Origination Date:	*01/2019*
Effective:	*01/2022*
Last Approved:	*01/2022*
Last Revised:	*01/2022*
Next Review:	*01/2025*
Owner:	*Daniel McManus: Compliance Officer North*
Policy Area:	*Admin 500 Administrative & Operations*
Applies To:	*Hackensack Meridian Health Network*
Applicability:	*Hackensack Meridian Health Network*

Hackensack Meridian Health Corporate Compliance Plan

Corporate Compliance Plan

Approved by the Audit & Compliance Committee of Board of Trustees 11/3/21

I. INTRODUCTION

Hackensack Meridian *Health* Network (also referenced throughout as "Hackensack Meridian" or "HMH") has a long-standing commitment to good corporate citizenship and best-practice governance. To that end, we have established a Corporate Compliance program or Compliance program that requires participation by every member throughout Hackensack Meridian, regardless of his or her position in the organization. The program assures that all actions conform to the highest ethical standards and comply with all applicable laws, rules and regulations.

Hackensack Meridian's Corporate Compliance Department is charged with the implementation of the organizational Compliance Plan ("Plan") and with assuring that HMH, its team members and staff comply with applicable laws and regulations, with particular focus on the Federal and NJ False Claims Acts, the Anti-Kickback Statute and Stark Laws.

The purpose of the Plan is to ensure compliance with all applicable laws and regulations by promoting ethical behavior among our team members and creating an entity-wide mechanism for assessing, monitoring and improving compliance standards. The Plan is embodied in the HMH Code of Conduct ("Code") and guided by the mission and vision of Hackensack Meridian *Health*. Through education of our team members we will instill the principles contained in the Code of Conduct. Through ongoing auditing and monitoring, we look to ensure that HMH is in compliance with all applicable federal, state and local laws, rules and regulations and third party payer requirements.

Goals:

1. Engender a corporate culture of "compliance" with ethical business practices at its core. Instill all team members with the principles embodied in the Code of Conduct, placing with each team member an affirmative duty to report any actual or perceived impropriety.
2. Ensure that HMH policies and procedures are effective and that activities are in compliance with all applicable laws and regulations, including that Federal and State health care programs including Medicare and Medicaid.
3. Develop a mechanism to monitor and measure ongoing compliance.
4. Exercise due diligence to prevent, detect and respond to any fraud, waste and abuse.

Objectives:

1. Perform risk analyses/vulnerability assessments via reviews of the current organizational environment on an ongoing basis.
2. Recommend changes to the HMH Code of Conduct to assure that the document remains effective in the context of corporate compliance.
3. Maintain a confidential and anonymous hotline (ComplyLine) to provide an additional avenue for team

members to report concerns and perceived violations of the organization's Code of Conduct and other policies and procedures.

4. Communicate the compliance program to team members.
5. Evaluate and document the effectiveness of the Compliance Program on an annual basis

II. WRITTEN STANDARDS OF CONDUCT

Every Hackensack Meridian *Health* team member must conduct himself or herself according to the institution's Code of Conduct. The Code of Conduct establishes compliance expectations and standards to ensure that HMH team members conform to the highest ethical standards and comply with all applicable laws, rules and regulations. In addition to the Code of Conduct, Medical Staff members are expected to follow guidelines set forth in the Medical Staff Rules and Regulations.

The Code of Conduct emphasizes the areas identified by management as having a greater impact on those ethical issues referred to in the Code. Those areas include but are not limited to:

a. Patient Care
b. Medical Records Management
c. Coding and Billing
d. Financial Management
e. Human Resource Management
f. Patient Privacy as Delineated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Code does not address every situation and does not set forth every applicable rule. Questions about the existence, interpretation or application of any law, regulation policy or standard should be directed, without hesitation, to a supervisor, manager/director, or to the Chief Compliance Officer.

Team members are empowered to identify and report any actual or perceived unethical or non-compliant behavior or practices without fear of retribution. Reporting mechanisms include reporting concerns to supervisors following the normal chain of command, The Office of Corporate Compliance, or ComplyLine.

Laws, regulations and policies are constantly evolving therefore; the Code of Conduct is revised and updated, as needed. Revisions are communicated in a timely manner through administrative notification and changes are posted to various Hackensack Meridian *Health* Intranet pages. Specific Hackensack Meridian *Health* corporate policies are procedures are available through the intranet and available to all team members. Policies that identify areas of particular risk that apply to the institution and address those potential risks to enforce an environment of compliance, include but are not limited to Code of Conduct, ComplyLine Operations Policy, Sanctions and Exclusion Policy, Conflicts, Dualities of Interest and Independence Policy, Fraud and Abuse Prevention – DRA Compliance Policy, Compliance Program Internal Investigations Policy, EMTALA Policy and policies regarding Privacy and Security of confidential information.

III. ORGANIZATION

The compliance infrastructure demonstrates Hackensack Meridian's "top down" commitment to complying with all applicable laws, rules and regulations. The HMH Compliance Program is aligned with seven program elements contained in the guidance for the healthcare industry issued by the HHS OIG[1]

Core Elements of an Effective Compliance Program

1. Written policies and procedures
2. Designated compliance officer and compliance committee
3. Effective training and education
4. Effective lines of communication
5. Internal monitoring and auditing
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Prompt response to detected problems through corrective actions

The departments throughout Hackensack Meridian *Health* that share operational responsibility for the implementation of the Compliance Plan include, but are not limited to Compliance, Privacy, Legal, Audit Services, and Human Resources.

Per the OIG, the compliance function "promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide team members guidance; to promote team member compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program."[2]

Additionally, the OIG indicates the "legal function advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted."[3]

The audit and compliance function, as defined by the OIG, "provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Audit Services ensure monitoring functions are working as intended and identify where management monitoring and/or additional Board oversight may be required. Audit Services helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Audit Services can fulfill the auditing requirements of the Guidelines."[4]

Per the OIG, the "human resources function manages the recruiting, screening, and hiring of team members; coordinates team member benefits; and provides team member training and development opportunities. [5]

Each department should independently report on its compliance and risk-management efforts. This information should also be disseminated to the Board. The OIG has advised that the "Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology."[6]

The OIG also suggests, "as part of its oversight responsibilities, the Board may want to consider conducting regular "executive sessions" (i.e., excluding senior management) with leadership from the compliance, legal, audit services, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called."[7]

A. Chief Compliance Officer

The Chief Compliance Officer is part of Senior Leadership and reports directly to the Board of Trustees and to the CEO of Hackensack Meridian *Health*. The Chief Compliance Officer shall not be the General Counsel or a member of the Legal Department.

Under the direction of the Chief Compliance Officer, the Department of Corporate Compliance shall be responsible for the implementation and operation of all aspects of the Corporate Compliance Program. When opportunities are identified, the Chief Compliance Officer will coordinate the development, implementation and monitoring of new processes to continually improve compliance performance.

While this Plan provides for the existence of the Chief Compliance Officer, who has ultimate responsibility and accountability for creating and facilitating a comprehensive strategy, to ensure that Hackensack Meridian *Health* is consistently complying with the federal and state regulations and ethical business standards, each member of the workforce remains responsible and accountable for his or her own compliance with applicable laws.

Chief Compliance Officer's duties and responsibilities include:

1. Development of appropriate management, and team member training and education in conjunction with hospital education and staff development.
2. Provide advice and support to management in an effort to continually improve systems. Reduce and eliminate exposure to regulatory actions related to compliance.
3. Develop and maintain appropriate reports to provide information needed by the executive management and Board of Trustees to continually assess the status and effectiveness of the Corporate Compliance Program.
4. Develop and implement consistent, entity wide communication that reinforces the goals of the Compliance Program.
5. Coordinate the operation of the ComplyLine. Providing periodic reports to Leadership and the Board regarding trends and issues identified through the ComplyLine.
6. The Chief Compliance Officer also serves as the Hackensack Meridian Chief Privacy Officer and ensures compliance with HIPAA, as an element of the overall Compliance Program.
7. The Chief Compliance Officer's responsibilities are fully delineated in his/her Job Description

B. Audit and Compliance Committee of the Board of Trustees

The Board of Trustees will provide oversight and assure that HMH is in compliance with applicable laws and regulations. The Board of Trustees has designated the Audit and Compliance Committee to provide that oversight.

1. Membership of the Audit and Compliance Committee of the Board shall consist of not less than eight members, appointed by the Chairman.
2. Committee responsibilities will be fully defined in a committee charter which shall be reviewed and approved on an annual basis.
3. Regular meetings shall be held at least quarterly.

4. The full duties and responsibilities of the Audit and Compliance Committee are contained in its charter.

   With respect to corporate compliance, the Audit and Compliance Committee shall at a minimum:

   a. Hold periodic briefings with Chief Compliance Officer.
   b. Evaluate the effectiveness and continuing viability of the compliance program.
   c. Maintain oversight of the program's progress.
   d. Review education, training and the Standards of Conduct to assure that compliance with applicable laws, rules and regulations are maintained.

C. Compliance Operations Group (COG)

The executive compliance functions shall be coordinated and implemented by the COG. This Group shall provide executive oversight, advice and general guidance on all matters relating to corporate compliance. Through the Chief Compliance Officer, the Group reports as appropriate to the Audit and Compliance Committee of the Board of Trustees on all significant issues relating to compliance with applicable laws, rules, regulations and the Hackensack Meridian *Health* Code of Conduct.

1. The Chair of the Committee is the Senior Vice President, Chief Compliance Officer and the Executive Vice President, Chief Operating Officer is the Executive Sponsor. The Chief Compliance Officer is responsible for reporting on compliance activities recommended or reported by the Department of Corporate Compliance Office. Membership of the Committee consists of the Chief Operating Officer, Chief Information Officer, General Counsels, Chief Financial Officer, Executive Vice President – Human Resources, President Physician Services, Executive Leadership of the Hackensack Meridian Health hospitals and Presidents of Care Transformation Services, Senior Vice Presidents of Revenue Cycle, Vice President of Special Care/Care Transition, Senior Vice President of Post-Acute Care, Senior Vice President of Home Care, Senior Vice President of Risk Management, Vice President of Ambulatory Services, Compliance Officers, Directors of Medical Information Services, Director of Audit Services, Vice Presidents of Health Information Management, Directors of Care Coordination, Director of Care Management, Director of Privacy, Director of Conflict of Interest Management and other senior leaders.
2. Regular meetings will be held at least quarterly.
3. The COG shall have the overall responsibility for continual improvement in the performance of the Corporate Compliance Program, including but not limited to the:

   a. Ongoing evaluation of the corporate values, culture and potential areas of compliance vulnerability as perceived by the executives, management and other team members.
   b. Ensuring Compliance Program effectiveness, including on-going auditing and monitoring of areas with an identified compliance component.
   c. Establishing heightened awareness of compliance issues and improving team member skills in dealing with these issues.
   d. Enhanced appreciation by executives and leaders for how to promote compliance in the work environment.
   e. Strengthening the Code of Conduct, including periodic review and revision to ensure relevance to team members.

E. Hackensack Meridian Department of Corporate

Compliance

The Hackensack Meridian Corporate Compliance Program is operated under the guidance of the Chief Compliance Officer and includes the following coverage areas:

- Audit Services
- Corporate Compliance
- Privacy
- Regulatory Affairs
- Corporate Governance

The Department of Corporate Compliance shall be responsible for the implementation and operation of all aspects of the Compliance Program. Compliance works closely with various departments throughout Hackensack Meridian to enhance the culture of compliance and ensure compliance with applicable federal and state regulations and internal policies and procedures.

IV. EDUCATION AND TRAINING

Education for compliance and privacy related issues for targeted and general audiences is available through the Department of Corporate Compliance. Education is a component of the overall comprehensive compliance program, auditing processes conducted through the department and a focus area for ensuring all HMH team members are given applicable instruction in pertinent compliance and privacy issues associated with their work.

The frequency and content of the education will be based on applicable changes and updates to local, state and federal laws and regulations; organization policy; and need for education in any given area. Need is identified through observation of practice, results of Corporate Compliance auditing and monitoring, or as expressed by individuals or groups involved in a compliance related-issue.

A. Initial Education

Every HMH team member will receive general compliance education including:

1. Compliance infrastructure
2. Regulatory environment
3. Introduction the Code of Conduct
4. Communication and reporting
5. ComplyLine function
6. Privacy – HIPAA/ HITECH

B. Ongoing Education

All HMH team members are required to complete mandatory online learning related to Compliance Standards, the Code of Conduct and Privacy policies and procedures. In addition, departments will conduct ongoing education:

1. To maintain and encourage open lines of communication.
2. To disseminate changes in the regulatory environment.

3. To address team member issues and concerns.
4. To resolve issues identified by team members when appropriate.

V. MONITORING AND AUDITING

All departments will continue intra and/or interdepartmental compliance and privacy auditing and monitoring for applicable laws and regulations, and will report where appropriate. Departments will participate in periodic audits/reviews conducted by the Department of Corporate Compliance, Audit Services or the Office of Privacy as identified in the Audit and Compliance Annual Work Plan or as requested by management, administration or the Board.

The Work Plan will be developed on an annual basis and will detail the schedule and scope of the audits and reviews to be conducted. Specific areas identified by the Chief Compliance Officer or Department of Corporate Compliance will be monitored using performance improvement tools and techniques integrated with Hackensack Meridian's Performance Improvement Plan.

A. Action Plans

When opportunities for compliance process improvement are identified, a plan of action will be created to capitalize on them. Plans will be implemented:

1. When action is taken to improve a process, the action will be tested on a trial basis.
2. When the initial action is not effective, a new action is planned and tested. The actions effect on compliance is measured, and successful actions are implemented and monitored to sustain the improvement

VI. SANCTION AND EXCLUSION SCREENING

Any individual considered for employment with HMH will have a background investigation performed by the Human Resources department or Human Resources' designee, which will include a check to determine whether or not the applicant is listed on the Health and Human Services/Office of Inspector General ("HHS/OIG") Cumulative Sanction Report, New Jersey State Treasurer's Exclusion related screening lists, other state related screening lists, and the General Services Administration's (GSA) List of Parties Excluded from Federal Programs.

The Purchasing department will screen all vendors and contracted agents for sanction or exclusion on the HHS/OIG, New Jersey State Treasurer's Exclusion, other state related screening lists and GSA listings during the requisite pre-approval review process, and the Office of Corporate Compliance will screen all HMH vendors on a monthly basis thereafter.

Physicians and advanced practice professionals (such as physician assistants, nurse practitioners, etc.) will be screened by each local medical staff office for sanction or exclusion through contracted vendor against the HHS/OIG listing, New Jersey State Treasurer's Exclusion list, other state related screening lists and GSA listings as part of the determination of privileges and credentialing process.

All job applicants, team members, and volunteers/students working in Behavioral Health services departments will be checked against the New Jersey Department of Human Services (NJDHS) Central Registry of Offenders against Individuals with Developmental Disabilities (Central Registry). When an alert is sent by NJDHS to HMH that the Central Registry has been updated, a re-screening of team members, volunteers/students will be performed.

Sanction and exclusion verification for all HMH current board members, team members, vendors, and medical staffs will be conducted monthly by the Office of Corporate Compliance using a contracted vendor against the OIG Cumulative Sanction Report, the New Jersey State Treasurer's Exclusion and other related state screening lists, the GSA, and the Department of Treasury Office of Foreign Assets Control (OFAC) exclusion listing of terrorism-sponsored organizations.

Hackensack Meridian *Health* will not contract with individuals or entities that are excluded from participation in federal and/or state health care programs.

VII. MEASURING AND ASSESSMENT

A. Measuring

Using the performance improvement monitoring mechanism, Compliance may collect data needed to:

a. Establish a baseline when a process is identified as having a compliance dimension.

b. Identify areas of possible improvement of existing processes.

c. Determine whether changes have improved processes.

d. Monitor ongoing compliance.

Data may be collected for:

- Priority issues identified by the Audit and Compliance Committee of the Board of Trustees or the Compliance Operations Group
- Establishment of benchmarks in high priority compliance processes
- Any process with a quantifiable regulatory or ethical aspect
- Processes related to Medicare, Medicaid and other third party reimbursement
- Compliance issues identified by the Network's team members with concurrence of the Compliance department.
- Processes identified in the Office of the Inspector General (OIG) work plan, Fraud Reports or Advisory Opinions
- Team member attitudes reflective of the corporate culture and the regulatory and ethical environment

B. Assessment

1. Data is assessed by the reporting department or Office of Corporate Office in a systematic fashion to identify:
    a. If a compliance process is functioning within expected parameters.
    b. Whether process changes have resulted in outcome improvement.
    c. Trends affecting sub-standard outcomes.
2. The reporting department or Office of Corporate Compliance compares performance:
    a. Internally over time when appropriate.
    b. Against regulatory standards
    c. To other organizations
3. Intensive assessment is initiated, as appropriate, based upon:

a. Events or outcomes that would result in fines or sanctions
b. Deviation from recognized standards
c. Variation from prior satisfactory outcomes

C. Ongoing Maintenance

Improvement is assessed within the framework of measurable compliance parameters.

a. Compliance with regulatory guidelines
b. Team member attitudes quantified by a standardized survey and compared to an index
c. ComplyLine activity and exit survey comments.

VIII. REPORTING CONCERNS AND COMPLAINTS; NON-RETALIATION POLICY

A. Open Communication

By maintaining open lines of communication, compliance issues can be proactively identified and resolved.

1. Chain of Command- Issue resolution at the local level is encouraged, followed by departmental management if necessary.
2. Human Resources- is available to resolve issues or facilitate the grievance process when other means of resolution fails.
3. Department of Corporate Compliance - is available as a resource for resolution of compliance related issues.
4. Privacy Official - as a resource for support and guidance regarding HIPAA Privacy Rule.
5. Compliance ComplyLine - is a confidential and anonymous means for team members to report compliance issues for which the normal chain of command has failed or is inappropriate.

B. Compliance ComplyLine

1. The ComplyLine is available twenty-four (24) hours a day, seven (7) days per week, 365 days a year, providing a confidential and anonymous means of reporting compliance related issues when normal reporting mechanisms are not appropriate.
2. The ComplyLine is either available via phone at 877- 888 -8030 or via the web portal **hackensackmeridian.alertline.com**
3. All calls to the ComplyLine will be confidential to fullest extent permitted by law.
4. No attempt will be made to trace the call or identify an anonymous caller.
5. ComplyLine operators will be trained in ComplyLine operations and bound by confidentiality.
6. All calls to the ComplyLine made in good faith will be investigated.
7. Hackensack Meridian *Health* has a strict policy of non-retaliation and retribution for all good faith reporting of violations of the Code of Conduct
8. Organizational policies regarding ComplyLine Operations will be maintained by the Compliance

Department.

C. Confidentiality and Non-Retaliation

All team members, patients, physicians and HMH data shall be considered confidential. Access will be limited to those who have signed a confidentiality agreement and have a legitimate "need to know." All copies of minutes, ComplyLine logs and intake forms, investigatory records and other information will be maintained in locked files.

Hackensack Meridian *Health* is committed to maintaining an environment free of fraud, waste, abuse or unethical practices of any kind and has a strict policy of non-retaliation and retribution for good faith reporting of these practices.

IX. RESPONDING TO CONCERNS AND COMPLAINTS; INVESTIGATION AND CORRECTION OF IDENTIFIED PROBLEMS

Reports to reasonable indications of fraud, waste or abuse, violations of this Compliance Program, violations of the Code of Conduct, Privacy related issues and violations of HMH policy and procedure or violations of applicable law or regulation are promptly investigated. The investigation shall include an assessment of the situation for potential fraud, waste, abuse, policy violations, Privacy breach rules, and unacceptable conduct. Individuals who may have knowingly or inadvertently caused or participated in such activities shall be identified. The results of the investigation may detect the need for further training and education; to facilitate corrective action; and to implement procedures necessary to ensure future compliance.

The Chief Compliance Officer, or his or her designee, is responsible for direction of the investigation of the alleged situation or problem. In undertaking investigations, the Department of Corporate Compliance may utilize other Hackensack Meridian *Health* departments and/or team members (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.

Due to the diversity of potential problems and situations, the process and method of investigation is left to the judgment and discretion of the Chief Compliance Officer. However, the Chief Compliance Officer or his or her designee may conduct interviews with any/all individual(s) necessary and may review any Hackensack Meridian *Health* documents including but not limited to those related to the claims development and submission process, patient records, e-mail and the contents of computers.

Documentation of all compliance-related complaints and investigations will be maintained in accordance with the established Record Retention and Destruction Policy of HMH.

X. OVERPAYMENTS

Overpayments from Medicare or Medicaid can occur in various ways (e.g., payments that exceed the permissible amount for an identified covered service, duplicate payments, payments for non-covered services, payments where another payer actually had the principal responsibility for the payment).

Per the ACA Section 6402(d)(2)(A)(iii), healthcare providers must report and return these overpayments within sixty (60) days of identification or by the date that a corresponding cost report is due. The overpayment notification should also contain the reason(s) why it occurred. Failing to refund an overpayment by the necessary deadline exposes the provider to enforcement under the False Claims Act and to civil monetary

penalties under the ACA. In the event of a potential overpayment, the appropriate Hackensack Meridian *Health* policy will be followed in refunding any identified overpayment. .

XI. ENFORCEMENT AND DISCIPLINE

Hackensack Meridian *Health* may impose disciplinary action or sanctions on any member of the workforce who intentionally or unintentionally violates established policies or procedures. This means that every confirmed act may result in corrective action or disciplinary action which can include but not be limited to, the removal of privileges, discharge of employment, contract penalties and in some cases civil and/or criminal prosecution. This is not intended as an exhaustive list, and the Compliance Operations Group may be recommended other sanctions.

Team members will be subject to disciplinary action or sanctions for:

1. Failure to perform any obligation or duty required of team members relating to compliance with this Program or applicable laws or regulations.
2. Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements of this Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.
3. Failure to report knowledge of suspected fraud, waste or abuse or Privacy violation.

Possible disciplinary action will follow in accordance with Hackensack Meridian *Health's* existing disciplinary policies and procedures. Depending on the severity of the event, progressive discipline is not required.

XII. ONGOING EVALUATION OF THE PLAN AND APPROVALS

The Hackensack Meridian *Health* Compliance Plan will be reviewed on an on-going basis and updated as necessary. Any revisions will be submitted to the Chief Compliance Officer for approval from the Audit and Compliance Committee of the Board of Trustees.

A. ^ https://oig.hhs.gov/compliance/compliance-guidance/index.asp

B. ^ https://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf

C. ^ https://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf

D. ^ https://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf

E. ^ https://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf

F. ^ https://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf

G. ^ https://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Thomas Flynn: SVP Chief Compliance Officer	01/2022
	Daniel McManus: Compliance Officer North	01/2022

Applicability

Bayshore Medical Center, Carrier Clinic, HMH Nursing & Rehabilitation, Hackensack Meridian Health Inc., Hackensack University Medical Center, Home Health and Hospice, JFK Medical Center, JFK Medical Center EMS, Jersey Shore University Medical Center, Legacy Meridian Health, Ocean University Medical Center, Old Bridge Medical Center, Palisades Medical Center, Physician Services Division, Raritan Bay Medical Center, Riverview Medical Center, Southern Ocean Medical Center, System Search Engine (All Sites)