# University of Texas Harris County Psychiatric Center

## COMPLIANCE PROGRAM

## I. STATEMENT OF POLICY OF ETHICAL PRACTICES ("Policy")

The University of Texas-Houston Harris County Psychiatric Center has a policy of maintaining the highest level of professional and ethical standards in the conduct of its business. The Hospital places the highest importance upon its reputation for honesty, integrity and high ethical standards. This Policy Statement is a reaffirmation of the importance of the highest level of ethical conduct and standards.

These standards can only be achieved and sustained through the actions and conduct of all personnel of the Hospital. Each and every employee, including management employees, of the Hospital is obligated to conduct himself/herself in a manner to ensure the maintenance of these standards.

Employees must be cognizant of all applicable federal and state laws and regulations that apply to and impact upon the Hospital's documentation, coding, billing and competitive practices, as well as the day to day activities of the Hospital and its employees and agents.

**Purpose:**

The University of Texas-Harris County Psychiatric Center Compliance Program symbolizes dedication to the highest standards of ethical behavior, expressed through corporate culture and through adherence to the law. UTHHCPC compliance plan reflects acceptance of a duty and commitment of resources, to meet those standards.

**Scope:**

The provisions of UTHHCPC Compliance Plan apply to everyone involved in overseeing, managing, and operating all components of UTHHCPC, including board members, corporate officers, mangers, supervisors, employees, medical staff, resident physicians, other health care professionals, students, volunteers and as applicable, contractors, consultants, and vendors.

**Goals:**

The goals of UTHHCPC Compliance Plan are in concert with the Office of the Inspector General's Compliance Program Guidance for Hospitals (1-7) and the University of Texas Health Science Center's Compliance Plan. These goals are:

1. To establish written standards of conduct, as well as written policies and procedures that promotes the hospital's commitment to compliance.
2. To appoint a Compliance Committee to implement and carry out the UTHHCPC Compliance Plan and the University of Texas Health Science Center Compliance Plan. (**Note: The OIG language states to appoint a Compliance Officer to implement and carry out the CP)**
3. To provide an internal reporting system for receiving complaints (such as an hotline) (phone Number)
4. To ensure that education, training, and communication about the standards and the CP requirements occur.
5. To create a system for monitoring and auditing the effectiveness of the compliance program.
6. To establish an appropriate disciplinary mechanism for the consistent enforcement of CP requirements
7. To develop a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary actions
8. To develop a risk identification and assessment procedures: Risk identifications and assessment is the process of identifying those laws, rules, and regulations applicable to UTHHCPC, its billing practices, and its relationship with the University.

**Oversight of the UTHHCPC Compliance Plan**

The University of Texas-Harris County Psychiatric Centers Compliance Committee is responsible for oversight of the organizations Compliance Plan.

**Purpose:**

The purpose of the UTHHCPC Compliance Committee is to provide cross-functional expertise, coordination and oversight to assist the organization in creating and implementing the operation of UTHHCPC Compliance Plan. The Committee may consist of both permanent members and temporary or ad hoc members who serve at need for specific issues. Permanent Compliance members include representatives of different departments:

Administration

Finance Department

Human Resources

UT Legal Department

Information Systems Technology

Medical Records

Medical Staff

Patient Financial Services

Privacy Officer

Utilization Management

Performance Improvement Director

Research

All individuals who bear primary responsibility for compliance plan

Ad hoc Committee members may be drawn from any area relevant to matters under discussion.

The Committee is also responsible for:

1. Establishing methods to improve quality of service and reduce vulnerability to fraud and abuse.
2. Revising the compliance program periodically in light of changes in the company or the regulatory environment.

2. Training employees in compliance.
3. Ensuring the company does not do business with prohibited people.
4. Investigating allegations of impropriety and overseeing corrective action.
5. Annual Review of the UTHHCPC Compliance Plan
6. Annual Review and Revision of the Risk Assessment

The Committee shall meet quarterly at predetermined times and dates.

A summary of the items addressed and actions taken at each meeting shall be made and retained by the chair.

**Employee Obligations**

Reporting obligations: Employees must immediately report any suspected or actual violations (whether or not based on personal knowledge) of applicable law or regulations by the Hospital or any of its employees. Any employee making a report may do so anonymously if he/she so chooses. Once an employee has made a report, the employee has a continuing obligation to update the reports as new information comes into his/her possession. All information reported d by any employee in accordance with the Compliance Policy shall be kept confidential by the Hospital to the extent that

confidentiality is possible throughout any resulting investigation: however, there may be a point where an employee's identity may become known or may have to be revealed in certain instances when governmental authorities become involved. Under no circumstances shall the reporting of any such information or possible impropriety serves as a basis for any retaliatory actions to be taken against any employee making the report.

Acknowledgment Statement. Each employee must complete and sign from time to time an Acknowledgement Statement to the effect that the employee fully understands the Compliance Program, and acknowledges his/her commitment to comply with the Program as an employee of the Hospital. Each acknowledgment statement shall form a part of the personnel file of each employee. It shall be the responsibility of each manager to ensure that all employees under his/her supervision who are materially involved in any of the Hospital's documentation, coding, billing and competitive practices have executed such an acknowledgment.

## The University of Texas Health Science Center at Houston

## Compliance Hotline and Reporting Policy and Procedure

Response to Allegations of Questionable Conduct or Non-Compliant Activity

The University of Texas Health Science Center at Houston (UTSHC-H or the University) is committed to implementing appropriate corrective action to all allegations of questionable conduct or activity that are not compliant with applicable laws, regulations, and policies by its employees or other agents in a timely and appropriate manner. Additionally, the UTHSC-H is committed to providing appropriate guidance to its employees and agents regarding potential violations of law. To ensure that the UTHSC-H exercises due diligence in responding to any and all reports of potential violations of laws, regulations, policies or questionable conduct, from any source, the UTHSC-H Institutional Compliance Committee (ICC), on behalf of the UTHSC-H, adopts this procedure.

The Chief Legal and Compliance Officer is designated as the UTHSC-H official responsible for receiving and processing all reports of questionable conduct or suspected non-compliance that involve the activities or operations of the UTHSC-H. Any other UTHSC-H official who receives a report of suspected non-compliance is responsible for notifying the Chief Legal and Compliance Officer of the report at the earliest possible time and transferring all information regarding the report to the Chief Legal and Compliance Officer immediately.

It is the individual responsibility of all individuals who are employed by, affiliated with, under a contract or agreement, or otherwise under the control of the University, including but not limited to faculty, students, and staff (individually referred to herein as a "University Member"), to report any activity that appears to be in violation of any state or federal law or regulation, UT System regulation or policy, UTHSC-H regulation or policy, the UTHSC-H Standards of Conduct (found at HOOP 2.01), and/or any

applicable accreditation or other regulatory requirements through the normal administrative channels (*i.e.,* reporting to the appropriate supervisor). If the circumstances are such that a University Member does not feel comfortable reporting these issues through the normal administrative process, they must report the suspected non-compliant activity or misconduct directly to the Chief Legal and Compliance Office or through the University's confidential mechanism.

The UTHSC-H has established a confidential mechanism for employees to report instances of suspected non-compliance: (1) outside the normal chain of command; and (2) in a manner that preserves confidentiality to the extent allowed by law and which assures non-retaliation. The confidential mechanism is a toll-free telephone line, operated by an external contractor. The phone number for the Compliance Hotline is 1-888-472-9868.

Employees or agents of the UTSHC-H may report suspected misconduct or non-compliant activity to the Chief Legal and Compliance Officer directly or to members of the staff of the Institutional Compliance division of the Office of Legal Affairs and Institutional Compliance. Employees or agents of the UTHSC-H may also seek guidance regarding potential violations of law, policies, or procedures from the Chief Legal and Compliance Officer or staff members of the Institutional Compliance division of the Office of Legal Affairs and Institutional Compliance.

## A. Responsible Parties

1. **The Chief Legal and Compliance Officer** is responsible for: maintaining all necessary and appropriate documentation of reports of suspected non-compliance involving **the** UTHSC-H; reporting all hotline calls or compliance reports to the Triage Team; investigating or coordinating/monitoring the investigation of all reports of suspected non-compliance made through the external confidential reporting mechanism (*i.e.,* the toll free "hotline" number) or otherwise made to or received by the Chief Legal and Compliance Officer or staff of the Institutional Compliance division of the Office of Legal Affairs & Institutional Compliance; reporting all hotline calls or compliance reports, the actions of the Triage Team, the investigation of the calls or reports, and the resolutions of these matters to the Institutional Compliance Committee; and reporting significant hotline calls or compliance concerns to the UT System-wide Compliance Officer.

2. **The Triage Team** is composed of the Vice President of Human Resources, the Chief of Police for The University of Texas at Houston Police Department, the Chief Audit Officer, and the Chief Legal and Compliance Officer. The Triage Team is responsible for reviewing new hotline calls and compliance reports, recommending appropriate action, reviewing the results of all investigations, recommending further action as necessary, and reviewing the reconciliation of the hotline log and the management reports. The Triage Team will have weekly standing meetings. It is the responsibility of each

Triage Team member to attend these meetings or to designate an appropriate person from their department to attend these meetings.

3. **The General Compliance Program Manager** is responsible for the day-to-day operation of the confidential reporting program. Day-to-day operations include, but are not limited to: initial receipt and review of report, logging report into system (assigning log number, creating file, creating intake form), maintaining report log, the creation and maintenance of necessary forms used in process, and the reconciliation of the hotline logs with the management reports created by the external contractor who operates the Compliance Hotline. The Triage Team on a quarterly basis will review all reconciliation's. Additionally, the General Compliance Program Manager is responsible for facilitating the weekly meetings of the Triage Team.

**B. Reports**

1. A report can be made through the external hotline, by letter, phone call, or email, exit interview statement, or through a meeting with the Chief Legal and Compliance Officer or other staff members of the Institutional Compliance division of the Office of Legal Affairs & Institutional Compliance.

2. Reports can be made anonymously. If anonymity is requested, no attempt shall be made to identify the individual. Information provided by the individual, or obtained in the course of investigation, shall be treated as confidential to the extent permitted by law. The UTHSC-H will ensure the anonymity, to the extent allowed by law, of all persons who choose to report questionable conduct or suspected non-compliant activity. Litigation demands or statutory requirements may compel the University to disclose the information reported and the identity of the reporting individual.

3. If the report is a suggestion or general inquiry (*e.g.*, the reporter would like to suggest that the University issue each employee a bumper sticker), the information will be referred to the appropriate department and an annotation reflecting this referral will be made in the log.

4. If a report or allegation involves a student as defined in HOOP Policy 6.03, the dean of the appropriate school will immediately be notified. If the student is also an employee of the UTHSC-H or the UT System Medical Foundation, the dean of the appropriate school and the Triage Team will jointly coordinate the investigation and any actions taken as a result of the investigation. If the student is not an employee of the UTHSC-H or the UT System Medical Foundation, the matter will be transferred immediately to the dean of the appropriate school. The dean of the appropriate school will have primary responsibility for the matter transferred.

5. The investigation of reports or allegations that may constitute intentional violations or reckless disregard of criminal law will be transferred immediately to the University of Texas at Houston Police Department. The University of Texas at Houston Police Department will have primary responsibility for the matters transferred.

6. The investigation of reports or allegations that may constitute intentional violations or reckless disregard of civil law will be transferred immediately to the Legal Affairs division of the Office of Legal Affairs & Institutional Compliance. Legal Affairs will have primary responsibility for the matters transferred.

7. If a report or allegation involves an alleged fraud, as defined in the UT System Business Procedure Memorandum No. 50, the matter will be transferred immediately to the Office of Audit & Advisory Services. The Office of Audit & Advisory Services will have primary responsibility for the matters transferred. As indicated in Business Procedure Memorandum No. 50, the Office of Audit & Advisory Services will notify the University of Texas at Houston Police Department immediately when an audit reveals suspected criminal activity.

8. If a report involves significant allegations regarding accounting, internal accounting controls, or auditing matters, the matter may be reported to the Audit, Compliance, and Management Review Committee of the University of Texas System Board of Regents through the UT System Audit Office as appropriate. The Triage Team is responsible for determining the matters to be reported in accordance with state and university policy. The Chief Legal and Compliance Officer is responsible for transmitting the information to the UT System Audit Office.

9. If a report or allegation involves a privacy violation, the matter will be transferred immediately to the UTHSC-H Privacy Officer. The UTHSC-H Privacy Officer will have primary responsibility for the matters transferred.

## C. Investigations

1. Upon the receipt of a report which does not involve alleged fraud, the intentional violation of or reckless disregard of criminal or civil law, a privacy violation, or a student, the Chief Legal and Compliance Officer is responsible for determining if the report is significant and for documenting the rationale of this determination.

    a. **Compliance reports:** If the Chief Legal and Compliance Officer determines that the report involves the potential violation of a policy or procedure, the steps outlined below in section C.2 will be followed.

Examples of compliance reports are reports of fraudulent billing or conflicts of interest.

b. **Other reports:** If the Chief Legal and Compliance Officer determines that the report is not a report of a potential violation of a policy or procedure, the Chief Legal and Compliance Officer will immediately assign the report to the appropriate department for investigation. The department is responsible for documenting their investigation and findings in a written report to the Chief Legal and Compliance Officer. The Chief Legal and Compliance Officer will report the allegations contained in the report, the assignment of the report, and the results of the investigation of the report to the Triage Team.

   An example of this type of report is a report regarding employee dissatisfaction.

2. The Triage Team will review all compliance reports. The Triage Team will agree on a documented investigative action plan and will assign the report to the appropriate party for investigation. As necessary, the Triage Team shall involve other individuals or committees to assist in an investigation or in formulating the appropriate response to a report. The Triage Team may also assign investigational responsibility of a report to other departments, individuals, or committees. If investigational responsibility is assigned to another individual, department, or committee, the Chief Legal and Compliance Officer will transmit the report in writing with investigation and reporting instructions.

3. If a report involves allegations regarding a member of the Triage Team or a member of a Triage Team member's staff, that Triage Team member will not participate in the review and resolution of that report. If a report involves the Office of Legal Affairs & Institutional Compliance or a staff member of the Office of Legal Affairs & Institutional Compliance, the matter will be immediately transferred to the Chief Audit Officer who will assume responsibility for the investigation and resolution of the matter. The Chief Audit Officer will follow the procedures contained in this policy for the investigation and resolution of the matter.

4. The Triage Team may consult with external counsel who may conduct the investigation for and on behalf of the University.

5. The Triage Team will determine the appropriate amount of time for the investigation of a report. The investigational time period will not ordinarily exceed twenty-one days.

6. All allegations or concerns received through reports will be investigated confidentially. The report and the ongoing investigation will only be

revealed to those necessary to conduct a thorough investigation. All witnesses interviewed or contacted will be informed that this matter is confidential.

7. If the caller or reporter identifies himself/herself, the Chief Legal and Compliance Officer (or his/her designee) shall make a follow-up call to the individual within five business days to inform them that the compliance issue is being investigated. The reporter may call the Institutional Compliance division of the Office of Legal Affairs & Institutional Compliance for status reports on the matter. However, because the investigation and resolution of compliance issues often involve legally confidential information such as personnel actions, the caller may not be given complete information on the nature of the investigation or the resolution of the issue.

8. At the close of the investigation, the investigator will inform the Chief Legal and Compliance Officer in writing of the interviews conducted during the investigation, the documents reviewed, and any findings made by the investigator. The Chief Legal and Compliance Officer will transmit this report to the Triage Team. The Triage Team will determine if the investigation is sufficiently documented and has answered all of the relevant questions.

9. If the case is sufficiently documented and has answered all of the relevant questions, the Triage Team will determine if the report is substantiated or unsubstantiated.

**D. Recommendations**

1. If a report is substantiated, appropriate corrective or disciplinary action must be taken before the report can be considered closed.

2. The Triage Team will inform the department chair, manager, or head of the work unit that a report has been substantiated and that a corrective action plan must be developed by them. The corrective action plan will focus on implementing changes in internal processes to improve, prevent, or detect compliance inadequacies. The department chair, manager, or head of the work unit must submit the corrective action plan in writing to the Chief Legal and Compliance Officer. The corrective action plan will be transmitted to the Triage Team by the Chief Legal and Compliance Officer for their review. The corrective action plan may include one or all of the following elements: specific areas requiring compliance attention, requirement of additional training, change in policies and procedures, further audit and/or investigation, and/or disciplinary action.

3. Disciplinary action may be imposed as part of a corrective action plan for all UTHSC-H administration, faculty, and employees. All disciplinary action

will be administered in accordance with UTHSC-H policies and procedures for administration, faculty, and employees.

4. A summary report of all investigations will be provided to the UTHSC-H Institutional Compliance Committee periodically. The Institutional Compliance Committee (ICC) will be informed of the allegations, the investigation, and any corrective or disciplinary action taken. The ICC may direct further action if necessary. Additionally, the ICC may direct reviews of the affected departments or work areas to ensure that all corrective action has been fully implemented to prevent recurrence of similar non-compliance in the future.

**E. Trend Reporting**

1. The Chief Legal and Compliance Officer is responsible for preparing and submitting a trend report of all allegations to the Institutional Compliance Committee at the end of the fiscal year. This report will summarize all reports and highlight major trends. Additionally, the Chief Legal and Compliance Officer is responsible for preparing and submitting trend reports to the UT System-wide Compliance Officer as requested.

2. Based on identified trends, the Chief Legal and Compliance Officer may recommend to the Institutional Compliance Committee the development of training, policies and procedures, or other corrective action to address the identified trends.

**F. Retaliation**

1. All University Members shall be allowed to discuss freely and to raise questions and/or concerns to managers or to other appropriate personnel about activities they feel may be in violation of any applicable state or federal law or regulation, UT System regulation or policy, UTHSC-H regulation or policy, the UTHSC-H Standards of Conduct, or any other applicable accreditation or regulatory requirements, without fear of retaliation or other reprisal.

2. No employee, contractor, or agent of the UTHSC-H shall intimidate, coerce, discharge, demote, suspend, threaten, harass, or in any other manner discriminate in the terms and conditions of employment in retaliation against any individual who in good faith:

   a. exercises any right under, or participates in any process established by federal, state, or local law, regulation, UTHSC-H policy, UT System regulation or policy, the UTHSC-H Standards of Conduct, or any other applicable accreditation or regulatory requirements;
   b. files a report or complaint regarding a violation of federal, state, or local law, regulation, UTHSC-H policy, UT System regulation or policy, the UTHSC-H

Standards of Conduct, or any other applicable accreditation or regulatory requirements;

c. discloses or threatens to disclose information about a situation they feel is inappropriate, or potentially illegal;
d. testifies, assists, or participates in an investigation, compliance review, peer review, proceeding, or hearing;
e. opposes any act or practice made unlawful by federal, state, or local law, regulation, UT System regulation or policy, UTHSC-H policy, the UTHSC-H Standards of Conduct, or any other applicable accreditation or regulatory requirements, provided that the manner of the opposition is reasonable and does not itself violate law.

Any University community member who believes they have been retaliated against for raising a compliance question or concern should immediately contacts the Chief Legal and Compliance Officer.

**G. Records Retention**

1. The Chief Legal and Compliance Officer is responsible for maintaining all necessary and appropriate documentation of reports of suspected non-compliance involving the UTHSC-H. All files and records will be kept in a locked file cabinet. Report logs will be retained for two years after the resolution of the last incident logged. All investigation records will be retained for ten years after the resolution of the incident.

2. Departments, individuals, or committees who are assigned the investigation of reports by the Chief Legal and Compliance Officer or the Triage Team shall maintain all records of their investigation or actions in a locked file cabinet or office. Additionally, all files and records pertaining to the investigation will be maintained according to the UTHSC-H Records Retention Schedule.

**H. Definitions**

1. "Fraud" refers to embezzlement, misappropriation and other fiscal irregularities. The term fraud includes but is not limited to any dishonest, illegal or fraudulent act involving UTHSC-H property; forgery or alteration of checks, drafts, promissory notes, and securities; forgery or alteration of employee benefit or salary related items such as time cards, billings, claims, surrenders, assignments, changes in beneficiary, etc.; forgery or alteration of medical related items such as reports, charts, prescriptions, x-rays, billings, claims, etc.; forgery or alteration by employees of student related items such as grades, transcripts, loans, fee or tuition documents, etc.; misappropriation of funds, securities, supplies or any other asset; illegal or fraudulent handling or reporting of money transactions; acceptance or solicitation of any gift, favor, or service that might reasonably tend to influence the employee in the discharge of his or her official duties; and the destruction or

disappearance of records, furniture, fixtures, or equipment where theft is suspected.

2. "Good faith" refers to the disclosure of violations or possible violations of any state or federal law or regulation, UT System regulation or policy, UTHSC-H regulation or policy, the UTHSC-H Standards of Conduct, or any other applicable accreditation or regulatory requirements made with a belief in the truth of the disclosure which a reasonable person in the reporting individual's position could hold based on the facts. A disclosure is not made in good faith if made with reckless disregard for or willful ignorance of facts that would disprove the disclosure.

3. "Compliance Report" refers to a report involving financial misstatements, accounting or audit irregularities, imminent risk to life or health, violation of state or federal laws carrying severe criminal or civil penalties, or other risks of substantial negative impact on the safety, integrity, reputation, or financial viability of the UTHSC-H.