Reference Guide

2023

January 2023

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You will need to enter your username and password if attempting to view content on PolicyStat from outside the internal network.

COREWELL HEALTH – EAST REGION

COREWELL HEALTH MISSION, VISION AND VALUES

Compliance is a key part of our culture. It helps each of us make the best possible decisions. Compliance is everyone's job and responsibility.

MISSION
Improve health, instill humanity and inspire hope.

VISION
A future where health is simple, affordable, equitable and exceptional.

VALUES
Compassion. Collaboration. Clarity. Curiosity. Courage.

Compassion - Demonstrating compassion means that team members help each other and advocate for one another. If a team member needs help determining how to ***do the right thing***, assist them or contact compliance to resolve questions and concerns.

Collaboration - We recognize the need for strong collaboration to create a culture of compliance and work to partner, educate and advise across our organization. The compliance teams are always here to help mitigate potential risks as they are reported.

Clarity - Clarity is about openness, transparency and authenticity. Clarity must be a priority in all that we do as we ***think big*** about our initiatives. It's important to be clear and up-front about our expectations.

Curiosity - Use your curiosity to ask questions and share concerns if something feels unusual or inappropriate.

Courage - Team members should ***be bold*** and report any concerns that could impact our patients, health plan members or organizational integrity.

OUR CULTURE OF CARING PARTNERSHIPS

Living our Mission through our Values creates our Culture of Caring Partnerships centered on patient and family experience. Creating and supporting our Culture of Caring Partnerships is the basis for our strategic programs and initiatives.

We are committed to conducting business with integrity. We comply with applicable Federal civil rights laws and do not discriminate. We ensure individuals are not excluded from participating in, denied the benefits of, or subjected to discrimination under any health program or activity that is provided, based upon race, color, national origin, age, disability, sex, sexual orientation, gender identity or religion.

COMPLIANCE TRAINING

COREWELL HEALTH CODE OF EXCELLENCE

What we do and how we do it matters. As a health system, we have the ability to help people live healthier lives. Through our daily actions and interactions, we can help people feel respected, understood and loved. Corewell Health's Code of Excellence ("Code") sets clear expectations for our commitment to caring for others with the highest professional standards of ethics and integrity. It is intended to help each of us make the best decisions possible and provide an exceptional experience for every individual.

Our Code outlines principles and standards that we must follow:

We do the right thing. We do the right thing no matter if anyone notices or is watching. This includes conducting ourselves in accordance with our values, adhering to all professional standards for responsible and ethical business practices and complying with all laws and regulations governing our business. We acknowledge that it isn't always easy to do the right thing. If we are unsure of the right thing to do, we ask for help.
We make sure everyone has a voice. We raise concerns and instances of actual or potential ethical or compliance issues. We do not allow retaliation against anyone seeking help or raising a concern in good faith.
We treat everyone with compassion, dignity and respect. We will serve everyone in our communities without regard to race, color, sex, national origin, handicap/disability, age, HIV status, marital status, sexual orientation, gender identity, gender expression, religious beliefs, sources of payment for care or other protected status or category. We work to create environments free of harassment violence and intolerance.
We value diversity equity and inclusion. We embrace a diverse and inclusive organizational culture that fosters respect for all. At the same time, we acknowledge that inequities persist in our communities. We pledge to listen deeply and engage authentically with those impacted by systemic racism, so we can partner with others toward the goal of achieving health equity.
We maintain a healthy workplace. We promote a positive work environment for everyone. We act in safe and healthy ways and do our jobs with clear minds.
We are good stewards of our resources. These resources include our people, facilities, funding, information, technology, equipment, and supplies. We use them responsibly and ensure that others do too. We share them or allow others access to them only for legitimate business purposes and with proper authorization.
We code and bill our services appropriately. We strive to ensure and maintain complete and accurate documentation of medical services provided. We expect accurate coding from our provider partners. We report and return any overpayment once identified from a government healthcare program, commercial payor, or patient.
We are transparent with quality and pricing. We give clear and accurate information as it relates to charges for the items and services we provide. We proactively share information about the quality of our care, the outcomes of our services, and the experiences of our patients and members. We attempt to answer questions and resolve disputes related to our services to the patients, members and payer's satisfaction.
We protect the confidentiality and privacy of our patients and members. We collect information about a patient's and member's medical condition, history, medication and family illnesses to provide the best possible care and health plan services. We protect individuals' health information while allowing the flow of information needed to provide and promote high quality health care.
We are honest, accurate and fair in our business relationships. We provide true and accurate information to the public, regulatory agencies, news media, and others who have interest in our activities. We engage in social media in a way that is truthful and respectful of others. We follow our policies and principles of good business ethics pertaining to the exchange of gifts and business courtesies with suppliers. We address potential conflicts of interest before they arise, and when they do arise, we manage them through disclosure and removing the individual(s) with conflict from decision-making related to the interest or matter.

COMPLIANCE TRAINING

COMPLIANCE PROGRAM

Our Corporate Compliance Program is comprised of internal policies and procedures designed to ensure compliance with rules, regulations and laws to uphold our reputation as a top healthcare provider. Our Program has been implemented to deter, detect, report and correct errors and improper conduct.

Within our Compliance Program we have a Compliance Plan.

OUR COMPLIANCE PLAN

- Demonstrates our commitment to following required rules, regulations and laws
- Supports our Mission, Vision and Values
- Protects patients and their rights
- Promotes ethical conduct throughout our organization to utilize our policies and procedures to detect, prevent, and correct potential compliance issues
- Supports and is in alignment to meet the requirements of our Corporate Integrity Agreement (CIA) with the Federal Government

In addition, Corporate Compliance Plan is in accordance with the "**Organizational Sentencing Guidelines**" established by the Office of Inspector General (OIG) and contains the **Seven** required elements of an Effective Compliance Program.

SEVEN REQUIRED ELEMENTS OF AN EFFECTIVE COMPLIANCE PLAN

1. Establishing Compliance Oversight

The responsibility for implementing, monitoring and overseeing the Compliance Program occurs at multiple levels:

- The Interim **Chief Compliance Officer (CCO)**, **Leah Voight,** is responsible for day-to-day operations of the Corewell Health East Region Compliance Program
- The **Business Ethics and Compliance Committee (BECC)** assists the CCO and actively engages in all compliance functions
- Board of Directors provides oversight of the program through its **Audit and Compliance Committee**

2. Implementing Standards of Conduct, Policies and Procedures

Policies and procedures are integral to day-to-day operations and serve an important purpose, they are essential tools in building our compliance program. They document our commitment to help **detect**, **prevent** and **correct** potential compliance issues.

Policies and procedures also help verify how we will comply with laws, contractual obligations, and accreditation regulations and standards. They can also help establish common clinical standards for how we care for patients.

Policies are easily accessible through the online policy management tool: **Intranet/Documents/Policies - PolicyStat**

3. Conducting Effective Training and Education

We are committed to providing effective education and training for all team members. Our Annual Education Program Policy ensures that all team members are knowledgeable of the Accreditation standards, Contractual obligation, Federal, State or Local regulations, and Regulatory Agency standards, along with internal policies and procedures. Compliance Annual Education also assists with outlining various aspects of our Compliance Program.

Timely completion of AE is a condition of employment and a component of the annual performance review.

Team members who fail to participate and complete annual compliance education are subjected to corrective action, up to and including termination from employment.

4. Developing Effective Lines of Communication

We each have a responsibility to conduct business ethically, morally, legally, with honesty and integrity. We are committed to creating an environment where open and honest communications are the expectation. All team members are expected to report compliance fraud, waste and abuse along with quality or safety concerns or issues. Our leadership and the compliance team are here as a resource and a partner for you. We are available to help answer questions and resolve issues.

5. Conducting Internal Monitoring and Auditing

Our leadership and compliance team perform planned audits and routine monitoring. These activities identify compliance risks and resolve problems in identified areas.

Our **Auditing Program** includes periodic risk assessments, peer reviews, on-site visits, interviews, questionnaires, documentation reviews and annual work plan development.

Our **Monitoring Program** includes use of compliance risk plans through BWise, (our Governance, Risk and Compliance tool) for tracking department metrics to monitor and mitigate department risk.

6. Investigating and Remediating Issues

Concerns or issues reported are reviewed and investigated by Compliance in partnership with human resources. Each issue is evaluated based on all the identified facts. If a concern is substantiated, the compliance team will work with leadership of the impacted team to respond appropriately and implement corrective action that will help prevent the problem from reoccurring. Most issues are resolved within 7 to 15 days of initial report.

COMPLIANCE TRAINING

7. Enforcing Standards through Disciplinary Guidelines

Compliance partners with the Human Resource team to include compliance related violations in the Progressive Discipline Policy. This policy consists of standardized guidelines for a fair and consistent approach to managing performance and conduct issues.

BUSINESS ETHICS

Our Business Ethics and Compliance Policy helps us understand how to conduct business ethically and consistently with legal and/or regulatory requirements that may apply to assigned duties and responsibilities.

As Team Members, we have a responsibility to:

- Conduct business ethically and in compliance with all applicable laws, regulations, and internal policies
- Abide by professional principles or code of ethics and bylaws for Medical Staff
- Maintain truth in all internal record keeping and transactions
- Ensure compliance with federal regulations pertaining to vendor and vendor products
- Use company assets appropriately – "borrowing" or removal of company property is not permitted
- Understand permissible political activities

As Team Member, we must also:

- Understand permissible political activities
- Understand direct political contributions to campaign funds or public statements may not be made on behalf of Corewell
- Ensure we do not employ or make payments of any kind to entities or members who appear on any government list

CONSEQUENCES OF HAVING AN INEFFECTIVE COMPLIANCE PROGRAM INCLUDE:

If any of the elements are found to be non-compliant, the following are possible consequences for having an ineffective Compliance Plan and a Corporate Integrity Agreement (CIA) may be imposed as part of the consequences.

CORPORATE INTEGRITY AGREEMENT

As part of a civil settlement that we entered with the Department of Justice in 2018, William Beaumont Hospital has been placed under a **Corporate Integrity Agreement (CIA)**.

The CIA extends through July 2023 and all specific requirements should be completed by the end of the year.

CIA's include specific obligations aimed at preventing future misconduct and are commonly used as government enforcement tools allowing a *"second chance"* to continue participation in federal health care programs such as Medicare and Medicaid ***if*** we follow specific program requirements.

Our CIA requires the following activities:

- Creating a centralized tracking system for all contracts and agreements
- Documenting and monitoring various components of certain contractual arrangements
- Providing / tracking related compliance trainings
- Issuing several specific training programs
- Maintaining our compliance program, policies and procedures

CONFLICT OF INTEREST

Conflicts of Interest can happen anytime we, or a family member, have any type of financial interest (such as providing services, supplies, furnishings or equipment) or other interest (such as political or social) that could impair – or even appear to impair – fairness and impartiality on the job.

Possible Conflict - Vendor Relations

We must ensure compliance with federal regulations pertaining to vendor and vendor products and must not allow the influence of outside sources, into our decision-making or business activities, practice of medicine, education, or in the delivery of health care services. As referenced in our Conflicts of Interest Program Policy we must never accept gifts such as free or discounted tickets for travel, theater, or concerts. In addition, meals and refreshments, loans or financial

support for business or continuing education, receiving free drugs, devices or other product samples, may not be accepted if offered.

Possible conflicts to remember:

- Serving on an outside Board that interacts with Corewell Health
- Providing any Corewell Health information on non-work-related surveys
- Proctoring not consistent with policies
- Accepting any form of compensation from representatives of industry for issuing or changing a patient's prescription
- Receiving compensation from industry for "shadowing" or preceptor services
- Providing consulting services not consistent with Corewell Health policies
- Royalties, publication or speaking fees earned, but not disclosed, to Corewell Health
- Interest from stocks, bonds or real estate, that stem from doing business with Corewell Health
- Accepting gifts, cash, checks, gift cards, meals, or endorsements that are outside the conflict-of-interest policy guidelines.

A conflict of interest can happen to anyone. Knowing what to do when it happens is key.

REPORTING CONCERNS

You have a voice and a responsibility to raise concerns and instances of actual or potential ethical or compliance issues. Report activity you believe violates a law, regulation, policy or poses a safety concern.

For matters involving **department** policy or procedures, you should **first contact your immediate supervisor or local HR representative.**

If there is a compliance or safety issue where you might not feel comfortable speaking directly to your supervisor or HR, you may report your concern to our Trust Line – **844-929-4235** or online:

https://secure.ethicspoint.com/domain/media/en/gui/80148/index.html

Information you provide will be treated confidentially.

- Interest from stocks, bonds or real estate, that stem from doing business with Corewell Health
- Our Trust Line is managed by an outside, independent vendor
- A live person will answer your call 24/7
- You may report your concern **anonymously**, should you choose, but you will need to provide as many details as possible to support the concern
- All concerns reported will be thoroughly reviewed and investigated
- Once the investigation is complete, the concern will be addressed appropriately and in accordance with policy
- Team members may be subject to disciplinary action for confirmed violations including termination of employment hospital privileges and/or business relationships

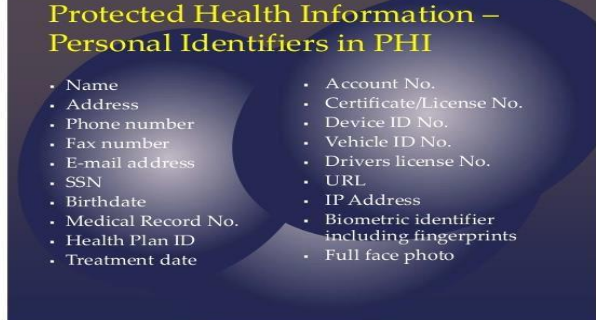
Individuals who report a concern in good faith to the Trust Line will not be subject to retaliation for making a report.

HIPAA / PHI PRIVACY OF PROTECTED HEALTH INFORMATION

The **Health Insurance Portability Accountability Act**, commonly referred to as "**HIPAA"**, is a Federal law that ensures health insurance coverage and provides nationally recognizable regulations/standards for the use/disclosure/protection of an individual's health information.

The HIPAA Act has various components designed to provide privacy standards to protect patient's medical records and other health information. It also provides standards for patient rights and control over how their personal health information is used and disclosed. HIPAA provides for the protection of individually identifiable health information that is maintained in a medical record and when electronically transmitted. **Protected health information "relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual."**

PHI relates to physical records, while ePHI is any PHI that is created, stored, transmitted, or received electronically. Health information such as diagnoses, treatment information, medical test results, and prescription information is considered protected health information under HIPAA, as are national identification numbers and **demographic information such as addresses, phone numbers, birth dates, gender, ethnicity, and contact and emergency contact information.**



COMPLIANCE TRAINING

PROTECTED HEALTH INFORMATION (PHI)
PHI can be written or typed (paper) electronic: audio or video recordings, or as a photograph when obtained by team members.
TREATMENT, PAYMENT OR OPERATIONS
We may only **USE**, **ACCESS** or **DISCLOSE** (share) PHI for:
Treatment – To provide care to our patients
Payment – To allow the heath care provider to obtain payment for services rendered
Operations – Education for residents (HIPAA allows training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as providers), accounting audits, compliance investigations or internal quality analysis
Limited circumstances for Sharing PHI
When Michigan State Law requires that we report a specific concern such as:
- Gunshot wounds in an emergency room
- Making reports of abuse or neglect to Michigan's Child Protection Agency or Adult Protection Agency
- Prevent or lessen a serious and imminent threat to the health or safety of an individual or the public

Communication PHI w Family and Friends
As providers, we may communicate (disclose) with someone involved with the patient's care, however the patient must be given the opportunity to agree or object to the disclosure. If the patient is deemed incapacitated by the physician, disclosures are allowed to the individuals involved in the patients care based on a good faith judgment by a health care professional that the disclosure is in the patient's best interest.
Review the patients file to determine if there are any documented restrictions regarding disclosures of PHI. Identify individuals who are listed as ***"Driver Only"*** and verify what information may be shared.
"Minimum Information Necessary"
We must make every reasonable effort to limit use, access and /or disclosure of PHI to the **minimum information necessary** to accomplish an intended purpose or to accomplish a work-related task.

For example: *A patient has a very rare and unusual condition. The receptionist who does not provide any direct patient care, would not need to see the X-rays or test results of the patient to do his/her job.*

Patient records contain "other" data – previous illnesses, past procedures, employer information, family history, spouse or children information. When the patient is referred to another physician for a specific treatment, this information should not be disclosed as it is not relevant to the referral.
When is PHI no longer protected?
PHI is protected until the patient has been deceased for 50 years OR when the PHI from a medical record is stripped ***(de-identified)*** of all "direct identifiers" that could be used to identify a patient.
ACCESSING AND PROTECTING PHI
All team members are encouraged to use "**MyChart"** to review their health information or manage appointments. Team Members with job related access to our medical information systems – **EPIC** - may access their **own** health information – even as an inpatient!
As a Team Member you **do not** need an authorization to review your health information. If you identify inaccurate information in your health information, **do not** change or amend in any way. Request an amendment to your medical record through the Health Information Management (Medical Records) department.
Accessing Medical Records - Friends and Family
We recognize that patients may wish for their family or friends, who work for us, to have access to their medical records, for various reasons. With permission, we will allow a friend or family member to look at your medical record.
For a friend or family member to obtain access, the Friends and Family Access to Electronic Medical Records form must be complete.
The Friends and Family Access to Electronic Medical Records Form:
- Friends and family must have completed a form, signed by the patient or guardian on file with Medical Records, **BEFORE** accessing the medical record

Minor Children (<18 years old) – you may access your child's medical record if you have a signed Family and Friends Authorization Form, **and** it is on file with Medical Records **prior to** accessing the medical record
- This authorization is good for **3 years or until the patient turns 18,** whichever is sooner

RESEARCH USE AND DISCLOSURE OF PHI
All research must be approved by the Institutional Review Board (IRB). The IRB may not authorize the use or disclosure of PHI for research purposes except:

- If the facility has obtained a HIPAA authorization from the individual subject of the information; or
- If the IRB approves a waiver of the individual authorization requirement; or
- For reviews preparatory for research; or
- For research on the PHI of a decedent; or
- If information is deidentified with the researcher's representation and the PHI is needed for the research after the descendent has passed; or
- If the information is partially de-identified into a limited data set and the recipient of the information signs a data use agreement

You may **NEVER** use or share PHI in presentations or project results, posters, case reports, oral presentations, abstract or publications without a signed HIPAA authorization.

PROTECTING PHI

What can we do to keep PHI secure? It starts by not talking about PHI in public places and ensuring documents or paperwork that contain PHI are not left unsecured. Other ways to secure PHI…

Do not SHARE your PASSWORD with anyone for any reason!

Do not use PERSONAL EMAIL to send or receive PHI

Do not STORE PHI on a cloud drive

MINIMUM NECESSARY when leaving a message

Do not PRINT or FAX to a public printer or fax machine

Any document containing PHI should be stored securely in a drawer or cabinet. If the document is no longer needed, shred it - don't throw it into the trash bin! **LOCK YOUR COMPUTER!!!** Every time you walk away from your computer remember to hit "Ctrl-Alt-Del" to lock/unlock.

MISDIRECTED PHI (how to avoid an accidental incident)

Most misdirected PHI or HIPAA violations occur from simple mistakes. Remember these tips for protecting PHI:

Double check all paperwork to ensure that patients are presented with only their own paperwork

When sending PHI via email, double check recipient email addresses for spelling and accuracy

When emailing patient information, ensure recipients are part of patients care team, if not, consider removing PHI or the recipient not involved in care

If forwarding an email, review the entire email chain and delete any unnecessary PHI before sending

When sending PHI via fax, call before to notify the document is being faxed to ensure documents are quickly retrieved and to verify the fax number is accurate before sending

HIPAA AND PATIENT RIGHTS

As individuals, we believe that our medical and other health information is private and should be protected, and we want to know who has this information. Under HIPAA, patients have the right to restrict sharing of their health data for certain purposes other than treatment, payment or operations.

Right to Access

Patients have a right to access their own health information. HIPAA stipulates the following **Patient Right** under its privacy rule:

- On patient's **first visit**, we must provide a **Notice of Privacy Practice** that states how we may use and disclose a patient's health information. We also must explain that permission is necessary before health records are shared with any other person
- Patients have a right to **View or Obtain a copy of their PHI** (medical record, lab tests, claim information) in a format the patient prefers (if the provider can do so) even when they are an "**inpatient**"
- Medical records may be printed, scanned, emailed (encrypted), loaded on to a flash-drive (Corewell Health provided only) or burned to disks when a patient requests

COMPLIANCE TRAINING

Under the **Right to Access**, **"View or Obtain"** medical records, there are a few key points to remember:

- Only the patient or a personal representative has the right to access their records
- Medical records may only be sent to another provider as needed for "treatment or payment" or with the patient's permission
- Patients cannot be denied copies of their medical records because they have not paid for services received
- Patients do not have to be present in the office to request medical records
- Patients may be charged "reasonable costs" for copying and mailing of records

Right to Amend

HIPAA stipulates the following **Patient Right** under its privacy rule:

- Patients have a right to **Request an Amendment** be made to their PHI
- A patient has the right to request changes be made to correct errors in their record or to add information they feel has been omitted

Right for Exclusion

HIPAA stipulates the following **Patient Right** under its privacy rule:

- Patients have a right to be **Excluded from a Facility Directory** while inpatient
- Our hospitals and skilled nursing homes maintain a Facility Directory so we may share whether someone is currently a patient at the facility
- Patients have the right to be excluded from a Facility Directory without providing a reason. This is called **"Total Privacy"**

Miscellaneous Rights

HIPAA stipulates the following **Patient Right** under its privacy rule:

- Patients have a right to use **Different Contact Information** (phone number/address) when communicating with us
- Patients have a right to **Pay Out of Pocket** for medical care so the medical care will not be billed to any insurance company

HIPAA VIOLATIONS

WHAT IS A HIPAA VIOLATION?

ALL information (paper, electronic, recorded, videos or photographs) we have that links to a patient is considered PHI. Accessing this information, EPIC or any medical record for any reason other than payment, treatment or operations, or without the patient's written authorization, or as allowed by law, is a **HIPAA VIOLATION**.

Most HIPAA violations occur from simple mistakes: one patient is given another patient's discharge instructions or after-visit summary paperwork.

Other violations which include "intentional" violations include:

- Using EPIC to find a friend, family member, or coworkers contact information, birthday", or spelling of name
- Looking up a "celebrity" in EPIC to find their address/ or reason for admission
- Viewing a friend's medical record because you are curious or concerned
- Searching for a patient and viewing the "Patient Lookup Screen"
- Losing or exposing a document that contains a patient's information
- Beginning a research project without Internal Review Board (IRB) approval

Intentional HIPAA violations result in disciplinary action up to and including termination of employment.

INCIDENTIAL DISCLOSURE

An **incidental disclosure** is a verbal disclosure of PHI that can't be avoided. For example:	We must take **reasonable precautions** to prevent others from hearing our conversations. For example:
Speaking to a patient in Bed A when the patient in Bed B can overhear.	Moving to a more private area when discussing a patient's current medical condition.
Speaking to another care provider at the nurse's station.	Refrain from discussing a patient's medical care in an openly public area such as the cafeteria or elevator.

BREACH REQUIREMENTS

Should we experience a HIPAA Violation that results in **BREACH**, there are several steps we must take. We must do the following:

- Send a notice outlining the breach must be to the individual(s) impacted
- Notification must be as soon as possible, but no more than 60 days after discovery of the breach
- And Office of Civil Rights must be notified
- Notify the Compliance – Privacy Department and the Office of Civil Rights
- If more than 500 individuals are impacted, media must be made aware of the breach

COMPLIANCE TRAINING

CONFIDENTIALITY AND INFORMATION SECURITY

PRIVACY DEPENDS ON SECURITY

Privacy and Information Security work hand-in-hand. Only by following good security practices and established policies can we continue to maintain privacy for our patients.

PHYSICAL SECURITY OF COMPUTERS

Make sure to position your computer – and yourself – so passwords cannot be easily seen by someone looking over your shoulder (called "shoulder surfing") and so passers-by cannot view sensitive data on your screen. Take extra precautions when traveling to ensure your laptop is always safe. Always lock your computer when you step away, even if it's for just a few minutes.

USE OF COMPANCY EMAIL AND INTERNET

The use of electronic message systems and communications is provided to support business requirements and job functionality. It is a quick and cost-effective means to create, transmit, and respond to messages and documents electronically. You must take reasonable precautions to ensure the confidentiality and integrity of electronic messages. Refer to the Electronic Communication Standard Policy and Electronic Messaging Policy when transmitting any electronic Communications and PHI.

There may be the occasional need to exchange personal messages. When utilizing email for personal messages, activities must be reasonable, acceptable to management and not affect job performance. It is a violation to utilize email for activities or communications that are offensive, intimidating, illegal, out of compliance with corporate standards, or interfere with network services or equipment.

COMPUTERS AND CYBER ATTACKS

Phishing is the fraudulent practice of purporting to be from a reputable source to lure personal information from individuals for malicious use. Phishing attempts come in multiple ways: Email, Social Networks, Phone or Fax. Phishing is the most successful of cyber-attacks.

Spear Phishing – is a more sophisticated form of phishing that targets YOU personally. While phishing is a broader term for any attempt to steal personal information from any individual (passwords, usernames, credit card detail, etc.) **spear phishing** targets a specific individual and appears to come from someone the individual knows and trusts like a friend, boss, employer or bank.

The messages often include personal information such as your name, address or employer to make them seem "legit."

Spear Phishing aims towards our: Emotions, Quick Decision Making, Urgency, Curiosity and Fear.

WHY PHISHING INCREASES DURING A CRISIS

Criminals rely on deception and creating a sense of urgency to achieve success with their phishing campaigns. Crises such as the coronavirus pandemic give those criminals a big opportunity to lure victims into taking their phishing bait.

During a crisis, people are on edge. They want information and are looking for direction from their employers, the government, and other relevant authorities. An email that appears to be from one of these entities and promises new information or instructs recipients to complete a task quickly will likely receive less scrutiny than prior to the crisis. An impulsive click later, and the victim's device is infected, or account is compromised.

HOW DOES PHISHING WORK?

By manipulating our emotions and desires. Phishing messages inspire curiosity, fear, trust, need, generosity and desire.

HOW TO IDENTIFY PHISHING

Does the message:

- Ask for private information?
- Attempt emotional manipulation?
- Contain typos and grammar errors
- Have a missing recipient address?
- Have a general or missing greeting?
- Have an aliased sender address?
- Contain phishing links (shortened URL links) and give directions to do something
- Have incorrect or confusing text

HOW TO RESPOND TO PHISHING / WHAT TO DO

Investigate links before clicking and never click on links or call provided phone numbers, look it up yourself.

At home, delete messages that:

- Record everything you can remember about the incident
- Call the account provider and explain what happened
- If it involved a password, change it immediately
- If it involved identity theft, contact the credit bureaus to have a fraud alert put on the credit reports
- Close tampered accounts

- Report the incident to the police and Federal Trade Commissions (FTC)

At work, immediately report suspected phishing.

- Forward as an attachment to phish@beaumont.org then delete the message

OTHER SECURITY TIPS

- Lock your workstation when you leave your desk
- Do not connect your work laptop to a public Wi-Fi (Starbucks, etc.)
- Do not access websites that you're not familiar with
- Do not "Reply All" to messages
- Keep passwords secure (do not put on a post-it note)
- Make sure passwords are not easily guessed (August2020, Joey123)

COMPUTER ACTIVITY LOGS

Activities involving ePHI on our systems is recorded on logs and retained. At regular intervals, and when necessary, these logs will be reviewed and matched to user IDs. This is done for your safety as well as for the safety of our patients.

COPIER AND FAX MACHINE PRECAUTIONS

Paper versions of PHI also need to be protected. When sending a fax, use the appropriate cover sheet, defining the data as PHI and identifying the recipient. When receiving a fax or printing a document, retrieve the document from the printer or fax machine as soon as possible. When you are not using the printout, lock it away. When finished with the data, destroy it in an appropriate fashion.

SOCIAL MEDIA GUIDELINES FOR ADHERING TO HIPAA

As social media has become woven into the fabric of our everyday lives, Corewell Health believes that team members can act as the best ambassadors of our brand – extending our messaging, interacting with content and helping to support the brand.

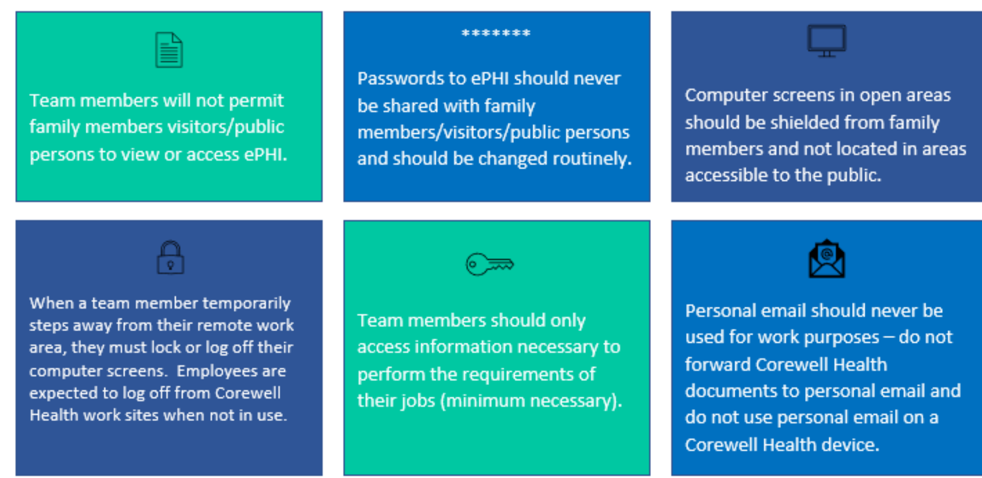
- **Never share PHI/Patient information** on social media. Even de-identified information or images can be considered PHI if accompanied with other data that could be used to identify an individual.
- **Do not share photographs/videos** of patients without proper authorization.
- **Do not** share, post or otherwise publish any information, including images, that you have obtained as a result of your professional relationship with a patient.
- **Do not interact** with any posts the patient makes about the medical conditions they have.
- **It is not recommended** to friend or follow patients on social media sites.

Our Social Media policy provides guidance for team members regarding the use of social media, both internally and externally, whether company-sponsored or personal.

WORKING REMOTE – How to Protect Sensitive Data

Team members working remote or from home on a regular basis, need to maintain control of PHI by keeping documents private and protected to ensure information is not visible to non-team members. Team members should make sure if they need to dispose of sensitive documents, that they are a securely destroyed or shredded. Documents containing PHI will also need to be secured after business house in a location not accessible by others.

Remember the following:



COMPLIANCE TRAINING

RECORDS RETENTION AND DESTRUCTION PROGRAM

You are required to prepare, maintain, and retain all relevant corporate records in accordance with Federal and State laws or regulations, and this Policy. Destruction of corporate records under the Document Retention Policy and Procedures will be

suspended as necessary and appropriate under the directive of the Office of General Counsel (OGC) in order to preserve corporate records relevant to investigations of alleged wrong doing or as required by court order.

LAWS AND REGULATIONS

FRAUD: According to the Office of Inspector General, FRAUD is defined as "wrongful or criminal deception intended to result in financial or personal gain." A variety of situations may be considered Fraud:

- Providing false information on a job application
- Billing for non-existent prescriptions
- Clocking in or using / altering a team members timecard
- Prescription drug switching
- Altering or providing false information on company documents
- Billing Medicare for appointments the patient failed to keep
- Using transportation services for non-related medical services

Healthcare FRAUD is a Federal Crime.

"Whoever knowingly and willfully executes or attempts to execute a scheme to defraud any healthcare benefit program… shall be fined…or imprisoned not more than 10 years… or both."

Federal Healthcare Fraud Statute 18 USC 1347

WASTE: Over-utilization or inappropriate utilization of services or misuse of resources that can result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions, but rather by the misuse of resources.

Examples of **WASTE**

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medication than necessary for the treatment of a specific condition
- Ordering a group of blood tests when only one test is needed
- Submitting claims for services that are consistently denied by Medicare and are not billable to the patient

ABUSE: Practices that may directly or indirectly result in unnecessary costs. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care. Generally, Abuse occurs unknowingly.

Examples of **ABUSE**

- Unknowingly billing for non-covered services
- Purchase of goods at inflated (higher than competitive) price
- Billing for brand name drugs when generics are dispensed
- Miscoding a claim or charging excessively
- Inappropriately allocating costs on a cost report

STARK LAW

When it comes to healthcare-related laws, one of the most important is the Stark Law, known also as the ***"Physician Self-Referral"*** law.

The Stark Law prohibits a **Physician** from ordering *any* **Designated Health Service (DHS)** reimbursable by Medicare/Medicaid from *any* entity with which the Physician or an **Immediate Family Member** has a **Financial Relationship.**

A Physician is defined as:

- Medical Doctor
- Doctor of Osteopathic Medicine
- Dentist
- Podiatrist
- Chiropractor
- Optometrist

Immediate Family Members are:

- Husband / Wife
- Birth or Adoptive Parent
- Stepparent, Stepchild, Stepbrother or Stepsister
- Father, Mother, Brother or Sister-in-law
- Grandparent / Grandchild or Spouse of a Grandparent / Grandchild

Designated Health Service (DHS) is:

- Clinical Laboratory Services
- Physical/Occupational Therapy
- Outpatient Speech/Language Service
- Radiology/Imaging Services
- Durable Medical Equipment
- Home Services
- Outpatient Prescription Drugs
- Equipment and Supplies
- Inpatient/Outpatient Hospital Services

Financial Relationship means:

- Ownership or investment in the entity
- Any compensation arrangement; direct or indirect that can include cash as well as in-kind, transfers such as office space, equipment, computer systems or anything valued at a cost greater than fair market value

Penalties for Stark violations include:

- Overpayment Refund obligation
- False Claims Act Liability
- Civil monetary penalties and program exclusion for *known* violations
- Potential $15,000 penalty for each service
- Civil assessment of up to three times the amount claimed.

ANTI-KICKBACK STATUE

Another healthcare related law which is just as important as the Stark Law, is the **Anti-Kickback Statute** (AKS).
CMS guidelines require all payments that health plans make to providers for services, to be fair market value, consistent with an "arm's length transaction, and for real and necessary services. The AKS prohibits health care providers/suppliers from offering, paying or soliciting or receiving anything of value to induce or reward referrals or generate Federal ***Health Care Program*** business.

What does this mean…?

It means that ANYONE who *"knowingly and willfully" offers*, pays, solicits or receives such compensation, is in violation of the Anti-Kickback law.

For Example:

- A drug company pays kickbacks to pharmacies to switch patient's prescriptions to their drugs.
- Referring patients to friends and family members for services or treatment in return for a fee.
- Accepting material gifts or perks from vendors in exchange for selecting the vendors products or services.

Penalties for Anti-kickback violations could include:

Criminal:

- Fines up to $25,000 per violation
- Up to a 5-year prison term per violation

Civil/Administrative:

- False Claims Act liability
- Civil monetary penalties and program exclusion
- Potential $50,000 per violation
- Civil assessment of up to three times the amount of kickback

FALSE CLAIMS

The **False Claims Act** (FCA) was passed as a result of the submission of fraudulent claims to the government. It applies to **anyone** submitting a claim for *any* item or service to *any* federal program.
The government defines a **CLAIM** as: a demand for payment or property made directly to the federal government or to a contractor or other recipient on behalf of the government.

- A claim ***does not need to be fraudulent*** to be subject to FCA liability, it need only be false or wrong; meaning that it seeks something to which the submitter is not entitled.
- If an overpayment or funds are received from Medicare or Medicaid that a person or organization is not entitled to, it must be reported and returned within **60 days** of identification and quantification.

Penalties for False Claim violations:

While the FCA is a Civil law, a person found liable for false claims, may also face Criminal charges.

- The Criminal penalty for violating federal False Claims Acts can include fines of up to $50,000 and/or imprisonment.
- Civil penalties of up to three times the amount falsely claimed plus an additional penalty of up to $11,000 per false claim are also possible.

The False Claims Act and some state false claims laws permit private citizens who have knowledge of fraud against the US/state government to file a lawsuit. This act is known as **Qui Tam.**

In a Qui Tam action there is a provision that allows people who are not affiliated with the government to file actions on behalf of the government.

ANTITRUST LAW

Another important healthcare law are Antitrust Laws. Antitrust laws are intended to promote fair competition. These laws encourage us and other healthcare organizations to continually strive to better serve our community.

Generally, **Antitrust laws prohibit activities that prevent fair competition** such as:

Agreements among competitors to set pricing or salaries and benefits, divide markets, or strategic and marketing plans	Activities that might block new competitors from entering the market.

We should avoid discussions or agreements with team members or representatives of other health care organizations about costs, price setting, reimbursement rates, terms with suppliers or customer, strategies or marketing plans, wage and benefit information ("competitively sensitive information").

WHISTLEBLOWER PROTECTION ACT

The Federal False Claims Act and Whistleblower Protection Act protect team members from retaliation for reporting violations or workplace issues. A **Whistleblower** is a person who reports information or activity that is deemed illegal, unethical, or in violation of an organizations policy.

Whistleblowers can choose to bring information or allegations either internally or externally.

Internally: A whistleblower can bring his/her accusations to the attention of other people within the accused organization such as an immediate supervisor.

Externally: A whistleblower can bring allegations to light by contacting a third party outside of an accused organization such as the media, government, law enforcement, or those who are concerned.

Once a Whistleblower has reported a concern, they should not be subject to any form of **retaliation**, retribution or be discouraged or intimidated by another individual.

Because **retaliation** can be subtle, it may not always be easy to identify.

Some examples: demotion, denying overtime/time off, intimidation or harassment, making threats, reducing hours or schedule changes.

Whistleblower Protected Activities

We are committed to providing a workplace free of retaliation or intimidation in any form for any individual who reports in "good faith" compliance, quality of care or patient safety issues or who engages in any of the following "protected activities".

Protected Activities include:

- **FILING A REPORT** about possible violation of any federal, state or local law, rule or regulation
- Reporting in **GOOD FAITH** a concern to management or compliance
- **REPORTING** a workplace injury, illness or hazard
- **COOPERATING** with law enforcement, investigations, or court actions
- **REFUSING to conduct a task that would violate the law**

NON-RETALIATION POLICY

"Corewell Health will discipline any team member who engages in retaliatory conduct against an individual who reports, in good faith, potential compliance concerns or quality or safety violations. The act of reporting does not protect a team member from appropriate disciplinary action regarding their own performance or conduct."

Non-Retaliation and Whistleblower Protection Policy

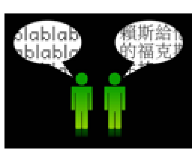
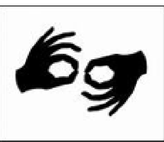
REGULATORY TRAINING

INTERPRETATION AND LANGUAGE SERVICES

We work in a highly regulated environment. We are committed to excellence and quality when caring for our patients, family and each other. Regulations help set clear guidelines on how to provide that care in a safe and effective way. Regulations around safety and security directly protect and benefit physicians, hospital staff, patients and our workplaces.

Over the years our patient population has become increasingly diverse. Patients may be limited in their ability to speak, read, write or understand English due to limited English proficiency, visual impairment (blind), or hearing impairment (deaf/hard of hearing). We are committed to providing equal access to effective communication and interpretation services for patients, their companions and families.

AVAILABLE SERVICES

Hospital Employed & Agency Interpreters	Qualified Bilingual Staff	Video Remote Interpreters	Over the Phone	American Sign Language
				

Due to the serious level of medical (medical terms) and legal (privacy and disclosure) aspects required to service the patient; you need a trained individual to assist in the communication.
An **interpreter** works with the spoken word and assists two people who speak different languages to communicate through speech or using sign language
A **translator** rewrites the content of text from one language to another
(One way to remember the difference: an interpreter “speaks”, and a translator “writes”)
Qualified interpreter vs non-qualified interpreter
Qualified interpreter:

- Assessed for professional skills
- Demonstrates high level of proficiency in at least 2 languages
- Has appropriate training and experience

Bilingual individuals Although team members or family members may be present to translate, they are non-qualified. To be qualified to serve as an interpreter formal competency training is required.
Individuals who may require this service: Deaf, Blind, Deaf and Blind, Hard of Hearing or Limited English Proficient (LEP).
Laws stipulate that all healthcare entities must provide equal access to services for those patients who may require them.

- **Deaf Patients** require Sign Language interpreter and other auxiliary aides to enhance effective communication
- **Hard of Hearing Patients** require the use of assistive devices to enable effective hearing
- **LEP Patients** require the assistance of a qualified foreign language interpreter

Years of research has shown that ineffective communication is an obstacle in the delivery of safe and high-quality patient care. Using qualified interpreters to communicate with patients will help providers:

- Avoid medical errors, unnecessary diagnostic tests and avert drug complications
- Help patients heal faster by helping them participate in their care
- Help prevent miscommunication resulting in the rescheduling of procedures or appointments
- Avoid unnecessary readmissions, saving the organization time and money

There are Federal Laws and Provisions that mandate Language Services be provided as well as the Joint Commission has an entire section “Patient Centered Communication Standards” exclusively devoted to ensuring patient safety and effective communication between providers and patients.

REGULATORY TRAINING

WHEN IS A QUALIFIED INTERPRETER REQUIRED?

The use of qualified interpreters throughout our system defined by various Language Services Policies and is governed by the listed clinical situations. Anytime there is a question about interpreter use, providers are encouraged to check these guidelines. Non-Clinical situations as defined, do not require the use of a qualified interpreter.

Please review the Situation chart for more information.

Clinical Situation	Non-Clinical
• Signing consents • Explaining medical procedures and medication • Discharge instructions • Pre- and post-op instructions • Patient education • History and physical • Explaining surgeries and treatments • Signing legal hospital forms • Questions surrounding patient acute conditions and pain status, etc.	• Need to interpret patient meal preferences • Parking instructions • General questions surrounding patient's demographic information and family members • Visitation hours • Contact information, admission and registration, etc.

The following **are not** qualified healthcare interpreters:

- Friend, relative or family member
- A child of any age
- An unqualified bilingual staff member
- Staff who have taken foreign language as part of their graduate education, may not interpret per our Language Services Policy.

Depending on where you work, some or all the following may be available:

- Hospital employed or agency interpreters trained to work exclusively in the medical field
- Video remote interpreters, qualified interpreters provided over a two-way secure connection
- Over the phone interpreters – qualified interpreters who are available 24/7
- Qualified bilingual staff – bilingual team members who have attended a designated training program and have successfully passed the final language test. These team members are allowed to interpret in their immediate work area only
- American Sign Language interpreters

Providers are required by the Joint Commission and policy to document the use of any language services. This requirement can be met by accessing the Interpreter ***Documentation Section*** in EPIC, under the communication tab and completing the required fields.

ABUSE AND TRAFFICKING

While victims of abuse and trafficking may report to an emergency medical care facility, most victims will not discuss the abuse or the abuser with their doctor or any other person. In addition to the physical trauma, victims can suffer ensuing chronic health and behavioral problems—often untreated—such as depression, alcohol and substance abuse, sexually transmitted diseases, prostitution, and suicide attempts.

It's important we identify signs of abuse in our patients, and we have a legal obligation to report these issues.

Intimate Partner Violence / Sexual Abuse

- Physical signs – bruises, physical injuries, black eyes, sprained wrists, red or purple marks on neck, lip wounds
- Withdrawn or unusually quiet
- Signs of fear
- Emotional signs of abuse – agitation, anxiety, apprehension, depression, low self-esteem
- Signs of control – having to ask permission to go anywhere, frequent calls or texts from partner, etc.

Child Abuse / Bullying

- Physical injuries – bruises, fractures, cuts, abrasions
- Changes in eating or sleeping habits
- School/behavior problems
- Violence to pets or others
- Fire setting
- Bodily complaints (e.g., upset stomach, headache)
- Suicide attempts or thoughts of suicide

Elder / Vulnerable Adult Abuse - neglect or exploitation

- Complaint of being hit or slapped
- Burns, bruises, bed sores, signs of restraint use
- Complaint of sexual coercion or assault
- Complaint of withheld meals, hygiene, therapy, medications, physical aids
- Complaint of stolen possessions or money taken from bank accounts, controlling of finances
- Kept isolated, denied information, threatened

Human Trafficking

We should also be aware of the two forms of human trafficking – Labor and Sex Trafficking. These pose huge risks to the health and well-being of our patients.

- **Labor trafficking** is the recruitment, harboring, transportation, provision or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage or slavery.
- **Sex trafficking** is the recruitment, harboring, transportation, provision or obtaining of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud or coercion, or in which the person included to perform such is under the age of 18.

Human Trafficking Red Flags

Labor Trafficking Red Flags	Sex Trafficking Red Flags
Inappropriate work / living conditions	Psychological / physical injuries
Reports excessive daily work hours	Inappropriate attire for time or year or situation
Reports overcrowded or unsafe work conditions	Hyper vigilance
No control over finances / immigration documents	Flat affect
Reports being transported to and from work / shift with others from same home	Hotel keys / cards, or gift cards
	"Branding" tattoos
Limited / no English – accompanied by an individual who speaks for them	Communicates with Slang
	Extreme attachment to cell phone

Domestic Violence:

- MCL 750.411: **Requires** that medical care providers and institutions file police reports under specific circumstances involving people who are suffering from any violently inflicted wound or injury.
- Medical care providers and institutions **must report immediately** to the police in the jurisdiction in which the hospital, pharmacy, physician or surgeon is located.

Child or Elder / Vulnerable Adult:

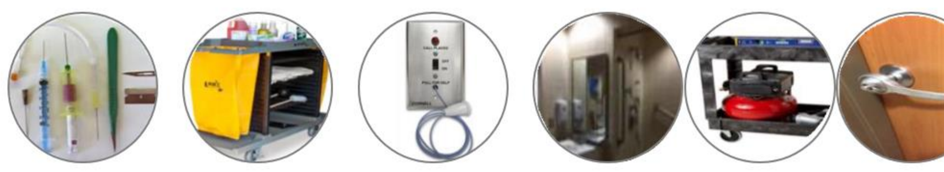
- **Mandatory reporting** for actual or suspected child abuse/neglect, elder or vulnerable adult abuse/neglect and/or financial exploitation
- Consult social work staff for guidance. Report suspicions to Adult or Children's Protective Services
- Refer to your site policies
- Law provides immunity for reporters

It is the expectation that if you have suspicion or evidence of abuse or trafficking, you contact a healthcare provider. It is your responsibility to follow your facility policy/protocol or notify your local Police Department.

SUICIDE AND LIGATURE RISKS

Suicide is a considerable health concern throughout the United States. We must keep our patients free from harming themselves. It is important to identify various items that could be used by a patient to attempt or commit suicide by way of suffocation, overdose, hanging or other forms.

Possible Risks: *medications, breakable windows, accessible light fixtures, plastic bags, oxygen tubing, bell cords, coat hooks, power cords, door hinges, sharps, plastic bags.*



MITIGATING STRATAGIES

Behavioral health patients receiving medical care in a non-behavioral health setting (e.g., medical inpatient units, ED, ICU) must be protected when exhibiting suicidal ideation or harm to others. Safety measures such as a Precaution Checklist should be used as well as:

- One-to-one monitoring with continuous visual observation
- Removal of sharp objects from the room or area
- Removal of equipment that may be used as a weapon

All objects that pose a risk for self-harm that can be removed without adversely affecting the ability to deliver medical care should

be removed (for example, remove oxygen tubing if patient does not require it)

- Utilizing a suicide precaution/environmental checklist
- If unsure of an object being a safety risk, SPEAK UP and ask for a second opinion
- This Suicide Precaution/Environmental Checklist identifies steps that can be taken to minimize the risk for a patient to commit suicide

Inpatient behavioral health units need to be ligature resistant or ligature free in the following areas:

- Corridors
- Common patient care areas
- Patient Rooms/bathrooms

Ligature resistant hardware must be present between the hallways and the patient rooms (including hinges, handles, and locking mechanisms), and the area between patient room and bathroom must be ligature resistant or ligature free. Patient rooms and bathrooms must have solid ceilings.

Drop ceilings can be used in the hallways and common patient care areas if all areas of the hallways are fully visible to staff and there are no objects that patients could use to easily climb up to the ceiling to remove panels and gain access to potential ligature points in the area above the ceiling.

IDENTIFYING PATIENTS AT RISK

The first step is to identify a patient that is at risk, certain demographics have a higher incidence of suicide. Men are more likely to die by suicide, but women are more likely to attempt. American Indian, Alaska Native youth and middle-aged persons have the highest rate of suicide. *Most important is to identify the risk factors because patients may not disclose suicidal ideations voluntarily.*

Risk factors: mental or emotional disorders, previous suicide attempt or self-inflicted injury, history of trauma or loss, barriers to accessing mental health treatment/unwillingness to seek treatment due to stigma, access to lethal means such as firearms and/or drugs.

All hospitals are required to develop a risk assessment tool appropriate for the patient population, care setting and staff competency.

- One screening tool that is used is the Columbia suicide scale, which is an assessment tool used in clinical settings to determine a patient's risk of suicide
- Document the patients' overall level of risk for suicide and the plan to mitigate the risk for suicide
- Warning signs of suicide (subtle symptoms or cues) www.mentalhealth.gov and www.afsp.org
  - Talking about it
    - Killing themselves or feeling hopeless
    - Having no reason to live or being a burden to others
    - Unbearable pain
  - Behavior
    - Giving away prized possessions
    - Withdrawing from activities and isolating themselves from family and friends
    - Looking for a way to end their lives
    - Increased use of alcohol or drugs
  - Mood
    - Depression or anxiety
    - Displaying extreme mood swings
    - Showing rage or talking about seeking revenge

SPEAK UP!

If a patient is in immediate danger, DO NOT leave them alone. Ask a co-worker for help. If something doesn't seem right in terms of ligature risks, environmental risks or the patient is at risk, then notify a health care professional that is taking care of the patient. THE PATIENT'S SAFETY AND YOUR SAFETY IS IMPORTANT!

Provide the patient with the Suicide information hotline: 1-800-273-8255 (TALK).

EMERGENCY MANAGEMENT

All our facilities utilize a standard set of emergency event codes to alert staff, patients and visitors when necessary. We are responsible for knowing what each code means and the appropriate response actions to take, if any. We're also responsible for knowing site-specific emergency numbers and report any emergency immediately. Notification methods include overhead announcements to notify all staff, patients and visitors, pages to designated personnel, or audible fire alarms.

REGULATORY TRAINING

QUICK REFERENCE GUIDES & EMERGENCY CODE POSTERS:

- Provide quick reference information for many types of emergencies/ incidents, including:
  - Emergency alert codes
  - Phone numbers
  - General actions to take during specific types of emergencies

OVERHEAD ANNOUNCEMENT	DESCRIPTION	RESPONSE
CODE RED	Fire	• **R**escue – **A**larm – **C**ontain – **E**xtinguish • **P**ull – **A**im – **S**queeze – **S**weep • do not use elevators • return to department/assigned area
MEDICAL ALERT	Medical emergency	• call site medical number • initiate BLS care if trained to do so
SEVERE WEATHER ALERT	Tornado watch/warning; any type of severe weather	• close curtains, move away from windows to protected area • follow instructions for patient movement if announced
SECURITY STAT	Physical management situation	• protect self, visitors and patients from harm • avoid location until All Clear is announced
CODE BLACK	Bomb threat	• search announced area/location • report any unusual items immediately – do not disturb them • evacuate as directed by Security
AMBER ALERT	Missing child (patient or visitor)	• secure all exits, conduct search for missing infant/child • contact Security if sighted
EXTERNAL INCIDENT EXTERNAL INCIDENT - HAZMAT	Hospital has been notified of large influx of casualties from a single incident. HAZMAT announced if patients require decontamination	• return to department/assigned area • initiate department specific mass casualty protocols • avoid decontamination area unless properly trained
SECURITY ALERT +		
ACTIVE VIOLENCE/ SHOOTER	Can include any type of violence/weapon	• secure immediate area until all clear given • if in affected area – **Run, Hide, Fight**
ELOPEMENT	Missing patient under elopement precautions	• call site Security number • conduct search, notify Security if patient located
LOCKDOWN	Situation requiring Security to temporarily limit the movement of staff, patients and visitors within the facility	• full lockdown – all facility access points closed • partial lockdown – controlled access to facility, entrance/exit from announced area only • unit specific – no entrance/exit to unit
MISSING VULNERABLE ADULT	Missing cognitively impaired adult (visitor only)	• search work area for missing adult • contact Security if sighted
FACILITY ALERT +		
SYSTEM/UTILITY FAILURE	Failure of IT application or utility. Specific system or utility will be announced after "Facility Alert"	• follow response procedure for announced system
CODE ORANGE	Internal hazardous spill	• prohibit anyone from entering area • contact Security • all staff – avoid announced area of spill
EVACUATION	Specific unit/area or full facility will be announced	• leave immediate area if unsafe • return to department or work area for further instructions
ALL CLEAR	Previously announced incident has ended	• return to normal operations

HOSPITAL INCIDENT COMMAND SYSTEM (HICS) & EMERGENCY OPERATIONS CENTER (EOC)

In the event of an emergency incident, site leadership may choose to manage operations using the Hospital Incident Command System (HICS).

The HICS framework is designed for hospitals to use in both emergency and non-emergency situations to respond quickly and recover from incidents. The system is applicable to small incidents as well as very large complex incidents/disasters and consists of procedures for organizing personnel, equipment, resources, supplies, and communications during disasters. It is designed to begin at the time an incident occurs and continues until the incident/disaster does not require management.

Corewell Health's Corporate & Site Emergency Operations Centers (also known as Command Centers) and Emergency Operations Plans (EOPs) may also be activated.

WHEN INCIDENT COMMAND & EMERGENCY OPERATIONS PLAN IS ACTIVATED

During an emergency the Hospital will use established communication channels (e.g., Everbridge, overhead page, digital pagers, email, telephone, 2-way radios, wireless telephone, UHF radio system, Mobile Heartbeat, satellite radios etc.) whenever possible, to communicate vital information to staff, licensed independent practitioners, providers, and volunteers.

- On Duty Staff
  - Should report to their assigned units and wait for further instructions.
  - Staff will continue their designated patient care activities in preparation for response to the directions provided by the Incident Command Center.
- Off-Duty Staff
  - Staff may be requested to report and assist during a disaster and/or emergency event, using site and departmental notification procedures.
- Physicians/Licensed Independent Practitioners/Mid-Level Providers:
  - The decision to notify the medical staff outside the hospital will be made by the Incident Command Structure, in coordination with the Medical Care Branch Director.
  - All medical staff called in for duty and assistance will report to the site's designated sign-in area. DO NOT REPORT TO THE EMERGENCY CENTER UNLESS DIRECTED BY THE INCIDENT COMMAND CENTER/DEPARTMENT MANAGER

Response During an Emergency/Disasters:
The Incident Command Staff will assure that critical tasks are filled by the most appropriate available staff member and tasks are performed as quickly and effectively as possible. In some emergencies, the Hospital will also establish a Labor Pool to supplement or staff essential response or emergency operating functions. Tasks will be evaluated frequently to assure the most appropriate staff members available are being used, burnout or incident stress problems are identified, and staff members in these jobs are rotated as soon as possible. Team members may be assigned responsibilities commiserate with their abilities but outside their normal job roles/responsibilities. Just-in-time training will be provided.
If you are assigned to a specific job / task and will be reporting to a different supervisor:

- Notify your normal supervisor that you have received an incident assignment and will not be performing your normal job
- Continue to perform the assignment until relieved by the person directly supervising you during the incident

DEACTIVATION OF EMERGENCY REPONSE
When the response to an incident has ended and the hospital or facility is ready to return to normal operations, an "All-Clear" alert will be communicated through official communication channels.

SITUATIONAL AWARENESS
In addition to codes, you should be aware of other indicators present in your environment.

- Behaviors to observe:
    - Verbal threats
    - "Victimized" mentality
    - Flat tires or damaged vehicles
    - Corrupt, threatening or disturbing emails
    - Intimidation
    - Documenting activities
    - Harassment
    - Frustration
    - Confusion
    - Hostility
    - Blame
    - Anger
- Be alert for objects, devices or vehicles in unapproved location
  If you recognize something suspicious or out of place at any time, avoid touching or otherwise disturbing the item.
    - Notify Security (at hospitals)
    - Call 911, then Security (at ambulatory site or business office)

WORKPLACE SAFETY - FIRE & ELECTRICAL HAZARDS

Healthcare facilities often have various items and conditions that could result in a fire if not managed effectively. Identifying common causes for workplace fires and electrical hazards can help to avoid or minimize the risk of a disaster.

Common examples of potential fire and electrical hazards in the workplace:
Alcohol Base Hand Rubs (ABHR) Hazard. ABHR's are a flammable liquid and will burn. Do not touch electrical equipment or hot items until your hands are dry. Beware of static electricity until dry.

FIRE HAZARDS		
Burnable liquids - Alcohol Based Hand Rubs (ABHR)	Do not touch electrical equipment or hot item until hands are dry	Fully dry hands before touching items or continuing to work
	Beware of static electricity	
Cylinders & Medical Gas Valves	Unsecured or improperly stored	Put it away properly
	Medical gas zones during a fire	Know your facilities procedures for shutting off medical gas
		Know how to idenify the correct valve and how to use it
Doors	Do not properly latch	Report all doors that do not latch or close properly
	Latches should not be taped open	
	Doors blocked or wedged open	Remove any items or wedges that hold doors open
Obstructions & Clutter	Elevator lobbies, corridors and stairwell	Should be clear at all times
	Fire extinguishers, pull stations or emergency equipment	Do not place items that would block these areas
	Isloation carts, chairs or computer equipment	During a fire alarm, put away all equipment

ELECTRICAL HAZARDS		
Life support equipment should be properly plugged into RED outlets supplied with emergency power	Equipment being brought out for use	Equipment needs to be inspected before being used. Inspection tags will be affixed to equipment to indicate proper functioning
Electrical cords	Damaged or split cords	
Power strips	Must NOT be purchased or brought into the hospital	"Inspection Due Date" should be on all equipment requiring inspection
		"Out of Date" equipment should be reported

Cylinder and Medical Gas Valve Hazards. If you see an unsecured or improperly stored cylinder, put it away. Store empty cylinders separately from other cylinders. A cylinder is considered empty if the gage reads less than 500 psi. It may become necessary to turn off the medical gas to a specific zone or room to prevent spread of fire or protect a patient in an oxygen rich environment.
Know your facilities procedures for using and shutting off medical gases and how to do so.

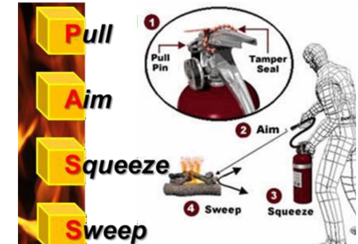
FIRE ALARM
There are various types of alarms that may be encountered: chime, horn, bell, siren. The base of the alarm may vocally say "FIRE" or "ALERT", and some alarms may be just strobe lights, without any sound. It's important to know what the fire alarm in your work area sounds like. If an alarm sounds, or if you see smoke or a fire, remember this word: **RACE**

Rescue: Remove all persons in immediate danger to safety. Prepare to move to another floor or outside if necessary.

REGULATORY TRAINING

Alarm: Use the phrase “Code Red” to alert other staff of a fire. If not already done, pull the alarm. Report a fire to site specific security or dial 911.
Contain: Close windows and doors as you leave the area. Indicate a room is empty by placing a diagonal stripe with tape or chalk on the door. If near any gas, oxygen or other valve which may control a hazardous substance, turn off.
Extinguish: Only if the fire is small and you can do so safely – smother the fire with a blanket, pan, lid or other material if on a person; anywhere else, know where and when to use nearby fire extinguisher.

Fire Extinguishers
Multipurpose (ABC) Dry Chemical Fire extinguishers are used for paper, cloth, burnable liquids and electrical fires.
Special purpose fire extinguishers are used in certain areas – computer rooms, commercial kitchens, procedure and operating rooms and Magnetic Resonance Imaging (MR Conditional) area.



WORKPLACE SAFETY - HAZARD COMMUNICATION

OHSA’ Hazard Communication Standard (HCS) is a general law which mandates all employers receive the information they need to inform and train team members properly on the hazardous substances they work with and to put into place team members protection/training programs. Michigan’s **Right to Know** law is an enhanced version of the Federal Right to Know program, requiring all team members that work with hazardous chemicals to conform with the law regardless of their employer’s status as manufacture or non-manufacturer.

Role and Responsibilities
Chemical Manufacturers must determine a chemical’s hazard and provide a label and produce Safety Data Sheets (SDS).
Labels should contain symbols called “Pictograms”, Signal Words, Hazard Statements, Product IDs and supplier/manufacturer identification.
Employers must provide a written hazard communication program to team members on the use of chemicals and train team members who work with hazardous chemicals and maintain the SDS.
Team members **must** know all chemicals in your work area, follow established safety rules and know the form and location of personal protective equipment (PPE) that must be used with each chemical.

Labels
The Michigan Right to Know Law requires that containers housing hazardous substances be labeled. A label is an immediate source of information about a hazardous chemical, providing the identity of the chemical and its most serious hazards. Labels cannot be removed or defaced.
If chemicals are transferred to a secondary container, label its contents with the chemical’s identity and a key “warning” word. Example: the new label should state: “Ammonium Hydroxide – CORROSIVE – causes burns.”
Where required, the following shall be provided on labels: Symbols called “Pictograms, Signal Words, Hazard Statements, Precautionary Statements, Product Identification, Name, address and telephone of the Supplier/Manufacturer
Safety Data Sheets (SDS) provide comprehensive, technical and emergency information, material’s physical properties of fast acting effects, level of person protective equipment needed, first aid treatment for exposures, and preplanning necessary for safe handling.
Personal Protective Equipment (PPE) protects team members from the risk of chemical injury by creating a barrier against workplace hazards and/or illness. Includes hand, eye, protective clothing and respiratory protection. PPE is not a substitute for good engineering, administrative controls or work practices, but should be used in conjunction with these controls to ensure the safety and health of all team members. PPE will be provided, used, and maintained when it has been determined that its use is required and that such use will lessen the likelihood of occupational injury.

SPILL TYPES:
Simple Spill. Is a spill of less than one liter, that can be easily cleaned up by one person in 10 to 15 minutes without risk of overexposure to self or other team members under normal conditions and is a chemical that you are trained on and are familiar with.
Emergency Spill. An emergency spill is greater than one liter of material spilled or any of the following criteria are met: a person is injured, identity of a chemical is unknown, multiple chemicals are involved, chemicals highly toxic, flammable or reactive, conditions that are immediately dangerous to life and health, spill occurs in a public place such as a corridor, spill has a potential to spread to other parts of the building, or spill may endanger the environment such as reaching waterways or outside ground.
Exposure. Chemicals can enter the body through inhalation, skin contact, eye contact or ingestion through mouth. The longer the exposure, the more likely you'll be affected. The **Permissible Exposure Limit (PEL)** is the maximum amount or concentration of a chemical that a worker may be exposed to under OSHA regulations. The 8-Hour Time Weighted Averages (TWA) are an average value of exposure over the course of an 8-week work shift.

Remember if you have signs and symptoms of an exposure report it to your supervisor or go to the emergency center.

BLOODBORNE PATHEGON (BBP) EXPOSURE CONTROL PLAN

The BBP Exposure control plan is in place to eliminate or minimize occupational exposure to blood and/or other body fluids through the development, implementation and enforcement or work practices, controls and education. Exposure risk is different based on job tasks, but all team members require education to be protected.

Our Control Plan meets the Michigan Occupational Safety and Health Administration (MIOSHA) Part 554. Bloodborne Infectious Diseases Standard and Occupational Safety and Health Administration (OSHA) 29 CFR 1910.1030

What are Bloodborne Pathogens?

- Bloodborne = carried or spread in human blood
- Pathogen = germ, virus or bacteria – something that can make you sick
- Bloodborne pathogens means pathogenic microorganisms (germs) present in human blood and body fluids that can cause disease in humans

These pathogens include, but are not limited to:

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human immunodeficiency virus (HIV)

Signs and Symptoms of the 3 most common BBP:

Hepatitis B	Hepatitis C	HIV
• About 30% of persons have NO symptoms. • Symptoms may include jaundice, fatigue, abdominal pain, loss of appetite, nausea, vomiting, joint pain	• About 80% of persons have NO symptoms. • Symptoms may include jaundice, fatigue, dark urine, abdominal pain, loss of appetite, nausea	• Symptoms may include diarrhea, nausea/vomiting, unexplained weight loss, fatigue, night sweats, sinus infections, tingling/burning of the hands & feet

In addition to blood, BBP can be present in other Potentially Infectious Materials (OPIMs) which include:
Semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, saliva in dental procedures, **any body fluids visually contaminated** with blood.

EXPOSURE INCIDENT

An exposure is a result of blood or other OPIM coming in to contact with eye, mouth or other mucous membrane, non-intact skin, or through the puncturing of skin that results from performing job tasks.

Example:

When someone else's body fluids enter your body while at work. This can happen through your eyes, nose, mouth, cuts, or getting stuck by a needle or sharp instrument.

EXPOSURE DETERMINATION

A list of hospital-specific job codes and their respective occupational exposure risk can be found as attachments to the BBP Exposure Control Plan

Category A

Occupations that require procedures or other occupation-related tasks that involve exposure or reasonably anticipated exposure to blood or other potentially infectious material or that involve a likelihood for spills or splashes of blood or other potentially infectious material.

Category B

Occupations that do not require tasks that involve exposure to blood or other potentially infectious material on a routine or non-routine basis as a condition of employment.

WORKPLACE EXPOSURE DETERMINATION

Team member exposures to blood/body fluids can happen during many job activities including but not limited to:
laboratory specimen processing/transport, handling soiled articles, collecting/handling blood or OPIM, handling sharps, drawing blood, giving injections, wound care.

Source of Exposures

- Sharp item, contaminated with blood or body fluids – needles (including acupuncture guide tubes) surgical instrument or glass
- Splash of blood or body fluid spill into eyes, nose or mouth

- Splash of blood or body fluid onto non-intact skin, wound, cut or scrape, or dry cracked skin

***ACTION**: Seek evaluation to determine risk from exposure*

EXPOSURE CONTROL METHODS

It is important to know and use appropriate standards, practices and precautions, referred to as Exposure Control Methods, to protect the health and safety of our patients, you, team members and others.

1. Universal Precautions

The primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and healthcare personnel.

- These precautions apply to all team members in the healthcare settings, regardless of the suspected or confirmed presence of an infectious agent.
- Combines the major features of Universal Precautions and Body Substance Isolation.
- Based on the principle that all the following may contain transmissible infectious agents: Blood, body fluids, secretions, excretions except sweat, non-intact skin, mucous membranes.
- Includes a group of infection prevention practices depending on the anticipated exposure which include: Use of Personal Protective Equipment (PPE), Environmental Measures, Hand Hygiene, Safe Work Practices to Prevent Exposure to Bloodborne Pathogens, Respiratory Hygiene/Cough Etiquette, Proper Waste Disposal.

2. Standard Operating Procedures

Standard Operating Procedures (SOPs)have been developed for Inpatient and Outpatient/Ambulatory locations to reduce the exposure to blood and OPIM.

- SOP's can be found in the BBP Exposure Control Plan.

3. Engineering Controls

Engineering Controls include safety needles, Sharp's containers, needleless devices, hand-washing sinks, alcohol-based hand rub (ABHR) Limitations of Engineering controls include safety devices on needles may not work properly, sharps boxes can become too full, or safety devices may require activation**.**

4. Contingency Plan

SOP must be followed unless the use/process results in increased risk/hazard to the associate or patient.

- Any deviations from the SOP shall be approved under the guidance of the System Employee Health Services Director, Medical Director or designee in writing.

5. Work Practice Controls

Work Practice Controls and Safe Work Practices include the following:

- **Hand hygiene**
- **Environmental cleaning and disinfection**
- **Biohazard Containers**
- **Using appropriate PPE**
- **Remain focused on the task being performed**

There are **Limitations of Work Practices**, such as Human error (i.e., missed hand hygiene opportunities, inappropriate donning/doffing PPE). In addition, remember cleaning chemicals kill most germs, but not all.

6. Personal Protective Equipment (PPE)

Use of: gowns, mask, respirators (N-95/PAPRs), gloves, eye protection - goggles or face shields.

Limitations of PPE: Needles and shared items can puncture gloves, poorly fitting gloves can rip or tear, or Body fluids can splash over masks and shields if they aren't worn properly.

- **Gowns** are used to protect a team member'sarms and exposed body areas and prevent contamination of clothing with blood, body fluids, and OPIM. Gowns are not reusable – use one time only – then put in hamper. Do not hang for reuse.
- **Masks** are used for 3 primary purposes:
  1. To **protect team members** from contact with infectious materials from patients (e.g., respiratory secretions and sprays of blood).
  2. To **protect the patient** when staff is performing procedures requiring aseptic technique. This is done to protect patients from exposure to infectious agents carried in team member's mouth or nose.
  3. To **protect everyone** during a respiratory outbreak or pandemic OR when placed on coughing patients during transport or in waiting areas to limit potential dissemination of infectious respiratory secretions.

- **Gloves** are used to prevent contamination of healthcare personnel hands when anticipating direct contact with blood or body fluids, mucous membrane, non-intact skin, other potentially infectious material (this could be contaminated patient care equipment and environmental surfaces) having direct contact with patients who are in transmission-based precautions (isolation).
- **Eye Protection** is necessary when it is likely that there will be a splash or spray of any respiratory secretions or other body fluids. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- **Personal Protective Equipment (PPE)** Proper selection of PPE will be determined by Department Managers with support from Safety /Infection Prevention if needed. Team members will be trained for appropriate PPE usage specific to the hazards as well as donning and doffing. PPE required in department will be ordered for use and must be discarded in general trash waste unless saturated / dripping with blood or OPIM which requires biohazard waste disposal after use. Reusable gowns go in the soiled linen hamper.

7. Housekeeping

Contaminated sharps are discarded immediately or as soon as possible in containers that are closable, puncture-resistant, leak proof on sides and bottoms, and appropriately labeled or color-coded. All regulated medical waste is placed in containers which are closable, constructed to contain all contents, leak proof, and appropriately labeled with a biohazard label/symbol or color-coded.

- Orange/red labels with a universal biohazard symbol shall be utilized to warn of potential hazards
- Labels shall be placed on Biohazard containers, soiled utility rooms, refrigerators/freezers used as storage for blood and OPIM, Sharp's disposal containers, or containers used to store, transport, ship blood or OPIM

PROTECT YOURSELF AGAINST BBP

Hepatitis B Virus (HPV)

- Vaccination available for all **Category A** team members at no charge
- The vaccine is offered to team members in a series of three injections over a 6-month period
- The vaccine is safe and more than 90% effective
- Prophylaxis available
- A blood test (titer) will be performed after the series to see if you are immune

The vaccine helps to protect the team member if an exposure happens

Hepatitis C

- No vaccine or prophylaxis available

HIV

- No vaccine available
- Prophylaxis available but must be administered within 2 hours of exposure

POST EXPOSURE EVALUATION

If exposed, immediately wash the area with soap and water and thoroughly rinse area with water. Report to supervisor or anyone in charge immediately. Fill out First Report of Injury form. Team members should contact Employee Health or the Emergency Department for medical evaluation.

- If source patient (where the blood/body fluid came from) can be identified, the supervisor shall initiate source patient testing panel to include Hepatitis B (HBV), Hepatitis C (HCV), and HIV
- Team members should follow-up with Employee Health for results, counseling, and follow-up on the next business day

BBP TRAINING AND RECORDKEEPING

BBP training is mandatory for all new hires and annually thereafter required by the Michigan Occupational Safety and Health Administration (MIOSHA) and the Occupational Safety and Health Administration (OSHA). Training Records are maintained upon completion of training and monitored for compliance.

CORONAVIRUS DISEASE 2019 (COVID-19)

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Overview - Signs and Symptoms

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus.**

People with these symptoms may have COVID-19:

Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or

smell, sore throat, congestion or runny nose, nausea or vomiting or diarrhea.

Prevention

General recommendations:

- Get vaccinated for COVID-19
  - Safe & effective at preventing COVID-19 disease, especially severe illness & death
  - Reduces the risk of spreading COVID-19 to other people
- Avoid close contact with people who are sick & stay home when you are sick
- Wash your hands regularly with soap and water, or clean them with alcohol-based hand rub
- Cover your cough or sneeze with a tissue
- Clean and disinfect frequently touched objects and surfaces using a disinfectant
- Practice universal masking
- Practice social distancing
- Practice good hand hygiene

Mask Use pertaining to COVID-19

To help prevent potential transmission of COVID-19, HCP, visitors and patients must wear masks in all common areas (where patients/visitors may be) while there is ongoing COVID-19 transmission occurring in the community.

- Wear a surgical face mask or other Corewell Health provided face covering over the nose and mouth to help prevent transmission from infected individuals who may or may not have symptoms of COVID-19
- Cloth face coverings or homemade masks are not considered personal protective equipment (PPE). **Wear a Corewell Health provided mask for patient care.**
- Patients must wear face coverings when leaving their room or when others (e.g., HCP, visitors) enter the room.
- Face masks can become contaminated with respiratory secretions –use hand hygiene before and after handling. If the mask becomes contaminated or damaged, change it
- Masks must be worn by everyone in all common areas (e.g., atriums, hallways, elevators, etc.)
- Fully vaccinated team members *may* remove their mask (if desired) when there is no possibility of patient/visitor presence when community level is low or medium

Social Distancing For COVID-19

Practice social distancing while in common areas.

- Stay at least six feet from other people
- Avoid contact with others, such as handshakes or hugs
- Avoid touching surfaces that have been touched by others when possible
- Maintain social distancing while eating

Meetings – Conferences or Gathering

Meet remotely, when possible, follow Mask Guidelines, consider canceling, adjusting, or postponing large work-related meetings or gatherings that can only occur in person. When either of the above options are not viable, hold meetings in open, well-ventilated spaces where social distancing can be maintained. Follow infection prevention guidance in meeting limits are in place.

COVID-19: Prevention -Screening

Patients with suspected or confirmed COVID-19 are maintained in precautions. If infection is suspected.

Guests and visitors are passively screened for COVID-19 symptoms.

Every team member –regardless of role –must be assessed for COVID-19 symptoms and risk factors before working in our facilities.

HAND HYGIENE

Hand Hygiene

Cleaning your hands is the **number-one way to prevent the spread of infection**. Hand hygiene protects you, your coworkers, your loved ones, and our patients. Better hand hygiene means fewer infections for our patients. Not cleaning your hands properly and at the right time can lead to you taking germs from one place to another and better hand hygiene means fewer infections for our patients.

Proper Glove Use

Be mindful of the tasks at hand. Clean to dirty tasks ONLY - be mindful not to go Dirty to Clean – example:

- Avoid touching surfaces that have been touched by others when possible
- Maintain social distancing while eating
- Changing a dressing, then start an IV
- Doing perineal care, then mouth care
- Assessing a weeping wound, then charting in EPIC

- Cleaning the toilet, then cleaning a bedside table

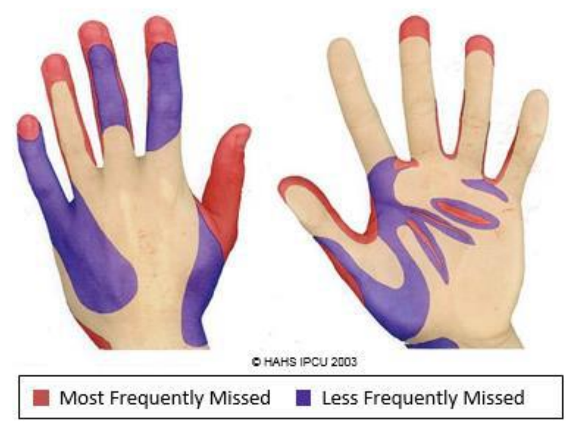
Remember: Gloves are not a substitute for hand hygiene! If coming in contact with another person's blood or body fluids, or no-intact skin, wear gloves.
Hand hygiene should be performed BEFORE putting on Gloves and AFTER taking them off,
Gloves + Hand Hygiene = CLEAN hands
Gloves - Hand Hygiene = DIRTY hands (Risk of transmission AND germs are invisible!)
Proper Handwashing – 20 second scrub AT LEAST!

Use Alcohol Foam:

- As the preferred method of hand hygiene
- When hands are **not visibly soiled**
- Before patient contact
- After contact with patient or patient environment
- Before and after using gloves
- 20 sec minimum

Use Soap and Water:

- When hands are **visibly soiled**
- Before eating
- After using the restroom
- 20 sec minimum of scrubbing with soap and water, then rinse with water



Hand Hygiene is Performed:

- Before entering the patient's room
- Before and After – putting on gloves, touching the patient or the patient's environment, performing any invasive procedure, providing patient care
- After exiting the patient room if there was contact with the patient or their environment

INFLUENZA (Flu)
Influenza (flu) is spread person-to-person by droplets.
Droplets are transmitted when a person with the flu coughs, sneezes or talks. These droplets can land in the mouths or noses of the people who are nearby or possibly be inhaled into the lungs. Less often, a person might also get the flu by touching a surface or object that has the virus on it and then touching their own mouth or nose.
How to Stop the Spread of the Flu
Get your annual influenza vaccination (flu shot), clean your hand often, practice respiratory etiquette, don't come to work sick. (Symptoms of the flu: fever, chills, cough, body aches).

Flu Vaccine Requirement
Per our Required Influenza Vaccine Policy **requires all team members**, including, but not limited to, physicians, fellows, volunteers, students, contracted personnel and professional staff.

TRANSMISSION BASED PRECAUTIONS

Precaution Signage used for Airborne, Droplet, Contact and Contact enhanced Respiratory reminders:

TYPES OF PRECAUTIONS

Airborne Precautions

Patients with airborne diseases produce infectious particles so small that they can be inhaled deep into the lungs. These small particles stay suspended in the air for hours. Diseases requiring Airborne Precautions include:

- Measles
- Chickenpox (Varicella) (in addition to Contact)
- Disseminated Shingles (in addition to Contact)
- Tuberculosis
- Precaution N-95 mask must be worn when entering an Airborne Precautions isolation room
- Team members with potential to enter a room of patients in Airborne Precautions for tuberculosis (TB) must be fit tested annually to ensure proper size of N-95 mask
- A "fit check" should be performed each time a N-95 mask is worn to ensure proper seal
- A surgical mask should be worn by the patient during transportation in the hospital
- Patients requiring Airborne Precautions must be housed in a negative pressure room with an activated alarm and closed door

Droplet Precautions (Influenza, Bacterial Meningitis, Pertussis (Whooping Cough), Mumps)

- Respiratory Droplets do not spread far
- Transmission occurs with inhalation of respiratory droplet or by contact with mucous membranes
  Mask must be worn when you enter, and eye protection is required if exposure to respiratory droplets is anticipated
- Negative pressure room not required
- Visitors should be offered a mask with eye protection prior to entering the room

Contact Precautions

- Limit the transmission of organisms that can be spread to the patient by touch or contact with items in the environment
- Gloves and gown must be worn
- Door to the room may remain open
- Contact Precautions are required for:
  - Patients with resistant organisms or C. difficile
  - Patients with bed bugs, scabies or lice

Enhanced Respiratory + Contact Precautions

- Limit the transmission of organisms that can be spread to the patient by touch or contact with items in the environment
  - Fit tested N95 or PAPR must be worn before entry
  - Eye protection must be worn before entry
  - Gown and gloves must be worn before entry

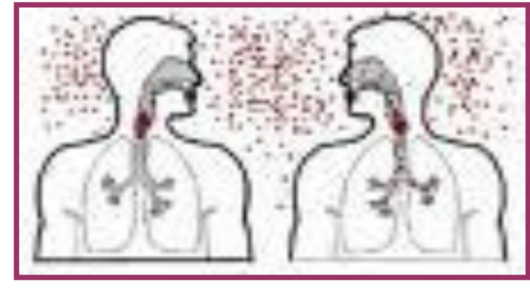
Proper PPE Donning and Doffing are available via QR Code on isolation Precautions Signs: Airborne, Droplet, Contact and Enhanced Respiratory + Contact Precautions

TUBERCULOSIS IN THE WORKPLACE

Tuberculosis is a bacterial infection caused by the organism Mycobacterium Tuberculosis (TB). This organism is carried in tiny airborne particles, which can be produced when persons who have pulmonary or laryngeal TB sneeze, cough, speak or sing. TB is spread when an individual inhales particles containing TB into their lungs.

Symptoms of TB Infection

- Cough lasting longer than 2 weeks
- Pain in chest
- Coughing up blood-tinged sputum
- Weakness or fatigue
- Unexplained, rapid weight loss
- Fever and/or night sweats
- Loss of appetite
- Night sweats

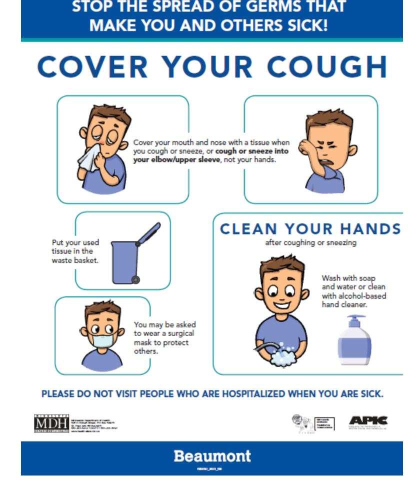


TB Surveillance

As team members, we will all be tested for the presence of TB upon hire and in the case of exposure to TB in the workplace. Monitoring for TB may include skin testing, blood work, chest x-rays, and/or questionnaires, depending on the person's history. If you think you have been exposed to TB, report as soon as possible to your supervisor or to Employee Health.

Risk Factors for TB

- Recent contact with someone with active TB without use of proper PPE, N95 mask/PAPR
- Recent travel to high-risk countries – China, Nigeria, South Africa, India, Indonesia, Pakistan
- Time spent in congregate settings such as nursing homes, prisons, or homeless shelters
- Microbiology workers who are in contact with TB specimens



INFLUENZA (Flu)

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How to Stop the Spread of the Flu

Get your annual influenza vaccination (flu shot), clean your hands often, practice respiratory etiquette, don't come to work sick. (Symptoms of the flu: fever, chills, cough, body aches)

Influenza Vaccine Requirement

Per our annual Required Influenza Vaccine Policy immunization is **required for all team members**, including, but not limited to, physicians, fellows, volunteers, students, contracted personnel and professional staff.

ORGANIZATIONAL TRAINING

PATIENT AND FAMILY EXPERIENCE

Effects of COVID-19 on the Patient Experience

The COVID-19 pandemic forced the exclusion of family members from bedsides. This isolation was felt by our patients and impacted team members and families as well. As we emerge from the restrictions of the pandemic, we welcome families back to the bedside.

Supporting Presence

Our supporting Presence standards facilitate a safe, secure, healing and supportive environment for patients and their families by encouraging and supporting the presence and participation of persons who play significant roles in the physical and emotional care of patients.

Partners and Friends play a very important part in providing a Supporting Presence: They provide a supporting presence and assist with providing Quality and Safety. They also provide physical and emotional support and comfort and help decrease feelings of isolation.

There are four Patient and Family-Centered Care Core Concepts:

Respect & Dignity

- Knocking
- Introduction
- Eye contact
- Speaking respectfully

Information Sharing

- Avoid medical jargon
- Timeliness
- Verifying appropriate parties

Participation

- Invite and encourage
- Listen and take cues
- Welcome family presence

Collaboration

- Shared decision making
- Engagement

Our Patient and Family Experience is designed to promote a safe and secure environment for treatment and healing as well as a safe and secure environment for team members for staff, patients and families. We will provide the care that we would want for our own family – spouse/partner, child, parent, friend…Every Patient, every time.

EMPATHY

What is empathy and why is it important to patient care? Empathy is the ability to sense another's emotions, step inside their shoes and imagine what they may be feeling. Empathy drives connection and is vital to providing quality patient care.

Four Qualities for providing empathy:

1. Take the perspective of another person
   It's dark in here and I'm overwhelmed
   (I understand…)
2. Recognize their perspective as the truth
   (… and I know what that's like, you're not alone)
3. Stay out of judgement
   (I don't even know what to say right now…)
4. Recognize emotion in others and communicate with empathy
   (but… I'm just so glad you told me)

Patient and Family Advisors (PFAs)

Patient and Family Advisors (PFAs) are engaged members of the health care team. They may be current or former patients and family members who want to help improve experiences and are willing to talk about their experience both positive and negative. They help improve quality and safety by giving input, planning and implementing changes that matter to patients and families. They also offer insights and unique perspectives that team members may not see.

ORGANIZATIONAL TRAINING

JUST CULTURE

WHAT IS JUST CULTURE?

A Just Culture is creating an open and fair environment where team members are comfortable speaking and saying when something has gone wrong. Understanding the difference between human error, at risk, and reckless behavior.

Team Members can influence outcomes through safe behavior

A Just Culture is creating an open and fair environment where team members are comfortable speaking and saying when something has gone wrong or almost occurred.

- It's important to support one another and **"Speak Up"** if you see a team member drift from proper practice, or to report the system or process failure when an error has occurred.
- Remember your chain of command if your concern is still not addressed.
- Encourage patients and families to "Speak Up" to let us know when something is not right.

Just Culture is understanding the difference between human error, at risk, and reckless behavior.

- To Err is Human and you are a fallible human being susceptible to **Human Error** (lapses, slips and errors).
- We may drift from safe behavior – this is **At-Risk Behavior** – a choice that increases risk without perceiving the risk or mistakenly believe the risk is justified.
- When you knowingly put others in harm's way, we will take appropriate action: **Reckless Behavior** - a conscious disregard of substantial and unjustifiable risk.

A fair and just assessment of choices will be made, errors reviewed; team member's consoled (for a human error), counseled (for drift) or held accountable for their choice (reckless behavior).

DIVERSITY AND INCLUSION

WHAT IT MEANS TO BE DIVERSE AND INCLUSIVE

Our team members represent a range of demographics: age, economic status, gender, gender identity, job classification, mental and physical ability, physical appearance, political affiliation, race and ethnicity, religious belief, sexual orientation and others.
We come from varied backgrounds and upbringing. Our ideas, how we learn, and our work styles are also different.
Diversity and Inclusion is more than simply complying with the law and bringing different people together.
It is:

- Being respectful of these differences
- Recognizing their value
- Leveraging them to be the best in delivering PFCC.

It's the responsibility of every team member to help maintain a culture that embraces diversity and inclusion.
We must consider it in all we do: when we interact with different teams, when we make decisions, manage relationships and projects, recruit and hire, team member engagement and retention, educational programs and prepare policies and procedures.
Being diverse, makes us stronger – Gender-diverse companies are 15% more likely to financially outperform those that are not as gender diverse; and ethnically-diverse companies are 35% more likely to financially outperform those that are not as ethnically diverse.

HOW WE SUPPORT DIVERSITY AND INCLUSION

Diversity and Inclusion Committees

Our Diversity and Inclusion Committees celebrate, recognize and bring awareness to site and system wide initiatives. The committees work to create an equitable and inclusive environment where all team members are treated with dignity and respect.

Resource Groups

Our Employee Resource Groups offer opportunities to share best practices, engage team members and support having an inclusive culture.

SENSITIVITY IN HEALTHCARE

PEOPLE WITH OBESTIY - WEIGHT BIAS AND STIGMA

Obesity is a medical diagnosis and treatable disease associated with having an excess amount of body fat. It is caused by genetic and environmental factors and can be difficult to control through dieting alone.
Obesity is diagnosed by a healthcare provider and is classified as having a body mass index (BMI) of 30 or greater.
Nearly 40 percent of Americans have obesity.
Michigan had the 8th highest adult obesity rate in the nation in 2019 and currently has an adult obesity rate of 36%

Obesity Is	**Obesity Is Not**
- A disease	- Your fault

- A worldwide health concern
- Caused by many factors
- Treatable and manageable
- Yours to manage alone
- Just about food
- Cured by a miracle treatment.

People who have a higher body weight are vulnerable to stereotypes, bias, bullying, and discrimination in our society. Known as “weight bias” or “weight stigma,” these experiences occur for both children and adults in many aspects of daily life.

Research studies show that patients with obesity face biased attitudes from physicians, nurses, psychologists, dietitians, medical students, and fitness professionals. Providers view patients with obesity to be lazy, lacking in self-control, awkward, weak-willed, sloppy, unsuccessful, unintelligent, dishonest, unmotivated to improve health, and noncompliant.

When patients feel judged or stigmatized about their weight, this can lead to lower trust of their healthcare providers, poorer treatment outcomes, and avoidance of future health care.

Reducing and Preventing Weight Bias

Implement sensitive communication strategies:

- Consider neutral terms for weight and BMI rather than terms like fat, morbidly obese
- Emphasize lifestyle change and health improvement
- Emphasize achievable behavior goals rather than weight
- avoid language that places blame on patient

Consider phrases such as: “Could we talk about your weight today?” “How do you feel about your weight?” “What words would you like to use when we talk about your weight?”

The language we use matters. Increase your self-awareness of personal attitude about body weight.

Informational Handouts are currently available for providers and patients: Promoting a Positive Office Environment for Patients with Obesity Checklist for Assessing the Office Environment Motivational Interview Example Scripts How to Have a Productive Conversation about Weight Bias

For Patients How to be Informed and Assertive Talking to your Doctor about Your Weight If You Are the Target of Weight Bias

HARASSMENT IN THE WORKPLACE

WHAT IS HARASSMENT?

Harassment is unwelcome verbal, physical or visual conduct or communication that is based on a person’s protected characteristic. A protected characteristic is a characteristic protected under federal, state or local law and includes a person’s sex, color, race, ancestry, religion, national origin, age, disability, height, weight, marital status, military or veteran status, citizenship or sexual orientation.

Harassment may include conduct that is:

- Verbal (epithets, slurs, derogatory comments or jokes)
- Physical (assault or other physical contact)
- Visual (pictures, signs, posters, cartoons, drawings, or gestures)

SEXUAL HARASSMENT

Sexual harassment is harassment based on someone’s sex or gender. It may be:

- Verbal (comments, slurs, jokes)
  Examples:
  - Derogatory terms related to someone’s religion, race, national origin, gender identity or disability
  - Conversations of a racist or sexist nature
  - Sexually suggestive emails
  - Repeated unwelcome requests for dates
  - Teasing of a sexual nature
- Physical (inappropriate or sexual touching)
  Examples:
  - Unwelcomed kissing or hugging
  - Unwelcomed touching, such as patting, pinching, rubbing, massaging or brushing up against someone
  - Cornering or blocking a person’s path
  - Stalking or following a person
  - Coerced sexual conduct
- Visual (sexual images, posters, cartoons, drawings, gestures)
  Examples:
  - Displaying inappropriate pictures, posters, cartoons, objects or screensavers
  - Staring in a sexually suggestive or offensive manner
  - Derogatory or sexual gestures

Sexual harassment may also include unwelcome sexual advances or conduct of a sexual nature when:

- Submission to the advance or conduct is a condition of employment
- Submission to or rejection of the advance or conduct is used as a basis for employment decisions
- The advance or conduct creates an intimidating, hostile, or offensive work environment

COMMON MISCONCEPTIONS ABOUT HARASSMENT

- Only women are victims of sexual harassment - A harasser may be ***male or female.***
- The harasser and victim are always of the opposite *sex.* – Harasser may of **same sex**.
- Harassment **must occur in the workplace** for it to be a violation of policy
  - Out of the work harassment may violate company policies if it involves co-workers and creates a hostile work environment.
  - Out of the workplace harassment may also occur when a manager pressures a subordinate for sexual favors
- The Acceptable Behavior and Harassment Prevention Policy applies only to team members.
  - Our policy is to maintain a harassment-free workplace. The harasser or victim may be anyone in the workplace including *team members, physicians, contractors, volunteers, students, patients, visitors, or vendors.*

"REASONABLE PERSON" STANDARD

The legal system uses a standard called "reasonable person" when analyzing whether conduct rises to the level of **actionable** harassment. Actionable workplace harassment violates civil rights laws and may lead to litigation and a potentially an award of damages.

- The standard asserts that for conduct to be considered harassment it must be offensive to a reasonable person under similar circumstances.

EEOC provides the following example:

An employee alleged that her coworker made repeated unwelcome sexual advances toward her. An investigation disclosed that the alleged "advances" consisted of invitations to join a group of employees who regularly socialized at dinner after work.

The EEOC assessment:

From the perspective of a *reasonable person*, the coworker's invitation to socialize in a group did not constitute sexual harassment.

*EEOC – Equal Employment Opportunity Commission

REPORTING HARASSMENT

All team members are responsible for maintaining an environment free from harassment and are expected to report incidents of harassment to their:

- Manager (if that person is not involved in the behavior or conduct)
- Local Human Resources
- Trust Line – 800-805-2283

All complaints of harassment will be investigated promptly, thoroughly and fairly. Any instances found to be substantiated will be addressed directly with corrective action, up to and including termination.

Any form of retaliation for good faith reporting of incidents of harassment is prohibited by our Acceptable Behavior and Harassment Prevention Policy.

WORKPLACE VIOLENCE

What is Workplace Violence?

According to statistics, healthcare workers are at a high occupational risk of being harmed because the hospital environment, medical diagnoses, and healthcare procedures can be unsettling, even terrifying, to some patients and their family members. Cases of patients or family members experiencing a sense of hopelessness or dissatisfaction, suddenly become enraged, and progress to violent behavior.

Workplace Violence refers to any threat, disruptive behavior, or violent act that occurs in a workplace. This includes any potentially dangerous behavior that may or does result in trauma, injury or death. Workplace violence includes a wide variety of unwelcomed behaviors such as: physical violence, intimidation, harassment, profanity, threats, stalking, shouting, bullying, to name a few.

There are numerous risks associated with WPV that can affect individuals directly or indirectly involved in the incident, their families, the organization, the enterprise and the public. Some of the risks are as follows:

- Significant impact on patient safety

- Bodily injury and psychological harm
- Loss of valuable team members
- Increased security depending on the nature of the issue
- Possible property damage
- Lost productivity

Why is this Important?

Violence against healthcare team members is more common than most people realize.

75% of nearly 25,000 workplace assaults occur annually in healthcare settings, however only 30% of nurses and 26% of emergency department physicians have reported incidents of violence.

…violent altercations are so common that most team members in the field consider them to be simply part of the job.

Wallace Stephens

- 47% of physicians have said that they'd personally been physically assaulted at work.
- 70% of EC physicians reported acts of violence against them but only 3% pressed charges.
- 80% of EC physicians acknowledged that these events have taken a toll on patients and >50% said that patients have been physically harmed.

Impact on Patient Safety

A large multisite study with 370 nurse respondents found that 52% of nurses perceived that workplace bullying impaired their ability to concentrate.

Root cause –of more than 3500 Sentinel Events over 10 years. Researchers have linked 200,000 deaths/year associated with increased patient falls, errors in treatments or medication, delays in care, adverse events and patient mortality,

Altered thinking impacting decision making, assessments, reactions, silence or inhibited communication

Why is this Important?

Statistics

- 45% of nurses have been verbally harassed or bullied by other nurses
- 41% of nurses have been verbally harassed or bullied by managers or administrators
- 38% of nurses have been verbally harassed or bullied by providers
- More than 50% of nurses who have reported harassment indicated that they were considering leaving the profession

Linked to High Quality Care:

- Respectful communication
- Shared goals, quality driven
- Positive relationships between members of the healthcare team, providers and patients and families

Purpose and Policy Statements:

The purpose of this policy is to identify a process with actionable steps to prevent and address Workplace Violence and to **protect the rights of patients, visitors and staff** to a safe environment.

- A safe environment will be established and reinforced by **early identification of escalating situations** and potentially violent behaviors, followed immediately by interventions to manage behavior.
- Each instance of WPV will be met with a measured, predictable response designed to **de-escalate situations, prevent violence, and maintain the dignity** of all involved.

This policy revision was created to accomplish two things:

1. To provide quick and effective intervention when violent situations arise
2. And to provide tools and resources to proactively intervene when signs of agitation, anxiety, and aggression are evident to prevent disruption and violence.

We are adding a very visible proactive partnership approach to WPV management by encouraging all staff to:

- ask questions to understand escalating behavior
- provide resources to help people cope, and
- set behavior expectations before they spiral into chaos or harm.

Recognizing the Risks of WPV:

Workplace violence can include threats, attempts or acts of physical violence classified as **Assault and Battery**.

Battery is the intentional touching or application of force to the body of another person in a harmful or offensive manner, particularly without the victim's consent.

Assault is the attempt to commit battery (even when no actual contact occurs).

ORGANIZATIONAL TRAINING

If a behavioral situation gets out of control or escalates to a level of violence, the risks could result in disciplinary and/or legal consequences for anyone who initiates the disruption or is involved in it.

Definitions to know:

Workplace Violence - violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.

Aggressive Behavior - behavior which is hostile or destructive against person or property including verbal (such as direct or veiled threats) or physical with intimidating, disruptive, violent or destructive behavior.

Disruptive Behavior – any action that purposefully gets in the way or delays the delivery of care or purposefully ignores hospital rules established to maintain the safety, security, and privacy of other patients, family members, visitors, and staff.

Ban - preclude an individual from receiving Elective Treatment from any Corewell Health facility, including the in-patient and ambulatory sites. In the case of family or visitors, it means to preclude from receiving visiting privileges, losing visiting privileges, or losing privilege to come onto or remain on property.

WPV Includes:

WPV and Disruptive Behaviors Include:

1. The use of intimidating or inappropriate physical or sexual contact and/or gestures
2. Verbal or non-verbal threats and/or obscene of offensive language.
3. The throwing of objects.
4. Physical actions that prevent medical orders and treatment from being carried out.
5. Photographing or audio/video recording other patients and staff without their consent.
6. Invading the personal space of restricted patient or staff areas.
7. Interference that prevents staff from providing care for other patients. Consult your manager for assessment and guidance for the situation.

Signs of Possible Risks: A person may display unsettling behaviors minutes, sometimes days, before becoming disruptive. Be aware of the following warning sings as they could escalate to an incident of WPV

- Changes in mood, demeanor, social engagement with others
- Making threatening comments or yelling
- Staring with intensity
- Pacing back and forth
- Being unresponsive or ignoring other people
- Engaging in uninvited touch
- Intentionally throwing or dropping objects
- Changes in certain habits such as attendance or tardiness

When and Where is Risk most likely to occur?

According to the Occupation, Safety and Health Administration (OSHA), these are times when risk is most likely to occur by patients in hospital settings:

- During patient admission,
- While bathing
- Mealtime
- During shift changes
- While being scanned for weapons
- While being transferred to another floor
- After receiving a difficult diagnosis
- After visitors leave

Most likely to have an incident in EC, Psychiatric Unit, Treatment Rooms, Waiting Rooms

Risk from a patient or family member

ORGANIZATIONAL TRAINING

Hospital environments, medical diagnoses and healthcare procedures can be unsettling, even terrifying, to some patients and their family members. For example, a patient may experience a sense of hopelessness or dissatisfaction, become enraged, and then engage in violent behavior. A family member may become disruptive due to fears of loss of a loved one. It is also important to note that patients with a psychiatric, violent or criminal history may pose a threat.

Managing Patient, Family or Visitor Risk

When the threat is direct and danger is imminent, notify security as soon as possible. Also notify department leadership team and attending physician.

Agitation, Aggression, Violence for proactive management.

Tools and Interventions:

- **HEART, PEARLS** and **CPI/de-escalation** interventions
- **Partners in Care** and **Safety Respect Agreement**
- **Behavior Response Team** and **Incident Response Checklist**
- **Action Planning** may include:
  - Discharge/transfer (patient)
  - Restricting visiting privileges (family)
  - Law enforcement/legal action (patient/family)

Exemptions - Acute psychiatric, cognitive, or physiologic condition requiring medical treatment.

Agitation, Aggression, & Violence Response

1. Be curious by asking those patients/family members who are displaying agitation and stress what is concerning them and offer coping resources and support.
2. Proactively share the behavior expectation tool - Partners in Care - with those experiencing changing emotions who are not responding to coping resources and support consultations. Provide verbal reminder(s) of expectations pointing out the troublesome behavior that occurred.
3. Activate the Safety and Respect Agreement if behavior expectations are violated and you suspect that the person cannot get emotions and/or behavior under control.

Partners in Care

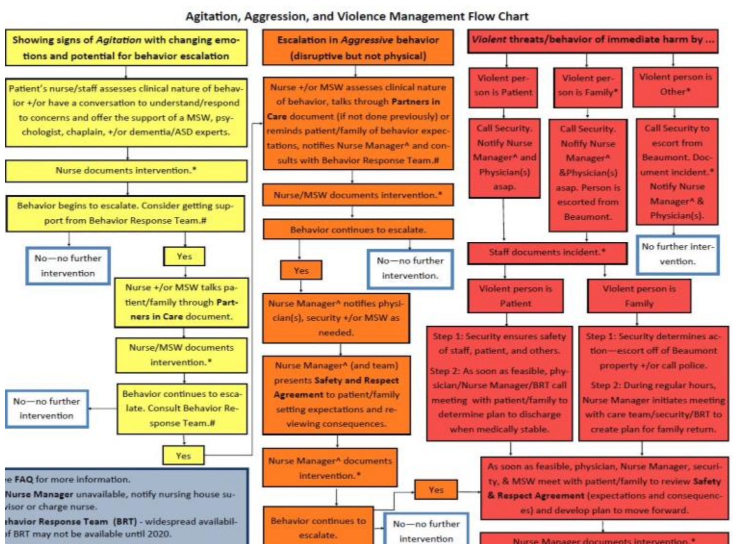
Ideally - provided to every patient upon admission. It models a two-way relationship ("partnership") that impresses upon the patient/family that they are important members of the healthcare team and expectations flow in both directions. It also encourages them to speak up – including when they are frustrated and BEFORE frustration escalates.

Safety and Respect Agreement

When efforts to de-escalate are not successful the Nurse Manager/Administrative Supervisor or designee will present and review the content of the agreement with patient/family outlining expectations and consequences. *Direct care nurse should never present the Agreement.* Once signed, a copy of the signed agreement should be placed in EHR. A copy may be provided to patient/family as requested. *The agreement does not have to be signed to be valid.*

The nurse manager (or designee) will document a "new flag" in **oneChart** under **"FYI/Hx Precautions.**

Agitation, Aggression and Violence Process Chart



ORGANIZATIONAL TRAINING

Behavior Response Team (BRT)
BRT is a nurse-led rapid response team consisting of a nurse, security and house supervisor who are trained to respond to patients who are demonstrating disruptive or aggressive behavior. They may also provide clinical care in collaboration with the primary nurse and provider. The BRT responds to calls, consults with staff, and gathers relevant clinical information from the primary nurse to:

- Assess the patient and the situation
- Develop an Action Plan
- Provide intervention based on the assessment of the situation
- Debrief with primary staff after the event

NOTE: BRT's are not available at all sites.
Documentation & Notification
Report WPV to manager, administrator, and/or security as soon as possible. Clear documentary evidence in **EHR** demonstrating reasonable steps taken to manage WPV behaviors.

- Banners – containing reason, date, name of ordering physician, review date:
    - **Lavender** banner for **Potential for Violence (PFV)**
    - **Purple** banner for **Active Risk of Violence (ARV)**
- Only a physician can remove a banner.
- RL Solutions Reporting should be used to report any incident of WPV. This ensures an RL Review process with Security and leadership involvement in the RL review.
- Security personnel will maintain a file which preserves all supporting evidence.

All incidents of WPV should be entered into **RL Solutions** for ongoing data tracking and trending. Notifying staff that do not have access to the EHR of PFV/ARV potential with signage posted outside of patients' room.
Management Overview – Minimizing Risk from a Co-worker
When a team member has experienced a work-related conflict and then engages in threats and/or commits combative behavior at the worksite, this is known as "worker to worker" violence. Managers and supervisors may be at highest risk.
Changes in the workplace such as pay, benefits, relocation, working conditions, job reassignment, team structure and work hours can trigger frustrations that could result in violence.
Management Overview – Staff Response and Reporting
Staff should respond to WPV by a colleague in a manner that addresses and decreases the likelihood of escalating the situation.
Staff should report all incidents of WPV through the appropriate chain of command:

- Human Resources
- RL Solution
- Compliance Trust Line
- Ulliance Employee Assistance Program (EAP)

Leadership, Human Resources and Security will handle all WPV related concerns when staff is at the center of the complaint.
For any substantiated WPV incident committed by a team member, corrective action will be taken up to termination of employment or contract, and possible external law enforcement reporting. There is a commitment from ELT & HR ensuring that all sites will have consistent response.
Workplace Violence (WPV) Incident Response Checklist is to be completed by the manager of any team member affected by WPV including those who may have reported anonymously.
Responding to WPV – Emergency Codes
We've developed a set of **Emergency Codes** to alert staff of impending medical or environmental emergencies including incidents of active violence in the workplace.
In cases of imminent danger or terrorism, you may hear this code: **Security Alert: Active Violence/Shooter** to notify you of a dangerous situation. The WPV may be targeted at more than one individual. In other cases, you may hear: **Security STAT: Physical Management –** which may indicate physical contact, but no weapon has been seen. In this case there may be one intended victim.
In either case, follow any instruction given – which may range from taking cover or exiting the building.
Responding to WPV – Run-Hide-Fight
Acts of violence often gain momentum very quickly. Remain alert, observe and assess the situation as quickly and accurately as possible.
In situations involving a high level of violence, security experts often recommend this strategy: ***Run-Hide-Fight***.
RUN:
If you become aware of a violent incident at work, you should first attempt to run to the nearest exit to evacuate the premises.
Try to determine where the danger is occurring. Is it in or moving toward your location? How many shooters are involved? Is any explosive device(s) involved?
If you have your cell phone or other electronic device with you, put it on mute (airplane mode would be best).

ORGANIZATIONAL TRAINING

HIDE:
If you don't feel it is safe to evacuate the building, find a place in the building to hide where you think the shooter is least likely to find you. If possible, lock the door. If not, particularly if the door swings outward, take a belt, strap or necktie and wrap it around the door closer mechanism. If the doors swing inward, use your body weight or heavy objects to secure doors. Another method is to wrap a belt or strap around the door handle.
FIGHT:
NOTE: Due to the potential danger that may result, the act of fighting should be considered as a last resort.
Whether hiding alone or with others, develop and share a plan of attack.
Find objects that can improvise as weapons – chairs, books, laptops, equipment, office supplies, etc.
Attack the aggressor bodily, both high and low (head, groin and knees).
Attempt to get the aggressor face-down on the floor, pin down his head and limbs - disarm the aggressor; remove any weapon(s).
Attempt to stay as calm and focused as possible. Call 911, then call the Security department. Report your location, nature of the incident, description of aggressor, identify any injury, and answer any other questions if able.

Workplace violence is extremely serious. The after-effects from workplace violence can be long term and deep— affecting family members, the workplace, and the community.

CONTRACTS AND ARRANGEMENTS TRAINING

FOCUS ARRANGEMENTS

Health care laws, like the Stark Law and the Anti-Kickback Statute, set forth specific compliance obligations for certain contracts and arrangements between health systems and physicians, vendors, or other third-party referral sources. These requirements may trigger additional contracting and monitoring steps than encountered when contracting in other settings.
For our CIA purposes, these contracts are defined as **Focus Arrangements**.

How are Focus Arrangements Defined?

Focus Arrangements, as defined by our CIA, are defined as the following:

- Every arrangement or transaction that involves the offer, payment, solicitation or receipt of anything of value between Corewell Health and any party who is in a position to make or receive referrals for health care services or business to or from Corewell Health
- Every contract or arrangement that supports a financial relationship between Corewell Health and any physician, or physician's immediate family member, who makes a referral to Corewell Health for designated health services

REFERRAL SOURCE

A **Referral Source** is a physician, physician's immediate family member, or any other person or entity who makes referrals to or receives referrals from Corewell Health for health care business or services. **Referral Sources include but are not limited to**: Physicians and physician groups, immediate family members of physicians, other hospital systems, Imaging Centers, Clinical Laboratories, and Home Health / Hospice / Long Term Care entities.

What is a Physician and Who are Considered "Immediate Family Members?"

Physicians are defined as: M.D., D.O., Dentist, Podiatrist, Optometrist, Chiropractor

Immediate Family Members include Husband or Wife, birth or adoptive parent, stepchild, stepbrother, or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild

What are Designated Health Services (DHS)?

Designated Health Services (DHS) are any of the following services:
Clinical Laboratory, Physical Therapy, Outpatient Speech-Language Pathology, Occupational Therapy, Radiology (MRI, CT, Ultrasounds, Nuclear Medicine Services), Radiation Therapy, Durable Medical Equipment (DME), Parenteral and Enteral Nutrients and Supplies, Home Health, Outpatient Prescription Drugs, Inpatient and Outpatient Hospital services

LAWS AND REGULATIONS

There are several health care specific laws that are applicable to contracts. In this section we focus on the following:

- False Claims Act (FCA)
- Stark (Physician Self-Referral) Law
- Anti-Kickback Statute (AKS)

Overview of Laws & Regulations

Statute	Health care specific?	Directly regulates operations?	Establishes penalties for violating other laws?	Creates whistle-blower risk?	Criminal penalties?
Stark Law (Physician Self-Referral Law)	X	X		X	
Anti-Kickback Statute	X	X		X	X
False Claims Act			X	X	X*

The False Claims Act (FCA):

- prohibits the knowing submission of a false or fraudulent claim or the use of a false record or statement for payment by a government program or retaining an overpayment
- defines a <u>claim</u> as a "demand for money or property" made to the federal government or to a contractor or other recipient on behalf of the government

- is implicated when a claim to the federal government is a result of a physician's self-referral in violation of the Stark Law or as a result of a prohibited kickback in violation of the Anti-Kickback Statute.
  Examples of False Claims include the:
  - Billing for services not rendered
  - Billing for services is already covered under another claim
  - Billing for miscoded services
  - Billing when services are not supported by the patients' medical record
  - Referrals for services, that while medically necessary for the patient, are tainted by an improper relationship between a physician and the entity providing the service, in other words, those services that result from violations of the **Stark Law** or **the Anti-Kickback Statute**

STARK LAW

The Stark Law "prohibits a ***physician*** from making a ***referral*** to an **entity** for the furnishing of ***designated health services (DHS)*** payable by Medicare if the physician or an ***immediate family member*** of the physician has a financial relationship with the entity unless an exception applies.

The law also prohibits an entity from billing or receiving any payment from Medicare or from any individual or entity for DHS furnished pursuant to the prohibited referral.

Areas identified as being at high-risk for non-compliance with the Stark Law include:

- Physician Compensation
- Physician Real Estate Leases
- Medical Directorships
- Physician Marketing
- Joint Ventures
- Education / Research Grants
- Physician Loans

Stark Law Exceptions

There are multiple **exceptions** to the Stark Law that permit physicians to make referrals to health care organizations for federally covered designated health services even if a financial relationship exists.

Common **Exceptions** Include:

- Employment contract with physician or family member
- Independent contract services agreement with physician or family member
- Lease of space or equipment
- Incidental medical staff benefits
- Non-monetary compensation (limited)
- Recruitment of physician

Stark Law Considerations

Any claims billed to Medicare or Medicaid in violation of the Stark law (physician referral prohibition) must be repaid regardless of intent or the amount paid to the referring physician. Failure to repay these claims can give rise to a violation of the **False Claims Act.**

Fair Market Value (FMV) and Commercially Reasonable (CR)

Fair Market Value (FMV) is defined as the value in ***arm's-length transactions*** that is consistent with general market value. And general market value is the compensation determined as the result of bona fide bargaining between well-informed parties to an agreement who are not otherwise in a position to generate business for the other party. We utilize industry data and/or outside third-party services to help determine Fair Market Value for focus arrangements.

To be **Commercially Reasonable (CR)**, a payment must be a common business practice in the industry, the service provided must meet the duties required, and the transaction must further a legitimate business purpose. Violations of the Stark Law may result in:

- Denial of Medicare claims for improperly referred services
- Repayment of Overpayments in connection with associated Medicare claims
- Civil Monetary Penalties
- False Claims Act liability
- Exclusion from Medicare and Medicaid programs
- Anti-Kickback Statute

CONTRACTS AND ARRANGEMENTS TRAINING

ANTI-KICKBACK STATUTE (AKS)

The **Anti-Kickback Statute (AKS)** is a Federal law that prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business (including Medicare and Medicaid).

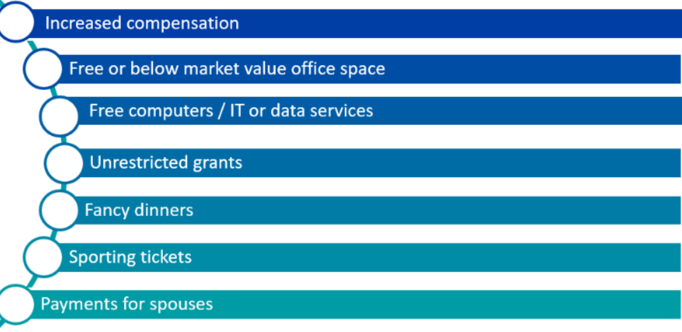
The intent of the parties to the arrangement matters because if even one purpose of the transaction was intended to induce referrals, then the AKS can be triggered. Violations of the AKS have criminal implications.

Anti-Kickback Examples

Pharmaceutical companies providing lavish meals or travel to doctors in exchange for doctors prescribing their drugs. Behavioral Health companies providing a referral fee to care management staff who direct patients to them for care. A Health System offering physicians excessive compensation to encourage the physician to refer patients to their facilities. A Pharmacy providing gift cards and other promotions to Medicare and Medicaid patients in exchange for the patients transferring their prescriptions to the pharmacy.

AKS Risk Areas

Financial arrangements or non-cash inducements such as:



AKS Exceptions

Exceptions to AKS are known as **Safe Harbors.** Safe Harbor provisions outline additional elements of certain types of arrangements that, when met, offer support for the appropriateness of an arrangement. Arrangements that satisfy all the elements of Safe Harbors are generally not prosecuted.

Transactions not satisfying all the elements are not necessarily illegal, but they do require further analysis.

Common Safe Harbors: include the following:

- Discounts
- Employment Relationships (employer / team members)
- Personal Services / Management Contracts
- Co-pay / Pharmacy Waivers
- Space / Equipment Rentals
- Group Purchasing Organizations
- Practitioner Recruitment

Stark Law and AKS Differences

While there are many similarities between Stark Law and AKS, key differences include the following:

- Stark Law applies to Medicare and Medicaid only, whereas the AKS applies to **all federal healthcare programs**, including TRICARE (military service member coverage).
- Stark Law applies to referrals involving **physicians and designated health services (DHS)** only, whereas the AKS applies to **anyone** and **any** items or services that are paid in part or full by any Federal health care program.
- Unlike AKS, Stark Law is a strict liability statute meaning intent is not considered. Even arrangements that are entered into with good intent, such as protecting patients' ability to receive care, could be problematic if the requirements are not followed.

What is a Whistleblower?

Whistleblowers have played a critical role in exposing violations of the Anti-Kickback Statue and Stark laws, maintaining the integrity of the system, protecting patients, and saving taxpayer money.

Whistleblowers are people who come forward to disclose evidence they have of possible wrongdoing. Whistleblowers play a critical role in letting an organization, the government and the public know:

- that a law has potentially been broken
- that a rule or regulation has potentially been violated
- that a government contractor has possibly cheated misused government funds
- that a company is possibly misrepresenting its financial situation
- that a company has failed to address situations that could create a danger to public health and safety

Whistleblower Protection Against Retaliation

Reporting of possible compliance related concerns or the filing of Qui tam cases by a whistleblower on behalf of the government offer the whistleblower a chance to raise concerns without fear of retaliation and, for Qui tam cases, provide the whistleblower with an opportunity to share in funds recovered as a result of a government investigation or lawsuit.

Federal and state whistleblower laws have anti-retaliation provisions intended to encourage individuals to report possible compliance related concerns without fear of retaliation.

The False Claims Act also prohibits retaliation against anyone filing a whistleblower lawsuit.

Focus Arrangement Risk Area - Physician Employment Agreements (P.E.As.) In 2019 the American Medical Association reported that more physicians are employed by health systems and practices than are in private practice. The AMA cited data from the Physician Practice Benchmark Surveys.

While each physician must evaluate their own circumstances, reports indicate that decreasing reimbursement, increasing costs, regulatory burden, healthcare reform uncertainty and practitioner lifestyle preferences are a few of the reasons for the rise in physician employment arrangements.

These arrangements continue to be an enforcement focus area by regulatory agencies and whistleblowers.

Stark and AKS Considerations for PEAs

Prior to negotiating an employment arrangement with a physician, both parties should familiarize themselves with specific concepts under AKS and Stark.

The Bona Fide Employment Exception under the Stark Law requires that the physician employment is for identifiable services and that remuneration is consistent with fair market value and not determined in a manner that considers the volume of referrals.

In addition, both parties must consider the bona fide employment safe harbor under AKS. This provides that remuneration "does not include any amount paid by an Employer to a team member who has a bona fide employment relationship with the Employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare or a state healthcare program."

NON-COMPLETE / NON-SOLICIT

Non-competition and non-solicitation provisions are common elements in most P.E.As. Noncompetition agreements, also known as covenants, not to compete, typically restrict a team member from providing the same or similar services within a certain geographic area upon the team member's departure from the hospital or hospital-owned practice.

FAIR MARKET VALUE (FMV)

Fair Market Value is an important step in negotiation of a PEA. Fair Market value must encompass the physician's total compensation. Organizations who contract with physicians must have policies and procedures in place outlining the standards or methodology to be used in determining FMV.

The Physician Compensation Team has set policies and procedures for contracting, including determination of Fair Market Value.

TRACKING FOR COMPLIANCE

One key to demonstrating compliance with the Stark Law and Anti-Kickback Statute is having proper documentation reflective of actual services performed and time worked (tracking remuneration).

Corewell Health requires physicians to submit time sheets and/or other appropriate document as a condition of payment.

We use the MediTract timekeeping module called TERMs to track time and services provided. We will discuss this further in the last section of this training.

Risk Area for PEAs Compensation

Compensation is a key component of physician contracts and arrangements and is subject to increasing government scrutiny. Each arrangement must clearly address what the entity is paying for, how it is paying it, the method by which payment is calculated, and how the physician accounts for his or her work.

Compensation may reflect a base salary as well as other variables based on ancillary duties, which may include on-call coverage, attendance at meetings, peer review activities, administrative tasks, and other services. Regardless of the model of pay, the most critical elements of any compensation plan are ensuring consistency with FMV. In addition, it must be **clear** that there is no consideration of volume, value, or potential referrals for the hospital.

When negotiating compensation, factors to consider may be the bona fide need for a specialty, the geographic area, relocation expenses, and incentive payments.

Physician Rental and Lease Agreements

Rental and lease agreements are also subject to Anti-Kickback and Stark risks. In 2000, the Office of Inspector General issued a Fraud Alert addressing space rentals. Lease and rental agreements continue to be a **significant** risk area.

CONTRACTS AND ARRANGEMENTS TRAINING

The Anti-Kickback law includes a Safe Harbor for rental agreements.
For an agreement to fit this exception, the agreement must:

- Be in writing and fully executed by both parties
- Specify the premises covered
- Specify the schedule if access to the premises will be interval
- Be set for fair market value rental rates
- Not take into account the volume or value of referrals
- Not exceed what is reasonable to accomplish the business purpose of the rental

Rental and lease agreements may include more than just rent of space or equipment. The arrangement may involve additional terms such as the use of "shared staff" or "shared space".

Consider also that sometimes a hospital is the lessee and the physician in the lessor. While the situation is flipped, the same regulations apply. As with any arrangement between Corewell Health and a referral source, a thorough review by the Office of General Counsel and Corporate Compliance is required.

JOINT VENTURE

A joint venture is an association of two or more individuals or companies engaged in a singular business enterprise for profit without actual partnership or incorporation.

Given the highly regulated healthcare environment and complicated tax implications, joint ventures can be extremely risky.

Physicians and hospitals interested in enhancing services through new technologies, improved access or other improvements may seek out a joint venture. Often consisting of a non-profit tax-exempt entity and a for-profit entity, the parties join forces in the provision of working capital or some other asset(s) to share in potential profits or losses.

An example of a joint venture is a surgical group owning an ambulatory surgical center (ASC) working with a hospital to expand services to the community.

Importance of Policies and Procedures

Policies and procedures are integral in day-to-day operations and serve an important purpose, they are essential tools in building our compliance program. They document our commitment to help detect, prevent and correct potential compliance issues.

Policies and procedures also help verify how we will comply with laws, contractual obligations, and accreditation regulations and standards. They can also help establish common **clinical standards** for how we care for patients.

Policies and procedures are guides on how to perform operations compliantly, but to be effective they must reflect the **actual process and practices being performed**.

Policies are easily assessable through the online policy management tool: Intranet/Documents/Policies - **PolicyStat** (Policy Management system)

POLICIES AND PROCEDURES FOR CONTRACTING

Listed below are policies that can be found in PolicyStat that you should review and be aware of your responsibilities:

- Signature Authority
- Signature Authority for Focus Arrangement and Referral Source Agreement Contracting
- Compliance with WBH Corporate Integrity Agreement (CIA)
- Business Ethics and Compliance Policy
- Focus Arrangements / Referral Source Agreements
- Fair Market Value – Real Estate Arrangements with Referral Sources
- Compliance with Federal and State Privacy Laws and Regulations (Privacy Laws)
- Stark and Antikickback Awareness

CONTRACTS AND ARRANGEMENTS TRAINING

MEDITRACT CONTRACT LIBRARY

MediTract is our contract processing and central repository system. MediTract's Contract Library is a centralized tracking system for all contract types and allows us to effectively manage provider and vendor contracts while mitigating compliance risks. The library also stores contract amendments, Business Associate Agreements (BAAs) and Certificate of Insurance (COI) forms in one, centralized database and allows for contract lists to be created by department.

The Contract Library is broken down into three sections (called organizations in the tool): Physician, Contracting, and Supply Chain.

- Physician contains all physician employment agreements including FTE, contingent, recruitment, and ICAs.
- Contracting and Supply Chain contain all other agreements.

Contract Library Roles

In order to access Contract Library, users are set up based on their role and department. There are different levels of access a user may be granted based on business need:

- **Scan/Add Documents:** upload new/replacement contracts, COIs, BAAs, and attachments
- **Reviewer:** read-only access to contract files
- **Author:** add attachments and notes to the contract file, add critical dates to the contract record, add and edit vendor profiles
- **Editor:** create, edit, and archive contract files

Process Manager

Process Manager is a healthcare-specific, end-to-end contract life cycle management solution. Process Manager uses workflow steps, accountable process owners, and reminders to automate contract creation. Process Manager also uses an automated mechanism to facilitate proper approvals and easy auditing to ensure compliance.

Per policy, ALL CONTRACTS are to be initiated via a contract request submitted through Process Manager.

Processing the contract through Process Manager automates the contract creation process for standardization of data and to facilitate proper approvals before execution of the contract.

Process Manager Roles

Similar to Contract Library, Process Manager is role driven based on the individual's role and department.

- **Moderator:** has read-only access to all phases in the workflow in which they are assigned
- **Initiator (requestor):** take action on new workflows, including new contracts and amendments to existing contracts, and complete form fields
- **Reviewer:** reviews and approves electronic document, redlines documents, sign documents
- **Phase Owner:** moves the contract workflow onto the next review steps, has the ability to approve, reject, and retract the phase

TERMS & Accumulator Overview

TERMs	Accumulator
TERMs – (Time Effort Reporting Management System) that tracks physician timekeeping by CARTs allocation and contract type. TERMs is currently implemented for all FTE physicians and contingent physicians at legacy William Beaumont Hospital.	**Accumulator** tracks Non-Monetary Benefits paid to physicians to ensure daily and annual dollar value caps imposed by the government are monitored.

KEY DOUMENTS AND POLICIES

COMPLIANCE

Code of Excellence
Conflict of Interest Program
Corporate Compliance Program
Compliance with WBH Corporate Integrity Agreement Requirements
Business Ethics and Compliance Policy
Sanction Screening
Electronic Communication Standard Policy
Electronic Messaging Policy
Confidentiality and Usage Agreement
Information Security Policy
Document Retention Policy and Procedures
Reporting Compliance Issues to the Compliance Office
Friends and Family Access to Electronic Medical Records
Compliance with Federal and State Privacy Laws and Regulations Policy
Fraud, Waste and Abuse Prevention Program
Stark Law and Anti-Kickback Statute Awareness
Non-Retaliation and Whistleblower Protection Policy
Trust Line Policy
Management Certification of Compliance Risk Assessment
Identity Theft and Prevention Policy
Mobile Device Security Standard
PC and Laptop Security Standard

REGULATORY

Clinical Language Services
Clinical Language Services for the Deaf, Blind, and Hard of Hearing Patients and their Companions
Clinical Language Services: Healthcare Documents Translation Services
Clinical Language Services: Language Access Services for Limited English Proficiency (LEP) Patients
Infection Prevention Guidance in the Setting of ongoing COVID-19 Community Transmission Authority Statement: Infection Prevention and Control
Bloodborne Pathogens Exposure Control Plan

ORGANIZATIONAL

Nondiscrimination in Health Program and Activities Harassment Policy
Workplace Violence
Disruptive Behavior Policy
Hazzard Communication
Active Shooter/ Person with a Weapon/ Hostage Policy
Progressive Discipline Policy