SECTION:	COMPLIANCE	SUB SECTION:	GENERAL
SUBJECT:	COMPLIANCE PROGRAM ELEMENTS		
APPROVED BY:	Chief Executive Officer		

POLICY

It is the policy of Arrowhead Regional Medical Center (ARMC) to maintain a compliance and ethics program consistent with federal, state and regulatory guidelines that develops a culture which promotes compliance and ethics, integrity and quality service. It is the expectation that all employees, medical staff, volunteers and contractors will comply with ARMC's Compliance and Ethics Plan.

PROCEDURES

I. The ARMC Compliance and Ethics program consists of the essential elements required for effective compliance as recommended by the U.S. Department of Health and Human Services, Office of the Inspector General, Compliance Program Guidance. These elements are the basis in which all compliance and ethics components are formulated and implemented at ARMC. They are as follows:

A. ARMC will develop and distribute written standards of conduct, and written policies and procedures that promote ARMC's commitment to compliance. ARMC has implemented a Code of Conduct in addition to policies and procedures that delineate the framework for compliance and ethics within the organization. The Code of Conduct is distributed to all employees, etc. upon hire and made available through ARMC Tools. Policies and procedures related to compliance can be located in ARMC Tool, Administrative Operations Manual, Section 1000 – Compliance.

B. ARMC will designate a Chief Compliance Officer and other appropriate compliance staff to maintain an effective compliance and ethics program. The Chief Compliance Officer and Compliance department will be responsible for overseeing and monitoring the implementation of the compliance program, including: developing policies and procedures designed to ensure compliance with federal, state and regulatory requirements; creating an awareness of the compliance program through training and various forms of communication; reporting on a regular basis to the hospital director and governing body; revising the compliance program as appropriate; performing investigations and subsequent corrective actions. The Chief Compliance Officer will report directly to the hospital director and governing body.

C. ARMC's Compliance department will develop and implement regular, effective education and training programs for all affected employees. Training will include topics related to fraud and abuse and mechanisms for reporting such issues, including whistleblowing and whistleblowing protections, as well training and education geared towards other applicable laws and regulations and the Compliance Program guidelines.

D. The Compliance department will provide open lines of communication between the Chief Compliance Officer/Compliance department and ARMC employees. In addition a process has been established by which employees can confidentially and anonymously (as appropriate) report issues of potential misconduct or a violation of ARMC policy and procedure, federal, state or

other regulatory requirement via the Compliance and Ethics Helpline (1-877-797-ARMC or 1-877-797-2762).

E. The Compliance department will develop a system to respond to allegations of improper/illegal activities and coordinate with Human Resources for the enforcement of appropriate disciplinary action against employees who have failed to comply with ARMC's standards of conduct, policy and procedures, or Federal and State laws.

F. The Compliance department will perform periodic audits and monitoring of ARMC operations through the Annual Compliance Work Plan. The Annual Compliance Work Plan will include risk areas to be audited and monitored for each calendar year; information will be reported to senior leadership and the governing board.

G. The Compliance department will, upon report or reasonable indications of suspected noncompliance initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program have occurred, and if so, take steps to correct this problem.

REFERENCES: **Federal Register: Publication of the OIG Compliance Program Guidance for Hospitals**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

9/21/15	**Policy, Procedure and Standards Committee**
9/21/15	**Deborah Pease, Associate Administrator** Applicable Administrator, Hospital or Medical Committee
3/25/14	**Board of Supervisors** Approved by the Governing Body

REPLACES: **Administrative Policy No. 1000.02 Issue 2**

EFFECTIVE: **5/25/05** **REVISED:** **08/31/15**

REVIEWED: **4/7/08, 9/22/10**