

The Right Door for Hope, Recovery and Wellness

Chapter Title Governance	Section # G		Subject # 800.1
Subject Title Compliance Investigation, Reporting, Documentation, & Resolution	Adopted 03/15/05	Revised 11/14/17	Reviewed 4/28/08; 10/26/09; 2/13/14; 4/14/15; 6/29/16; 11/14/17; 2/27/19

PROCEDURE

Application

This procedure shall apply to The Right Door for Hope, Recovery and Wellness.

1.0 Intent

It is the intent of The Right Door for Hope, Recovery and Wellness to establish and maintain mechanisms for the investigation, reporting, resolution, and documentation of suspected violations or potential misconduct with assurances for confidentiality and non-retaliation. It is the intent of The Right Door for Hope, Recovery and Wellness to also ensure that all Board Members, employees, and contractors fulfill the requirements of the Deficit Reduction Act.

2.0 Deficit Reduction Act & Compliance

- 2.1 The Right Door for Hope, Recovery and Wellness shall have internal processes to monitor for actions by providers to prevent fraud, abuse, and waste, and to identify actions likely to result in unintended expenditures.
- 2.2 The Right Door for Hope, Recovery and Wellness Board members, employees and contractual providers will receive training or education on federal and state False Claims Acts and Whistleblower Provisions.
- 2.3 The Right Door for Hope, Recovery and Wellness Board members, employees and contractual providers are required to report any suspected occurrences of fraud, abuse and waste. The designated The Right Door for Hope, Recovery and Wellness Compliance Officer will investigate the allegations and will assure that appropriate reporting occurs.
- 2.4 The Right Door for Hope, Recovery and Wellness Compliance Officer will inform the Affiliation Compliance Administrator if incidents occur which require reporting to state or federal agencies or place The Right Door for Hope, Recovery and Wellness in jeopardy.

3.0 HIPAA/HITECH Act Reporting, Investigation and Documentation

- 3.1 The Right Door for Hope, Recovery and Wellness will comply with the Health Insurance Portability Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Subtitle D—

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Privacy, the Department of Health and Human Services (DHHS) security and privacy regulations, and Commission on Accreditation for Rehabilitation Facilities (CARF) accreditation standards, as well as our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements. The following procedure will assist The Right Door for Hope, Recovery and Wellness in fulfilling its obligation under DHHS privacy regulations to mitigate damages caused by breach of individual privacy.

3.2 **Reporting breaches:** The purpose of reporting health information breaches, and suspected breaches, is as follows:

3.2.1 Minimize the frequency and severity of incidents.

3.2.2 Provide for early assessment and investigation before crucial evidence is gone.

3.2.3 Quickly take remedial actions to stop breaches, correct problems, and mitigate damages.

3.2.4 Implement measures to prevent recurrence of incidents.

3.2.5 Facilitate effective disciplinary actions against offenders.

3.2.6 Properly make required notifications.

3.3. **Duty to Report:** All employees, providers, contractors, persons served, interns, temporary staff of The Right Door for Hope, Recovery and Wellness have a duty to report breaches and should feel free to report breaches without fear of retaliation.

3.4 **Protection for those who Report:** The Right Door for Hope, Recovery and Wellness will not take any adverse personnel or other action against a person who reports actual or suspected breach of security, confidentiality or policies and procedures protecting the security and confidentiality of health information so long as the report is made in good faith.

3.4.1 Making a knowingly false report, however, may result in disciplinary action under The Right Door for Hope, Recovery and Wellness policies and procedures.

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3.4.2 Program directors and supervisors will ensure that the investigating officer has access to necessary persons and information to conduct a thorough investigation.

3.5 Investigation of a report

3.5.1 Upon receiving the report, the HIPAA Security or Privacy officer will take the following steps:

3.5.1.1 Take any necessary immediate corrective action.

3.5.1.2 If the breach appears to involve gross negligence, willful misconduct, or criminal activity of a person or persons holding access privileges, immediately, in conjunction with the CEO and/or HR Director, suspend that person's or those persons' access ending investigation, including taking all necessary steps to prevent access.

- In the case that the breach investigation involves the CEO the board chair will be contacted by the Compliance Officer for administration of this procedure.

3.5.1.3 Contact appropriate lawyers for consultation.

3.5.2 The CEO may appoint an investigating officer, which may be the HIPAA Security Officer, Privacy Officer, or Compliance Officer, to conduct an investigation in appropriate cases. Factors to consider in determining whether an investigation is necessary include the following:

3.5.2.1 Seriousness of the breach

3.5.2.2 Whether the breach involved unsecured (readable) or secured (not readable – that is encrypted or destroyed) data.

3.5.2.3 Whether the breach resulted in actual harm.

3.5.2.4 Extent of any harm.

3.5.2.5 Whether the breach has the potential for legal liability.

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3.5.2.6 Whether the breach involved gross negligence, willful misconduct, or criminal activity.

3.5.2.7 Whether the breach put patients' or other individuals' welfare at risk.

3.5.2.8 Whether a series of similar or related breaches has occurred.

3.5.2.9 Whether the suspected offender has committed other breaches.

3.5.2.10 Whether the breach must be reported to the individual who is the subject of the breach, to DHHS, and/or the media.

3.5.2.11 In the case that the CEO is the subject of the investigation, the Board Chair will be contacted for appointing an investigating officer.

3.5.3 The investigating officer will conduct a thorough investigation into all the facts and circumstance of the breach or suspected breach and will provide the CEO (or board chair in the case that the CEO is the subject of the investigation) a detailed report of the facts and circumstances of the breach, including recommendations for corrective action.

3.5.4 The investigation shall include a risk analysis of the breach, including, but not limited to, answering the following questions:

- Who was involved?
- How many patients'/others' information were breached?
- Did the perpetrator improperly access the data or copy, change, or transfer the data?
- When did the breach happen?
- What are the risks to the subject(s) of the breach?
- What was the motive for the breach if not accidental?
- Does the potential for further harm exist?

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- What can The Right Door for Hope, Recovery and Wellness do to limit or eliminate further damage?

- What steps can The Right Door for Hope, Recovery and Wellness do to prevent this type of breach in the future?

3.5.5 **HITECH Act**

3.5.5.1 If the breach qualifies as a breach under the HITECH Act definition of breach in Subtitle D – Privacy, Part I, § 13400, the data is unsecured, and the breach poses a significant risk to the affected individuals, The Right Door for Hope, Recovery and Wellness must, without unreasonable delay and in no case later than 60 days after the discovery of the breach, notify the individual(s) whose protected health information (PHI) was involved in the breach.

3.6 **Documentation**

3.6.1 The report and recommendations will be discussed with appropriate personnel and appropriate action to prevent recurrence of the breach, mitigate any harm caused by the breach, and necessary disciplinary action(s) will occur.

3.6.1.1 Provide copies of the report with an endorsement as to any corrective action taken, including suspensions of access, and recommendations for future action to all the following people and departments, as necessary and appropriate:

- CEO
- HR Director
- Directors, Managers and Supervisors

3.6.2 All reports will be kept for not less than 6 years from the date of the report.

3.6.3 No such report will be made a part of a patient's medical record. The report is a risk management tool.

3.7 **Resolution**

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3.7.1 A breach notification must be provided without unreasonable delay, and in no case later than 60 days after the discovery of a breach.

3.7.1.1 The notice must include:

- Description of the types of unsecured PHI that were involved in the breach (i.e. Name, SSN, Patient ID, insurance number, date of birth, home address, disability code, etc.)

- Brief description of what The Right Door for Hope, Recovery and Wellness is doing to investigate the breach to mitigate losses, and to protect against further breaches.

- Contact information for individuals to ask questions or learn additional information, which will include a toll-free telephone number, an email address, and/or postal address. The HHIPAA Security Officer or HIPAA Privacy Officer shall respond to all such contacts.

3.7.1.2 The notification, unless the contact information is insufficient or out-of-date, shall be sent by first class, certified mail to the individual, guardian, legal representative or next-of kin of the individual or, if specified as a preference the individual, by email.

3.7.1.3 If the contact information is insufficient or out-of-date, The Right Door for Hope, Recovery and Wellness will use a substitute form of notice, such as, if the breach involves 10 or more individuals for which there is insufficient or out-of-date information, a conspicuous posting on the home page website or notice in major print or broadcast media in geographic areas in which the individuals affected by the breach likely reside as determined by the HIPAA Security Officer in conjunction with legal and risk management administration. Such notice will include a toll-free number where the individual can learn whether the individual's unsecured PHI was possibility involved in the breach.

3.7.1.4 If the HIPAA Security or Privacy Officers, in consultation with the CEO or designee determines that the breach requires urgency because of the possible imminent release of unsecured PHI, immediate notification may also be made by telephone or other appropriate means.

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3.7.2 If the breach involves 500 or more individuals' unsecured PHI, The Right Door for Hope, Recovery and Wellness will provide notice, as required by HIPAA and the HITECH Act, to prominent media outlets in the state or jurisdiction of the individuals and immediately to DHHS.

3.7.2.1 The HIPAA Security Officer must report breaches of fewer than 500 individuals to DHHS not later than 60 days from the end of the calendar year in the form of a log.

3.7.2.2 Notifications may be delayed if law enforcement represents that the notification will impede a criminal investigation or damage national security.

4.0 Reporting Other Compliance Violations

4.1 Employees, providers, contractors, persons served, and other individuals are to report suspected violations or potential misconduct to the CEO, or in situations involving the CEO, to the Compliance Officer by phone/voicemail, email, in person, in writing, or to one of the Affiliate CMH Compliance Officers. A posting shall be placed at all The Right Door for Hope, Recovery and Wellness offices with the applicable contact information of all Affiliate CMH Compliance Officers. A standard form shall be made available for individuals wanting to utilize a specific form to file a report in writing.

4.2 Reports made to Affiliate CMH Compliance Officers will be forwarded for investigation and follow up to the CEO, or in situations involving the CEO to the organization's Compliance Officer in which the potential/suspected violation was to have occurred.

4.3 Staff are expected to cooperate in the investigation of an alleged violation of the Compliance Plan or related policies.

4.4 FRAUD AND ABUSE:

4.4.1 The Right Door for Hope, Recovery and Wellness employees, contractual providers and the provider network will report all suspected fraud and abuse to the Compliance Officer. The report will include the nature of the complaint and the name of the individuals or entity involved in the suspected fraud and

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abuse, including address, phone number and Medicaid identification number if applicable.

- 4.4.2 The MSHN Compliance Officer will be immediately informed of any suspicion of Medicaid Fraud and Abuse prior to attempting to investigate or resolve the alleged fraud and/or abuse.
- 4.4.3 The MSHN Compliance Officer will report suspected fraud and abuse to the MDHHS Office of Health Services Inspector General.

4.0 Confidentiality

- 4.1 Individuals making a report are encouraged to disclose their identity, recognizing that anonymity may hamper complete and timely investigation. However, no anonymous report shall be refused or treated less seriously because the complainant/reporter wishes to remain anonymous.
- 4.2 No promises will be made to any individuals making a report or witnesses providing supporting information about the report by the CEO, the Compliance Officer, or anyone else in regard to his/her culpability or what steps may be taken by The Right Door for Hope, Recovery and Wellness in response to the report.
- 4.3 Confidentiality and anonymity of the individual making the report and the content of the report will be preserved to the extent permitted by law and by the circumstances. Information about reports, investigations, or follow-up actions shall not be disclosed to anyone other than those individuals charged with responsibility in investigation and investigative findings as well as legal counsel.

5.0 Non-Retaliation

- 5.1 No employee, provider, contractor, person served, or other individual making such a report in good faith shall be retaliated against by The Right Door for Hope, Recovery and Wellness employees or agents and will be protected by the Michigan Whistleblower's Protection Act (P.A. 469 of 1980).
- 5.2 Discipline for engaging in acts that violate applicable laws and regulations, making knowingly false reports, failure to report known violations, or discipline for any other performance-related reason unconnected to reporting potential violations is not retaliation.

6.0 Investigation

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- 6.1 Within five business days of receiving a report, the Compliance Officer shall provide a written acknowledgement of receipt (sample attached) to the individual making the report (if known) and conduct an initial assessment to determine whether the report has merit and warrants further investigation.
- 6.2 If it is determined that the matter does not constitute a violation of any applicable laws or regulations and warrants no further action, the issue will be closed following the appropriate documentation and reporting by the Compliance Officer.
- 6.3 If it is determined that the matter does not constitute a violation of any applicable laws or regulations, but does identify an area for improvement or raises concern for potential future violations, the matter will be referred to the Quality Improvement Director for appropriate assignment and follow-up action.
- 6.4 If it is determined that the matter requires further investigation, the Compliance Officer shall take the necessary steps to assure that documents or other evidence are not altered or destroyed through the following possible means:
- Suspending normal record/documentation destruction procedures;
 - Taking control of the files of individuals suspected of wrongdoing;
 - Limited access of files, computers, and other sources of documents by individuals suspected of wrongdoing; and/or
 - Placing individuals under investigation on temporary suspension.
- 6.5 If the Compliance Officer concludes that reporting to a governmental agency (HCFA, OIG, DOJ) or a third party, may be appropriate, the CEO shall be informed immediately. Upon recommendation by legal counsel and with notice to the Board, the CEO shall make such report to the appropriate government agency within 30 days after the determination that a violation has occurred.
- 6.6 Documentation retention and destruction must take place in accordance with the established The Right Door for Hope, Recovery and Wellness Record Retention procedures. The Right Door for Hope, Recovery and Wellness must retain all potentially responsive documents if it has been served with a government investigation. If The Right Door for Hope, Recovery and Wellness is served with a subpoena or search warrant or has reason to believe a subpoena or search warrant may be served, the CEO is responsible for immediately directing staff to retain all documents that may be potentially responsive to the subpoena or search warrant.
- 6.7 When corporate compliance issues arise involving an investigation and potential legal consequences, the following questions should be asked:

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- Should an internal investigation be conducted?
- Should legal counsel be contacted?
- Should disclosure be made to the appropriate government agency?
- Does the staff person need separate counsel?

6.8 If the CEO is the subject of a subpoena or search warrant the CEO and Corporate Compliance Officer shall each contact the chairperson of the Board who will be responsible for the administration of this procedure.

6.9 A full investigation shall be completed within 90 days from the date of the initial report. An extension may be granted by the Compliance Committee.

7.0 Documentation

A record shall be maintained by the Compliance Officer or designee for all reports of potential/alleged violations utilizing the attached Compliance Investigation Report form. The record may also include copies of interview notes and documents reviewed and any other documentation as appropriate.

8.0 Resolution

Following the investigation, the Compliance Officer shall document and report the findings of the investigation to the CEO and Compliance Committee. In cases where actions of the CEO are investigated, the report of findings is made to the Board Chairperson.

If appropriate, a remedial action plan shall be developed to address any confirmed violations or address areas of concerns raised during the investigation.

If appropriate, disciplinary action shall be taken in accordance with the organization's disciplinary policies and procedures.

9.0 PIHP Required Reporting

The following reports are required by Mid-State Health Network and will be reported as outlined:

1. Quality Improvement Data (monthly)
2. Encounter Data (monthly)
3. Medicaid Utilization and Net Cost Data (annually)

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4. Performance Indicators (quarterly)
5. Consumer Satisfaction (annually)
6. Child and Adolescent Functional Assessment Scale - CAFAS (annually)
7. Critical Incidents (monthly)
8. Treatment Episode Data Set (TEDS) Data (monthly)
9. Substance Use Disorder (SUD) Prevention Data
10. Supports Intensity Scale (SIS)
11. Level of Care Utilization System (LOCUS)

Other Reports as determined to meet Pre-paid Inpatient Health Plan (PIHP) Obligations

- Compliance / Complaint Reports (per occurrence, annual aggregate)
 - The Right Door for Hope, Recovery and Wellness CEO and/or designee, shall inform, in writing, the MSHN CEO of any material notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory (excluding Recipient Rights related to non-PIHP activities), prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services. The Right Door for Hope, Recovery and Wellness CEO and/or designee shall inform, in writing, the MSHN CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.
- Litigation Reports (annually)
- Medicaid Fair Hearing Reports (per occurrence, annual aggregate)
- Medicaid Grievance and Appeals Report
- Fraud & Abuse Report (per occurrence and annual aggregate)
 - Minimally the report will include the following:
 1. Number of complaints of fraud and abuse that warrant preliminary investigation
 2. For each instance that warrants a full investigation, supply:
 - a. The providers name and number;
 - b. The source of the complaint;
 - c. The type of provider;
 - d. The nature of the complaint;
 - e. The approximate range of dollars involved; and
 - f. The legal and administrative disposition of the case, including actions taken by law enforcement official (if case was referred)
- Medicaid Event Verification Methodology Report (annually)

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Kerry Possehn, Chief Executive Officer	Date		