SONOMA VALLEY HEALTH CARE DISTRICT
GOVERNANCE COMMITTEE MEETING

AGENDA

Wednesday, September 16, 2020
8:00 AM

TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing,
use the link below:

https://sonomavalleyhospital-org.zoom.us/j/93608166817?pwd=VXFtYit3ZVgxaHhFZy85R1RFYTRadz09

and Enter the Meeting ID: 936 0816 6817
Passcode: 153945

To Participate via Telephone only (no video), dial:
1-669-900-9128 or 1-669-219-2599
and Enter the Meeting ID: 936 0816 6817
Passcode: 153945

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District meeting, please contact the District Clerk, Vivian Woodall, at vwoodall@sonomavalleyhospital.org or (707) 935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Boerum*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up.*		
3. CONSENT CALENDAR: • Meeting minutes 05.27.20	*Boerum*	Action
4. SVH COMPLIANCE PLAN 2020	*Boerum*	Action
5. NEXT MEETING DATE	*Boerum*	Inform
6. ADJOURN	*Boerum*	

SUBJECT: Compliance Program Plan	POLICY:
	PAGE 1
DEPARTMENT: Organizational	EFFECTIVE:
REVISED:	

CHANGE SUMMARY

WHAT: The Compliance Committee reviewed and updated the entire Compliance Program Plan to ensure a complete and up-to-date program based on best practices. Updates included identification of the current members of the Compliance Committee, roles and responsibilities, establishing the Compliance Hotline, communication to employees, required training for both employees and our Governing Board, identifying conflicts of interest and reporting responsibilities.

WHY: Past due for a regular review and update, in accordance to the plan itself. Last update was completed in 2014.

OWNER:
Lynn McKissock, Chief Compliance Officer

AUTHORS/REVIEWERS:
Danielle Jones, Chief Quality Officer
Dawn Kuwahara, Chief Ancillary Officer
Fe Sendaydiego, Chief Information Officer
Mark Kobe, Chief Nursing Officer
Rosemary Pryszmant, HIM Manager & Privacy Officer
Sarah Dungan, Controller
Stacey Finn, Medical Staff Coordinator

Dear Colleague:

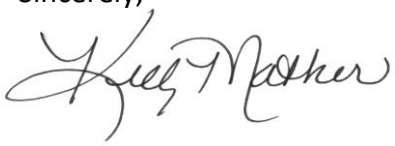
Sonoma Valley Hospital (SVH) is fully committed to compliance with the law and ethical standards. In this age of strict government regulation and public scrutiny of business practices, a high level of commitment to compliance is essential.

SVH has developed this Compliance Program Plan to further our mission to provide high-quality patient care in a manner that ensures compliance with the law and the highest business ethics. This Compliance Plan includes a comprehensive discussion of certain laws, the hospital's policies, and expectations about your conduct. However, no written program or policy can cover all circumstances. We therefore ask that you read this Compliance Plan carefully to understand not only its written words, but its purpose and meaning as well.

If you have any questions about this Compliance Program or think an event has occurred that violates this Compliance Program, you should contact our Chief Compliance Officer, Lynn McKissock, at (707) 935-5480. Alternatively, you can anonymously contact our Compliance Hotline by calling (707) 935-5151 or sending a fax to (707) 935-5179. You are encouraged to ask questions and to report violations of this Compliance Program.

You can count on SVH to provide the support and environment necessary to make this Compliance Program a success. Similarly, the hospital is counting on you to take this Compliance Program seriously and conduct yourself accordingly.

Sincerely,



President and Chief Executive Officer
Sonoma Valley Hospital

SECTION I — COMPLIANCE PROGRAM SUMMARY

Definitions of Commonly Used Terms

A list of words that are commonly used in this Compliance Program and their meanings follows:

- **"Hospital"** means Sonoma Valley Hospital, and all of its subsidiaries and affiliates that are covered by this Compliance Program.
- **"Personnel"** means all employees and volunteers of the Hospital, and all contractors or others who are required to comply with this Compliance Program.

Purpose of this Compliance Program

Sonoma Valley Hospital (SVH) is committed to ensuring compliance with all applicable statutes, regulations and policies governing our daily business activities. To that end, the Hospital created this Compliance Program to serve as a practical guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies. This Compliance Program is intended to further our day-to-day commitment that our operations comply with federal and state laws, to provide guidance for all employees, and to serve as a mechanism for preventing and reporting any violation of those laws.

While this Compliance Program contains policies regarding the business of the Hospital, it does not contain every policy that Personnel are expected to follow. For example, this Compliance Program does not cover payroll, vacation and benefits policies. The Hospital maintains other policies with which employees are required to comply. You should discuss with your supervisor any questions regarding which policies apply to you.

It is the policy of the Hospital that:

- All employees are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of noncompliance without fear of retribution; and
- Mechanisms exist to investigate, discipline and correct noncompliance.

Who is Affected?

Everyone employed by the Hospital is required to comply with the Compliance Program. Because not all sections of the Compliance Program will apply to your job function, you will receive training and other materials to explain which portions of this Compliance Program apply to you.

While this Compliance Program is not intended to serve as the compliance program for all of our contractors, it is important that all contractors perform services in a manner that complies with the law. To that

end, agreements with contractors may incorporate certain provisions of this Compliance Program.

This Compliance Program is effective only if everyone takes it seriously and commits to comply with its contents. It is important that you not only understand and comply with the written words of this Compliance Program, but that you also understand and appreciate the spirit and purpose of this Compliance Program. When in doubt, ask your supervisor, review the appropriate section of this Compliance Program, or take other steps to ensure that you are following the Compliance Program.

Compliance requirements are subject to change as a result of new laws. We must all keep this Compliance Program current and useful. You are encouraged to let your supervisor know when you become aware of changes in law or hospital policy that might affect this Compliance Program.

How to Use This Compliance Program

The Hospital has organized this Compliance Program to be understandable and easy to navigate. A brief description of how this Compliance Program manual is organized follows.

Section I – Compliance Program Summary

Section II – Code of Conduct
This section contains specific policies related to your personal conduct while performing your job function. The primary objective of these policies is to create a work environment that promotes cooperation, professionalism and compliance with the law. Compliance with the Code of Conduct is a significant factor in employee performance evaluations. All Personnel must sign an Acknowledgement of Receipt of the Hospital's Code of Conduct.

Section III – Compliance Program Systems and Processes
This section explains the roles of the Chief Compliance Officer and the Compliance Committee. It also contains information about Compliance Program education and training, auditing and corrective action. Most importantly, this section explains how to report violations anonymously, either in writing or by calling the Hospital's Compliance Hotline at (707) 935-5151 or sending a fax to (707) 935-5433.

Section IV – Compliance Policies
This section includes specific policies that apply to various aspects of the Hospital's business and operations. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All policies are available to all employees via the SVH Intranet.

Here are some tips on how to effectively use this Compliance Program:

- **Refer to Table of Contents.** The Table of Contents contains a thorough list of topics covered in this Compliance Program. Use the Table of Contents to quickly locate the topic you are looking for.
- **Important Reference Tool.** This Compliance Program should be viewed as an important reference manual that can be referred to on a regular basis to answer questions about how to perform your job. Although it may not contain all of the answers, it will contain many and can save you time.

- **Read it in Context.** The Hospital has created this Compliance Program to incorporate numerous compliance policies, many of which may not apply to you. When reviewing this Compliance Program and the policies contained in it, keep in mind that the policies are to be applied in the context of your job. If you are uncertain about it or how a policy applies to you, ask your supervisor.
- **Keep it Handy.** Keep this Compliance Program manual easily accessible and refer to it on a regular basis.
- **Talk to Your Co-Workers.** Regular dialogue among co-workers and supervisors is a great way to ensure that policies are being uniformly applied. While this discussion is encouraged, always remember that the provisions of this Compliance Program should guide you on compliance matters.

SECTION II — CODE OF CONDUCT

Our Compliance Mission

The mission of Sonoma Valley Hospital is to maintain, restore, and improve the health of everyone in our community.

In concert with our medical staff, the Hospital strives to provide comprehensive quality health care to our community. Our team of dedicated health care professionals shall provide a compassionate and caring environment for patients, and their families and friends, while continuously striving to improve the quality of care that is accessible and affordable.

The Hospital shall collaborate with its medical staff and affiliated organizations to improve health outcomes, enhance quality of life, and promote human dignity through health education, prevention and services across the health care continuum.

The Hospital's Board of Directors (referred to herein as the "Governing Board") adopted the Compliance Program, including this Code of Conduct, to provide standards by which Personnel must conduct themselves in order to protect and promote the Hospital's integrity and to enhance the Hospital's ability to achieve its objectives. The Hospital believes this Code of Conduct will significantly contribute to a positive work environment for all.

No written policies can capture every scenario or circumstance that can arise in the workplace. The Hospital expects Personnel to consider not only the words written in this Code of Conduct, but the meaning and purpose of those words as well. You are expected to read this Code of Conduct and exercise good judgment. You are encouraged to talk to your supervisor or the Hospital's Chief Compliance Officer if you have any questions about this Code of Conduct or what is expected of you.

All Personnel are expected to be familiar with the contents of this Code of Conduct. Training and education will be provided periodically to further explain this Code of Conduct and its application.

Compliance with Laws

It is the policy of the Hospital, its affiliates, contractors and employees to comply with all applicable laws. When the application of the law is uncertain, the Hospital will seek guidance from legal counsel.

Open Communication

The Hospital encourages open lines of communication between Personnel. If you are aware of an unlawful or unethical situation, there are several ways you can bring this to the Hospital's attention. Your supervisor is the best place to start, but you can also contact the Hospital's Chief Compliance Officer or call the Compliance Hotline (707) 935-5151 to express your concerns. All reports of unlawful or unethical conduct will be investigated promptly. The Hospital does not tolerate threats or acts of retaliation or retribution against employees for using these communication channels.

Your Personal Conduct

The Hospital's reputation for the highest standards of conduct rests not on periodic audits by lawyers and accountants, but on the high measure of mutual trust and responsibility that exists between Personnel and the Hospital. It is based on you, as an individual, exercising good judgment and acting in accordance with this Code of Conduct and the law.

Ethical behavior on the job essentially comes down to honesty and fairness in dealing with other Personnel and with patients, vendors, competitors, the government and the public. It is no exaggeration to say that the Hospital's integrity and reputation are in your hands.

The Hospital's basic belief in the importance of respect for the individual has led to a strict regard for the privacy and dignity of Personnel. When management determines that your personal conduct adversely affects your performance, that of other Personnel, or the legitimate interests of the Hospital, the Hospital may be required to take action.

The Work Environment

The Hospital strives to provide Personnel with a safe and productive work environment. All Personnel must dispose of medical waste, environmentally sensitive materials, and any other hazardous materials correctly. You should immediately report to your to supervisor any situations that are likely to result in falls, shocks, burns, or other harm to patients, visitors, or Personnel.

The work environment also must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status or other factors that are unrelated to the Hospital's legitimate business interests. The Hospital will not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated. For additional information, please refer to Hospital policy #HR8610-188 "Anti-Harassment Policy."

If you believe that you are subject to such conduct, you should bring such activity to the attention of the Hospital, either by informing your supervisor, the Hospital's Chief Compliance Officer, or by calling the Compliance Hotline. The Hospital considers all complaints of such conduct to be serious matters, and all

complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale or possession of illegal drugs or any other controlled substance, except to the extent permitted by law for approved medical purposes.

For additional information, please refer to policy #HR8610-371 "Workplace Violence Prevention Program."

In addition, Personnel may not be on the Hospital premises or in the Hospital work environment if they are under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed. For additional information, please refer to policy #HR8610-316 "Drugs & Alcohol Free Workplace."

Employee Privacy

The Hospital collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the Hospital or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the Hospital's Personnel policies or practices. For additional information, please refer to policy #HR8610-198 "Personnel Records."

Use of Hospital Property

Hospital equipment, systems, facilities, corporate charge cards and supplies must be used only for conducting Hospital business or for purposes authorized by management.

Personal items, messages or information that you consider private should not be placed or kept in telephone systems, computer systems, offices, work spaces, desks, credenzas or file cabinets. Employees should have no expectation of privacy with regard to items or information stored or maintained on Hospital equipment or premises. Management is permitted to access these areas. Employees should not search for or retrieve articles from another employee's workspace without prior approval from that employee or management.

Since supplies of certain everyday items are readily available at Hospital work locations, the question of

making personal use of them frequently arises. The answer is clear: employees may not use Hospital supplies for personal use.

Use of Hospital Computers

The increasing reliance placed on computer systems, internal information and communications facilities in carrying out Hospital business makes it absolutely essential to ensure their integrity. Like other Hospital assets, these facilities and the information they make available through a wide variety of databases should be used only for conducting Hospital business or for purposes authorized by management. Their unauthorized use, whether or not for personal gain, is a misappropriation of Hospital assets.

While the Hospital conducts audits to help ensure that Hospital systems, networks and databases are being used properly, it is your responsibility to make sure that each use you make of any Hospital system is authorized and proper.

Personnel are not allowed to load or download software or data onto Hospital computer systems unless it is for business purposes and is approved in advance by the appropriate supervisor. Personnel shall not use Hospital e-mail systems to deliver or forward inappropriate jokes, unauthorized political materials, or any other potentially offensive materials. Personnel are strictly forbidden from using computers to access the Internet for purposes of gambling, viewing pornography or engaging in any illegal activities.

Employees should have no expectation of privacy with regard to items or information stored or maintained on Hospital premises or computer, information, or communication systems.

Use of Proprietary Information

Proprietary Information

Proprietary information is generally confidential information that is developed by the Hospital as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with Hospital services and products. It also includes computer access passwords, procedures used in producing computer or data processing records, personnel and medical records, and payroll data. Other proprietary information includes management know-how and processes; Hospital business and product plans with outside vendors; a variety of internal databases; and copyrighted material, such as software.

The value of this proprietary information is well known to many people in the Hospital industry. Besides competitors, they include industry and security analysts, members of the press, and consultants. The Hospital alone is entitled to determine who may possess its proprietary information and what use may be made of it, except for specific legal requirements such as the publication of certain reports.

Personnel often have access to information that the Hospital considers proprietary. Therefore, it is very important not to use or disclose proprietary information except as authorized by the Hospital.

Inadvertent Disclosure

The unintentional disclosure of proprietary information can be just as harmful as intentional disclosure. To avoid unintentional disclosure, never discuss with any unauthorized person proprietary information

that has not been made public by the Hospital. This information includes unannounced products or services, prices, earnings, procurement plans, business volumes, capital requirements, confidential financial information, marketing and service strategies, business plans, and other confidential information. Furthermore, you should not discuss confidential information even with authorized Hospital employees if you are in the presence of others who are not authorized — for example, at a conference reception or in a public area such as an airplane. This also applies to discussions with family members or with friends, who might innocently or inadvertently pass the information on to someone else.

Direct Requests for Information

If someone outside the Hospital asks you questions about the Hospital or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the Hospital. Under no circumstances should you continue contact without guidance and authorization. If you receive a request for information or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the Hospital's business, you should refer the request to the office of the Hospital's Chief Executive Officer. Similarly, unless you have been authorized to talk to reporters, or to anyone else writing about or otherwise covering the Hospital or the industry, direct the person to your supervisor.

Disclosure and Use of Hospital Proprietary Information

Besides your obligation not to disclose any Hospital proprietary information to anyone outside the Hospital, you are also required to use such information only in connection with the Hospital's business. These obligations apply whether or not you developed the information yourself.

Proprietary and Competitive Information about Others

In the normal course of business, it is not unusual to acquire information about many other organizations, including competitors (competitors are other hospitals and health facilities). Doing so is a normal business activity and is not unethical in itself. However, there are limits to the ways that information should be acquired and used. Improper solicitation of confidential data about a competitor from a competitor's employees or from Hospital patients is prohibited. The Hospital will not tolerate any form of questionable intelligence gathering.

Recording and Reporting Information

You should record and report all information accurately and honestly. Every employee records information of some kind and submits it to the Hospital (for example, a time card, an expense account record, or a report). To submit a document that contains false information — an expense report for meals not eaten, miles not driven, or for any other expense not incurred — is dishonest reporting and is prohibited.

Dishonest reporting of information to organizations and people outside the Hospital is also strictly prohibited and could lead to civil or even criminal liability for you and the Hospital. This includes not only reporting information inaccurately, but also organizing it in a way that is intended to mislead or misinform those who receive it. Personnel must ensure that they do not make false or misleading statements in oral or written communications provided to organizations outside of the Hospital.

Exception

Nothing contained herein is to be construed as prohibiting conduct legally protected by the National Labor Relations Act or other applicable state or federal law.

Gifts and Entertainment

The Hospital understands that vendors and others doing business with the Hospital may wish to provide gifts, promotional items and entertainment to Hospital Personnel as part of such vendors' own marketing activities. The Hospital also understands that there may be occasions where the Hospital may wish to provide reasonable business gifts to promote the Hospital's services. However, the giving and receipt of such items can easily be abused and have unintended consequences; giving and receiving gifts, particularly in the health care industry, can create substantial legal risks.

General Policy

It is the general policy of the Hospital that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could be reasonably construed to be, an inducement in exchange for influence or assistance in conducting Hospital business. It is the intent of the Hospital that this policy be construed broadly such that all business transactions with vendors, contractors and other third parties are transacted to avoid even the appearance of improper activity. For additional information, please refer to policy #HR8610-143 "Receiving of Gifts and Gratuities."

Spending Limits — Gifts, Dining and Entertainment

The Hospital has developed policies that clearly define the spending limits permitted for items such as gifts, dining and entertainment. All Personnel are strictly prohibited from making any expenditures of Hospital or personal funds for gifts, dining or entertainment in any way related to Hospital business, unless such expenditures are made in strict accordance with Hospital policies.

Marketing and Promotions in Health Care

As a provider of health care services, the marketing and promotional activities of the Hospital may be subject to anti-kickback and other laws that specifically apply to the health care industry. The Hospital has adopted policies elsewhere in this Compliance Program to specifically address the requirements of such laws.

It is the policy of the Hospital that Personnel are not allowed to solicit, offer or receive any payment, compensation or benefit of any kind (regardless of the value) in exchange for referring, or recommending the referral of, patients or customers to the Hospital.

Marketing

The Hospital has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care. Part of those efforts involve advertising, marketing and other promotional activities. While such activities are important to the success of the Hospital, they are also potential sources of legal liability as a result of health care laws (such as the anti-kickback laws) that regulate the marketing of health care services. Therefore, it is important that the Hospital closely monitor and regu-

late advertising, marketing and other promotional activities to ensure that all such activities are performed in accordance with Hospital objectives and applicable law.

This Compliance Program contains various policies applicable to specific business activities of the Hospital. In addition to those policies, it is the general policy of the Hospital that no Personnel engage in any advertising, marketing or other promotional activities on behalf of the Hospital unless such activities are approved in advance by the appropriate Hospital representative. You should ask your supervisor to determine the appropriate Hospital representative to contact. In addition, no advertising, marketing or other promotional activities targeted at health care providers or potential patients may be conducted unless approved in advance by the Hospital's legal counsel.

All content posted on Internet websites maintained by the Hospital must be approved in advance by the Hospital's Public Information Officer or legal counsel. Social media may be used by Personnel for business related purposes only when expressly authorized by the Hospital to do so, and then only if authorized personnel strictly adhere to all Hospital policies and procedures regarding non-disclosure of proprietary, confidential and personal information, the Hospital's Code of Conduct, and applicable laws. For additional information in regards to use of social media, please refer to policy #HR8610-300 "Social Media Policy."

Conflicts of Interest

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise any Personnel's business judgment, delivery of patient care, or ability of any Personnel to do his or her job or perform his or her responsibilities. A conflict of interest may arise if you engage in any activities or advance any personal interests at the expense of the Hospital's interests.

An actual or potential conflict of interest occurs when any Personnel is in a position to influence a decision that may result in personal gain for that Personnel, a relative or a friend as a result of the Hospital's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the Personnel is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Personnel's household. You must avoid situations in which your loyalty may become divided.

An obvious conflict of interest is providing assistance to an organization that provides services and products in competition with the Hospital's current or potential services or products. You may not, without prior consent, work for such an organization as~~,~~ a consultant, or a member of its Governing Board. Such activities may be prohibited because they divide your loyalty between the Hospital and that organization. Failure to obtain prior consent in advance from the Hospital's Chief Executive Officer, Chief Compliance Officer or legal counsel may be grounds for termination.

Outside Employment and Business Interests

You are not permitted to work on any personal business venture on the Hospital premises or while working on Hospital time. In addition, you are not permitted to use Hospital equipment, telephones, computers, materials, resources or proprietary information for any outside work. You must abstain from any decision or discussion affecting the Hospital when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the Hospital's Chief Executive Officer, Chief Compliance Officer or legal counsel.

Contracting with the Hospital

You may not contract with the Hospital to be a supplier, to represent a supplier to the Hospital, or to work for a supplier to the Hospital while you are an employee of the Hospital. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with the Hospital.

Required Standards

All decisions and transactions undertaken by Personnel in the conduct of the Hospital's business must be made in a manner that promotes the best interests of the Hospital, free from the possible influence of any conflict of interest of such Personnel or the Personnel's family or friends. Personnel have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest — whether or not you consider it an actual conflict — before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all Personnel and provide some examples of potential conflict of interest situations in addition to those discussed above.

1. Personnel may not make or influence business decisions, including executing purchasing agreements (including but not limited to agreements to purchase or rent equipment, materials, supplies or space) or other types of contracts (including contracts for personal services), from which they, a family member, or a friend may benefit.
2. Personnel must disclose their "significant" (defined below) financial interests in any entity that they know to have current or prospective business, directly or indirectly, with the Hospital. There are two types of significant financial interests:
    a. Receipt of anything of monetary value from a single source in excess of $5,000 annually. Examples include salary, royalties, gifts and payments for services including consulting fees and honoraria; and
    b. Ownership of an equity interest exceeding five (5) percent in any single entity, excluding stocks, bonds and other securities sold on a national exchange; certificates of deposit; mutual funds; and brokerage accounts managed by third parties.
3. Personnel must disclose any activity, relationship or interest that may be perceived to be a conflict of interest so that these activities, relationships and interests can be evaluated and managed properly.
4. Personnel must disclose any outside activities that interfere, or may be perceived to interfere, with the individual's capacity to satisfy his or her job or responsibilities at the Hospital. Such outside activities include leadership participation (such as serving as an officer or member of the board of directors) in professional, community or charitable activities; self-employment; participation in business partnerships; and employment or consulting arrangements with entities other than the Hospital.

5. Personnel may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the Hospital. Personnel may not accept cash gifts and may not accept non-monetary gifts including meals, transportation or entertainment valued in excess of $25 from vendors, contractors or other third parties that have current or prospective business with the Hospital. Questions regarding the gift limitations should be directed to the Hospital's Chief Compliance Officer.
6. Any involvement by Personnel in a personal business venture shall be conducted outside the Hospital work environment and shall be kept separate and distinct from the Hospital's business in every respect.
7. Personnel should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the Hospital, the use of any of the Hospital's equipment, supplies or property, or any direct relationship with the Hospital's business or operation.
8. Personnel must guard patient and Hospital information against improper access or use by unauthorized individuals.
9. The Hospital's materials, products, designs, plans, ideas and data are the property of the Hospital and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.
10. Personnel must avoid any appearance of impropriety when dealing with clinicians and referral sources.
11. All vendors and contractors who have or desire business relationships with the Hospital must abide by this Code of Conduct. Personnel having knowledge of vendors or contractors who violate these standards in their relationship with the Hospital must report these to their supervisor or manager.
12. Personnel shall not sell any merchandise on Hospital premises and shall not sell any merchandise of a medical nature that is of a type or similar to what is sold or furnished by the Hospital, whether on or off Hospital premises, unless prior approval is obtained from the Hospital's Chief Compliance Officer.
13. Personnel shall not request donations for any purpose from other Personnel, patients, vendors, contractors or other third parties, unless prior approval is obtained from the Hospital's Chief Compliance Officer.
14. Personnel may not endorse any product or service without explicit prior approval to do so by the Hospital's Chief Compliance Officer.

Disclosure of Potential Conflict Situations

You must disclose any activity, relationship, or interest that is or may be perceived to be a conflict of interest and complete the attached Conflict of Interest Certification Form within ninety (90) days of being subject to this Code of Conduct (that is, being hired by the Hospital, beginning to volunteer at the Hospital, or assuming any responsibilities at the Hospital). At least annually thereafter, you must review this Code of Conduct and your most recent Conflict of Interest Certification. You are not required to file a Conflict of Interest Certification Form annually unless there is a change in your circumstances that you

have not previously reported. At any time during the year, when an actual, potential, or perceived conflict of interest arises, you must revise your certification form and contact the Hospital's Chief Compliance Officer. It is your responsibility to promptly report any actual or potential conflicts.

All certification forms must be sent to the Hospital's Chief Compliance Officer. The Chief Compliance Officer will review all disclosures and determine which disclosures require further action. The Chief Compliance Officer will consult with the Hospital's Chief Executive Officer or legal counsel if it is unclear whether an actual conflict of interest exists or if the Chief Compliance Officer determines that an actual conflict of interest exists. The outcome of these consultations will result in a written determination, signed by all decision-makers involved, stating whether or not an actual conflict of interest exists. If a conflict of interest is determined to exist, the written determination shall set forth a plan to manage the conflict of interest which may include that:

1. The conflict of interest is permitted;
2. The conflict of interest is permitted with modification or oversight, including such steps as reassignment of responsibilities or establishment of protective arrangements;
3. The conflict of interest will require the Personnel to abstain from participating in certain governance, management or purchasing activities related to the conflict of interest; or
4. The conflict of interest must be eliminated or, if it involves a proposed role in another organization or entity, must not be undertaken.

The Chief Compliance Officer will review any written determination with you, discuss any necessary action you are to take, and ask you to sign the written determination. The signed written determination will be kept with your certification form.

Anti-Competitive Activities

If you work in sales or marketing, the Hospital asks you to perform your job not just vigorously and effectively, but fairly, as well. False or misleading statements about a competitor are inappropriate, invite disrespect and complaints, and may violate the law. Be sure that any comparisons you make about competitors' products and services are fair and accurate. (Competitors are other hospitals and health facilities.)

Reporting Violations

The Hospital supports and encourages each employee and contractor to maintain individual responsibility for monitoring and reporting any activity that violates or appears to violate any applicable statutes, regulations, policies or this Code of Conduct.

The Hospital has established a reporting mechanism that permits anonymous reporting, if the person making the report desires anonymity. Employees who become aware of a violation of the Hospital Compliance Program, including this Code of Conduct, must report the improper conduct to their direct supervisor or the Chief Compliance Officer. That supervisor, or a designee, will then investigate all reports and ensure that appropriate follow-up actions are taken.

Hospital policy prohibits retaliation against an employee who makes such a report in good faith. In addition, it is the policy of the Hospital that no employee will be punished on the basis that he/she reported what he/she reasonably believed to be improper activity or a violation of this Program.

However, employees are subject to disciplinary action if after an investigation the Hospital reasonably concludes that the reporting employee knowingly fabricated, or knowingly distorted, exaggerated or minimized the facts to either cause harm to someone else or to protect or benefit themselves.

SECTION III — COMPLIANCE PROGRAM SYSTEMS AND PROCESSES

This Compliance Program contains a comprehensive set of policies. In order to effectively implement and maintain these policies, the Hospital has developed various systems and processes. The purpose of this section of the Compliance Program is to explain the various systems and processes that the Hospital has established for the purpose of providing structure and support to the Compliance Program.

Compliance Officers and Committee

Chief Compliance Officer

The Hospital has a Chief Compliance Officer who serves as the primary supervisor of this Compliance Program. The Hospital's Chief Compliance Officer occupies a high-level position within the organization and has authority to carry out all compliance responsibilities described in this Compliance Program. The Chief Compliance Officer is responsible for assuring that the Compliance Program is implemented to ensure that the Hospital at all times maintains business integrity and that all applicable statutes, regulations and policies are followed.

The Chief Compliance Officer provides frequent reports to the Governing Board about the Compliance Program and compliance issues. The Governing Board is ultimately responsible for supervising the work of the Chief Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Governing Board oversees all of the Hospital's compliance efforts and takes any appropriate and necessary actions to ensure that the Hospital conducts its activities in compliance with the law and sound business ethics.

The Chief Compliance Officer and Governing Board shall consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

Responsibilities of the Chief Compliance Officer

The Chief Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting on a regular basis to the Governing Board (no less than annually) on the progress of implementation and operation of the Compliance Program and assisting the Governing Board in establishing methods to reduce the Hospital's risk of fraud, abuse and waste.
- Periodically revising the Compliance Program in light of changes in the needs of the Hospital and changes in applicable statutes, regulations and government policies.

- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the program, and a comprehensive review of the compliance department.
- Developing, coordinating and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that all appropriate Personnel are knowledgeable about, and act in accordance with, this Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents of the Hospital are aware of the requirements of this Compliance Program as they affect the services provided by such contractors and agents.
- Ensuring that employees, independent contractors, and agents of the Hospital have not been excluded from participating in Medicare, Medicaid (Medi-Cal) or any other federal or state health care program.
- Ensuring that the Hospital does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid (Medi-Cal), or any other federal or state health care program.
- Coordinating internal compliance review and monitoring activities.
- Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Maintaining a good working relationship with other key operational areas, such as internal audit, coding, billing and clinical departments.
- Designating work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance Program.

The Chief Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents and physicians.

The Chief Compliance Officer has direct access to the Governing Board, Chief Executive Officer and other senior management, and to legal counsel. The Chief Compliance Officer has the authority to retain, as he or she deems necessary, outside legal counsel.

Compliance Committee

The Hospital has established a Compliance Committee to advise the Chief Compliance Officer and assist in monitoring this Compliance Program. The Compliance Committee provides the perspectives of individuals with diverse knowledge and responsibilities within the Hospital.

Members of the Compliance Committee

The Compliance Committee consists of eight (8) representatives. The members of the Compliance Committee include those individuals designated below, and includes representatives of senior management, chosen by the Hospital's Chief Executive Officer in consultation with the Chief Compliance Officer:

- Chief Compliance Officer/Chief HR Officer
- Chief Financial Officer or Controller
- Chief Information Officer
- Privacy Officer/HIM Manager
- Chief Nursing Officer
- Medical Staff Coordinator
- Chief Quality Officer
- Chief Ancillary Officer

The Chief Compliance Officer serves as the chairperson of the Compliance Committee. The Compliance Committee serves in an advisory role and has no authority to adopt or implement policies. The Chief Compliance Officer will consult with members of the Compliance Committee on a regular basis and may call meetings of all or some members of the Compliance Committee.

Functions of the Compliance Committee
The Compliance Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program.
- Working with the Chief Compliance Officer to develop further standards of conduct and policies to promote compliance.
- Recommending and monitoring, in conjunction with the Chief Compliance Officer, the development of internal systems and controls to carry out the standards and policies of this Compliance Program.
- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Chief Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate and respond to complaints and problems related to compliance.
- Assisting the Chief Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and business units in which the members of the Compliance Committee work.
- Consulting on vendor contracts with the Hospital to promote adherence to this Compliance Program as it applies to those vendors.

The tasks listed above are not intended to be exhaustive. The Compliance Committee may also address other compliance-related matters as determined by the Chief Compliance Officer.

Training and Education

The Hospital acknowledges that this Compliance Program will be effective only if it is communicated and explained to Personnel on a routine basis and in a manner that clearly explains its requirements. For this reason, the Hospital requires all Personnel to complete specific training programs on a periodic basis. Training requirements and scheduling are established by the Hospital for its departments and affiliates based on the needs and requirements of each department and affiliate. Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics. Training will be provided by qualified internal or external education personnel. New employees are trained early in their employment. Training programs may include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards.

All formal training undertaken as part of the Compliance Program is documented. Documentation includes at a minimum the identification of the Personnel participating in the training, the subject matter of the training, the length of the training, the time and date of the training, the training materials used, and any other relevant information.

The Chief Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting the Hospital's employees. The training program is modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address results of the Hospital's audits and investigations; results from previous training and education programs; trends in Hotline reports; and guidance from applicable federal and state agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions.

The Chief Compliance Officer seeks feedback to identify shortcomings in the training program, and administers post-training tests as appropriate to ensure attendees understand and retain the subject matter delivered.

Specific training for appropriate corporate officers, managers, and other employees may include areas such as:

- Restrictions on marketing activities.
- General prohibitions on paying or receiving remuneration to induce referrals.
- Proper claims processing techniques.
- Monitoring of compliance with this Compliance Program.
- Methods for educating and training employees.
- Duty to report misconduct.

The members of the Hospital's Governing Board will be provided with periodic training, not less than annually, on fraud and abuse laws and other compliance matters.

Where feasible, outside contractors will be afforded the opportunity to participate in, or be encouraged to develop their own, compliance training and educational programs, to complement the Hospital's standards of conduct and compliance policies. The Chief Compliance Officer will ensure that records of compliance training, including attendance logs and copies of materials distributed at training sessions, are maintained.

The compliance training described in this program is in addition to any periodic professional education courses that may be required by statute or regulation for certain Personnel. The Hospital expects its employees to comply with applicable education requirements; failure to do so may result in disciplinary action.

Lines of Communicating and Reporting

Open Door Policy

The Hospital recognizes that clear and open lines of communication between the Chief Compliance Officer and Hospital Personnel are important to the success of this Compliance Program. The Hospital maintains an open door policy with regard to all Compliance Program related matters. Hospital Personnel are encouraged to seek clarification from the Chief Compliance Officer in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

Submitting Questions or Complaints

The Hospital has established a telephone hotline for use by Hospital Personnel to report concerns or possible wrongdoing regarding compliance issues. We refer to this telephone line as our "Compliance Hotline."

The Compliance Hotline contact numbers are:

Phone: (707) 935-5151
Fax: (707) 935-5179

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Chief Compliance Officer at the following address:

Chief Compliance Officer
Sonoma Valley Hospital
347 Andrieux Street
Sonoma, CA 95476

The Compliance Hotline numbers and the Chief Compliance Officer's address are posted in conspicuous locations throughout the Hospital's facilities.

Calls to the Compliance Hotline are answered by the Chief Compliance Officer. All calls are treated confidentially and are not traced. The caller need not provide his or her name. The Hospital's Chief Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the Compliance Hotline and letters mailed to the Chief Compliance Officer are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Hotline, or in writing, that suggest violations of compliance policies, statutes or regulations, are documented and investigated promptly. A log is maintained by the Chief Compliance Officer of calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Chief Compliance Officer to the Hospital's Governing Board and Chief Executive Officer.

Non-Retaliation Policy

It is the Hospital's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance. However, Hospital Personnel cannot use complaints to the Chief Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

Enforcing Standards and Policies

Policies

It is the policy of the Hospital to appropriately discipline Hospital Personnel who fail to comply with the Code of Conduct or the policies set forth in, or adopted pursuant to, this Compliance Program or any federal or state statutes or regulations.

The guiding principles underlying this policy include the following:

- Intentional or reckless noncompliance will subject Personnel to significant sanctions, which may include verbal warnings, suspension or termination of employment, depending upon the nature and extent of the noncompliance.
- Negligent failure to comply with the policies set forth in this Compliance Program, or with applicable laws, will also result in sanctions.
- Disciplinary action will be taken where a responsible employee fails to detect a violation, if this failure is attributable to his or her negligence or reckless conduct.
- Internal audit or review may lead to discovering violations and result in disciplinary action.

Because the Hospital takes compliance seriously, the Hospital will respond to Personnel misconduct.

Discipline Procedures

Employees found to have violated any provision of this Compliance Program are subject to discipline consistent with the policies set forth herein, including termination of employment if deemed appropriate by the Hospital. Any such discipline is within the sole discretion of the Hospital. Each instance involving disciplinary action shall be thoroughly documented by the employee's supervisor and the Chief Compliance Officer.

Upon determining that an employee of the Hospital or any of its affiliates has committed a violation of this Compliance Program, such employee shall meet with his or her supervisor to review the conduct that resulted in violation of the Compliance Program. The employee and supervisor will contact the Chief Compliance Officer to discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Chief Compliance Officer during the investigation of the violation. Legal counsel will be consulted prior to final actions or disciplinary measures, as appropriate.

Auditing and Monitoring

The Hospital conducts periodic monitoring of this Compliance Program. Compliance reports created by this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Chief Compliance Officer.

The Chief Compliance Officer will develop and implement an audit plan. The plan will be reviewed at least annually to determine whether it addresses the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high-volume services.

Periodic compliance audits are used to promote and ensure compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes and regulations and federal health care program requirements. The audits will focus on specific programs or departments of the Hospital, including external relationships with third-party contractors. These audits are designed to address, at a minimum, compliance with laws governing kick-back arrangements, physician self-referrals, claims development and submission (including an assessment of the Hospital's billing system), reimbursement and marketing. All Personnel are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor.

The Hospital shall conduct periodic reviews, including unscheduled reviews, to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications to the Compliance Program will be implemented when monitoring discloses that compliance issues have not been detected in a timely manner due to Compliance Program deficiencies.

The periodic review process may include the following techniques:

- Interviews with Personnel involved in management, operations, claim development and submission, and other related activities.
- Questionnaires developed to solicit impressions of the Hospital Personnel.
- Reviews of all billing documentation, including medical and financial records and other source documents that support claims for reimbursement and claims submissions.
- Presentations of a written report on compliance activities to the Chief Compliance Officer. The report shall specifically identify areas, if any, where corrective actions are needed. In certain

cases, subsequent reviews or studies may be conducted to ensure that recommended corrective actions have been successfully implemented.

Error rates shall be evaluated and compared to error rates for prior periods as well as available norms. If the error rates are not decreasing, the Hospital shall conduct a further investigation into other aspects of the Compliance Program in an effort to determine hidden weaknesses and deficiencies.

Corrective Action

Violations and Investigations

Violations of this Compliance Program, failure to comply with applicable federal or state laws, and other types of misconduct threaten the Hospital's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger the Hospital's business and reputation, and can lead to serious sanctions against the Hospital. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Chief Compliance Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. The Chief Compliance Officer may create a response team to review suspected noncompliance including representatives from the compliance, audit and other relevant departments.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation with legal counsel.

Depending upon the nature of the alleged violations, the Chief Compliance Officer's internal investigation could include interviews with relevant Personnel and a review of relevant documents. Legal counsel, auditors or health care experts may be engaged by the Chief Compliance Officer to assist in an investigation where the Chief Compliance Officer deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, results of the investigation (e.g., any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the Chief Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Chief Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

Reporting

If the Chief Compliance Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal,

civil or administrative law, then the misconduct will promptly be reported as appropriate to the OIG or any other appropriate governmental authority or federal and/or state law enforcement agency having jurisdiction over such matter. Such reports will be made by the Chief Compliance Officer on a timely basis.

All overpayments identified by the Hospital shall be refunded to the appropriate public or private payer or other entity.

SECTION IV — COMPLIANCE POLICIES

1. Confidential Reporting
   - e-Notification System #GL8610-144
   - Non-Retaliation for Reporting (Whistleblower Laws) Code of Conduct #GL8610-128
   - HIPAA Committee Reporting, Monitoring and Enforcing #IM8610-119
2. Compliance Enforcement
   - HPAA Security – Person or Entity Authentication Policy #IM8610-161
   - Auditing the Compliance Program Security Evaluation Policy #IM8610-157
3. Federal and State Fraud and Abuse
   - Contract Administration, Non-patient care services #GL8610-138
   - Contract Administration for Patient Care Services #GL8610-139
4. Patient Care and Rights
   - Patient Rights and Responsibilities #PR8610-160
   - Informed Consent #PR8610-134
   - Patient Privacy – HIPAA
   - EMTALA #PC7010-07
   - Quality Care #QA8610-102
5. Health Information Management Services
   - Coding Documents for Inpatient Services Coding Guidelines #MR8700-116
   - Patient Record Documentation #MR8610-104
   - Record Retention #RC8610-114
   - Medical Claims Processing Manual – Coding Code of Ethics #MR8700-114
6. Employment-Related Policies
   - Equal Opportunity #HR8610-100
   - Anti-Harassment Policy #HR8610-188

- Drugs & Alcohol Free Workplace #HR8610-316
- Smoking Policy #GL8610-190