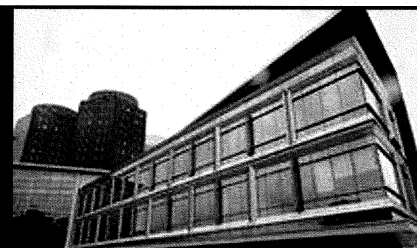




Stony Brook University Hospital Administrative Policies and Procedures



Code: LD0039

Corporate Compliance Code of Conduct

Subject:

**Responsible Department,
Division Or Committee** Compliance

Policy:

University Hospital shall have a Corporate Compliance Code of Conduct that will be strictly adhered to by all University Hospital representatives.

Definitions:

Nominal Value: nominal value is considered such a small amount that acceptance of an item of nominal value could not reasonably be interpreted or construed as attempting a State employee or public official. Items of insignificant value, as, for example, a regular cup of coffee or a soft drink, are considered nominal. Nominal value would not include a meal nor would it include an alcoholic beverage.

Procedures:

CORPORATE COMPLIANCE CODE OF CONDUCT

I. OUR COMMITMENT TO ETHICS & COMPLIANCE

II. STANDARDS OF CONDUCT

- A. Refrain from Misrepresentations
- B. Submit Accurate and Appropriate Billings
 - 1. Hospital Billing Activities
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 - 3. Medical Staff
- C. Ensure Proper Use of the Hospital's Assets

- D. Ensure Facility Certification
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- F. Prevent Unfair Trade Practices
- G. Prevent Referrals and Kickbacks
- H. Adhere to Tax-Exempt Requirements
- I. Prevent Inappropriate Gifts and Entertainment
- J. Engage in Appropriate Fund Raising
- K. Prevent Theft
- L. Commit to Fairness
- M. Avoid Conflicts of Interest
- N. Comply with Labor and Employment Laws
- O. Comply with Immigration Requirements
- P. Provide Emergency Care
- Q. Comply with Environmental Health and Safety
- R. Ensure Proper Control of Medications
- S. Adhere to Research Grant Requirements
- T. Avoid Scientific Misconduct
- U. Ensure Appropriate Political Participation/Government Relations
- V. Ensure Accurate Use of Hospital Information
 - 1. Safeguarding the Privacy of Our Patients
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 - 3. Information Owned by Others
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III. COMPLIANCE WITH THE CODE

- A. Questions Regarding the Code
- B. Reporting of Suspected Violations
- C. Investigation of Suspected Violations
- D. Discipline for Violations
- E. Acknowledgment and Certification of Compliance

requested and the response given **CORPORATE COMPLIANCE PLAN**

REPORTING VIOLATIONS

Stony Brook University Hospital's Compliance Office is located at 3 Technology Drive, Suite 200, East Setauket New York 11733. Our regular business hours are 8:00 a.m. to 4:30 p.m. Monday through Friday (special appointments may be arranged).

The Corporate Compliance Officer is Marshall Lieberman. He can be contacted at 444-5876. You may also call the Compliance Office Hotline at 1-866-623-1480 (which is available 24 hours a day, seven days a week) to report any information either anonymously or by name. If you wish to send a fax, the number is 444-5791. Any correspondence should be marked "CONFIDENTIAL".

I. OUR COMMITMENT TO ETHICS AND COMPLIANCE

Stony Brook University Hospital (the "Hospital") is proud of its long tradition of ethical and responsible conduct. Each employee, agent, and medical staff member, including state, research foundation, and personnel employed through contracted agencies (collectively, "Hospital representatives") of the Hospital is expected to adhere to this high standard of conduct whenever he or she acts on behalf of the Hospital, whether in dealings with other Hospital representatives, patients and their families, vendors, government regulators or the general public. Violations of legal or ethical requirements jeopardize the welfare of the Hospital, Hospital representatives and patients, and the communities it serves.

The Hospital CEO shall have ultimate authority and responsibility for the implementation of a viable Corporate Compliance Program. Specifically, the CEO and/or designee per hospital policy has authority and responsibility for compliance with governmental laws and regulations, including taking all necessary and required actions to assure accurate billings for patient services and to direct repayment and to report misconduct to enforcement authorities when required by law or when self-disclosing.

The Corporate Compliance Program is intended to define the standards of conduct (hereinafter referred to as the "Code of Conduct" or the "Code") expected of Hospital representatives, to provide guidance on how to resolve questions regarding legal and ethical issues, and to establish a mechanism for reporting of possible violations of law or ethical principles within the Hospital. The guidelines contained in the Code are designed to assist Hospital representatives in making the right choices when confronted with difficult situations. The Code imposes requirements that are often more exacting than those mandated by law, reflecting the Hospital's goal of conducting oneself with the highest level of integrity. The willingness of each Hospital representative to raise ethical and legal concerns is essential. Ultimately, the responsibility for ethical behavior rests with each person's exercise of independent judgment.

All Hospital representatives must abide by the letter and spirit of all applicable laws and regulations and must act in accordance with the principle that full disclosure of all facts related to any activity will reflect favorably upon the Hospital. Hospital representatives must adhere to the highest ethical standards of conduct in all business activities and must act in a manner that enhances the Hospital's standing within the community. To this end, the Hospital will promote relationships based on mutual trust and respect and provide an environment in which individuals may question a practice without fear of adverse consequences.

The appointment of and retention of Hospital representatives, along with the granting of medical staff privileges at any Hospital facility is contingent upon acceptance of and compliance with the Code. It is expected that outside colleagues, e.g., vendors, consultants and others whose actions could be

attributed to the Hospital, will adhere to similar standards in their dealings with us and with others on our behalf.

The Compliance Program described in this document is intended to establish a framework for legal compliance by the Hospital, particularly compliance with federal and state laws on fraud and abuse. It is intended to reflect collective good judgment and common sense. It is not intended to replace other compliance practices or rules and regulations as defined in the Stony Brook University Hospital Administrative Policies and Procedures Manual. Whenever a Hospital representative sees a situation that does not appear to comply with the Code, he or she has the responsibility to bring the concern to the attention of his/her supervisor or the Compliance Officer. An employee who has a question regarding the application or interpretation of the Code should use the procedure specified in Section III.

Additionally, the Hospital recognizes its need to conduct its business and patient care practices in an honest, decent and proper manner, especially as they relate to marketing, admission, transfer, discharge and billing. This requirement of ethical behavior is embodied in the Standards of Conduct below, as well as the Hospital's Policies and Procedures.

II. STANDARDS OF CONDUCT

The Hospital's activities involve thousands of transactions each day. The Hospital, therefore, must have strict rules to guard against fraud or dishonesty and guidelines for addressing possible problems that may arise. If you detect or suspect any improper activities on the part of any employee or agent of the Hospital or any person with whom the Hospital deals, you must report this information immediately so that the appropriate investigation is initiated (see Section III). Withholding knowledge of improper activities is a violation of the Code. If evidence of a violation of this Code is established, any involved Hospital representative may be subject to disciplinary action up to and including dismissal, consistent with the applicable collective bargaining agreements. Any such evidence will be reviewed by the Compliance Officer, and where appropriate, the Office of University Counsel. Hospital representatives' activities are to be conducted in a manner to protect the integrity of clinical decision making, regardless of how the Hospital compensates or shares financial risk with its leaders, managers, clinical staff and licensed practitioners. Hospital representatives are expected to:

A. Refrain from Misrepresentations

Honesty based on clear communications is the cornerstone of ethical disclosure of information. Hospital representatives shall be honest and make no misrepresentation or dishonest statements in conducting Hospital business. Hospital representatives must report and record all information accurately and honestly whether on marketing materials, patient records, requests for payment, time sheets, clinical research records, financial reports or otherwise. Marketing materials will accurately reflect accreditation, licensure and services available.

B. Submit Accurate Billings and Financial Report

1. Hospital Billing Activities

Hospital billing activities are to be performed in a manner consistent with Medicare, Medicaid and other third party payers' regulations and requirements. The Hospital will comply with all pertinent Medicare regulations in its billing practices, including but not limited to, the regulations regarding investigative devices, drugs, procedures, proper discharge codes for transfer cases, bad debt reporting, medical necessity, credit balances, outpatient services connected with inpatient days, duplicate billing and appropriate DRG coding. The Hospital also prohibits several practices related to claims such as false statements, mail fraud, wire fraud or conspiracy to commit fraud. It is the continuing goal of all Hospital representatives participating in billing to comply with all established legal and regulatory mandates. This

expected behavior is reflected in the Corporate Compliance Program's Code of Conduct. In addition, a Patient Accounts Departmental Compliance plan has been developed and implemented. It will be reviewed periodically, or as required to meet new regulatory requirements. It will address written policies/procedures, education/training, communication, auditing/monitoring and corrective action. The Patient Accounts Department Director serves as the Billing Compliance Liaison. The following conduct is unacceptable by Hospital representatives when billing patients, third party payers or others, including Medicare and Medicaid:

Knowingly making any false statement of fact for use in determining rights to a benefit or payment;

- Knowingly making any false statement of fact in any application for payment or benefit;
- Knowingly concealing or failing to disclose an event affecting a right to a benefit or payment with the intent to fraudulently secure the benefit or payment in an amount greater than is due or when no such benefit is authorized;
- Knowingly converting a benefit or payment for a use other than for the use of the person in whose name the application for the benefit was made;
- Knowingly requesting a payment in violation of the terms of an assignment or an agreement with the payer;
- Knowingly claiming, charging, accepting, or receiving any payments for tests and/or procedures, unless they are medically necessary, and are billed according to applicable regulations.

2. Laboratory Services

It is the continuing goal of all Hospital representatives participating in billing for laboratory services to comply with all established legal mandates. This expected behavior is reflected in the Corporate Compliance Program's Code of Conduct. A Laboratory Administration Compliance Plan has been developed and implemented. The Laboratory Administration Compliance Plan should provide a dual function: (a) discourage wrongdoing and (b) utilize established policies and procedures for internal auditing and reporting of any wrongdoing that does occur so that any issues or irregularities can be appropriately addressed.

The Laboratory Administration Compliance Plan will be a dynamic document with review annually, or as required to meet new regulatory requirements. It will address written policies/procedures, education/training, communication, auditing/monitoring and corrective action. The Director of Laboratory Administration serves as the Laboratory Compliance Liaison.

3. Medical Staff

All physicians are expected to be familiarized with and abide by applicable laws, rules and regulations pertaining to billing. Medical staff will be responsible for adequate documentation in the medical record to support the level of services for which any bill is supplied. This responsibility includes following the applicable rules on documentation for coding of Evaluation and Management services. A Corporate Compliance Plan pertaining to billing issues has been implemented by the Clinical Practice Management Plan and is applicable to teaching physicians.

C. Ensure Proper Use of the Hospital Assets

All managers must utilize appropriate internal accounting controls over all areas of their responsibility to

ensure the safeguarding of the Hospital's assets and the accuracy of financial records and reports. These established accounting practices and procedures must be followed to ensure the complete and accurate recording of all transactions. The Hospital has adopted controls in accordance with applicable industry standards and federal and state requirements, including the NYS Governmental Accountability, Audit and Internal Control Act. All Hospital representatives, within their areas of responsibility, are expected to adhere to these established controls.

All records must be fully and accurately completed and maintained consistent with proper business practices. The creation of fully accurate and complete records is a duty of each representative of the Hospital. Outside payments must be made only with a draft or check or through other properly documented sources. No payment on behalf of the Hospital should be approved or made without adequate supporting documentation or with the intention or understanding that any part is to be used in any way other than described in the supporting documents.

All accounts must be disclosed and recorded. Proper authorization must be obtained before opening any new account. Every payment must be recorded to the Hospital's books promptly, accurately and through normal financial reporting channels.

Vendors must be selected solely on their merits, in the best interest of the Hospital and in accordance with the New York State Public Officer's Law, New York State Finance Law, and applicable New York State regulations.

D. Ensure Facility Certification

Hospital representatives must not make false statements with respect to the conditions or operation of any facility for participation in the Medicare or Medicaid Program. Hospital representatives must not make false statements with respect to information regarding ownership and control of a facility.

E. Obtain Certificates of Need/Licensure

The Hospital is licensed by various regulatory and accreditation bodies. Each Hospital representative is expected to be familiar with the regulations governing his or her area, to stay abreast of new developments and to alert his or her supervisor to possible noncompliance. Questions regarding regulatory requirements should be referred to the Associate Director, Medical and Regulatory Affairs.

State law may require the Hospital to obtain the prior approval of the New York State Department of Health before purchasing major medical equipment, changing the services it provides or making other significant capital expenditures. Additional information may be found in Administrative Policy #LD: 0005, "Certificate of Need Applications." Questions regarding Certificates of Need should be referred to the Department of Planning.

F. Prevent Unfair Trade Practices

The Hospital will comply with all laws pertaining to restraint of trade and unfair competition. Such laws generally forbid any kind of understanding or agreement, whether written or verbal, between competitors to fix or control fees for services, or to engage in any other conduct that results in restraint of competition. The following conduct is prohibited:

- Attempts to unlawfully monopolize the provision of medical services;
- Fixing or unlawfully controlling fees or prices, including setting unreasonably low fees or prices to drive or keep competitors out of the market;

- Telling a supplier that the decision to purchase goods or services is dependent upon the supplier's seeking medical services at Hospital; or engaging in any other antitrust arrangements (e.g. tying arrangements);
- Unlawfully reducing or eliminating competition over price, terms of business or services offered;
- Unlawfully refusing to deal with, or to boycott, suppliers, third party payers or other providers;
- Conducting discussions, conversations or other communications with competitors about the division of either patients, geographic areas, or services; the circumstances under which business will be conducted with suppliers, insurance companies, patients or customers (including boycotts); or marketing efforts;
- Discussing with competitors the future business plans of the Hospital or those of any competitors;
- Discussing with competitors such information as pricing, reimbursement, or salary levels.

Participation in surveys among competitors regarding information on salaries, fees, etc. is permissible only if (1) the survey is managed by a non-competitor third party; (2) the information provided by survey participants is based on data more than three months old; (3) at least five hospitals participate in the survey; and (4) the information provided is not identifiable. Two competitors should not share this information directly between themselves even if the information is available through public sources. If you have questions regarding trade practices, contact the Office of University Counsel.

G. Prevent Unlawful Referrals and Kickbacks

Both federal and state laws specifically prohibit any form of kickback, bribe or rebate made directly or indirectly, overtly or covertly, in cash or in kind to induce the purchase, recommendation to purchase, or referral of any kind of health care goods, services or items paid for by Medicare or the Medicaid program. The term "kick back" as defined in these statutes means the giving of remuneration, which is interpreted under the law as anything of value. Federal and state "anti-referral" laws impose substantial penalties relative to billing for services referred by physicians or other health care practitioners who have a contractual or business relationship with the Hospital.

The Hospital must scrupulously avoid being either the offer or the recipient of an improper inducement. Care must be taken in structuring relationships with persons not employed by the Hospital so as not to create a situation where the Hospital appears to be offering an improper inducement to those who may be in a position to refer or influence the referral of patients to the Hospital.

As a provider of patient care, the Hospital also should not receive any improper inducement from its vendors to influence it in making decisions regarding the use of particular products or the referral or recommendation of patients to other providers of goods and services paid for by Medicare or Medicaid.

No Hospital representative shall make a referral for a designated health service* to an entity in which he or she (or an immediate family member) has a financial relationship**. Hospital representatives must become familiar with these laws and assure that all activities are conducted in such a manner that no question may arise as to whether any of these laws have been violated. Any questions concerning these statutes or any business arrangement subject to anti-kickback or anti-referral laws should be directed to Office of University Counsel.

*Examples include Inpatient and Outpatient Services, Laboratory, Physical Therapy, Occupational Therapy, Radiology, Radiation Therapy, Durable Medical Equipment, and Home Health Services, and all outpatient supplies, drugs, and equipment.

**Includes ownership or investment interest in an entity. Also includes any compensation arrangement involving any remuneration to physician or immediate family member by the entity.

H. Adhere to Tax-Exempt Requirements

The Hospital is a tax-exempt governmental entity. In order to comply with the applicable law, the Hospital must operate for the benefit of the community and must avoid what the tax law calls "private inurement" and "private benefit". All non-exempt individuals or entities must pay fair market value for use of Hospital services or property. Violation of the tax law can give rise to criminal penalties.

The Hospital's sales tax exemption may be used only for legitimate Hospital activities. Personal items cannot be purchased through the Hospital even if the Hospital is reimbursed by the Hospital representative. All appropriate taxes must be withheld from Hospital representatives' wages, and the use of a purchase order to compensate individuals must be limited to true independent contractors and must comply with New York State Finance Law.

New York State has issued tax-exempt bonds, which are secured by mortgages covering much of the Hospital property. These bonds contain restrictions on the use of this property and on other Hospital activities, which, if violated, could jeopardize New York State's ability to borrow money in the future. Questions on these issues should be referred to the Office of University Counsel.

I. Prevent Inappropriate Gifts and Entertainment

Giving or accepting gifts and entertainment can sometimes be construed as an attempt to influence the other party. No personal gifts can be offered or received if the action could raise a reasonable question concerning whether the gift was offered or received to influence a person in the exercise of proper business judgment, as stipulated in the Public Officers Law. One cannot provide or accept gifts of more than nominal value per the New York State Public Officer's Law. See New York State Ethics Commission Advisory No. 94-16 for guidance. A copy of this opinion is available through the Office of University Counsel, the Hospital's Compliance Officer or from the New York State Ethics Commission.

The giving or accepting of gifts of more than nominal value, per the New York State Public Officer's Law, is unacceptable and punishable by disciplinary action. Gifts defined as anything of value given to a State employee under circumstances in which it could reasonably be inferred that the gift was intended to influence or reward the employee pertaining to his/her State duties; including but not limited to money, services, loans, travel, meals/refreshment, entertainment, hospitalities, discounts or promises; it may be provided in kind, by purchase of a ticket, payment in advance or reimbursement for an expense that has been incurred or an activity that has occurred. Gifts from disqualified sources are a violation of the gift provision. Disqualified source defined as any person or entity that does business with, is in litigation with, appears before or negotiates with SBUH, lobbies SBUH; applies for or receives funds from SBUH or contracts with SBUH or another agency when SBUH receives the benefit of the contract, an example of a disqualified source for SBUH are pharmaceutical companies. Unsolicited Advertising and Marketing items from a disqualified source (for example promotional materials of little intrinsic value, pens, note pads, calendars, slice of pizza/hero sandwich, donut/pastry and coffee) are acceptable. Please refer to the New York State Ethics Commission Advisory No. 94-16 for guidance. A copy of this opinion is available through the Office of University Counsel, the Hospital's Compliance Officer or from the New York State Ethics Commission.

J. Engage in Appropriate Fund Raising

The Hospital adheres to SUNY policy in that only fund raising or solicitation of funds that results in a benefit to the University is permitted, unless specifically authorized by the President or designee. Such events must be consistent with the missions, goals and mandates of the University. Coordination of East Campus fundraising activities through the Advancement Office is essential for Customer Satisfaction as well as to comply with HIPAA regulation requiring the provision to opt-out of fundraising communications. HIPAA Privacy Rule 45 CFR 164.514(f)(1)-(2), 164.520(b)(1)(iii)

(B). "Hospitals must make reasonable efforts to ensure that those who decide to opt out of receiving future fundraising communications do not continue to receive such communications.

Business or other commercial solicitation not directly related to University operations is permitted on campus only if the vendor, organization, group or individual has obtained a permit. All fund raising activities must be conducted pursuant to the University policy.

K. Prevent Theft

Hospital representatives must not take, convert, consume or use property or funds belonging to the Hospital or any company or private person without the owner's consent or proper authorization. If you suspect a Hospital item is missing due to theft, you should report it to the University Police.

L. Commit to Fairness

The principal rules governing examinations, appointments, promotions, transfers, reinstatements, etc. are contained in the "Rules of Classified Service." These rules apply to all employment under the direct jurisdiction of the State Department of Civil Service (including Stony Brook University Hospital).

All Hospital representatives must abide by the rules, regulations, and policies of equal employment/educational opportunity and affirmative action. Affirmative action and equal opportunity affect all employment practices. Students or Hospital representatives having disabilities that require reasonable accommodations or auxiliary aids may be accommodated through the Office of the ADA Coordinator.

Hospital representatives who consider themselves to be victims of discrimination may file a grievance in writing with the Office of Diversity and Affirmative Action [within forty-five (45) calendar days] of the alleged discrimination act. If you choose to file a complaint within the University, you do not lose your right to file with an outside enforcement agency such as the State Division of Human Rights or Equal Employment Opportunity Commission.

The Hospital reaffirms the principle that Hospital representatives have the right to be free from "sexual harassment," which is a form of discrimination based on gender. The Hospital also does not tolerate gender harassment, or discrimination against individuals who fall within any protected category, and treats this as a form of misconduct. Sanctions are enforced against individuals engaging in such behavior.

M. Avoid Conflicts of Interest

A conflict of interest arises if a person's judgment and discretion is or may be influenced by personal considerations, or if the interests of the Hospital are jeopardized. Please refer to the standards listed in Stony Brook University Hospital Administrative Policies and Procedures Manual Code #RI0002 concerning Conflict of Interest:

- Hospital representatives must promptly disclose any existing or new relationships that may give

the appearance of a conflict of interest to the Compliance Officer.

- Substantial ownership in a competitor, supplier or an entity which refers patients may create a conflict of interest. Any doubts or questions about an investment should be reported to the Compliance Officer.
- Immediate family members should not supervise or report to each other.
- Other outside employment is prohibited to the extent it interferes with an employee's performance.
- Equipment, materials or proprietary information owned by the Hospital should not be used for any outside employment purpose.

The Hospital has a responsibility to preserve and enhance the public's trust in government. The New York State Ethics Commission states that any violation of that trust reflects poorly on employees and some violations can result in the loss of a job, a substantial fine or criminal prosecution. Situations which present the appearance of a conflict of interest, or in which a conflict of interest exists, should be avoided. For a more complete guidance to State policy on these types of issues, please refer to New York State Ethics: A Guide to Public Law and Public Officer's Law, both published by the New York State Ethics Commission. See also New York State Public Officer's Law §§73, 74.

N. Comply with Labor and Employment Laws

It is the Hospital's policy to comply fully with all applicable labor laws and other statutes regulating the employer-employee relationship and the workplace environment. Under federal and state law, it is illegal for the Hospital or a Hospital representative to pay or to receive any money or other thing of value from any labor organization that represents Hospital employees (does not include amount paid in the normal course of business, e.g. union dues, political action committee). No Hospital representative may interfere or retaliate against another Hospital representative who seeks to invoke his or her rights under those laws. Questions regarding the laws governing labor and employee relations may be referred to the Director of Labor Relations.

O. Comply with Immigration Requirements

The Hospital hires only persons who are legally authorized to work in the United States, consistent with federal law. Only prospective employees who are U.S. citizens or who possess a "green card" or visa, which entitles them to work, will be hired. The appropriate documentation of citizenship status must be presented to the Human Resources Office at the time of hire. Questions on immigration issues should be referred to the Human Resources Office or to the Office of International Affairs.

P. Provide Emergency Care

The Hospital will provide medical screening, regardless of ability to pay, to patients who present themselves to its Emergency Department and request examination. If the patient has an emergency medical condition, the Hospital will treat and admit the patient, and will only transfer him/her after he/she has been stabilized. Any such post-stabilization transfer is only allowed in limited circumstances consistent with state and federal law. With respect to any person who is in need of immediate hospitalization, the Hospital will not question the patient or any member of his or her family concerning insurance, credit or payment of charges provided that the patient or a member of his or her family shall agree to supply such information promptly after the patient's admission. All Emergency Department personnel must be aware of the Hospital's policy in this regard.

Q. Comply with Environmental Health and Safety Requirements

All Hospital representatives who deal with hazardous materials and regulated medical waste must comply with environmental laws and regulations, and follow the environmental safety procedures explained in the Hospital's programs and existing manuals. These laws pertain to hazardous materials, regulated medical waste, air pollution and water pollution. Hospital representatives are expected to:

- Comply with all laws and regulations governing the handling, storage and use of hazardous materials, other pollutants and regulated medical wastes;
- Comply with its permits that allow it to safely discharge pollutants into the air, sewage systems, water pollution control facilities, or onto or into land;
- Hire only reputable licensed services to transport and dispose of hazardous and polluted materials and regulated medical wastes; and
- Accurately maintain the records required by the environmental laws and regulations, including those that require precise description of the amount, concentration and make-up of hazardous materials or other regulated pollutants and regulated medical wastes that are used, stored, discharged or generated; and the time, place of origin, destination and transporter of hazardous materials, and discharge of pollutants. These records should be handled pursuant to Hospital policy.

No one at the Hospital may participate in concealing improper discharge or disposal of hazardous materials, pollutants or regulated medical wastes. Any Hospital representative who has reason to believe that there have been violations of this or any other aspect of the Hospital's environmental compliance procedures should report immediately to the Compliance Officer, who will in turn investigate and, when appropriate, notify pertinent government agencies as required by law. Before proceeding to act on any instruction of questionable propriety, or to take any environment-related action about which they are unsure, Hospital representatives are expected to discuss their questions with the Director of Environmental Health and Safety or the Compliance Officer.

Both federal and state laws regarding the promotion of occupational safety and avoidance of job-related hazards are designated to ensure that each of us works in a safe environment. Due regard and attention should be paid to those laws and regulations. Each of us plays a valuable role in providing the services of the Hospital. Without a safe and non-hazardous environment in which to work, none of us can achieve the goals of community service to which we strive. Should you notice a potential or actual infringement of the laws and rules regarding occupational safety, you must advise your supervisor, the Director of Environmental Health & Safety, or the Compliance Officer.

R. Ensure Proper Control of Medications

The Hospital, and therefore its representatives, is legally responsible for the proper distribution and handling of pharmaceutical products and preventing unauthorized access to them. The diversion of any prescription drug or controlled substance, including a drug sample, in any amount, for any reason, to an authorized individual or entity is forbidden. It is the Hospital's policy that all Hospital representatives be both diligent and vigilant in carrying out their obligations regarding the Hospital's prescription drugs and controlled substances in accordance with all applicable laws, regulations, and Hospital policies and procedures. The policies and procedures are available in written form in the Stony Brook University Hospital Administrative Policy and Procedures Manual. Every authorized professional employee is expected to adhere to the highest professional standards in safeguarding pharmaceuticals; preventing unauthorized use or access; securing and documenting the use of scheduled controlled substances and for their return or disposal.

Drugs dispensed by the Hospital's Pharmacy may not be used by staff for their own use, unless prescribed according to Hospital policy, or for use in their private practice. Hospital representatives should utilize the prescription benefit included in their health coverage when prescription drugs are required.

Any violation of any law or Hospital policy involving prescription drugs or controlled substances will constitute grounds for dismissal. Should you become aware of potential violations of any law, policy or regulation relating to pharmaceuticals, you must advise your supervisor or the Compliance Officer immediately.

S. Adhere to Research Grant Requirements

All grant proposals involving human subjects must be submitted for Institutional Review Board (IRB) review and approval. To assure the integrity of research conducted under the auspices of the Hospital, wherever the actual research is carried out, all grant proposals and research must conform to IRB standards and to the Hospital's Informed Consent Policy (See Committee on Research Involving Human Subjects [CORIHS] Guidelines for Investigators). Grant recipients must be certain that funds used are in accordance with the approved research protocol.

The Institutional Animal Care and Use Committee (the "IACUC") has been established in accordance with federal law and the Public Health Service policy to evaluate the University's program of animal use. All proposals for animal care and use must be approved by the IACUC to assure compliance with federal and state laws and guidelines.

Researchers must be vigilant in considering whether grants could involve improper inducements for the referral of patients to the Hospital. This could occur, for example, in a study of drug efficacy underwritten by a pharmaceutical company if the protocol were not appropriately designed. If improper, such referral practices would constitute "kickbacks" in violation of federal and state law. Any questions concerning whether the anti-kickback or other statutes may be involved in a research proposal should be directed to the Office of University Counsel, University Office of Government Relations, or University Office of Research Compliance.

T. Avoid Scientific Misconduct

All Hospital representatives must adhere to the highest professional standards of scientific integrity and reports of scholarly activities. All allegations brought forward in which it is believed that an individual or individuals are not meeting the level of integrity required in the conduct of research and/or scholarly activities will be investigated pursuant to SUNY-Stony Brook policy and procedure regarding responsible conduct in scholarly activities. Allegations of scholarly or scientific misconduct shall be reported, in compliance with the policy of SUNY-Stony Brook governing scholarly misconduct, to the Vice President of Research or Research Compliance Officer.

Scientific misconduct is defined as fabrication, falsification, plagiarism or other serious deviation from accepted scientific practices in proposing, carrying out, or reporting results of scholarly activities or research and the retaliation against a person who reported or provided information about suspected or alleged misconduct and who has acted in good faith. The definition is not meant to include actions involving honest error or honest differences in interpretation or judgments of data. Scientific misconduct may also be defined as failure to submit research projects for Institutional Review Board (IRB) or Institutional Animal Care and Use Committee (IACUC) approval to obtain informed consent.

U. Ensure Appropriate Political Participation/Government Relations

Both federal and state laws prohibit organizations from contributing to political candidates or

officeholders. In addition, state law makes it a misdemeanor for employees of the state to use their authority or official influence, directly or indirectly, to compel or induce another employee to pay or promise to pay a political assessment, subscription or contribution. Federal law states that no one will be reimbursed for personal political contributions. Personal compensation will not be altered in any way under any circumstances to reflect such contributions. While the Hospital encourages Hospital representatives to participate in the American political process if they so desire, Hospital representatives must distinguish between personal and organizational political activities. Unless specifically requested by the Hospital to represent it before legislative or other governmental bodies, Hospital representatives must clearly label any personal communication with legislators as their own beliefs. If contacted by legislators or regulators regarding the Hospital's position on public issues, please refer them to the Office of University Counsel. Any government lobbying activities must comply with applicable lobbying, ethical and other applicable laws. To assure full compliance with these laws and policies, it is expected that no Hospital representative will engage in lobbying without prior authorization from the Chief Executive Officer.

Hospital representatives must obtain clearance from the Department of Human Resources prior to discussing the employment or possible retention as a consultant of any current or former government representative. No Hospital representative may provide or pay for meals, refreshments, travel or lodging expenses for government representatives. No Hospital representative should entertain a public official without authorization from the Chief Executive Officer and/or where appropriate the Office of University Counsel.

V. Ensure Appropriate Use of Hospital Information

1. Safeguarding the Privacy of Our Patients

To protect individuals against misuse of information, access to patient information must be limited to the extent permitted by Hospital policy and state and federal law. Any Hospital representative who engages in unauthorized disclosure, access or misuse of information in violation of the privacy rights of our patients or others may be subject to disciplinary action in addition to possible civil or criminal sanctions. Any person who becomes aware of such unauthorized disclosure should report it immediately to their supervisor or the Compliance Officer. Legitimate means must be used to collect information. Whenever practical, it should be obtained directly from the individual concerned. Special confidentiality rules apply to patients in drug and alcohol treatment programs as well as in disclosure of information regarding a patient's HIV status. When release of any information with respect to patients with these illnesses is contemplated, these rules must be adhered to strictly. Questions on the patient confidentiality rules and other HIPAA Privacy Matters should be referred to the Privacy Officer.

2. Confidentiality of Hospital Information

No Hospital representative shall disclose to others any confidential information obtained during the course of employment. Confidential information includes the Hospital's methods, processes, techniques, computer software, equipment, service marks, copyrights, research data, clinical and pharmacological data, marketing and sales information, personnel data, patient lists, patient clinical data, financial data, plans and all other proprietary information which are in the possession of the Hospital and which have not been published or disclosed to the public. Hospital representatives are responsible and accountable for the integrity and protection of business information.

Documents and electronic media containing sensitive information concerning patients and Hospital representatives should be handled carefully and must be properly secured. Particular attention must be paid to the security of data stored on the computer system. If you observe employee misuse of confidential information or individuals whom you do not recognize using terminals in your area,

immediately report this to your supervisor and/or the Security Officer.

3. Information Owned by Others

Disclosure of confidential information (e.g. software, data, reports) received from outside organizations for the benefit of Stony Brook University Hospital must not take place unless the terms of its use have been formally agreed to by the Hospital and the other party. If Hospital representatives have information in their possession that could possibly be confidential to a third party or may have restrictions placed on its use, they should consult with the Office of University Counsel. A written agreement must be approved by the Office of University Counsel. Once obtained, Hospital representatives must not use, copy, distribute or disclose that information unless done in accordance with the terms of the agreement.

Software is an intellectual property which is protected by copyright laws and may also be protected by patent trade secret laws or as confidential information. Before accepting software or signing a license agreement which must have been approved by the Office of University Counsel, Hospital representatives must follow established Stony Brook University Hospital Administrative Policies and Procedures Manual #IM0014, Security of Computer Resources. The terms and conditions of such license agreements—such as provisions not to copy or distribute software—must be strictly followed. The exception is a copy for backup purposes. If you acquire software for your personally owned equipment, you should not copy for backup purposes. If you acquire software for your personally-owned equipment, you should not copy any part of such software in any work you do for the Hospital, place such software on any Hospital-owned computer system, or generally bring such software onto the Hospital premises.

4. Records Retention/Destruction

Hospital representatives are expected to comply fully with the records retention and destruction schedule for the department in which they work. If Hospital representatives believe that documents should be saved beyond the applicable retention period, their supervisor should be consulted. This supervisor should contact the Health Information Management Department, Risk Management Department, Office of University Counsel, Compliance Officer, or the Finance Department depending on the nature of the documents in question.

5. Government Investigations

Hospital representatives must adhere to the following procedures and as detailed in Stony Brook University Hospital Administrative Policies and Procedures Manual to ensure the Hospital responds in a proper manner to all government investigations. Any Hospital representative who is approached by any federal or state law enforcement agency seeking information about any aspect of the operations of the Hospital or the job-related activities of any of the Hospital's officers or Hospital representatives must call the Office of University Counsel or the Compliance Officer before turning over any information (see Stony Brook University Hospital Administrative Policies and Procedures Manual LD:0038, Policy and Procedure for an Employee Responding to Government Investigations).

Some agencies are entitled by statute to immediate access to information; they include the Office of the Inspector General of the United States Department of Health and Human Services and state Medicaid Fraud Control Units: New York State Department of Health. Officials of either of these agencies must present proper identification before access can be provided. In virtually all cases, when a request by personnel of either agency is made, access to the requested information should be delayed pending notification of the Office of University Counsel. Such notification should occur simultaneously with the requested access. Notification will ensure that the organization is aware of the inquiry, properly responds to it, and can take whatever action is necessary with regard to it. If, under extraordinary

circumstances only, access cannot be delayed pending notification of the Office of University Counsel, then the Office of University Counsel should be contacted immediately thereafter.

Other governmental agencies may look at Hospital documents and other materials only with the Hospital's consent or by proper legal process. To ensure that government agencies are provided with the information to which they are entitled on a timely basis and, at the same time to prevent the improper disclosure of private information, it is imperative that Hospital representatives contact the Office of University Counsel as promptly as possible after receipt of, or compliance with, any request for information. In addition, please be certain to (1) obtain the name and organizational affiliation of all persons from whom a request for access to information is received or to whom access is permitted before any access is allowed, (2) maintain a written record of each and every document to which access is given, (3) keep a detailed record of all telephone contacts made, including specifically the name and affiliation of the parties to each conversation, the information during the conversation.

Specific federal and state confidentiality laws relating to medical records pertaining to AIDS and substance abuse (controlled drugs and alcohol), to psychiatric records, and to students' "education records" may limit the general authority of government investigators. Hospital representatives should be certain that any disclosure of such records complies with the policies and procedures of the Hospital and where applicable, of SUNY, federal and state law.

III. COMPLIANCE WITH THE CODE

A. Questions Regarding the Code

The Hospital Compliance Officer is responsible for implementation of the Hospital's Corporate Compliance Program, including the Code of Conduct. The Hospital Compliance Officer will work with others in the Hospital, as necessary, with respect to elements of implementation, including training and enforcement of this Code.

Any Hospital representative who has a question regarding the applicability or interpretation of the Code should direct the question to the Hospital Compliance Officer in person, in writing, or by telephone. Correspondence relating to the Code should be addressed to the Hospital Compliance Officer and marked "CONFIDENTIAL."

B. Reporting of Suspected Violations

Hospital representatives must report suspected violations. As a matter of policy, no Hospital representative will be disciplined or subjected to retaliatory action because he or she made a report in good faith. Where possible, the confidentiality of the Hospital representative making the report will be protected.

Reports of possible violations of law or ethical standards may be made to the Hospital representative's supervisor. If the report is made to the supervisor, the supervisor is then required to report the suspected violation to the Hospital Compliance Officer. The Hospital representative can also report directly to the Hospital Compliance Officer. (See form: Report of Suspected Violation, attached.) A Hospital representative need not be absolutely certain that a violation has occurred before making such a report; reasonable belief that a violation may have occurred is sufficient. Hospital representatives are required to come forward with any such information, without regard to the identity or position of the suspected offender. Reports will be acted upon promptly and the complainant will be notified of the result.

Reporting enables the Hospital to investigate potential problems quickly and to take prompt action to deal with them. Reports may be made on a confidential basis to the Hospital Compliance Officer at 4-

5876, to the Office of University Counsel at 4-8250, or by writing to: Hospital Compliance Officer, Stony Brook University Hospital, 3 Technology Drive, Suite 200, Zip Code 9296. All investigative activity will be reported to the Stony Brook University Hospital Governing Body.

C. Investigation of Suspected Violations

All reported violations of the Code will be promptly investigated by the Hospital and will be treated confidentially to the extent consistent with the Hospital's interests and its legal obligations. If an investigation of an alleged violation is undertaken and the Hospital Compliance Officer believes the integrity of the investigation may be at stake because of the presence of Hospital representatives under investigation, the Hospital representative(s) allegedly involved in the misconduct should be removed from his/her current work activity until the investigation is completed consistent, where applicable, with the appropriate collective bargaining agreement. In addition, steps should be taken to prevent the destruction of documents or other evidence relevant to the investigation.

It is the Hospital's policy to cooperate with any government investigation. Because the Hospital should act only with the advice of its legal counsel in these matters, all cooperation with the government must be coordinated by the Office of University Counsel. Clinical services and divisions are not authorized to engage external consultants, auditors, or legal counsel in connection with compliance matters except with the advance approval of the Hospital Compliance Officer.

D. Non-Retaliation

It is our policy that SBUH employees are to report instances of known or suspected violations of law, regulation, SBUH policy and procedure or Code of Conduct. To promote the reporting of known or suspected violations SBUH has adopted a code of non-retaliation for individuals who in "good faith" provide information they believe or perceive to be true. No disciplinary action or retaliation shall be taken against such an individual for reporting or participating in an investigation of an alleged violation. Any individual, who intentionally provides false information, condones or commits any form of retaliation shall be subject to disciplinary action. Individuals who self-report their own misconduct are not exempt from the consequences of their actions. However, self-reporting efforts may be taken into consideration in determining a course of action.

E. Discipline for Violations

Any discipline applicable to union members shall be taken in accordance with the appropriate collective bargaining agreement. Disciplinary actions may be taken for:

- Authorization of, or participation in, actions that violate the Code.
- Failure to report a violation of the Code or to cooperate in an investigation.
- Failure by a violator's supervisor(s) to detect and report a violation of the Code if such failure reflects inadequate supervision or lack of oversight.
- Retaliation against an individual for reporting a violation/possible violation of the Code, as required by New York Healthcare Whistleblowers Act.

Disciplinary action may, when appropriate, include dismissal. Disciplinary decisions will be reported to the Stony Brook University Hospital Governing Body.

F. Acknowledgment and Certification of Compliance

The Hospital requires that all Hospital representatives sign an acknowledgement confirming that they have received and read the Code and understand it, and acknowledge that the Code has been

communicated to all Hospital representatives and agents under their supervision. In addition, each year these Hospital representatives will be asked to submit an updated Code of Conduct acknowledgment and compliance form.

The Hospital requires that all Hospital representatives and agents under their supervision sign an acknowledgement titled "Workforce and Electronic Information Access Confidentiality Acknowledgement Statement" to confirm that they received, read and will comply with the SBUH Code of Conduct. In addition, each year all Hospital representatives will be asked review the Code of Conduct and submit a signed "Workforce and Electronic Information Access Confidentiality Acknowledgement Statement" to the Office of Compliance zip=9296.

Forms:

None

Keywords:

compliance, code of conduct

Policy Cross Reference:

LD0071 Reporting of Compliance Violations

Relevant Standards, Codes, Rules, Regulations, Statutes:

State of New York Commission on Public Integrity Advisory Opinion No.08-01

Scope: Hospital Wide

Author:

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(Assigned by Policy Review Committee)

Steven Strongwater M.D.
Chief Executive Officer