CoxHealth Compliance Training for Physicians and Mid-Level Providers

2012
Objective of This Education

- Provide you with an overview of:
  - What Every Physician Needs to Know about Compliance
  - Role of the Corporate Integrity Department (CID)
  - Structure of CID established to ensure compliance
  - CoxHealth’s Corporate Integrity Agreement (CIA) with the government
  - Key policies that make up the compliance program that you should be aware of
For those of you not intimately involved, RAC stands for Recovery Auditor Contractor.

Medicare (and now Medicaid) have contracted with independent companies to review Medicare (and Medicaid) claims to ensure proper payment based on the documentation/service.

There are 4 Medicare RACS assigned to specific regions. We are in Region D and our contractor is HealthDataInsights (HDI).
The Medicare RAC is restricted to a 3-year look-back period.
- Medicaid has indicated a 5-year look back (Missouri)

Medicaid RAC program initiated in Missouri January 2012.

The RAC contractor is Cognosante, LLC, McLean, Virginia
- First focus we see is on repayment of credit balances
- A credit balance is any patient account that has been overpaid (has a credit balance) and monies are due back to Medicaid.
The RACs

As of the writing of this presentation (March 2012), CoxHealth and its integrated physicians have received requests on 2,398 patient accounts

- Majority are Medical Necessity Reviews with records being sent.
- Trends in status of patient/inpatient vs. outpatient
- Short stay inpatient hospitalizations (1 – 3 days stays)
- Cardiac procedures
The RACs

- The dollars –
  - To date, $10,065,240 in payments have been questioned
  - $3,224,577 are still pending in appeals processes
  - $6,717,679 has been resolved/final determination made
    - $5,381,855 retained by Cox
    - $24,893 in additional payments
    - $1,333,823 lost in take-backs
Receipt of Denial/Demand Letter from RAC
- If no response received, recoupment is initiated on day 41 (from date of letter)

Rebuttal – provider may submit a written rebuttal to the MAC/RAC (MAC is Medicare Administrative Contract or Carrier) within 15 days of receipt of denial.

Appeal – If the contractor does not overturn based on information in rebuttal letter, you may file a formal appeal.
There are 5 steps to the formal appeals process:

1. **Redetermination** – written documentation to the MAC (carrier)
   - Must be filed within 120 calendar days from the date of denial/demand letter

2. **Reconsideration** (2nd level appeal), written documentation to the Qualified Independent Contractor (QIC)
   - Must be filed within 180 calendar days of the denial from the Redetermination
Medicare/RAC Appeals Process

There are 5 steps to the formal appeals process

◦ Appeal to the Administrative Law Judge (Level 3)
  • Hearing usually held by Video–Teleconference or telephone
  • Must be filed within 60 days of Reconsideration determination

◦ Appeals Council Review (Level 4)
  • Must be filed within 60 days of ALJ determination

◦ Judicial Review in U.S. District Court (Level 5)
  • Must be at least $1,300 in controversy
  • Must be filed within 60 days of Appeals Council determination.
The Best Defense is Always a Good Offense
Always “paint a picture” with your words about the condition of the patient.

- This will help other providers who may be assisting with care to ensure appropriate care
- The clearer the documentation, the better chance we have of being paid appropriately for services (and being able to retain those payments)
- Be careful with the copy and paste functions of EHR. The government is auditing for the same comments visit after visit in physician documentation.
We (Audit and Compliance) have seen instances where the physician documented “no weight changes” in a visit, yet the nurse/medical assistant has documented the actual weight and the change from visit to visit was 15 pounds in 3 months.

Seems like a weight change to me.

Minor errors of this nature call into question the credibility of the entire record.
CMS announced that the RAC Pre-Payment Review demonstration will start around June 1, 2012.

This initiative is designed to reduce improper payments (before they are made).

CMS announced that Medicare fee-for-service won the top spot last year for improper payments, coming in at an estimated $28.8 billion –

- Causes for those payments being considered improper were a determination that services were medically unnecessary and/or there was insufficient documentation to substantiate the service.
Medicaid ranked second for the most improper payments with an 11% error rate and $12.4 billion in improper payments – the issue here is payments for ineligible individuals.

We can expect more and more review from CMS to eliminate improper payments; and it will be focused on the physician documentation.
The following comments have been found in Medical Record documentation, and it is NOT helpful to ensuring appropriate care for the patient or appropriate payment for services. **DO NOT DOCUMENT IN THE RECORD**

- Personal opinions
- Thoughts and Feelings
- Disputes/Complaints
- Criticisms of patient, family members or other clinical staff
- Discussions with Legal/Risk Management
For example,

- The below are taken directly from a patient’s medical record.
  - **Too much information**: “one time patient fell asleep in cat litter after taking 10 Zanaflex tablets”.
  - **Not helpful**: “this is going to be a very unpleasant woman to take care of. I can already tell.”

- Patients often request copies of their medical records and receive them. These statements are hurtful and paint a bad picture to the jury if there is ever a malpractice claim for some reason/valid or invalid.
For example,

- The below are taken directly from a patient’s medical record.
  - **Harmful**: “I do not really see any reason to admit her but the emergency room states they do not want to send her home. . . . I will most likely have to let her stay until she is willing to leave”. “When she is ready to go, will try to kill her with kindness”.
  - **Harmful**: “essentially she wants to be admitted because her mother cannot take care of her, her mother is stressed out and she is just “freaking out”.
  - Compliance just needs to hold the claim in both of these cases.
Good documentation helps ensure quality patient care
EVERYONE knows that you must protect your patient’s health information, but do you know what to do if you feel your patient is impaired and may cause harm to others while operating a motor vehicle?

For example, patient presents to the hospital or your clinic and you have advised him/or her not to drive as you do not feel they are safe. You are aware the patient is not taking your advice and – by the way, they drive a semi-truck for a living.
The physician may notify the Missouri Department of Revenue if a patient is “diagnosed or assessed as having a disorder or condition that may prevent such person from safely operating a motor vehicle”.
  ◦ Use Form 1528 – available at Corporate Integrity Intraweb Site – Forms and Contracts tab.
  ◦ Or go to: www.dor.mo.gov
  ◦ Fitness to operate a motor vehicle safety and responsibly.
  ◦ The form asks for a patient signature, but you may send it in if the patient refuses to sign.
    • As long as you are “operating in good faith” and for the protection of others, you are immune from civil liability.
This is what the form looks like.
Quality, eRx and EHR Incentive Programs
As you know the government, Medicare specifically, is transitioning the manner in which they pay providers.

- Moving from the old method of paying solely based off of the services rendered to a portion of the pay being based off of defined quality measures.

Examples of this type of payment are:

- Present on Admissions issues
- Hospital Quality Reporting
- Physician Quality Reporting
- ePrescribing Incentive (or penalty)
- EHR Incentive Program, “Meaningful Use”
All Physicians will be required to participate in the ePrescribing program in 2013.

- A hardship exemption can be filed to CMS for consideration for low prescribing activity or limitations due to regulatory requirements, i.e. controlled substances. This exemption would apply to physicians who have a small number of E & M charges billed to Medicare compared to the rest of their charges billed to Medicare (some specialists).
- This payment is based on whether or not you meet the criteria. If you meet the criteria you will get a payment equal to 1% of your total reimbursement for Medicare Part B Claims. If you do not meet the criteria, your reimbursement will be reduced.
## ePrescribing Payment Adjustment

<table>
<thead>
<tr>
<th>Criteria/threshold</th>
<th>2013 Penalty</th>
<th>2014 Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 valid Medicare claims where you used ePrescribing during the visit.</td>
<td>25 valid Medicare claims where you used ePrescribing during the visit.</td>
<td></td>
</tr>
<tr>
<td>If the criteria above not met, there is a Financial penalty</td>
<td>–1.5% of all Medicare Part B reimbursement</td>
<td>– 2.0% of all Medicare Part B reimbursement</td>
</tr>
<tr>
<td>Payment (or penalty) will be based on the following Reporting period</td>
<td>Jan 1 – Jun 30, 2012</td>
<td>Jan 1 – Dec 31, 2012</td>
</tr>
<tr>
<td>Reporting method</td>
<td>Claims – valid inclusion of G–code</td>
<td>Claims – valid inclusion of G–code or PQRS</td>
</tr>
</tbody>
</table>
ePrescribing Incentive Program

- A physician is Not eligible for the ePrescribing incentive payment if he/she is receiving payment under Medicare EHR Incentive Program
## Physician Quality Reporting Service (PQRS)

<table>
<thead>
<tr>
<th>Reporting Mechanisms</th>
<th>Reporting Period</th>
<th>Criteria for Satisfactory Reporting of Individual Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims-based (G-codes)</td>
<td>Jan – Dec</td>
<td>Report at least 3 Physician Quality Reporting System measures*; and</td>
</tr>
<tr>
<td>Registry (MQIC)</td>
<td></td>
<td>Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period</td>
</tr>
</tbody>
</table>

**Incentive** = 1% of Medicare Part B Payments
EHR Incentive Program

- Created by the HITECH Act as part of the American Recovery and Reinvestment Act of 2009
- Authorizes the Centers for Medicare & Medicaid Services (CMS) to provide reimbursement incentives for eligible professionals and hospitals who are successful in becoming “meaningful users” of certified electronic health record (EHR) technology.
Goals of EHR Meaningful Use

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections

from: HealthIT.gov
“Advancing America’s Health Care”
Stages of Meaningful Use

Stage 1: 2011 – 2012 – 2013
Data capture and sharing

Stage 2: 2013 – 2014
Advance clinical processes

Stage 3: 2015
Improved outcomes

from HealthIT.gov: "Advancing America's Health Care"
EHR Incentive Programs

Medicare program
  - Hospital
  - Eligible Providers

Medicaid
  - Hospitals
  - Eligible Providers
Meaningful Use Stage 1

Hospital report 19 of 24 measures
- 14 Functional Core measures
- 5 of 10 Menu set measures

Eligible providers report 20 of 25 measures
- 15 Functional Core measures
- 5 of 10 Menu set measures
# Meaningful Use Functional Core Measures

<table>
<thead>
<tr>
<th>Functional Core Measures</th>
<th>Hospital</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use CPOE</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Implement drug–drug and drug–allergy interaction checks</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maintain Problem List of active diagnoses</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Generate and transmit permissible prescriptions electronically (eRx)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Maintain active Medication List</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maintain Medication Allergy List</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Record Demographics</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Record and chart changes in Vital Signs</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Record Smoking Status for patients 13 years old and older</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Report clinical quality measures to CMS</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Implement clinical decision support rules</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide patients with an electronic copy of their health information</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide electronic copy of discharge instructions</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provide clinical summary for each office visit</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Electronic exchange of clinical information with other healthcare entities</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Protect electronic health information</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

All are required to qualify for EHR Incentive Program
# Functional Core Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Hospital</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use CPOE</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Implement drug–drug and drug–allergy interaction checks</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Maintain Problem List of active diagnoses</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Generate and transmit permissible prescriptions electronically (eRx)</td>
<td>---</td>
<td>40%</td>
</tr>
<tr>
<td>Maintain active Medication List</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Maintain Medication Allergy List</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Record Demographics</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Record and chart changes in Vital Signs</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Record Smoking Status for patients 13 years old and older</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Report clinical quality measures to CMS</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Implement clinical decision support rules</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Provide patients with an electronic copy of their health information</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Provide electronic copy of discharge instructions</td>
<td>50%</td>
<td>---</td>
</tr>
<tr>
<td>Provide clinical summary for each office visit</td>
<td>---</td>
<td>50%</td>
</tr>
<tr>
<td>Electronic exchange of key clinical information with other healthcare entities</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Menu Set Measures: Select 5

for Stage 1 report on 5 of 10 measures

<table>
<thead>
<tr>
<th>Functional Menu Measures: Select 5</th>
<th>Hospital</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implement drug formulary checks</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>2. Record Advance Directives patients 65 and older</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>3. Incorporate clinical lab–test results</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>4. Generate lists of patients by specific conditions</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>5. Send reminders for preventive/follow–up care</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>6. Patient–specific education resources</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>7. Patient electronic access to health information</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>8. Medication reconciliation</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>9. Summary of care record for transitions of care</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>10. Submit electronic data to immunization registries</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>11. Submit electronic data on state reportable lab results</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>12. Submit surveillance data to public health agencies</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

Measures implemented for reporting are bolded
Physician and Provider Meaningful Use

- Manage Problem List
- Manage Medications
  - Maintain Medication List
  - Use E-Prescribing when allowed by regulation and patient preference
  - Evaluate Drug–drug and drug–allergy interaction alerts
- Use CPOE
- Provide Clinical Summary for office visits
Future Meaningful Use Criteria

- Menu Set measures deferred in Stage 1 required in Stage 2
- Performance thresholds increase for Stage 1 measures
- Measurement period: 90 days becomes 1 year
- Additional measures added in Stages 2 and 3
- Stage 2 to be implemented in 2014
Questions about Meaningful Use, Quality Reporting Incentives, ePrescribing can be directed to the Corporate Integrity Department.

- 269–7655

We do not know all the answers, but we know all the right people who do.
Be aware of what you are signing
We have seen a few invalid orders faxed to physician’s offices for signature for DME products for their patients.

One inquiry from the Department of Justice on diabetic shoes for a patient with both feet amputated. Erroneously signed by physician (not purposefully ordered for the patient)

You, nor your compliance officer, want to have to respond to the DOJ and explain why you ordered diabetic shoes for a double amputee.

- The form was just faxed to the Doctor’s office, looking like it was from a reputable firm.
Orders for DME

- An order for diabetic supplies for a patient living in our area, supplier out of Florida, was received at one of our clinics.
  - The patient’s purse was stolen while she was vacationing in Florida.

- Contact the Compliance Department with these concerns so we can create a file.
  - On the first incident, we were able to show the DOJ that I had called the Fraud hotline on that same company a week or so prior to the bogus order
  - That documentation substantiated my claim that the companies are just faxing orders, hoping a few will get signed by mistake – this one did.
A recent news article reported that two undercover federal agents were part of an investigation that led to the conviction of a Chicago doctor on five health care fraud charges and four counts of making false statements involving a health care benefits program.

Picked up on by government because the physicians ordered a high number of specific tests compared to his peers.

- Echos, EKGs, nerve conduction studies, cartoid doppler and abdominal ultrasounds.
New Method of Detecting Fraud

- The Federal Agents posed as patients
- The physician faces up to 10 years in prison for each count of health care fraud and five years in prison for each count of making false statements, plus up to $250,000 in fines on each count.
Proposed regulations regarding refunding overpayments.

Government currently proposing a 10 year look back – RAC and Cox operating on a 3-year look back.

A provider has 60 days from the date of “identification” of an overpayment

- Clarification language is still not real helpful on defining “identification” of an overpayment; it is further defined as “reasonable inquiry”. Cox policy is the 60 days start ticking once the audit is completed and we know which accounts require a refund.
ICD–10 Update

- Currently implementation has been postponed; however, we are still seeing an October 1, 2013 implementation date on the CMS website.
- The only information published states that HHS Secretary Kathleen Sebelius announced that HHS will initiate a process to postpone the date...
Now that we have shared some things you need to know based on issues we have identified in the past year which affect compliance.

Let’s do a refresher on the Cox Compliance Program, Code of Conduct and Corporate Integrity Agreement.
The Center of the Corporate Compliance Program at CoxHealth is the Code of Conduct.
  ◦ This document defines expected behaviors of those who work within CoxHealth facilities

The Structure utilized to help ensure compliance with the Code of Conduct, health care laws, regulations, policies, etc. is defined in the Corporate Compliance Program policy
  ◦ Program is administered by the Corporate Integrity Department

There are various other policies and procedures that delve into specific compliance areas.
Since the Code of Conduct is the Key to Cox’s Program . . . .

Let’s go over some of the guidelines set forth
Code of Conduct

Who is covered by the Code of Conduct?

- Employees
- Volunteers
- Board Members
- Medical Staff
- Students
- Vendors
The Code of Conduct Requires that you . . . .

• Act in a manner that would make your mother proud!
Code of Conduct

• Conduct business and other practices in compliance with all applicable laws and regulations

• Act with Compassion, Respect and Integrity in all business dealings

• Set an example for others by acting with Compassion, Respect and Integrity
Access to care.

- All patients have access to care without regard to race, color, religion, national origin, handicap or disability, financial status, age, sex, or ability to pay.

Appropriate Billing, Charging, Coding for Services:

- All billing, charging, coding shall accurately reflect the services provided. Be careful with “cut and paste” functions in electronic health records. These can create significant issues if the “paste” is not corrected for the current services.
- Do not provide medically unnecessary services which could be viewed as False Claims
- Do not bill for services provided by someone else unless the incident to requirements for Medicare are met.
Financial, medical and other company records shall be accurate.

- Documentation in the patient medical record must be accurate, clearly define the services provided and who provided those services.
- If someone is scribing for you, make sure the record indicates that.
- Do not share your password/sign-on with others so they may document for you.
- Corrections in the records must be made appropriately so that the original document is not deleted, but it is clear it is being replaced or updated. Call Health Information Management if you need assistance correcting a record.
Adherence to the Compliance Program.

- The Code of Conduct requires everyone working within CoxHealth to adhere to the Compliance Program. You will find a link to the policy later in this presentation.
- Open communication is key to the success of our Compliance Program.
Confidentiality:

- We must maintain the confidentiality of all patient records, patient information and other company documents.

- We must report all breaches of patient protected health information (PHI) to the person whose data has been shared inappropriately and to the Department of Health and Human Services, if we determine there is a risk of harm to the individual.

- Call the Privacy Officer with your concerns and questions
  - Robin Gann – (417) 269-6144
Adherence to Conflict of Interest Policy:

- Using your position to get a personal benefit or to refer a service to a relative, receive payment, gift or improper entertainment in exchange for a favorable recommendation to purchase is a violation of the Code of Conduct.

- Be sure to complete the Conflict of Interest form provided to you from the Medical Staff Office; be sure to update your COI form if something changes.
Conflict of Interest

- You should be reporting instances where you are receiving payment for any reason from a vendor that CoxHealth does business with, e.g., you spoke on behalf of a product and were paid for that speaking engagement.
- You should report significant ownership in a competing organization.
- Just because you have a conflict of interest in a specific area does not mean that you cannot participate in decision-making processes at CoxHealth; you will just not be allowed to vote if the decision is about a product that you have a conflict for.
Unbiased Decision Making.

The acceptance or solicitation of any “gift”, bribe, kickback, consulting arrangement, gratuity or other payment made to influence a business decision is unacceptable.
Code of Conduct

Harassment–Discrimination – Prohibited:

- Creating an uncomfortable work environment for others can be considered harassment.
- Do not make inappropriate sexual remarks to others as this could be considered sexual harassment.
- Do not discriminate based on race, color, religion, sex, ethnic origin, age, disability, financial status or source of payment.
Cooperation with Government Officials

- CoxHealth will fully cooperate with regulatory officials
- Departments/employees must notify the Corporate Integrity Department or the Administrative Offices
A Work Environment Free From Retaliation:

- Retaliation is any act designed to cause harm to another when it is taken to “get even” for a perceived slight, or other action
- Retaliation against any person who reports a concern to the Corporate Integrity Department, in good faith, is strictly prohibited.
How do you report a concern of retaliation?

Contact:
- Corporate Integrity Office (417–269–7655)
- Legal Department (417–269–6577)
- HR Hotline (417–269–6696)
- Hotline 269–5297 (COX–LAWS)
- Toll Free Hotline 1–888–340–5297
Respect Patient’s Rights. They have the right to:

- Receive considerate care that protects their dignity and privacy
- Choose to be involved in their care
- Practice their religion and beliefs
- Make the decision to discontinue treatment

*If you need assistance, contract the Corporate Integrity or Legal Departments for an Ethics Case Review or feedback.*
Feel free to contact the Corporate Integrity Department for ethical questions regarding patient care.

- An Ethics Case Review can be set up if you are unsure how to proceed with the care of your patient due to conflicting instructions from family members.
- A Futile Care Committee can meet to assist you and family members with situations where you believe care is futile and family members are insisting you provide care that you feel is counter-productive and may be harmful.
Ethical Research Practices:

- CoxHealth supports human subject research in accordance with all Federal regulations.
- Research is defined as:
  - A systematic investigation designed to develop or contribute to generalizable knowledge.
  - An attempt to make a comparison or draw conclusions from gathered data
  - An attempt to reach for generalizable principles of historical or social development
  - Seeking underlying principles or laws of nature that have predictive value and can be applied to other circumstances for the purpose of controlling outcomes
  - Creating general explanations about things that have happened in the past
  - Something that can help to predict future outcomes

- Research must be approved prior to initiation by the CoxHealth Institutional Review Board (IRB)

Contact the Corporate Integrity Department to learn more about conducting research at CoxHealth
Prohibition of Disruptive Behavior . .

- I am sure many of you can sympathize with this guy

- However, there are much better ways to solve concerns and issues than “taking a hammer to it”.

- Remember your mother . . .
Why is Disruptive Behavior such an issue in health care settings?

Because it puts our patients at risk and there is enough inherent risk in hospitals/health care without adding one that we can control.

It is well known that:

- Staff are hesitant to bring a possible issue to your attention if they are afraid of getting yelled at or made to fill stupid
- It affects overall morale within the work environment – and we all know a happy employee is a better employee
- It causes high staff turnover – and we all know experience correlates with quality of care
Violations of the Code of Conduct Will Result in Disciplinary Action

- Violations must be reported
- Depending on the circumstance – the actions may be reported to the appropriate government agency as required by law.
- For a more thorough review of the Code of Conduct you can access the Standards manual on the CoxHealth intraweb site or contact the Corporate Integrity Department for a copy.
You have completed Module 1

You may close out of this module and go back to the main menu to begin Module 2.