ORGANIZATION POLICY

POLICY TITLE: INVESTIGATION OF COMPLIANCE OFFENSES AND CORRECTIVE ACTIONS

POLICY NUMBER: 1202

It is the policy of Onslow Memorial Hospital to investigate any reporting of compliance offenses as a result of employee reports, routine monitoring and auditing activities, patient compliance, or findings by outside investigative agencies. Corrective action will be taken as appropriate based on the results of the investigation.

I. PROCEDURE:

A) Initial Report
All reports of possible compliance violations and all inquiries by outside regulatory agencies will be directed promptly to the Compliance Officer. The person making the report through his/her chain of command or the Hotline, shall provide whatever facts are readily available, but shall not delay reporting the Compliance Officer in order to gather more information.

B) Initial Evaluation
The Compliance Officer will conduct an initial evaluation, with the advice and assistance of the Compliance Committee, or its subcommittee(s) as necessary. The initial evaluation normally will include a determination of whether the matter is related to non-compliance and may include a review of applicable documentation, laws and regulations, and interview of staff and supervisors. The Compliance Officer will keep the appropriate parties informed throughout the process and will maintain full and accurate documentation of all steps taken during the initial evaluations. The investigation and the material information related to the investigation will be kept confidential and disseminated only to parties who require knowledge. The initial evaluation shall commence as soon as possible after the report of the potential violation is received, but in no event more than thirty (30) days following notification.

C) Procedures for Evaluation/Investigation of Non-Compliance

1. Compliance Officer receives report of suspected non-compliance conduct and contacts legal counsel to establish investigation protocol and attorney-client or attorney work product privilege, as may be appropriate.

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2. Compliance Officer or designee review relevant laws, rules, guidelines, etc., to determine if allegations have merit.

3. In accordance with the investigation protocol, the Compliance Officer or designee may interview employees, physicians, vendors, patients or other parties. If the compliance concern involves a patient (e.g. expired equipment/products or recall), the patient's treating physician will be notified immediately. The Compliance Officer or designee may also undertake a review of documents or areas of hospital operations. The Compliance Officer will be given complete access to all requested information and involved parties or departments will assist the Compliance Officer, as necessary, and as requested to facilitate the initial evaluation.

4. The Compliance Officer may take action necessary to protect or preserve relevant documentation or other evidence. To prevent document tampering, the Compliance Officer may limit access to computer records and gather documents for centralized storage or review. The Compliance Officer may also seek through consultation with Human Resources and employee's chain of command to have involved parties removed from the site of the potential compliance problems, such as temporarily relocating an employee to another Department, as may be necessary to preserve the integrity of the investigation. The Compliance Officer will, to the extent possible, communicate regularly and coordinate these activities with affected OMH management.

5. At the conclusion of the investigation, the Compliance Officer will report to the Compliance Committee and legal counsel. The Compliance Officer will recommend an appropriate course of action to achieve resolution of the matter.

D) Results

After completing the evaluation, the Compliance Committee will determine whether or not a possible violation has occurred and, in any case, whether or not further action is advisable.

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1. Significant Events – If it appears that a substantive violation may have occurred, the Compliance Officer will report the findings to the Compliance Committee, along with recommended actions. The Compliance Committee will then determine the scope of any further steps to be taken.

   If further investigation is warranted, the Compliance Committee may recommend that outside legal counsel and/or outside consultants be retained to help conduct the inquiry. The Compliance Officer will serve as liaison with any such external parties.

   The Hospital Authority Board will be informed of any significant occurrences and investigations, along with their progress and outcomes.

2. Minor Occurrences – The assessment may find no significant violation of any law or regulation. In such case, the Compliance Officer, together with the appropriate parties, such as department director or senior management, will determine whether or not further education, clarification, or other corrective actions are needed in the area that resulted in the initial report.

E) Referral to Outside Authorities
If an investigation finds credible evidence of fraud or other criminal activity, Compliance Officer will contact senior management and legal counsel immediately after conferring with the Compliance Committee. Through legal counsel, the appropriate government agency will be notified as soon as possible and best efforts will be used to report within sixty (60) days of the discovery of credible evidence. If an investigation or audit finds overpayments from third-party payors, senior management will be notified, so that appropriate repayments can be made.

F) Post-Investigation Retaliation or Retribution
Any incidences or reports of retaliation or retribution resulting from investigations of compliance offenses or corrective actions will be considered possible compliance violations.

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G) <u>Questions</u>
If you have any questions regarding the procedure for internal investigations or the proper protocols for responding to an outside investigator/authority, please contact the Compliance Officer.

EFFECTIVE DATE: September 1, 2000

REVIEW: January 2012, January 2015
January 2018

REVISION DATE: November 2004, October 2008

DEPARTMENTS PRIMARILY AFFECTED: ALL DEPARTMENTS AND MEDICAL STAFF

AUTHORIZED BY:

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