's "Compliance Manual".

All Affected Individuals are required to review and be familiar with the Code of Conduct, the Compliance Program Structure and Guidelines and the Compliance Policies and Procedures.

The Hospital expects to conduct its business in a manner that supports integrity in our operations and it will conduct its business in compliance with all applicable federal and state standards. To that end, our Compliance Program is designed to effectively prevent, detect and correct non-compliance with applicable laws, rules and regulations, including Federal health care program requirements (e.g., the Medicare and Medicaid programs). Addendum A includes a non-exhaustive list of some of the applicable laws and regulations that apply to Hospital operations and may impact the risk areas applicable to the Hospital's compliance program.

Our Compliance Program has many goals. Among them are: (i) detecting and preventing fraud, waste and abuse, (ii) organizing our resources to address compliance issues as quickly and efficiently as possible, and (iii) putting in place a system of checks and balances to prevent recurrence of any such issues.

All Affected Individuals are required to cooperate fully with the Compliance Program and obligations set out in this Compliance Manual.

In short, we are committed to doing the right thing legally and ethically, and our Compliance Program is designed to assist us in effectively keeping to that commitment. Conduct that is contrary to these expectations will be considered a violation of the Compliance Program and our Code of Conduct.

If you have any questions regarding the Compliance Program, please refer to the Code of Conduct, the Compliance Program Structure and Guidelines, and Compliance Policies and Procedures; or speak with our Compliance Officer for more detailed information.

KEY DEFINITIONS

Unless otherwise defined in the Compliance Manual, the terms listed below have the following meanings:

- (1) **"Affected Individuals"** means all persons who are impacted by the Hospital's "risk areas," including the Hospital's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers. Affected Individuals are sometimes referred to in this Compliance Manual as "you."
- (2) **"Compliance Officer"** means the individual designated by the Hospital with responsibility for the day-to-day operation of the Compliance Program. The Compliance Officer is the focal point for our Compliance Program. The Compliance Officer reports directly to, and is accountable to, the Chief Executive, other senior manager, and its governing body.
- (3) **"Compliance Steering Committee"** means the group established by the Hospital to coordinate with the Compliance Officer to ensure that the Hospital is conducting its business in an ethical and responsible manner, consistent with our Compliance Program.
- (4) **"Contractors"** means contractors, agents, subcontractors, and independent contractors.
- (5) **"Effective compliance program"** means the Hospital's compliance program adopted and implemented that, at a minimum, meets the requirements of 18 NYCRR Subpart 521-1 and that is designed to be compatible with the Hospital's characteristics (i.e., size, complexity, resources, and culture), which: (i) is well-integrated into our operations and supported by the highest levels of the organization, including the chief executive, senior management, and the Board of Trustees; (ii) promotes adherence to our legal and ethical obligations; and (iii) is reasonably designed and implemented to prevent, detect, and correct noncompliance with applicable Federal health care programs and other requirements, including fraud, waste, and abuse most likely to occur for the Hospital's "risk areas" and "organizational experience."
- (6) **"Federal health care program"** means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government, including certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans' programs and the State Children's Health Insurance Programs. The Federal Employees Health Benefits Program is not included in this definition.
- (7) **"Good faith participation in the Compliance Program"** includes, but is not limited to, the following actions when taken in good faith:
 - (a) reporting
 - (i) actual or potential compliance issues to appropriate personnel, including but not limited to, any action or reasonably suspended action taken by or within the Hospital that is illegal, that may constitute fraud, waste or abuse, or that is otherwise in violation of any adopted Hospital policy;
 - (ii) instances of intimidation or retaliation;
 - (iii) potential fraud, waste or abuse to the appropriate State or Federal entities, including, but not limited to the appropriate regulatory officials as provided in New York Labor Law §§ 740 and 741.

- (b) participating in
 - (i) investigation of potential compliance issues;
 - (ii) self-evaluations;
 - (iii) audits; and
 - (iv) remedial actions.

(8) "Organizational experience" means the Hospital's:

- (i) knowledge, skill, practice and understanding in operating the Compliance Program;
- (ii) identification of any issues or risk areas in the course of internal monitoring and auditing activities;
- (iii) experience, knowledge, skill, practice and understanding of participation in Federal health care programs and the results of any audits, investigations, or reviews we have undergone; and
- (iv) awareness of any issues Facility should reasonably become aware of for Facility's category or categories of service.

(9) "Risk areas" are those areas to which the Hospital's Compliance Program applies. This includes those areas of operation affected by the Compliance Program and applies to:

- (i) billings;
- (ii) payments;
- (iii) ordered services;
- (iv) medical necessity;
- (v) quality of care;
- (vi) governance;
- (vii) mandatory reporting;
- (viii) credentialing;
- (ix) contractor, subcontractor, agent or independent contract oversight; and
- (x) other risk areas that are or should be identified through our organizational experience.

COMPLIANCE REPORTING REQUIREMENTS

- A. All Affected Individuals must abide by the Compliance Program and are required to report suspected misconduct, possible violations of Federal or State law or regulations, possible violations of the Compliance Program and other compliance-related concerns. You may report to the Compliance Officer, to the Compliance Hotline, to your supervisor or to management. Issues reported to a supervisor or management must in turn be immediately reported to the Compliance Officer. (See the Hospital's **Reporting Unethical or Illegal Conduct Policy (POL-24-007)**.)
- B. You may make reports confidentially. To report confidentially, we suggest using the Compliance Hotline. The confidentiality of persons reporting compliance issues will be maintained, unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, the New York State Attorney General's Medicaid Fraud Control Unit ("MFCU"), the New York State Office of the Medicaid Inspector General ("OMIG") or law enforcement, or disclosure is required during a legal proceeding. In addition, persons reporting compliance issues will be protected under the Hospital's **Whistleblower Non Intimidation Non Retaliation for Good Faith Participation in the Compliance Program Policy (POL-24-015)**.
- C. Affected Individuals may also report compliance issues anonymously if they so choose. To report anonymously, please use the Compliance Hotline.
- D. **As explained in detail in our Whistleblower Non Intimidation Non Retaliation for Good Faith Participation in the Compliance Program Policy (POL-24-015), retaliation or intimidation in any form against an individual who in good faith reports possible misconduct or illegal conduct is strictly prohibited.** Acts of retaliation or intimidation should be immediately reported, and if substantiated, the individuals responsible will be appropriately disciplined.

NAME	CONTACT INFORMATION
<u>Compliance Officer</u>	Ph: See Addendum B
See Addendum B	Email: See Addendum B
<u>Compliance Hotline</u>	Ph: See Addendum B

CODE OF CONDUCT

CODE OF CONDUCT

This Code of Conduct sets forth the standards of conduct that all Affected Individuals must adhere to and follow.

I. CODE OF CONDUCT: COMMITMENT TO COMPLIANCE

- A. The Hospital strives to provide high quality services to all patients without regard to age, race, color, sexual orientation, marital status, religion, sex, or national origin.
- B. The Hospital is committed to conduct its business in compliance with all applicable laws, rules and regulations and in accordance with ethical principles. Facility expects the same from all Affected Individuals. Facility does not and will not tolerate any form of unlawful or unethical behavior by Affected Individuals or anyone associated with the Hospital. The Hospital will follow the letter and spirit of applicable laws, rules and regulations, conduct its business ethically and honestly, and act in a manner that enhances the Hospital's standing in the community.

II CODE OF CONDUCT: SCOPE OF APPLICATION TO AFFECTED INDIVIDUALS

- A. The Compliance Program - and specifically this Code of Conduct - applies to all Affected Individuals. The term "Affected Individuals" is defined in this Compliance Manual.
- B. All Affected Individuals have a responsibility to help create and maintain a work environment in which compliance concerns may be openly raised, and promptly reviewed, discussed and addressed.

III CODE OF CONDUCT: STANDARDS

A. General Standards

- 1. You must be honest and lawful in all of your business dealings and avoid doing anything that could create even the appearance of impropriety.
- 2. You must:
 - a. comply with the Code of Conduct;
 - b. refuse to participate in any action you think may be possibly unethical, illegal or in violation of the Code of Conduct, a Compliance Policy and Procedure or the Compliance Program;
 - c. report compliance issues and any unethical or illegal conduct to the Compliance Officer;
 - d. cooperate with compliance inquiries and investigations; and work to correct any improper practices that are identified.The Hospital expects and requires your good faith participation in the Compliance Program.
- 3. Acts of retaliation or intimidation for good faith reporting of any suspected violation of, or for other good faith participation in, the Compliance Program will not be tolerated and are themselves violations of the Compliance Program. See **Whistleblower Non Intimidation Non Retaliation for Good Faith Participation in the Compliance Program Policy (POL-24-015)**.

B. Standards Related to Quality of Care/Credentialing/Medical Necessity

1. All patients/residents will have access to admission and treatment without regard as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or sponsorship.
2. Each patient/resident will receive medically necessary services that are required to assure the patient/resident attains or maintains the highest practicable physical, psychosocial and mental well-being.
3. The Hospital provides care that conforms to acceptable clinical and safety standards.
4. Comprehensive assessments of each patient/resident's medical condition(s) will be conducted upon admission and throughout their stay, in accordance with all applicable federal and state regulations and time limits, including instructions needed to provide effective and person-centered care which meets professional standards. The Hospital will timely, accurately and completely document the care provided to its patients/residents.
5. Rehabilitative services, such as physical therapy, occupational therapy, speech-language pathology and mental health services, are provided, but only to the extent that these services are reasonable and necessary for the treatment of the patient/resident.
6. The Hospital will protect and promote the rights of all patients/residents, including, but not limited to, the right to respect, privacy, a dignified existence, self-determination, and the right to participate in all decisions about their own care and treatment.
7. The Hospital has implemented and maintains an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) Program that focuses on indicators of the outcomes of care and quality of life.
8. The Hospital maintains an emergency preparedness program that meets Federal and State requirements, including, but not limited to: (i) an emergency plan; (ii) policies and procedures; (iii) a communication plan; and (iv) a training and testing program.
All professional staff associated with the Hospital will be properly licensed, certified and/or registered as required by applicable laws, rules and regulations. The Hospital will take steps on a regular basis to monitor and ensure such compliance. See the Hospital's **Compliance Reviews of Clinical Staff Credentials Policy (POL-24-006)**.
9. In addition to the general credentialing process, the Hospital will confirm the identity and determine the exclusion status of all Affected Individuals. In doing so, the Hospital will review the following State and Federal databases at least every thirty (30) days:
 - a. the OMIG Exclusion List;
 - b. the U.S Department of Health and Human Services Office of Inspector General's (the "OIG") List of Excluded Individuals and Entities; and
 - c. the General Services Administration's System for Award Management.

Our Contractors are also required to comply with the requirements in this paragraph. See the Hospital's **Contractor Agreement Requirements Policy (POL-24-023)**.

The results of such checks will be promptly shared with the Compliance Officer and other appropriate compliance personnel. See the Hospital's **Compliance Reviews for Excluded or Ineligible Individuals/Entities Policy (POL-24-016)**.

C. Standards Related to Coding, Billing and Documenting Services

1. The Hospital will comply with the coding, billing, documentation and submission rules and requirements of all of its payers, including government payers such as Medicare and Medicaid, and commercial payers, as well as all applicable Federal and State laws, rules and regulations governing the coding, billing, documentation and submission of claims.
2. The Hospital is committed to preparing accurate claims, consistent with such requirements. All coding, billing and documentation of services must be accurate and truthful.
3. Specifically, among other rules, we follow 18 NYCRR § 521-1.3 (d)'s requirements that the Hospital's compliance program shall apply to the Hospital's risk areas.
4. Affected Individuals may never misrepresent charges or services to or on behalf of the government, a patient/resident or a payer. False statements, intentional omissions or deliberate and reckless misstatements to government agencies, payers or others will expose those involved to disciplinary action. As but one example, no Affected Individual will knowingly engage in any form of upcoding of any condition or service in violation of any law, rule, regulation or requirement. Among other things, any Affected Individual involved in such activities is subject to potential termination of employment or contract, and potential criminal and civil liability.
5. Billing codes - including CPT, HCPCS and ICD diagnostic codes - should never be selected on the basis of whether the given code guarantees or enhances payment. Rather, only those codes that correspond to the actual service rendered and documented should be selected.
6. Only those services that are consistent with accepted standards of care may be billed. In this regard, billing and coding must always be based on adequate documentation of the justification for the service provided and for the bill submitted, and this documentation must comply with all applicable requirements.
7. In addition, the following standards must be maintained with respect to all billing and documentation:
 - a. A comprehensive person-centered and up-to-date plan of care is maintained for each patient/resident in a skilled nursing unit which assesses both strengths and needs, includes measurable objectives and timetables to meet the patient's/residents' medical, nursing, physical, mental and psychosocial needs, as identified in the comprehensive assessment, incorporates the patient's/resident's personal and cultural preferences and facilitates participation by the patient's/resident's representative if one has been appointed.
 - b. All patient/resident assessment documents, including but not limited to Minimum Data Sets (MDS) and Care Area Assessments (CAA), must be fully, timely, and accurately completed in accordance with all applicable federal, state, and local rules and regulations.

- c. Under no circumstances may any Affected Individual knowingly misrepresent any information on any patient/resident assessment forms, or in any other document, in an attempt to ensure reimbursement or obtain a higher reimbursement rate.
 - d. Only those medical services to patients/residents that are consistent with acceptable standards of medical care may be billed.
8. In accordance with Federal and New York State law,² the Hospital provides to all Affected Individuals a detailed description of: (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) State civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws. The Hospital also provides Affected Individuals with detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse. The employee handbook also includes specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the Hospital's policies and procedures for detecting and preventing fraud, waste and abuse.
9. The Hospital does not retain any payments to which it is not entitled. The Hospital will timely report, return and explain any identified overpayments in accordance with applicable law, rules, regulations and requirements.

For more information, see "Mandatory and Other Reporting" below; and

See

Billing, Coding and Documentation Policy (POL-24-020);

Waiving/Reducing Coinsurance, Deductible and Copayment Amounts Policy (POL-24-022);

Financial Assistance ("FAP") Public Policy & Billing and Collections Policy (Plain Language Summary Included) (POL-24-014);

Compliance with Federal and State Anti-Referral and Anti-Kickback Laws Policy (POL-24-011); and

Compliance with Federal and State False Claims Laws and Whistleblower Protections Policy (POL-24-017).

D. Standards Relating to Business Practices

- 1. All business records must be accurate, truthful and complete, with no material omissions.
- 2. The Hospital will forego any business transaction or opportunity that can only be obtained by improper or illegal means and will not make any unethical or illegal payments to induce or reward the use of our services.
- 3. No Affected Individuals will engage, either directly or indirectly, in any corrupt business practices intended to influence the manner in which the Hospital performs services or otherwise engages in business practices.

See the Hospital's **Code of Conduct and Business Ethics Policy (POL-24-001).**

² See 42 USC § 1396a(a)(68); 18 NYCRR § 521-1.4(2)(ix).

E. Standards Relating to Record Retention and Access to Records

1. The Hospital will comply with all applicable laws, rules, regulations and requirements relating to the retention of billing and medical records.
2. The Hospital will make available to the New York State Department of Health (“DOH”), the OMIG and the MFCU, upon request, all records demonstrating that the Hospital adopted, implemented and operates an effective compliance program and have satisfied the requirements of 18 NYCRR SubPart 521. Such records will be retained by the Hospital for a period not less than ten (10) years from the date the program was implemented, or any amendments were made, in accordance with 18 NYCRR § 521-1.3(b), or for such longer period of time as may be required by applicable laws, rules, regulations or contractual requirement. (See **Compliance Document Retention Policy (POL-24-012)**.)
3. In order to help ensure the effectiveness of the Compliance Program, the Compliance Officer and appropriate compliance personnel will have access to all records, documents, information, facilities and Affected Individuals that are relevant to carrying out their Compliance Program responsibilities.

F. Patient Referrals/Marketing Activities

1. In general, Federal and State anti-kickback laws prohibit offering, paying, soliciting or receiving any remuneration to induce or reward referrals of items or services that are reimbursed by a Federal health care program (including, but not limited to, Medicare and Medicaid). This includes the giving of any form of remuneration, including virtually anything of value, in return for a referral. The decision to refer patients is a separate and independent clinical decision made by physicians or other appropriate licensed practitioners. In certain situations, there may be exceptions and/or “safe harbors” to the anti-kickback laws. The Hospital does not offer, pay, solicit or receive remuneration to or from physicians, or anyone else, either directly or indirectly, for patient referrals, in violation of applicable laws, rules and/or regulations.

See BCH’s **Compliance with Federal and State Anti-Referral and Anti-Kickback Laws Policy (POL-24-011)**; and **Compliance with Federal and State False Claims Laws and Whistleblower Protections Policy (POL-24-017)**.

2. All marketing activities and advertising by Affected Individuals must be truthful and not misleading, must be supported by evidence to substantiate any claims made and must otherwise be in accordance with applicable laws, rules and regulations. In this regard, our best "advertisement" is the quality of the services we provide. Affected Individuals should never disparage the service or business of a competitor through the use of false or misleading representations.
3. Affected Individuals may not offer, pay, solicit or receive any gifts or benefits to or from any person or entity that would compromise the Hospital’s integrity (or even create an appearance that the Hospital’s integrity is compromised), or under circumstances where the gift or benefit is offered, paid, solicited or received with a purpose of inducing or rewarding referrals or other business between the parties, in violation of applicable laws, rules, regulations or requirements. The guiding principle is simple: Affected Individuals may not be involved with gifts or benefits

that are undertaken to influence any business decision in a manner that violates the law. Cash or cash equivalents may not be given or accepted under any circumstances.

See **Gifts, Gratuities, and Business Courtesies Policy (POL-24-010)** and **Compliance with Federal and State Anti-Referral and Anti-Kickback Laws Policy (POL-24-011)**.

G. Mandatory and Other Reporting

1. As part of its commitment to providing high quality care and services, the Hospital complies with all applicable Federal and State mandatory reporting laws, rules and regulations. To this end, the Hospital will ensure that all incidents and events that are required to be reported are reported in a timely manner and will monitor compliance with such requirements. This includes required reporting to appropriate government agencies or parties.
2. The Hospital will also ensure its compliance with the requirement that, upon enrollment and annually thereafter, it certifies that it has met the requirements of New York Social Services Law (*i.e.*, N.Y. Social Services Law § 363-d and 18 NYCRR Subpart 521-1). Further, the Hospital will provide a copy of the certification required by 18 NYCRR § 521-1.3 to each Medicaid Managed Care Organization (including managed care providers and managed long term care plans) (collectively, "MMCO") for which the Hospital is a participating provider upon signing the participating provider agreement with the MMCO, and annually thereafter. As applicable, the Hospital will also comply with other State and Federal certification requirements that are or may become applicable to it.
3. The Hospital will ensure that all identified overpayments are timely reported, returned and explained in accordance with applicable laws, rules, regulations and requirements. For example, it is the Hospital's policy to exercise reasonable diligence in identifying overpayments, not to knowingly retain any funds which are received as a result of overpayments and to report, return and explain any overpayments received from Federal health care programs (including, for example, but not limited to, Medicare and Medicaid) within 60 days from the date the overpayment is identified (or within such time as is otherwise required by law or contract). Any such monies that are improperly collected will be refunded, in accordance with applicable laws, rules, regulations and requirements, to the appropriate party at the correct address.

See the Hospital's **Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)**.

4. Moreover, in appropriate circumstances (*e.g.*, after an internal investigation confirms possible fraud, waste, abuse or inappropriate claims), the Hospital's will utilize the appropriate self-disclosure process and report, as necessary and appropriate, to the OMIG, OIG, Centers for Medicare and Medicaid Services, or other appropriate payer/the Hospital. In such circumstances, the Hospital may consult with legal counsel or other experts, as needed.

See the Hospital's **Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)**.

H. Standards Relating to Confidentiality and Security

1. In compliance with Federal and State privacy laws, all Affected Individuals will keep patient/resident information confidential and secure.
2. The Hospital has also implemented and maintains a HIPAA Compliance Program that addresses privacy and security. All Affected Individuals must adhere to the standards of the HIPAA Compliance Program.
3. Confidential information acquired by Affected Individuals about the business of the Hospital must also be held in confidence and not used for personal gain, either directly or indirectly, or in any manner that violates applicable laws, rules, regulations or requirements.

I. Government Inquiries

1. It is the Hospital's policy to comply with applicable laws, rules, regulations and requirements, and to cooperate with legitimate government investigations or inquiries. All responses to requests for information must be accurate and complete and must not omit any material information. Any action by Affected Individuals to destroy, alter, or change any of the Hospital's records in response to a request for such records is strictly prohibited and will subject them to immediate termination of employment or contract or removal from their position with the Hospital and possible criminal prosecution, among other things.
2. You may speak voluntarily with government agents, and the Hospital will not attempt to obstruct such communication. It is recommended, however, that you contact the Compliance Officer before speaking with any government agents.
3. You must receive authorization from the Compliance Officer before responding to any request to disclose the Hospital's documents to any outside party.
4. It also is the Hospital's policy to comply with all lawful directives of the DOH, OMIG or other appropriate government agencies with respect to the adoption, implementation and maintenance of our Compliance Programs pursuant to applicable laws, rules and regulations, including, but not necessarily limited to, 18 NYCRR Subpart 521-1.

See the Hospital's **Responding to Government Inquiries, Investigations Policy (POL-24-008)**.

J. Specific Compliance Provisions for Agreements with Contractors

1. It is the Hospital's policy to ensure that all contracts with our Contractors specify that the Contractor is subject to the Hospital's Compliance Program, to the extent that the Contractor is affected by our risk areas (within the scope of the contracted authority and affected risk areas). Contractors subject to the Hospital's Compliance Program as detailed in this paragraph are considered Affected Individuals. The Hospital follows OMIG's guidance regarding agreements in place prior to the effective date of OMIG's updates compliance regulations.
2. In addition, such contracts will also include termination provisions for the failure to adhere to the Hospital's Compliance Program requirements.

See the Hospital's **Contractor Agreement Requirements Policy (POL-24-023)**.

COMPLIANCE PROGRAM STRUCTURE AND GUIDELINES

COMPLIANCE PROGRAM STRUCTURES AND GUIDELINES

The following elements comprise the Hospital's Compliance Program's Structure and Guidelines. Each element governs a different and important aspect of the Compliance Program. The Structure and Guidelines are intended to provide Affected Individuals with an overview of the Compliance Program's framework that supports its day-to-day operations. The framework is designed to allow room for continuous improvement in, and evolution of, the Compliance Program so the Hospital can continue to conduct business in a manner that supports integrity and ethics in the Hospital's operations and compliance with the laws, rules, regulations and requirements to which the Hospital is subject.

ELEMENT 1: Written Policies and Procedures

- A. **Formal Policies.** The Code of Conduct, the Compliance Program Structure and Guidelines, and the Hospital's specific Compliance Policies and Procedures (i.e., our Compliance Manual) have all been formalized in writing and adopted by the Hospital. These documents demonstrate the Hospital's commitment to complying with applicable legal, regulatory and other requirements, appropriate guidance that are applicable to the Hospital's risk areas (including any Medicaid program policies and procedures), and our contractual commitments.

See the Hospital's **Compliance Policy Development and Approval Policy (POL-24-013)**.

- B. Specifically, the Hospital's written Compliance Policies and Procedures and the Code of Conduct are designed to:
- (i) articulate the Hospital's commitment and obligation to comply with all applicable Federal and State standards. In so doing, the Hospital identified governing laws and regulations that are applicable to the Hospital's risk areas, including, but not limited to, applicable Federal health care programs (i.e., Medicare and Medicaid) policies and procedures;
 - (ii) describe compliance expectations as embodied in standards of conduct (i.e., our Code of Conduct). These standards of conduct serve as a foundational document which describes the Hospital's fundamental principles and values, and our commitment to conduct its business in an ethical manner;
 - (iii) document the implementation of the Hospital's Compliance Program and its requirements and outline its ongoing operation. Among other things, the Hospital's Compliance Policies and Procedures are designed to describe, at a minimum, the structure of the Compliance Program, including the responsibilities of all Affected Individuals in carrying out the functions of the Compliance Program;
 - (iv) provide guidance to Affected Individuals on dealing with potential compliance issues. Specifically, the Hospital's guidance is designed to, at a minimum:
 - (a) assist Affected Individuals in identifying potential compliance issues, questions and concerns, set forth expectations for reporting compliance issues, and explain how to report such issues, questions, and concerns to the Compliance Officer; and
 - (b) establish the expectation that all Affected Individuals will act in accordance with the standards of conduct, that they must refuse to participate in unethical or illegal conduct,

and that they must report any unethical or illegal conduct to the Compliance Officer (see the Hospital's **Reporting Unethical or Illegal Conduct Policy (POL-24-007)**);

- (v) identify the methods and procedures for communicating compliance issues to the appropriate compliance personnel (see the Hospital's **Reporting Unethical or Illegal Conduct Policy (POL-24-007)**);
- (vi) describe how the Hospital investigates and resolves potential compliance issues and the procedures for documenting the investigation, and the resolution or outcome (see the Hospital's **Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)**);
- (vii) include a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Program, including, but not limited to:
 - (a) reporting potential compliance issues to appropriate personnel;
 - (b) participating in investigation of potential compliance issues;
 - (c) self-evaluations;
 - (d) audits;
 - (e) remedial actions;
 - (f) reporting instances of intimidation or retaliation; and
 - (g) reporting potential fraud, waste or abuse to the appropriate State or Federal entities

(See the **Whistleblower Non Intimidation Non Retaliation for Good Faith Participation in the Compliance Program Policy (POL-24-015)** and **Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)**);

- (viii) include a written statement setting forth the Hospital's policy regarding Affected Individuals who fail to comply with the written policies and procedures, standards of conduct, or State and Federal laws, rules and regulations. That policy, which may be found in the Hospital's **Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)**, also establishes the Hospital's standards for taking and escalating disciplinary actions that must be taken in response to non-compliance. Generally speaking, intentional or reckless behavior is subject to more significant sanctions. Sanctions may include oral or written warnings, suspension, and/or termination;
- (ix) additionally, the Hospital also complies with the requirements of the Federal Deficit Reduction Act (42 USC § 1396a(a)(68)) to maintaining and disseminating policies regarding false claims law and whistleblower protections (see **Compliance with Federal and State False Claims Laws and Whistleblower Protections Policy (POL-24-017)**); and
- (x) the Hospital will meet at least annually to review all Compliance Program Policies and Procedures and standards of conduct in order to determine: (i) if such written policies, procedures, and standards of conduct have been implemented; (ii) whether Affected Individuals are following the policies, procedures, and standards of conduct; (iii) whether such policies, procedures, and standards of conduct are effective; and (iv) whether any updates are required. Policies will be

reviewed and approved by the Hospital's appropriate organizational unit, which can include the Compliance Steering Committee, Compliance Officer, CEO and Board of Trustees on an annual basis.

ELEMENT 2: Designation of Compliance Officer and the Compliance Steering Committee

- A. Duties of the Compliance Officer.** The Compliance Officer is the focal point of the Hospital's Compliance Program and is responsible for the Program's day-to-day operations. (See **Compliance Personnel Policy (POL-24-003)**.)

The Compliance Officer's primary responsibilities include:

- (i) overseeing and monitoring the adoption, implementation and maintenance of the Compliance Program and evaluating its effectiveness;
- (ii) drafting, implementing, updating and coordinating a compliance work plan no less frequently than annually or, as otherwise necessary, to conform, to changes to Federal and State laws, rules, regulations, policies and standards. The compliance work plan will outline the Hospital's proposed strategy for meeting the requirements of an effective compliance program for the coming year, with a specific emphasis on applicable requirements relating to the Hospital's written Compliance Policies and Procedures, training and education, auditing and monitoring, and responding to compliance issues;
- (iii) reviewing and revising the Compliance Program, and, at least annually, the written Compliance Policies and Procedures and Code of Conduct, to incorporate changes based on the Hospital's organizational experience and promptly incorporate changes to Federal and State laws, rules, regulations, policies and standards. The Hospital will also conduct a review, at least annually, to determine whether such Policies and Procedures and standards of conduct have been implemented, are being followed by Affected Individuals, and whether they are effective and/or any updates are required;
- (iv) reporting directly, on a regular basis, but no less frequently than quarterly, to the Hospital's governing body, chief executive, and Compliance Steering Committee on the progress of adopting, implementing, and maintaining the Compliance Program;
- (v) assisting in establishing methods to improve our efficiency, quality of services, and reducing the Hospital's vulnerability to fraud, waste and abuse; and
- (vi) investigating and independently acting on matters related to the Compliance Program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors and the State.

BCH shall designate an individual to serve as the Compliance Officer. The Hospital is committed to ensuring that the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the Compliance Program, based on the Hospital's risk areas and organizational experience. The Hospital will assess its allocation of staff and resources as part of the Hospital's annual review of our Compliance Program's effectiveness (see, "Annual Compliance Program Review" in Element 6, below).

- B. **Duties of the Compliance Steering Committee.** The Compliance Steering Committee (“Committee”) coordinates with the Compliance Officer in order to ensure that the Hospital is conducting its business in an ethical and responsible manner, consistent with the Hospital’s Compliance Program. The Committee operates pursuant to a written charter. Among other things, the charter outlines the duties, responsibilities and membership of the Committee, designates a Chair and outlines the frequency of the Committee's meetings. (See **Compliance Steering Committee Charter and Purpose Policy (POL-24-018)**.)

The Compliance Steering Committee will review the Hospital’s **Compliance Steering Committee Charter and Purpose Policy (POL-24-018)** no less frequently than annually to address any updates.

The Compliance Steering Committee meets no less frequently than quarterly, and reports directly to, and is accountable to, the Hospital’s Chief Executive Officer and the Board of Trustees. The Committee's membership consists, at a minimum, of senior managers.

The Compliance Steering Committee's responsibilities include:

- (i) coordinating with the Compliance Officer to ensure that the Hospital’s written Compliance Policies and Procedures, and standards of conduct, are current, accurate and complete, and that the training topics that are part of the Compliance Program are timely completed;
- (ii) coordinating with the Compliance Officer to ensure communication and cooperation by Affected Individuals on compliance-related issues, internal or external audits, or any other function or activity required by applicable law, regulation or requirement;
- (iii) advocating for the allocation of sufficient funding, resources and staff for the Compliance Officer to fully perform their responsibilities;
- (iv) ensuring that the Hospital has effective systems and processes in place to identify Compliance Program risks, identify overpayments and other issues, and that effective Compliance Policies and Procedures for correcting and reporting such issues are operating; and
- (v) advocating for adoption and implementation of required modifications to the Compliance Program.

See the Hospital’s **Compliance Steering Committee Charter and Purpose Policy (POL-24-018)**; **Compliance Monitoring and Ongoing Risk Assessment Policy (POL-24-002)**; and **Compliance Education and Training Policy (POL-24-005)**.

ELEMENT 3: Training and Education

- A. As an integral part of the Compliance Program, the Hospital established and implemented an effective compliance training and education program. This program applies to all Affected Individuals and to the Hospital's Compliance Officer.
- B. Affected Individuals and the Compliance Officer will complete the training program no less frequently than annually. This training and education program is a part of the orientation of new Compliance Officers and Affected Individuals and occurs promptly upon hiring (i.e., typically within 30 days of the start of any employment, appointment or affiliation with the Hospital).
- C. Training is provided in a form and format that is accessible and understandable to all Affected Individuals, consistent with applicable language and other access laws, rules or policies.
- D. The Hospital developed and maintains a Compliance Program training plan. At a minimum, this training plan outlines the subjects or topics for training and education, the timing and frequency of the training, which Affected Individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated.
- E. The Hospital's training and education includes, at a minimum, the following topics:
 - (i) the Hospital's risk areas and organizational experience³;
 - (ii) the Hospital's written Compliance Policies and Procedures as identified above in Element 1, "Written Policies and Procedures";
 - (iii) the role of the Compliance Officer and the Compliance Steering Committee;
 - (iv) how Affected Individuals can ask questions and report potential compliance-related issues to the Compliance Officer and senior management, including the obligation of Affected Individuals to report suspected illegal or improper conduct and the procedures for submitting such reports, and the protection from intimidation and retaliation for good faith participation in the Compliance Program;
 - (v) disciplinary standards, with an emphasis on those standards related to our Compliance Program and the prevention of fraud, waste and abuse;
 - (vi) how the Hospital responds to compliance issues and implements corrective action plans;
 - (vii) requirements specific to payors for the categories of service the Hospital provides (e.g., Medicare and Medicaid requirements);
 - (viii) coding and billing requirements and best practices; and
 - (ix) claim development and the submission process.

³ "Risk areas" and "organizational experience" are defined in the Compliance Manual.

See the Hospital's **Compliance Monitoring and Ongoing Risk Assessment Policy (POL-24-002)** and **Compliance Education and Training Policy (POL-24-005)**.

ELEMENT 4: Effective Lines of Communication

- A. **Communication System.** The Hospital established and implemented effective lines of communication, ensuring confidentiality for the Hospital's Affected Individuals. The lines of communication are accessible, allow compliance issues to be reported as they are identified and include methods for anonymous and confidential good faith reporting of potential compliance issues. (See the Hospital's **Reporting Unethical or Illegal Conduct Policy (POL-24-007)**.)

Specifically:

- (i) the Hospital's lines of communication are accessible to all Affected Individuals and allow for questions regarding compliance issues to be asked and for compliance issues to be reported;
 - (ii) the Hospital publicizes the lines of communication to the Compliance Officer and they are made available to all Affected Individuals, as well as to all Medicaid recipients of service;
 - (iii) the Hospital has a method for anonymous reporting of potential fraud, waste and abuse, and compliance issues directly to the Compliance Officer;
 - (iv) the Hospital ensures that the confidentiality of persons reporting compliance issues is maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and that such persons are protected under the Hospital's policy for non-intimidation and non-retaliation (see the Hospital's **Whistleblower Non Intimidation Non Retaliation for Good Faith Participation in the Compliance Program Policy (POL-24-015)**; **Compliance with Federal and State False Claims Laws and Whistleblower Protections Policy (POL-24-017)**); and
 - (v) the Hospital makes available on the website, information concerning the Hospital's Compliance Program, including BCH's standards of conduct.
- B. **"Open Door Policy."** The Hospital has an "open door" policy for receiving reports and for answering questions concerning adherence to the law and the Compliance Program. By this the Hospital means that Affected Individuals are encouraged to meet with the Compliance Officer or their designee to discuss any fraud, waste, abuse or compliance related concerns with the understanding that any meeting or discussion will be kept confidential as required by the Hospital's policies and the Compliance Program.
- C. **Reporting Issues.** All Affected Individuals must abide by the Compliance Program and are required to report suspected illegal or improper conduct, possible violations of the Compliance Program and other compliance-related concerns. Affected Individuals may report issues to the Compliance Officer or other Hospital supervisory or management staff (see the Hospital's **Reporting Unethical or Illegal Conduct Policy (POL-24-007)**). The Addendum B to the Compliance Manual sets out telephone and other contact methods.
- D. **Reporting Conflicts of Interest and Related Party Transactions.** The Hospital requires all Affected Individuals subject to its Conflict of Interest and Related Party Transactions Policy (e.g.,

Officers, Trustees, key employees, etc.) to report any actual or potential conflicts of interest. This includes reporting any related party transactions. Affected Individuals should refer to **Conflict of Interest and Related Party Transactions Policy (POL-24-004)** to determine if they are required to report under that Policy, how to make a report, the process for consideration of reports and the consequences of failing to make a report, among other things.

- E. **Reporting to the Compliance Officer.** If a report is made to a supervisor or management or anyone other than the Compliance Officer, that person must in turn immediately inform the Compliance Officer of the report and the substance of what was reported so that the issues may be addressed.
- F. **Anonymous and Confidential Reporting Methods.** Affected Individuals may report issues or concerns anonymously if they so choose. Affected Individuals may report anonymously by calling the Compliance Hotline. Affected Individuals may also choose to identify themselves. In such case, the reporting person's identity will be kept confidential, whether requested or not, unless the matter is subject to a disciplinary proceeding, is referred to, or is under investigation by, the MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding.
- G. **Intimidation and Retaliation are Prohibited.** Retaliation or intimidation in any form against an individual who reports possible misconduct or illegal conduct or otherwise participates in good faith in the Compliance Program, is strictly prohibited. Acts of retaliation or intimidation should be immediately reported to the Compliance Officer, or to the Hotline and, if substantiated, the individuals responsible will be appropriately disciplined (see BCH's **Whistleblower Non Intimidation Non Retaliation for Good Faith Participation in the Compliance Program Policy (POL-24-015)** and **Compliance with Federal and State False Claims Laws and Whistleblower Protections Policy (POL-24-017).**)

ELEMENT 5: Disciplinary Standards to Encourage Good Faith Participation in the Compliance Program

- A. The Hospital has established well-publicized disciplinary standards, and has implemented enforcement procedures for those standards, in order to address potential violations and to encourage good faith participation in the Compliance Program by all Affected Individuals.
- B. Specifically, the Hospital's written Compliance Policies and Procedures establishing the Hospital's disciplinary standards and the procedures for taking such actions are published and disseminated to all Affected Individuals and are incorporated into the Hospital's training plan. Moreover, the Hospital enforces the disciplinary standards fairly and consistently, and the same disciplinary action applies to all levels of personnel.
- C. The types of discipline imposed will be commensurate with the severity of the violation, and may include one or more of the following: training, re-training, verbal warnings, written warnings, suspension and/or termination of employment or contract, as appropriate, under the circumstances.

See the Hospital's **Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)**.

ELEMENT 6: The System for Routine Monitoring and Identification of Compliance Risk Areas; Annual Compliance Program Reviews; Excluded Provider Checks

- A. The Hospital established an effective system for the routine monitoring, identification and assessment of compliance risks. This system includes, but is not limited to, internal monitoring and audits, and as appropriate, external audits, to evaluate the Hospital's compliance with Federal health care program (e.g., Medicare and Medicaid) requirements and the overall effectiveness of the Compliance Program.
- B. **Routine Monitoring and Auditing.** Routine audits will be performed by internal or external auditors who have expertise in applicable State and Federal requirements (e.g., the Medicare and Medicaid Programs) and other applicable laws, rules, regulations and requirements, or have expertise in the subject area of the audit.
- C. **Specific Risk Areas, Documentation and Reporting.** The Hospital's audits and monitoring will meet the following requirements, at a minimum:
- (i) internal and external compliance audits will focus on the Hospital's risk areas⁴;
 - (ii) the results of all internal or external audits, or audits conducted by the State or Federal government will be reviewed for risk areas that can be included in updates to the Hospital's Compliance Program and compliance work plan; and
 - (iii) the design, implementation, and results of any internal or external audits will be documented, and the results shared with the Compliance Steering Committee and the Hospital's Board of Trustees.
- D. **Overpayments and Corrective Actions.** Any identified overpayments, including, but not limited to Medicaid or Medicare identified overpayments, will be reported, returned and explained in accordance with applicable laws, rules, regulations and requirements, including for instance, NY Social Services Law § 363-d, 18 NYCRR SubPart 521-3 and 42 USC § 1320a-7k(d), and the Hospital will promptly take corrective action to prevent recurrence of the issues that caused the overpayment (see the Hospital's **Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)**).
- E. **Annual Compliance Program Review.** The Hospital also has a process to review; at least annually, whether the Hospital's Compliance Program is effective, whether any revision or corrective action is required, or whether there should be any other changes or modifications to the Compliance Program.

Specifically:

- (i) this review may be carried out by the Compliance Officer, Compliance Steering Committee, external auditors, or other staff the Hospital designates, provided that such other staff has the necessary knowledge and expertise to evaluate the effectiveness of the components of the

⁴ "Risk areas" is defined in the Compliance Manual.

Compliance Program they are reviewing and are independent from the functions being reviewed;

- (ii) the review should include on-site visits, interviews with Affected Individuals, review of records, surveys, or any other comparable method that is appropriate, provided that it does not compromise the independence or integrity of the review;
- (iii) the Hospital will document the design, implementation and results of the effectiveness review, and any corrective action implemented; and
- (iv) the results of the Hospital's annual Compliance Program review will be shared with the chief executive, senior management, Compliance Steering Committee and the Board of Trustees.

F. **Excluded Party Checks.** In accordance with the requirements of 18 NYCRR § 515.5 and 18 NYCRR § 521-1.4 (g)(3), the Hospital will confirm the identity, and determine the exclusion status, of Affected Individuals. Specifically, in determining the exclusion status of an Affected Individual, the Hospital will review, at a minimum, the following databases at least every thirty (30) days: (a) the OMIG Exclusion List; (b) the OIG's List of Excluded Individuals and Entities; and (c) the General Services Administration's System for Awards Management. The results of these checks will be promptly shared with the Compliance Officer and appropriate compliance personnel. Further, the Hospital requires its Contractors to perform these checks every thirty (30) days as well.

See the Hospital's

Compliance Reviews of Clinical Staff Credentials Policy (POL-24-006);

Compliance Monitoring and Ongoing Risk Assessment Policy (POL-24-002);

Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009);

Compliance Education and Training Policy (POL-24-005); and

Compliance Reviews for Excluded or Ineligible Individuals/Entities Policy (POL-24-016).

ELEMENT 7: The System for Promptly Responding to Compliance Issues

- A. The Hospital has established and implemented procedures and systems for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of the internal auditing and monitoring, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with State and Federal laws, rules and regulations, and requirements, including those of the Medicare and Medicaid Programs. The Hospital's procedures and systems include the following:
- (i) upon the detection of potential compliance risks and compliance issues, whether through reports received, or as a result of auditing and monitoring, the Hospital will take prompt action to investigate the conduct in question and determine what, if any, corrective action is required, and likewise promptly implement such corrective action;
 - (ii) the Hospital will document the investigation of the compliance issue. Documentation will include any alleged violations, a description of the investigative process, copies of interview notes and other documents essential for demonstrating that a thorough investigation of the issue was completed. Where appropriate, the Hospital may retain outside experts, auditors, or counsel to assist with the investigation;
 - (iii) the Hospital will also document any disciplinary action taken and the corrective action implemented; and
 - (iv) if the Hospital identifies credible evidence or credibly believes that a State or Federal law, rule or regulation has been violated, it will promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule or regulation. The Compliance Officer will receive copies of any reports submitted to governmental entities.
- B. **Investigations.** All compliance issues, however raised (*i.e.*, whether reported or discovered through audits/self-evaluations or other means), must be brought to the attention of the Compliance Officer.
- C. **Corrective Action and Responses to Suspected Violations.** When appropriate, corrective action plans will be created and tailored to the particular conduct and will provide a structure with time frames in order to attempt to ensure noncompliant activity does not recur. Corrective action will be implemented promptly and thoroughly and may include (but is not necessarily limited to): conducting training and education; revising or creating appropriate forms; modifying or creating new Compliance Policies and Procedures; conducting additional internal reviews, audits or follow-up audits; imposing discipline (up to and including termination of employment or contract), as appropriate and/or refunds to appropriate payers and/or self-disclosing to appropriate government agencies or payers. Corrective Action Plans and other corrective actions will continue to be monitored after they are implemented to ensure that they are effective.

See the Hospital's
**Compliance Monitoring and Ongoing Risk Assessment Policy (POL-24-002);
Protocols for Conducting Internal Investigations and Implementing Corrective Action,
Including Discipline Policy (POL-24-009); and
Compliance Education and Training Policy (POL-24-005).**

COMPLIANCE POLICIES AND PROCEDURES

COMPLIANCE POLICIES AND PROCEDURES

The following Policies, Procedures and Protocols are incorporated by reference into the Compliance Manual. Affected Individuals should contact the Compliance Officer or a designated individual in the compliance office to confirm the current version of the Policies, Procedures and Protocols. This list is not exhaustive and although a Hospital Policy, Procedure or Protocol is not on this list, it may still have application to matters addressed in this Compliance Manual. If there is a conflict between terms of the Compliance Manual and any of the Policies referred to below, the terms in the Compliance Manual shall take precedence and control.

Acknowledgement Compliance Manual

Billing, Coding and Documentation Policy (POL-24-020)

Code of Conduct and Business Ethics Policy (POL-24-001)

Compliance Document Retention Policy (POL-24-12)

Compliance Education and Training Policy (POL-24-005) Compliance Monitoring and Ongoing Risk Assessment Policy (POL-24-002)

Compliance Personnel Policy (POL-24-003)

Compliance Policy Development and Approval Policy (POL-24-013)

Compliance Reviews for Excluded or Ineligible Individuals/Entities Policy (POL-24-016)

Compliance Reviews of Clinical Staff Credentials Policy (POL-24-006)

Compliance Steering Charter and Purpose Policy (POL-24-018)

Compliance with Federal and State Anti-Referral and Anti-Kickback Laws Policy (POL-24-011)

Compliance with Federal and State False Claims Laws and Whistleblower Protections Policy (POL-24-017)

Conflict of Interest and Related Party Transactions Policy (POL-24-004)

Contractor Agreement Requirements Policy (POL-24-023)

Financial Assistance (“FAP”) Public Policy & Billing and Collections Policy (Plain Language Summary Included) (POL-24-014)

Gifts, Gratuities, and Business Courtesies Policy (POL-24-010)

Offering Professional Courtesy Policy (POL-24-021)

Protocols for Conducting Internal Investigations and Implementing Corrective Action, Including Discipline Policy (POL-24-009)

Reducing Coinsurance, Copayments and Deductible Amounts Policy

Reporting Unethical or Illegal Conduct Policy (POL-24-007)

Responding to Government Inquires, Investigations Policy (POL-24-008) Waiving/Reducing Coinsurance, Deductible and Copayment Amounts Policy (POL-24-022)

Whistleblower Non Intimidation Non Retaliation for Good Faith Participation in the Compliance Program Policy (POL-24-015)

COMPLIANCE DOCUMENTS

Annual Work Plan

Available at this link: TBD

Poster

Posters are located in a number of locations, including, but not limited to: Bulletin Boards outside cafeteria, Boardroom corridor, 2nd floor speech area, 2nd floor copy machine.

MISCELLANEOUS MATERIALS

HIPAA Compliance Program

Available at this link: TBD

ADDENDUM A - Listing of Compliance Related Federal and New York State Laws

Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) § 521-1.4(a)(2)(ix) states all Required Providers (which includes the Hospital) shall comply with the provisions of 42 USC 1396a(a)(68) (also known as the DRA). This Addendum identifies the requirements of the DRA and the detailed information that the New York State Office of the Medicaid Inspector General (“OMIG”) looks for in the Hospital’s written Policies and any employee handbook when assessing if a compliance program meets statutory and regulatory requirements.

The Centers for Medicare and Medicaid Services issued the Deficit Reduction Act frequently asked questions that provide guidance on the DRA requirements. If you wish to review a copy of the DRA requirements, please contact the Hospital’s Compliance Officer or the designated person in the Hospital’s compliance office.

DEFICIT REDUCTION ACT (DRA) REQUIREMENTS

18 NYCRR § 521-1.4(a) requires inclusion of Title 42 United States Code § 1396-a(a)(68), also known as the DRA, which states:
Any entity ... as a condition of receiving [Medicaid] payments, shall:

- (A) establish written policies for all [affected individuals], that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of this title);
- (B) include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse; and
- (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste and abuse.

REQUIRED STATUTORY AUTHORITIES ADDRESSED IN THE HOSPITAL’S POLICIES:

1. Federal False Claims Act, Title 31 United States Code §§ 3729 to 3733, excluding § 3730(h):
 - a. liability,
 - b. damages and penalties,
 - c. the knowledge requirement, and
 - d. the qui tam provisions.
2. Federal administrative remedies for false claims and statements, Title 31 United States Code §§ 3801 to 3812:
 - a. liabilities,
 - b. civil penalties and damages, and
 - c. periodic adjustment to civil penalties by Congress.

3. NYS False Claims Act, NYS Finance Law §§ 187 to 194, specifically §§ 187 to 190 and 192 to 194:
 - a. liability,
 - b. damages and penalties,
 - c. false claims and reverse false claims, and
 - d. the qui tam provisions.
4. NYS laws pertaining to civil liabilities, penalties, and administrative sanctions for false claims and statements:
 - a. Social Services Law § 145-b—False Statements; actions for treble damages, and
 - b. Social Services Law § 145-c—Sanctions.
5. NYS laws pertaining to criminal liabilities and penalties for false claims and statements:
 - a. Social Services Law § 145—Penalties,
 - b. Social Services Law § 366-b—Penalties for Fraudulent Practices,
 - c. Penal Law Article 155—Larceny,
 - d. Penal Law Article 175—Offenses Involving False Written Statements,
 - e. Penal Law Article 176—Insurance Fraud, and
 - f. Penal Law Article 177—Health Care Fraud.
6. Federal and state whistleblower protections, including application, protections, prohibited actions, and available remedies:
 - a. Federal False Claims Act (31 U.S.C. § 3730(h)),
 - b. NYS False Claims Act (State Finance Law § 191—Remedies),
 - c. NYS Labor Law § 740, and
 - d. NYS Labor Law § 741.
7. NYS laws and regulations applicable to BCH’s risk areas (non-exclusive list):
 - a. New York Public Health Law, to include, but not be limited to Public Health Law Article 28,
 - b. New York Labor Law to include, but not be limited to Labor Law §§ 740 and 741,
 - c. New York Mental Hygiene Law,
 - d. New York Not-for-Profit Corporation Law,
 - e. New York Social Services Law to include, but not be limited to Social Services Law Articles 5, 6 and 7,
 - f. Regulations of the NYS Department of Health – Title 10 New York Codes, Rules and Regulations to include, but not be limited to Chapter II, Subchapters L, O and P and Chapter V,
 - g. Regulations of the NYS Department of Mental Hygiene - Title 14 New York Codes, Rules and Regulations
 - h. Regulations related to the NYS Medical Assistance Program (Medicaid) Title 18 New York Codes, Rules and Regulations to include, but not be limited to Chapter II.

ADDENDUM B – LISTING OF COMPLIANCE PERSONNEL

The following is a list of compliance program specific personnel and their contact information:

Compliance Resource

Telephone Number

Compliance Hot Line:

Dial toll-free: 833-656-0413

Compliance Officer:

John Flanagan

914-831-2408

Compliance Committee:

- Chair John Flanagan
- #1 John Canning
- #2 Jill Wegener
- #3 Stephen Leinenweber
- #4 Chris Berner
- #5 Connie Cornell
- #6 Susan Murray
- #7 Prad Ananthasingam
- #8 Mirella Cardarelli
- #9 Ed Di Zenzo
- #10 Evgin Heath
- #11 Beth Blanck
- #12 Julia Behan-Hadlock
- #13 Lisa-Marie Coppolino

Hospital President & Chief Executive Officer: Nathaniel Beers, MD

Hospital Board of Trustees Chair:

Peter Rittmaster

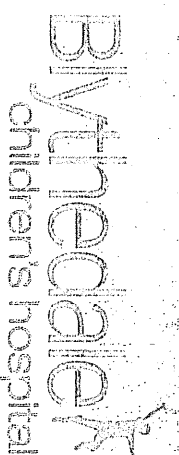
If you wish to make a Compliance Report, you can access an electronic submission platform through this link from the Hospital website:

<https://secure.ethicspoint.com/domain/media/en/gui/54200/issues.html?clientid=54200&locationid=-1&override=yes&agreement=no>

HIPAA

Confidentiality & Privacy

Blythedale Children's Hospital



What is HIPAA?

Health Insurance and Accountability Act of 1996

- Improve the efficiency and effectivity of healthcare system
- Ensure equal access to healthcare
- Protect and secure patient information
- Sharing Patient Information
- Securing Your Work Environment

Who is Covered by HIPAA?

Patients

Physicians

Hospitals

Health and Life Insurers

Public Health Authorities

Information Systems

Why do I need to learn about protecting patient information?

Security is essential to protecting our patients and their families

The hospital has a legal obligation to protect patient information

Good Security Standards follow the "80/20" Rule:

20% of security safeguards are technical, 80% of security safeguards rely on you!

Example: The lock on the door is the 20%.

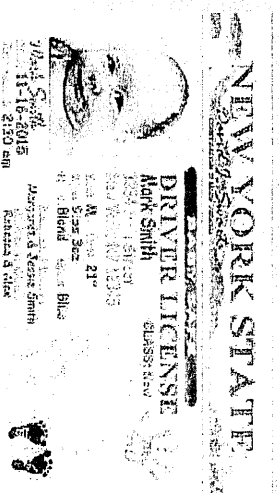
Remembering to lock, checking to see if it is closed, ensuring others do not prop the door open, keeping control of keys is the 80%.

What is Patient Health Information?

Any information that could be used to identify a specific individual including:

- Name
- Address
- Social Security Number
- Email Address

Information that describes the past, present, or physical or mental health condition
Information that describes past, present, or future payment for the provision of health care
Patient Photos



Where is Patient Health Information Found?

- An electronic or physical medical record
- A letter or fax
- A prescription label
- An x-ray

Places where Patient Health Information Does NOT Belong:

- Personal Email Accounts
- Text Messages
- Facebook, Twitter, Instagram and other social media ~~sites~~



Who is this

You are using a stolen phone.



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How BCH to Protect the Patient Information?

- Password and PIN #
- Encryption and secure emailing
- No file sharing devices / flash drives
- Firewall – Sophos
- Secure PHI over public Wi-Fi networks - Ironport

Encryption and Secure emailing

Encryption and remote security for mobile devices have been installed on all laptops and mobile devices and secure emailing to reduce the risk of exposure of confidential information

Secure Email

Do not put PHI in an email unless absolutely necessary

Only include the minimum amount of information necessary

Only send the information to those with a need to know

Only send it to those who are authorized to receive it

May never be sent to personal email accounts for employee use

How to Secure email

The screenshot shows an email client window with a menu bar (File, Message, Insert, Options, Format Text) and a toolbar with icons for Encrypt Message, Cut, Copy, Paste, Format Painter, Bold, and Italic. Below the toolbar, the 'Encrypt Message' button is highlighted. In the email composition area, the 'To:' field contains 'ITSupport@' and the 'Subject:' field contains '[secure] test email'. A red arrow points to the 'Subject:' field. The 'Send' button is visible in the bottom left corner.

File Message Insert Options Format Text

Encrypt Message Cut Copy Paste Format Painter Bold Italic

To: ITSupport@

Subject: [secure] test email

Send

Encrypt email.

Instructions to secure email is in the Intranet site

Status: Checked in and viewable by authorized users. Publication Start Date:

2017 Mileage Reimbursement

BLYTHE

Blythedale will become known as one of the leading specialty children's hospital
Achievement of this vision will result in serving significant numbers of new patients

Performance Evaluation 2016

Performance Evaluation

Add new link

HIPAA & Security

HIPAA - 10 Commandments

How to Secure E-Mail

How to Open Secure Emails

Add new link

Message Board

Speech Pathology hosts Ass
The Department of Speech Pathology
Discovery and on February 11

March 2008 30 hours ago

2017 Blythedale Annual Toy
The Annual Toy Sale will be held
and Toy Care Activity... Read

March 2008 4 days ago

New Visitor Restrictions

Blythedale
children's hospital

File Sharing/Flash Drives

USB Drives are quick and easy they are easy to lose or misplace

HIPAA Security Rule. PHI stored on a USB Drive is “ePHI” and automatically subject to a requirements in terms of storage, transport, and destruction of that data

Loss = Breach

A lost of stolen USB drive with ePHI on it is an *automatic* breach of HIPAA which can and will subject BCH to fines, negative publicity, and possibly criminal charges if willful negligence of HIPAA is determined

What's the Worst that Can Happen?

Stanford's Lucille Packard Children's Hospital – Hospital Laptop containing emails with PHI was lost. PHI of 57,000 children was compromised. Pending Fines of up to **\$5.6 Mil.** Massachusetts Eye & Ear – Doctor's laptop contained emails with PHI and documents was stolen. **Fined \$1.5 Mil.**

Adult & Pediatric Dermatology, of Concord, Mass., has agreed to a **\$150,000** HIPAA penalty after an thumb drive was stolen from a vehicle owned by one of its employees.

The HHS said the HIPAA penalty was not just for losing the thumb drive but because the practice had not identified the thumb drive in a HIPAA risk and had not managed the risk to protect its patient's data

Secure Work Environment

Physical safeguards are needed to protect BOH's PHI systems and related locations and equipment from unauthorized intrusion.

What You Should Do?

Do not have sensitive conversations in public areas of the hospital.

If unsure about a caller from outside the Hospital, take the organization's name and main number, the caller's name. Hang up then call them back on the main number and request to be transferred to that individual.

What You **Should** and **Should Not Do**

- What you Should do:

- > If you feel you need to use a personal device for work related activities you **Should** speak with your supervisor for approval.

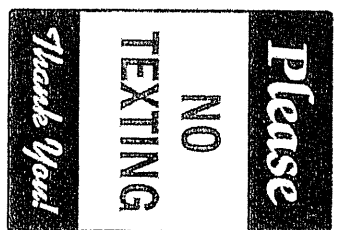
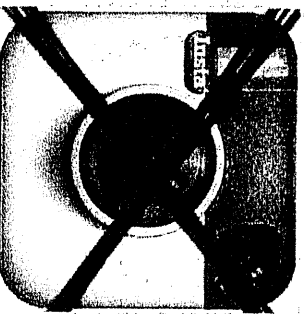
- > You **Should** report to your supervisor and IT Department if the device is lost or stolen.

- What you Should Not do:

- > You **Should Not** use your device for work if it is not approved.

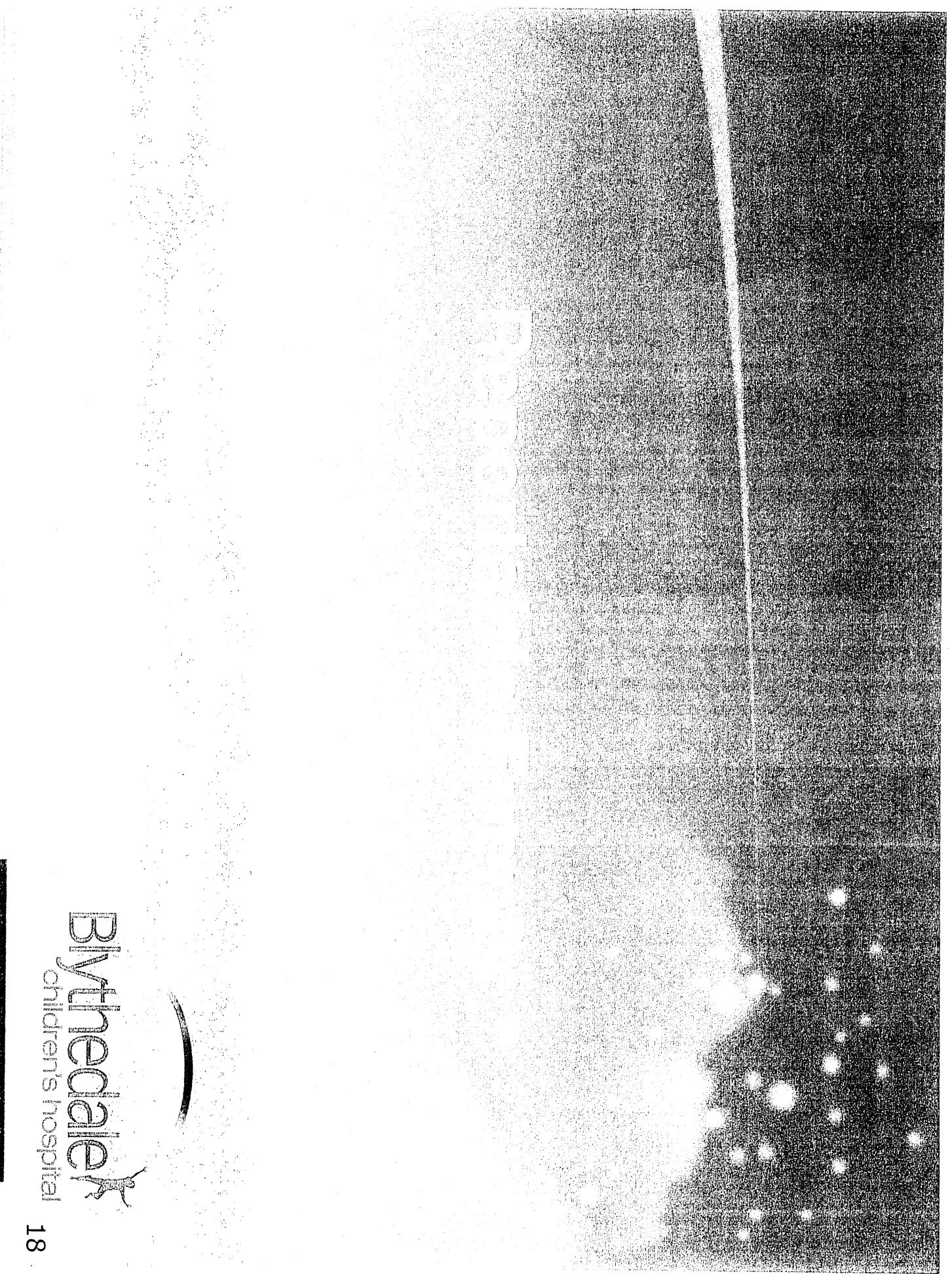
- > You **Should Not** take any pictures at the Hospital.

- > You **Should Not** text patient information, even on a hospital approved device.



What You Should Do

- Lock your computer's screen when leaving the area.
- Lock your office when you leave it.
- Do not leave any documents with sensitive information in public areas.
- Shred any documents with sensitive information when disposing of them.
- Never share your ID badge or access codes



Proton

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• What's a Reportable Event?

Any event that may put patient information or other confidential information at risk of unauthorized access or disclosure.

Why Report Events?

Reporting is crucial to protecting our patients.

Reporting is required by law.

Reporting events helps the Hospital trouble shoot its most vulnerable areas and target education.

Who do I report them to?

Your Supervisor

HIPAA Security Officer

What should I do if I'm not sure?

If you see something, say something!

Reportable Events

Which of the following should be reported?

- A. Patient information is consistently left on a printer in a common area.
- B. A doctor emails a patient's record to the patient's parents without encrypting it.
- C. A nurse talking loudly in the pods regarding a patient and their medical condition.
- D. A doctor loses their iPhone that contains patient information in email.
- E. Someone calls and attempts to get an employee to reveal sensitive information.
- F. All of the Above

Blythedale Security 10 Commandments

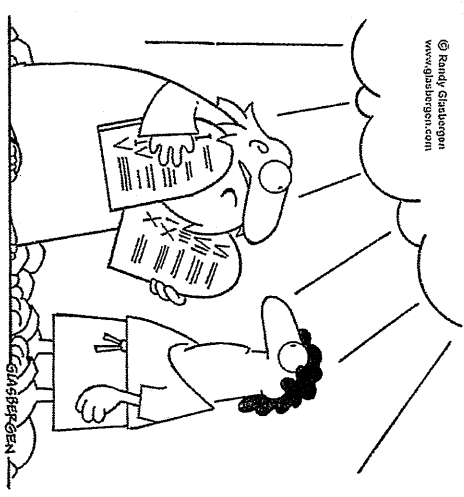
Thou shalt treat patient information as you'd like yours to be treated.

Thou shalt access & use patient information on a "need to know" basis only – idle curiosity is a sin and illegal.

Thou shalt not discuss patients unless it is necessary for treatment, payment, or the operation of the organization – otherwise it is gossip and wrong.

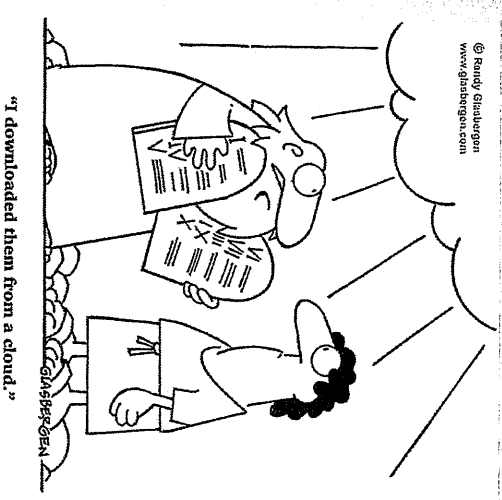
Thou shalt only email patient information if absolutely necessary and only include the minimum amount of information and send only to those who have a need to know and encrypt the email.

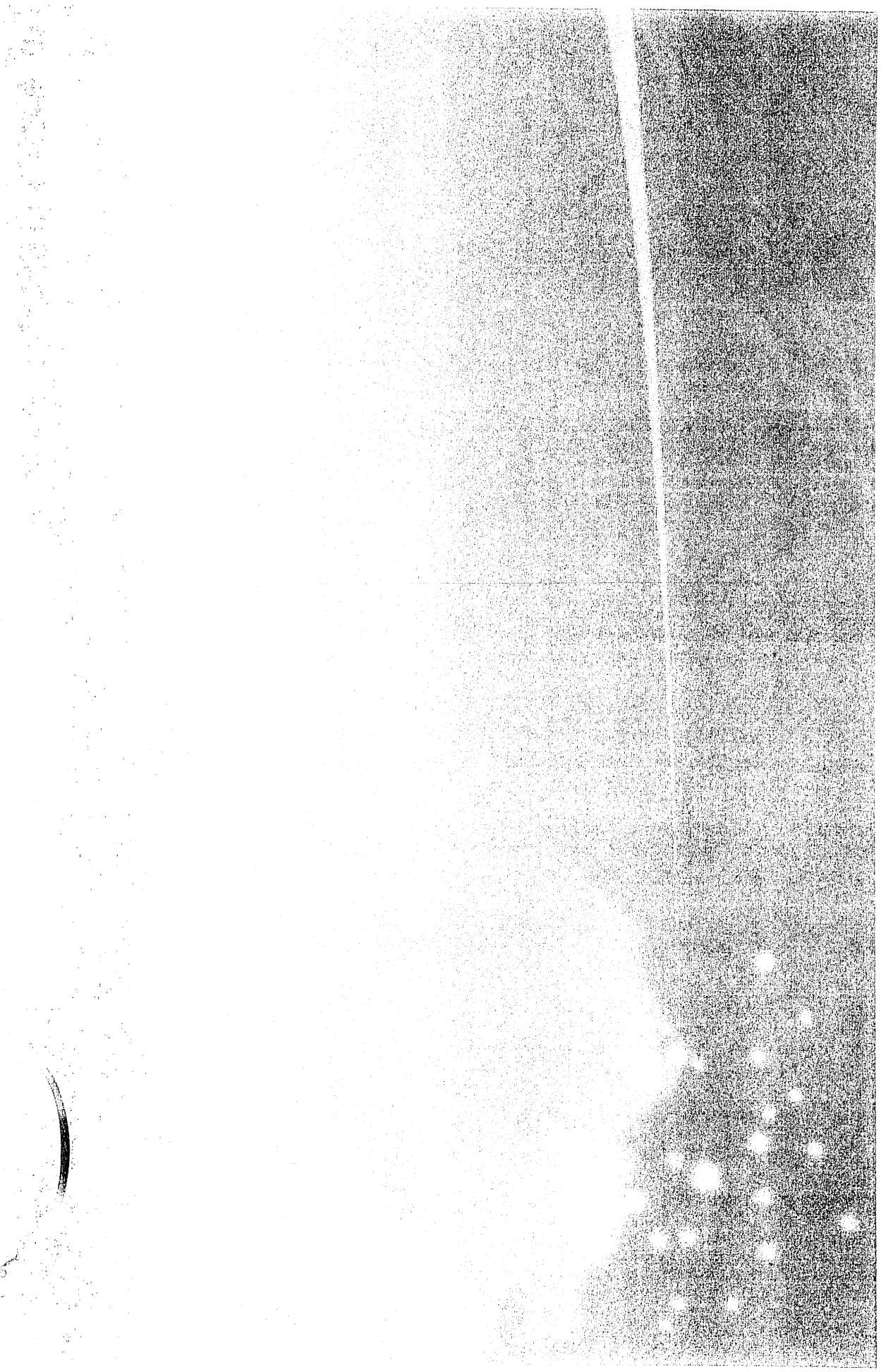
Thou shalt not email patient information to personal email accounts under any circumstances.



Blythedale Security 10 Commandments

- I. Thou shalt only store patient information on a Hospital approved device with proper security
- II. Thou shalt not post patient information, including pictures, on social media sites including Facebook, Twitter and Instagram.
- III. Thou shalt discuss patient information only in a private setting.
- IV. Thou shalt report any suspicious events or behavior.
- V. Thou shalt protect information as it's the most important thing to a patient's safety, privacy and treatment.



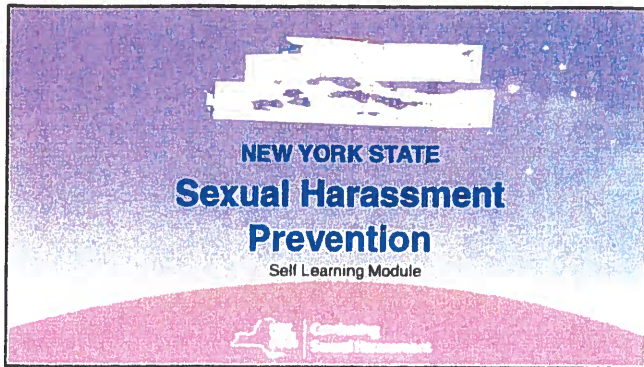


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EMERGENCY CODES

****Any Staff Member can call CODE by Dialing 80 from their Cisco Phones****

		
Code Red Fire RACE & PASS	Code Yellow Bomb Threat	Code Silver Security Weapon
		
Code TCI Escalating Patient	Code Brown Utility Failure	Code Orange Hazardous Material
		
Code Gray Severe Weather	Code Blue Medical Emergency	Code Pink Missing Abducted Child
		
Elopement in Progress		



1

What is Sexual Harassment?

Sexual harassment:
Is a form of sex discrimination and is unlawful
Includes harassment on the basis of sex, sexual orientation, self-identified or perceived sex, gender expression, gender identity and the status of being transgender.

 Combating Sexual Harassment

3

Sexual Harassment in the Workplace

Sexual harassment will not be tolerated.
This training will:
Help you better understand what is considered sexual harassment
• Show you how to report sexual harassment
• Show you external reporting options

 Combating Sexual Harassment

2

What is Sexual Harassment?

It includes unwelcome conduct, either of a sexual nature or which is directed at an individual because of that individual's sex when:
Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment;
Such conduct is made either explicitly or implicitly a term or condition of employment; or
Submission to or rejection of such conduct is used as the basis for employment decisions.

4

Hostile Environment

Sexual or discriminatory displays or publications anywhere in the workplace

Hostile actions taken against an individual because of that individual's sex



5

Who can be the Target?

Sexual harassment can occur between any individuals, regardless of their sex or gender.

The law protects employees, paid or unpaid interns, and non-employees who work in the workplace.



7

Quid Pro Quo Sexual Harassment

Occurs when a person in authority trades, or tries to trade, job benefits for sexual favors.

Occurs between an employee and someone with authority, who has the ability to grant or withhold job benefits.



6

Who can be the Perpetrator?

Anyone in the workplace:

- A coworker

- A supervisor or manager

- Any third-party (non-employee, intern, vendor, customer, etc.)



8

Where Can Workplace Sexual Harassment Occur?

Whenever and wherever employees are fulfilling their work responsibilities, including:

- Employer-sponsored events
- Conferences
- Office parties
- Off-site or during non-work hours



Retaliation



Sex Stereotyping

Harassing a person because that person does not conform to gender stereotypes is sexual harassment.

Harassment because someone is performing a job that is usually or was previously performed mostly by persons of a different sex is sex discrimination.



Protected Activities

Any employee engaged in "protected activity" is protected by law from being retaliated against.

Protected activities include:

- Making a complaint about harassment or suspected harassment
- Providing information during an investigation
- Testifying in connection with complaint



What is Retaliation?

Any action to alter an employee's terms and conditions of employment *because* that individual engaged in protected activities.

Examples:

- Sudden change in work schedule or work location
- Demotion



13

Supervisor's Responsibility



15

What is Not Retaliation

A negative employment action is not retaliatory merely because it occurs after the employee engages in protected activity.



14

The Supervisor's Responsibility

Supervisors and managers are held to a high standard of behavior. They are:

- Required to report any harassment reported to them or which they observe.
- Responsible for any harassment or discrimination they should have known about.
- Expected to model appropriate behavior.



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Mandatory Reporting

Supervisors must report any harassment that they observe or know of, even if no one is objecting to it.

Harassment must be promptly reported to the employer.

Supervisors and managers will be subject to discipline for failing to report suspected sexual harassment.

Supervisors and managers will also be subject to discipline for engaging in retaliation.



17

What Should I Do If I Am Harassed?

We will provide you with a complaint form to report harassment and file complaints. Submit it to:

Director of Human Resources or Chief Compliance Officer
or his or her designee

Forms may be delivered to the Human Resources office room 1603
or the Compliance Officer office Room 2542, or emailed to
Cdemuro@Blythedale.org or Jflanagan@Blythedale.org

You may also make reports verbally.

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What Should I Do If I Am Harassed?



18

What Should I Do If I Witness Sexual Harassment?

Anyone who witnesses or becomes aware of potential instances of sexual harassment should report it to a supervisor, manager or designee.

It is unlawful for an employer to retaliate against you for reporting suspected sexual harassment or assisting in any investigation.

20

Investigation and Corrective Action

- Anyone who engages in sexual harassment or retaliation will be subject to remedial and/or disciplinary action.
- An investigation of any complaint should be commenced immediately and completed as soon as possible.
- The investigation will be kept confidential to the extent possible.
- Any employee may be required to cooperate as needed in an investigation.



21

Additional Protections and Remedies



23

Investigation Process

- The Director of Human Resources or the Chief Compliance Officer will conduct an immediate review of the allegations, and take any interim actions.
- Relevant documents, emails or phone records will be requested, preserved and obtained.
- Interviews will be conducted.
- The individual who complained and the individual(s) accused of sexual harassment are notified of final determination and that appropriate administrative action has been taken.

22

NYS Division of Human Rights (DHR)

A complaint alleging violation of the Human Rights Law may be filed either with DHR or in NYS Supreme Court.

- Complaints may be filed with DHR any time within one year of the alleged sexual harassment.
- You do not need to have an attorney to file.
- More information: www.DHR.ny.gov



24

United States Equal Employment Opportunity Commission (EEOC)

An individual can file a complaint with the EEOC anytime within 300 days from the alleged sexual harassment.

You do not need to have an attorney to file.

A complaint must be filed with the EEOC before you can file in federal court.

More information: www.EEOC.gov.



Summary



25

27

Local Protections

Many localities enforce laws protecting individuals from sexual harassment and discrimination.

Contact your county, city or town to find out if laws exist.

Harassment may constitute a crime if it involves things like physical touching, coerced physical confinement or coerced sex acts.

Contact the local police department.



Other Types of Workplace Harassment

Any harassment or discrimination based on a protected characteristic is prohibited in the workplace and may lead to disciplinary action against the perpetrator.

Age, race, creed, color, national origin, sexual orientation, military status, sex, disability, marital status, domestic violence victim status, gender identity and criminal history.

Much of the information presented in this training applies to all types of workplace harassment.

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Summary

How to recognize harassment as inappropriate behavior.

Harassment because of any protected characteristic is prohibited.

Why workplace harassment is employment discrimination.

All harassment should be reported.

Supervisors and managers have a special responsibility to report harassment.



Combating
Sexual Harassment

29

Important Resources

Find the Complaint Form:

On the BCH Intranet and in Human Resources

For additional information, visit:

www.ny.gov/programs/combating-sexual-harassment-workplace



Combating
Sexual Harassment

30

CLEAN HANDS

COUNT

FOR HEALTHCARE PROVIDERS

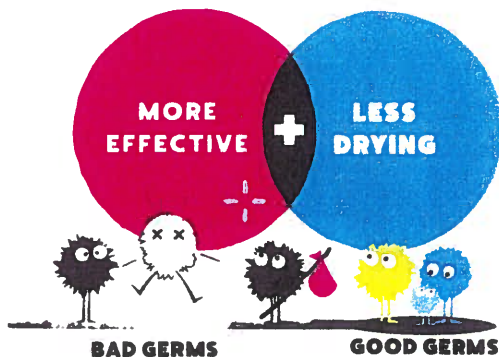
KNOW THE **TRUTH** TO PROTECT YOURSELF AND PROTECT YOUR PATIENTS

TRUTH:

Alcohol-based hand sanitizer is more effective and less drying than using soap and water.

THE NITTY GRITTY:

Compared to soap and water, alcohol-based hand sanitizers are better at reducing bacterial counts on hands and are effective against multidrug-resistant organisms (e.g., MRSA). Additionally, alcohol-based hand sanitizers cause less skin irritation than frequent use of soap and water.



TRUTH:

Using alcohol-based hand sanitizer does NOT cause antibiotic resistance.

THE NITTY GRITTY:

Alcohol-based hand sanitizers kill germs quickly and in a different way than antibiotics. There is no chance for the germs to adapt or develop resistance.

TRUTH:

Alcohol-based hand sanitizer does not kill *C. difficile*, but it is still the overall recommended method for hand hygiene practice.

THE NITTY GRITTY:

Always use gloves when caring for patients with *C. difficile*. In addition, when there is an outbreak of *C. difficile* in your facility, wash your hands with soap and water after removing your gloves.

TRUTH:

Some healthcare providers miss certain areas when cleaning their hands.

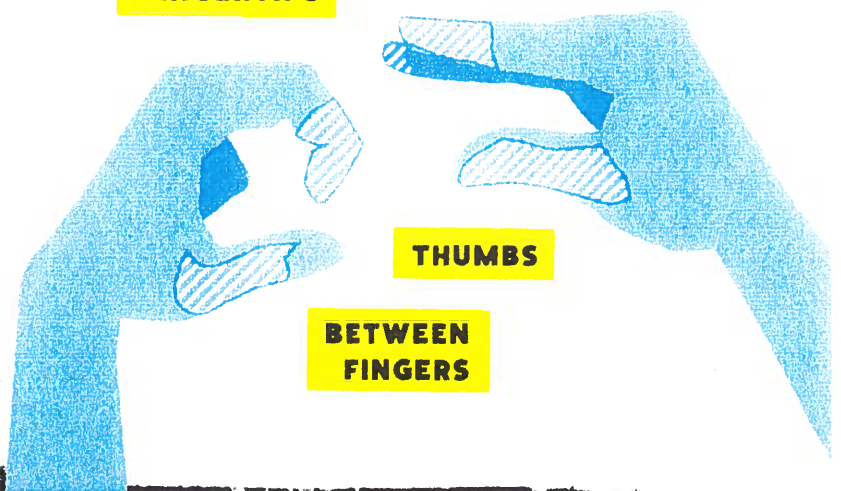
THE NITTY GRITTY:

Using alcohol-based hand sanitizer becomes a habit and sometimes healthcare providers miss certain areas:

FINGERTIPS

THUMBS

**BETWEEN
FINGERS**



Clean Hands Count 100% of the Time

PROTECT YOURSELF AND PROTECT YOUR PATIENTS FROM POTENTIALLY DEADLY GERMS

TRUTH:

The amount of product you use matters.

THE NITTY GRITTY:

Use enough alcohol-based hand sanitizer to cover all surfaces of your hands. Rub your hands together until they are dry. Your hands should stay wet for around 20 seconds if you used the right amount.

TRUTH:

Glove use is not a substitute for cleaning your hands. Dirty gloves can soil your hands.

THE NITTY GRITTY:

Clean your hands after removing gloves to protect yourself and your patients from infection.

TRUTH:

On average, healthcare providers perform hand hygiene less than half of the times they should.

THE NITTY GRITTY:

When healthcare providers do not perform hand hygiene 100% of the times they should, they put themselves and their patients at risk for serious infections.



www.cdc.gov/HandHygiene



This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and GOJO.

ORIENTATION

CELL PHONES

Please turn off cell phones while in the Hospital. They may be used in lobby areas when necessary, but not in patient/resident areas.

CHILD ABUSE & NEGLECT

Patients/residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Patients/ residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the patient/resident, family members, legal guardians, friends, or other individuals. Staff, students, interns, and volunteers should be alert to signs of child abuse and/or neglect. Any suspicions should be reported to your staff supervisor. The Hospital has a designated Child Abuse & Neglect Committee that will evaluate allegations for appropriate action.

EMERGENCIES

The Hospital employs a code system to handle emergencies. If you are arriving at the Hospital for your shift and a code is in progress, you will not be allowed into the building before the code is cleared. If you have finished your shift and a code is in progress, you will not be allowed to leave the building until the code is cleared.

Code Red Fire

If you see fire or smoke, pull the nearest fire alarm immediately and evacuate anyone in the immediate area. Code Red is automatically announced when the alarm is activated and repeated three (3) times. The announcement includes the zone number and the location within the zone. You can locate the zone you are in by looking at the top of the doorframes above the closest double doors in the corridor nearest to you. Additionally, a list of all the codes is posted next to the fire alarm pull stations. The building is divided into specific smoke compartments that are sectioned off by these double doors. If you are with children when the alarm is sounded, stay with them, and remain calm. Your supervisor will acquaint you with the fire procedures for the area in which you work. If you are in the School part of the building, you will help to evacuate the children. If you are in the Hospital areas, you will standby with the children and await an announcement. You will be instructed **if** it is necessary to evacuate. The procedure concludes with the operator announcing "All Clear" three times.

Remember: **R-A-C-E**

- R** – Remove/Rescue anyone from immediate danger
- A** – Alert by pulling the alarm
- C** – Contain the Fire by closing all doors and windows (the building is divided
- E** – Extinguish/Evacuate (use fire extinguisher if easily extinguishable/evacuate, if necessary, horizontally*)

**horizontally means hospital into the school or school into the hospital*

To use a fire extinguisher, remember **P-A-S-S**

- P** – Pull the pin
- A** – Aim the nozzle at the base of the fire
- S** – Squeeze the handle
- S** – Sweep side to side at the base of the fire

Code Brown **Utility Failure**
Code Grey **Severe Weather**
Code Silver **Security/Weapons**

Code Yellow **Bomb Threat – Security**
Code Orange **Hazmat (hazardous material)**

Code Blue Medical Emergency

In the event of a life-threatening emergency requiring medical assistance for a patient, employee, visitor, or volunteer, the CODE Blue procedure should be activated. To activate the code, dial "80" from the nearest phone in the Hospital. In the School, press the designated code button on the phone. Give the switchboard operator the exact location of the code and then stand by until the Code Team arrives.

Code Pink Pediatric Abduction/Missing Child

If you hear this code announced, be very aware of anyone around you who may be taking a child out of the building. Report anything suspicious to your staff supervisor. There will be a lockdown of the building during this code.

DRUGS & ALCOHOL

It is inappropriate for anyone to come into the Hospital under the influence or giving the appearance of being under the influence, of illegal drugs or alcohol. Anyone who does so will be asked to leave immediately.

ENVIRONMENT OF CARE

To manage our environment of care here at the Hospital we have systems and activities in place to do the following: Reduce and control environmental hazards and risks; Prevent accidents and injuries; Maintain safe conditions for patients/residents, staff, volunteers and others coming into the Hospital; Maintain an environment that is sensitive to patient needs for comfort, social interaction and positive distraction; Maintain an environment that minimizes unnecessary environmental stresses for patients, staff, volunteers and others coming into the Hospital; Assess and improve the knowledge and behavior of staff with regards to safety principles.

HAZARDOUS COMMUNICATION PROGRAM

As part of the "Right to Know" law, the Hospital has a written Hazardous Communication Program that is available to all volunteers. Safety Data Sheets (SDS) are available. Your supervisor will inform you if there is a possibility that you may come in contact with any hazardous chemicals.

IDENTIFICATION BADGES

All staff, students, interns, and volunteers must be identified by photo ID badges. If your badge is lost, stolen or damaged, please alert Human Resources immediately.

INFECTION CONTROL & OSHA TRAINING:

The Hospital has an active Infection Control Program aimed at protecting our patients and minimizing the spread of infections. Here are a few guidelines to follow in helping us to keep our patients infection free.

The Spread of Infection

In order for an infection to occur the following must be present:

1. Germs, such as viruses, assorted bacteria, fungus, or parasites cause infections.
2. A way for them to travel. Examples:
 - By contact** between people via the hands
 - By contact** between people and objects (faucets, doorknobs, medical equipment, etc)
 - In droplets** from coughs or sneezes
 - On dust** particles or by air currents
3. Not all germs cause disease. They are most harmful to people who are in a weakened condition. At the Hospital, there are children who are more likely to get an infection because of their medical conditions.

Hand Hygiene

The simple act of cleansing your hands will minimize the spread of germs. The rule is to cleanse your hands before and after touching a child, after touching blood or body fluids, after toileting, before and after meals and after removing gloves. You should wash your hands for 15 seconds with soap and lukewarm water after contact with blood or any body fluid. You can cleanse your hands with alcohol gel for all other situations. Wash hands with soap and lukewarm water after each fourth alcohol gel use.

Standard Precautions

Standard precautions are an essential part of the Infection Control Program and help to decrease the spread of germs. Hospitals are required to use these precautions with every patient regardless of the diagnosis and whether or not the patient has an infection.

How Standard Precautions Work:

1. Use of Gloves – Healthcare workers and visitors must wear gloves whenever they may touch blood or body fluids.
2. Masks, Goggles, Face Shields – are worn if there is a chance to splash blood/ body fluids into the eyes, nose, or mouth.
3. Protective Clothing – gowns or drapes are worn if there is a chance to soil clothing.

Contact Precautions

There are some infections which require additional measures in order to prevent their spread. At the Hospital the precaution we use most often is Contact. These are infections that are spread either by hand contact or contact with contaminated objects. Children who require contact precautions will have a pink sign displayed. Gloves are worn during all interactions with the child and contact with the child's bedside environment including equipment. Gowns must be worn if the child will come in contact with your clothing.

Bloodborne Pathogens

The three bloodborne pathogens which pose the greatest risk to healthcare workers are Hepatitis B (HBV), Hepatitis C (HCV), and HIV. They may be transmitted from exposure to blood/body fluids from patients infected with a bloodborne pathogen. Proper use of Standard Precautions will help prevent exposure.

HBV and HCV attack the liver. Symptoms can range from none to flu-like illness. Infection can lead to cirrhosis or liver cancer. There is a vaccine to prevent HBV infection but not HVC infection. HIV is the virus that causes AIDS. HIV attacks the immune system, making the body less able to fight infections.

Exposures

An exposure is defined as a needle stick with a used needle or a splash/splatter of blood or body fluids to the eyes, nose, mouth, mucous membranes, or non-intact skin. All exposures must be reported as soon as possible. Inform your supervisor and complete an occurrence report. All exposures are evaluated and follow-up treatment will be provided as necessary.

If an exposure occurs:

Needle stick: Wash the area well with soap and water and promote bleeding.

Non-intact skin: Wash area well with soap and water.

Splash to Eyes, Nose or Mouth: Rinse out with copious amounts of water.

OCCURRENCE/INCIDENT REPORTING

All incidents adversely affecting or potentially affecting patients/residents, staff, volunteers, and visitors should be reported promptly to your supervisor. A report will be completed.

PARKING

Please drive carefully and park properly in our parking area. As parking can be difficult, the Hospital employs a valet service, available to everyone, free of charge. The Hospital cannot be responsible for any loss or damage to your car or its contents while in the parking lot. Please do not park in spots clearly marked for patients and their families.

RESIDENTS (LTC)

Residents are children being cared for in the Hospital's Long Term Care Pavilion. The facility is Resident Centered, providing a home-like environment for the children.

RESIDENT RIGHTS (LTC)

Be aware of the following resident rights: the right to a dignified existence, self-determination, respect, full recognition of his/her individuality, consideration and privacy, and communication with and access to people and services inside and outside the facility.

SMOKING

The Hospital is a no smoking facility. Individuals wishing to smoke should be directed to Security to be instructed about acceptable smoking areas outside.



VALHALLA, NY

LEGEND

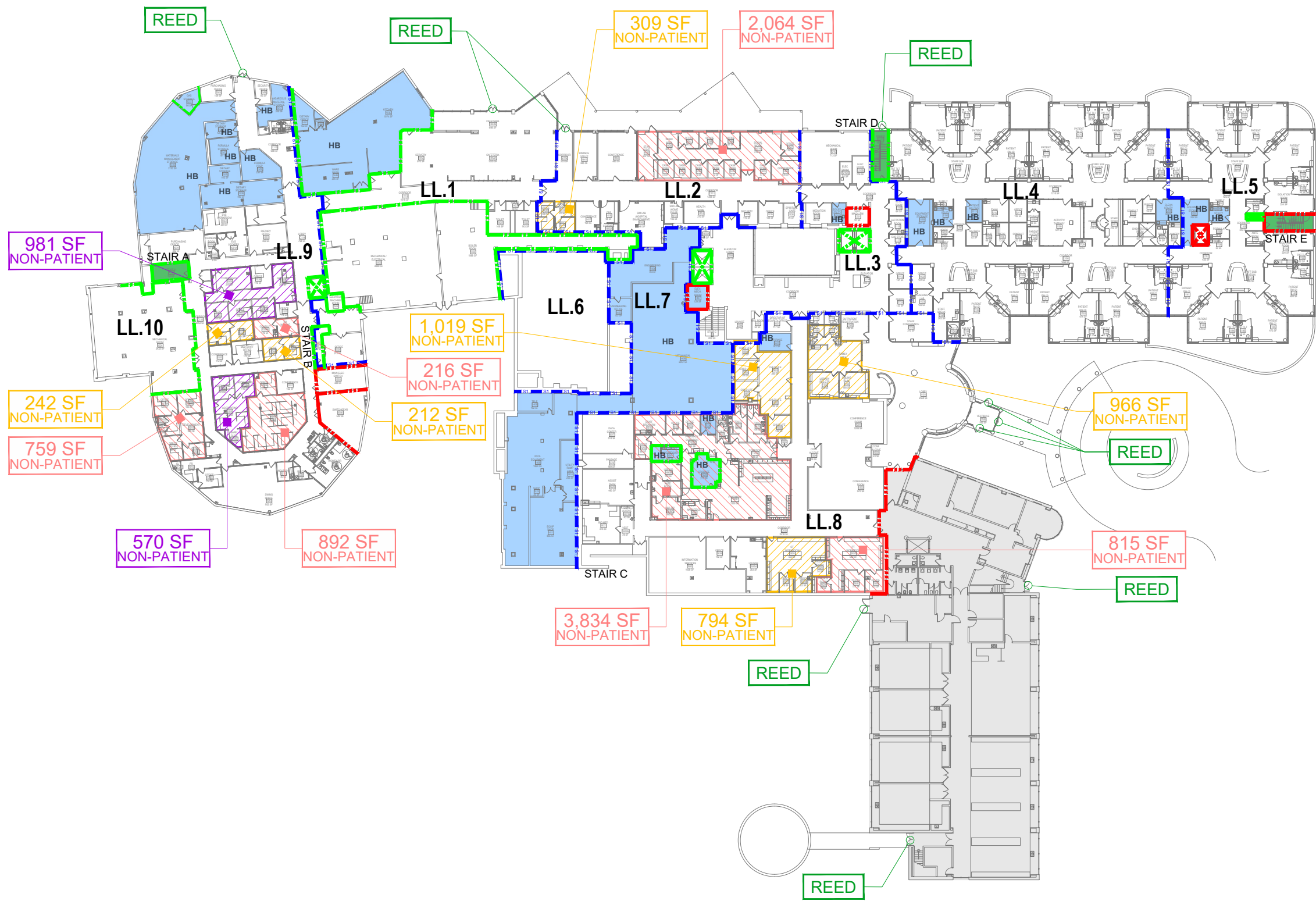
SYMBOL / LINETYPE	CONSTRUCTION / SPACE
	2HR FIRE BARRIER
	1HR FIRE BARRIER
	1HR SMOKE BARRIER

- NON-SURVEYED AREA
- HAZARDOUS AREA
TYPE B: SPRINKLERED
- SUITE AREA (WITH ALTERNATE COLOR)
PATIENT-S (SLEEPING)
PATIENT-NS (NON-SLEEPING)
NON-PATIENT
- REQUIRED EXTERIOR EXIT DOOR
H.EXIT DENOTES HORIZONTAL EXIT
- EXIT STAIRWAY OR EXIT PASSAGEWAY
- NOTE GENERAL NOTE

KEY PLAN	COMPARTMENT LEGEND		
	ID	AREA	NOTES
	LL.1	12,920 SF	FS
	LL.2	6,567 SF	FS
	LL.3	6,326 SF	FS
	LL.4	15,875 SF	FS
	LL.5	8,220 SF	FS
	LL.6	4,022 SF	FS
	LL.7	7,771 SF	FS
	LL.8	19,803 SF	FS
	LL.9	17,544 SF	FS
	LL.10	2,507 SF	FS
HEALTHCARE	FS: FULLY SPRINKLERED PS: PARTIALLY SPRINKLERED NS: NON-SPRINKLERED		



ORIGINAL DATE: 12/12/2025		REVISION DATES: ---	
SURVEYOR(S): SAW		DRAWN BY: DMZ	
LIFE SAFETY			DWG. #
LOWER LEVEL			LS.LL





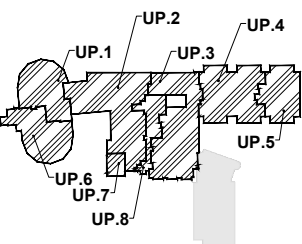
VALHALLA, NY

LEGEND

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KEY PLAN



COMPARTMENT LEGEND

ID	AREA	NOTES
UP.1	10,985 SF	FS
UP.2	21,490 SF	FS
UP.3	19,717 SF	FS
UP.4	15,177 SF	FS
UP.5	9,203 SF	FS
UP.6	11,408 SF	FS
UP.7	1,838 SF	FS
UP.8	5,157 SF	FS

FS: FULLY SPRINKLERED
PS: PARTIALLY SPRINKLERED



ORIGINAL DATE: 12/12/2025	REVISION DATES: ---
SURVEYOR(S): SAW	DRAWN BY: DMZ
LIFE SAFETY	DWG. #
UPPER LEVEL	LS.UP

