



*Date: 4/26*

***Policy Name: Corporate Compliance Plan***

***Policy Number: 506***

## **CORPORATE COMPLIANCE PLAN**

LAUNCH has developed a Corporate Compliance plan in an effort to comply with applicable State and Federal laws. The purpose of an effective corporate compliance plan is to reduce waste and prevent fraud and abuse. Adhering to LAUNCH's corporate compliance program is the responsibility of all affected individuals including; employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers. LAUNCH is committed to providing quality services and billing for services in a legal and ethical manner to ensure that the agency's reputation is protected, and the agency's mission is attained.

### **Mission Statement:**

Our mission is to empower children, youth and adults with diverse abilities to reach their full potential through personalized services. We support meaningful, inclusive lives where individuals are active in their choices and self-advocacy.

### **Board of Directors Endorsement**

The Board of Directors is committed to ensuring LAUNCH's compliance with all applicable rules and laws, which govern compliance. The Board of Directors has approved LAUNCH's Corporate Compliance plan and have an active role in the oversight of the implementation of the Corporate Compliance plan. The Board's Audit and Finance Committee meets with the Compliance Committee of the Agency quarterly to review and support Compliance needs.

The Board of Directors' orientation process includes training about the corporate compliance program and the governing body's responsibility to ensure that the agency maintains proper procedures and documentation. Board Members receive Compliance Training annually.

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**Definitions:**

“Affected persons”: All persons who are affected by LAUNCH’s risk areas including the employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

“Compliance Officer”: Oversee the Agency’s quality assurance, corporate compliance, service review, participant satisfaction and staff training activities with the support of Agency’s Executive Director and Associate Executive Director. Serve as LAUNCH’s Corporate Compliance Officer and Privacy Officer. LAUNCH’s Board of Directors has designated the Director of Quality Enhancement/Compliance Officer from AccessCNY as the agency’s Compliance Officer with the assistance of LAUNCH’s Executive Director and Associate Executive Director. *See job description for AccessCNY’s Quality Enhancement/Compliance Officer.*

“Compliance Committee”: LAUNCH is committed to ethical and legal conduct while providing quality services. This Committee is responsible to collaborate and support the agency’s Corporate Compliance Officer to ensure the written policies and procedures, the required standards of

conduct are current, accurate, and complete, and that the required compliance training topics are completed timely. This Committee serves in an advisory capacity as Committee to LAUNCH (“Agency”) to coordinate with the Compliance Officer to ensure the Agency is conducting business in an ethical and responsible manner consistent with the Compliance Plan. *Refer to Compliance Committee Charter.*

### **COMPLIANCE PLAN ELEMENTS**

LAUNCH is committed to ensuring compliance with all applicable laws and regulations. LAUNCH’s Corporate Compliance Plan complies with the Office of the State Medicaid Inspector General’s eight required elements and shall be applicable to:

- Billings
- Payments
- Medical necessity and quality of care
- Governance
- Mandatory reporting
- Credentialing
- Ordered Services
- Contractor, subcontractor, agent, or independent contract oversight; and
- Other risk areas that are or should with due diligence be identified by LAUNCH

#### **1. Designation of a Compliance Officer and Compliance Committee:**

LAUNCH’s Board of Directors has designated the Director of Quality Enhancement/Compliance Officer from AccessCNY as the agency’s Compliance Officer. The Compliance Officer reports directly to the Executive Director and has unrestricted access to the Board of Directors related to Compliance.

The Committee and Officer are responsible for reviewing compliance investigations, monitoring audit and risk trends, and ensuring that the agency’s compliance plan meets all required elements. The Compliance Committee Charter identifies member responsibilities and is reviewed annually. The committee reports directly and is accountable to the Executive Director and the Audit and Finance Committee of the Board of Directors.

*Responsibilities of the Compliance Officer are outlined in the AccessCNY’s Director of Quality Enhancement/Compliance Officer job description.*

*The Compliance Committee will coordinate with the Compliance Officer and assume the duties outlined in the Compliance Committee Charter(Policy #506A).*

#### **2. Written Policies and Procedures:**

LAUNCH has developed several policies and procedures as part of the agency’s compliance plan in compliance with and under the guidance of the Office of Medicaid Inspector General (OMIG). LAUNCH has also developed a Compliance Code of Conduct that all employees and Affected Individuals are required to adhere to. LAUNCH’s compliance policies and procedures include, but are not limited to compliance program education, internal and external audits, billing, State and Federal False Claims Act, reporting and investigating compliance issues, return of overpayments, non-intimidation and non-retaliation, record retention and destruction and protection and security of information in compliance with HIPAA and FERPA laws.

When contracting with Medicaid Managed Care Organizations, LAUNCH will adhere to all requirements set forth in each contract.

All compliance policies will be reviewed at least annually to determine:

- a) if all policies, procedures and standards of conduct have been implemented;
- b) whether affected individuals are following the policies, procedures and standards of conduct;
- c) whether policies, procedures and standards of conduct are effective; and
- d) whether any updates are required.

*Compliance Policies are available online at [www.LAUNCHCNY.org](http://www.LAUNCHCNY.org). Employees have access to policies through the Agency Public Drive. Compliance Policies are included herein and part of this policy herein. HR policies are also available on the LAUNCH ADP home page.*

### **3. Training and Education:**

All LAUNCH employees, interns, students and volunteers working in a Medicaid billable program receive training on the agency's Compliance Plan, Federal and State False Claims Act, Whistleblower Protections and HIPAA Privacy and Security requirements during orientation and annually. Board members receive training on LAUNCH's compliance plan during Board orientation and then during the annual presentation by the Compliance Officer. All other Affected Individuals receive training upon commencement of a new contract. All employees and affected individuals are required to sign an attestation that they received and understand the training and will not participate in or cover up fraudulent activities. After the initial orientation training, LAUNCH's Corporate Compliance and HIPAA training is provided to all employees and affected individuals on an annual basis.

Compliance training remains a priority as a standing item for individual program staff meetings as well as bi-monthly Management team meetings. Monthly Compliance emails are sent to managers identifying topics to focus on that month at staff meetings. Those topics are reinforced and discussed at Management team meetings. As new regulations are released, this information is shared with the applicable programs and discussed during regular compliance meetings.

*Refer to the agency's compliance and education plan for additional information(Policy #511)*

### **4. Communication Lines to the Compliance Officer:**

Reporting of compliance issues and/or suspected fraud is the responsibility of all LAUNCH employees and Affected Individuals. The Compliance Officer has been designated as the contact for complaints, questions, suggestions and reporting of compliance issues. All LAUNCH employees and affected individuals are required to report any misconduct, fraudulent acts and/or compliance issues that they witness, suspect or are asked to participate in or cover up. Reports can be made to a supervisor or directly to the Compliance Officer. Reports can be made in person, by phone or email or via the LAUNCH Compliance Hotline. The Compliance Hotline is a voicemail box and can be accessed directly at **(315) 410-3333**. All reports made to the hotline can be made anonymously as there is no way to identify the caller or the number the call is being made from. Hotline information is available on LAUNCH's website.

Upon receipt of a question or concern, any supervisor or director shall document the issue at hand and promptly report to the Compliance Officer.

Any questions or concerns relating to potential non-compliance by the Compliance Officer should be reported immediately to the Executive Director.

All Medicaid recipients have access to the Compliance Officer's contact information on the website and through intake and annual paperwork.

### **5. Disciplinary Policies:**

Corporate Compliance is an expectation of all LAUNCH employees, Board Members, and Affected Individuals. The agency has developed disciplinary policies that provide the potential consequences of non-compliance for employees, the Board of Directors, and other Affected Individuals such as contractors and vendors.

LAUNCH is committed to ensuring that the discipline for non-compliance is enforced in a fair, consistent, and firm manner at all levels of the organization. Employees and Affected Individuals who fail to comply with LAUNCH's Compliance Code of Conduct, Compliance Plan and standards, or who have engaged in conduct that has the potential of impairing LAUNCH's status as a reliable, honest, and trustworthy service provider will be subject to disciplinary action, up to and including termination of employment, contract, assignment or association with LAUNCH. All Affected Individuals are expected to assist as needed in any compliance investigations.

Disciplinary actions will also be taken for anyone who participates in non-compliant behavior or activities, encourages, directs or facilitates non-compliant behavior, participates in the cover up of such activities or fails to report such activities after witnessing or becoming aware of them. Anyone substantiated for fraud will be terminated.

Managers and supervisors will be disciplined for failure to adequately instruct their subordinates, or for failing to detect noncompliance with applicable policies and legal requirements, where reasonable diligence on the part of the manager or supervisor would have led to the earlier discovery of any problems or violations and would have provided LAUNCH with the opportunity to correct them.

*Human Resources policies and Disciplinary Policies for Employees(Policy #1009) located herein on the ADP Home page>Forms Library and the Agency Public Drive.*

*Disciplinary Policy for the Board of Directors(Policy #1010) is located herein in the Agency Public Drive and is provided to each board member.*

*Disciplinary Policies for Affected Individual herein on Agency Public Drive.*

*LAUNCH's Code of Conduct(Policy # 518) policy is located herein at ADP home page>Forms Library and Agency Public Drive.*

### **6. Auditing and Monitoring**

An ongoing auditing and monitoring system, implemented by the Compliance Officer and in consultation with the Compliance Committee, is an integral component of the agency's auditing and monitoring systems. This ongoing evaluation shall include the following:

- Review of relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions;
- Compliance audits of Corporate Compliance policies and standards; and

- Review of documentation and billing relating to claims made to federal, state, and private payers for reimbursement, performed internally or by an external consultant as determined by Compliance Officer and Compliance Committee.

LAUNCH has developed a system for self-monitoring to ensure that services are provided, and claims are billed in compliance with applicable rules and regulations as well as in compliance with the agency's Best Practices.

The agency has developed a risk assessment that each department completes annually. The Compliance Officer and Compliance Committee review the assessments and then prioritize risk of all agency programs. The Compliance Officer completes a work plan based on the results of the risk assessments that is shared with all agency programs for implementation. The Quality Enhancement department at AccessCNY has developed audit tools for each program to ensure compliance with applicable rules and regulations. Billing audits are conducted monthly to ensure all billing requirements are met. *See policy 514.*

Deficiencies from external audits are also monitored by the Quality Enhancement team to ensure deficiencies are corrected.

Compliance meetings are held regularly with program staff to review trends identified in internal and external audits, investigation findings, updated regulations, status of the compliance work plan, status of high-risk programs, and other related compliance activities. Programs are also encouraged to complete peer audits and those results are shared with the AccessCNY Consulting QE Department.

Sometimes internal audits and/or complaints reveal documentation and/or billing errors that require further investigation, return of overpayments and/or self-disclosure to the Office of Medicaid Inspector General.

LAUNCH complies with any requests from Medicaid Managed Care Organizations according to the requirements outlined in the contract.

All compliance concerns are shared with the compliance committee quarterly.

Exclusion screenings(*Policy #512*) are conducted according to the Exclusion Screening policy. Any concerns are reported to the Compliance Officer for further investigation and follow-up.

*Please refer to the following Audit Policies(Policy #1501) herein in the Agency Public Drive.*

### **7. Responding to Compliance Issues:**

LAUNCH takes all reports of non-compliance seriously and has established a procedure for investigating compliance issues. Please refer to the Compliance Investigation policy (*Policy #510*)

When an individual makes a complaint or a compliance issue is discovered, the Compliance Officer initiates an investigation immediately; the type of investigation is dependent on the nature of the complaint.

The Compliance Officer, in conjunction with legal counsel as appropriate, shall ensure that all reports of suspected or actual non-compliance with LAUNCH's Compliance Code of Conduct, Compliance Plan, and compliance policies are thoroughly investigated and corrective actions are taken as appropriate.

Information obtained during a compliance investigation is confidential and only shared with the appropriate Management personnel, as necessary. LAUNCH may be required to disclose information obtained in an investigation when outside agencies such as OMIG, law enforcement, OPWDD, or OMH become involved.

The Compliance Officer shall maintain a record of the investigation, including copies of all pertinent documentation for ten years. The investigation may include, but is not limited to, the following:

- Interviews with individuals having knowledge of the facts alleged;
- A review of documents;
- Root cause analysis; and
- Legal research and contact with governmental agencies for the purpose of clarification.

The investigation record is confidential and will not be released without the approval of the Executive Director or legal counsel.

The Compliance Officer will ensure that corrective action plans are developed and implemented for all confirmed issues of non-compliance.

The Compliance Officer shall report quarterly to the Compliance Committee regarding each investigation conducted.

The Compliance Officer shall report compliance activity to the Board of Directors in a quarterly written report, including reports of non-compliance and investigative findings.

If LAUNCH identifies that an overpayment was received from any third-party payer, the appropriate regulatory (funder) and/or prosecutorial (attorney general/police) authority will be appropriately notified with the advice and assistance of counsel when necessary. It is Agency policy to not retain any funds that are received as a result of overpayments. In instances where it appears that an affirmative fraud may have occurred, appropriate amounts shall be returned after consultation and approval by involved regulatory and/or prosecutorial authorities. Systems shall also be put in place to prevent such overpayments in the future.

### **Statutory Guidelines**

LAUNCH is committed to compliance with all State and Federal laws and regulations. Compliance with the following federal and state laws and regulations will be adhered to at all times. Affected individuals are encouraged to reach out to the Compliance Officer with any concerns.

#### *Deficit Reduction Act of 2005*

Chapter 3 of the Deficit Reduction Act (DRA) includes several provisions intended to improve 'payment integrity' in the Medicaid program. Section 6032 requires health care organizations to

specifically inform employees about the federal False Claims Act, and similar state laws, and about the whistleblower protections incorporated into these laws.

#### Federal False Claims Act

The False Claims Act, 31 U.S.C. 3729 *et seq.*, is a federal law that imposes liability on any person or entity who submits a claim to the federal government that they know (or should have known) is false. This act is designed to prevent and detect fraud, waste and abuse in federal healthcare programs, including Medicaid and Medicare.

#### New York State False Claims Act (State Finance Law §§187-194)

The State False Claims Act imposes fines and penalties on individuals and agencies that file false and fraudulent claims for payment from any state or local government, including health care programs such as Medicaid.

*LAUNCH's False Claims Act Policy(Policy # 513) is aligned with the NYS False Claims Act and the Federal False Claims Act and is contained herein on the Agency Public Drive.*

#### Whistleblower or "Qui Tam" Provisions

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act contains a "Qui Tam" or whistleblower provision. The False Claims Act prohibits discrimination by the agency against any employee for taking lawful actions under the False Claims Act.

*LAUNCH's Whistleblower policy(Policy #517) is contained herein on the Agency Public Drive.*

#### New York Labor Law §740

An employer may not take any retaliatory personnel action against an employee, former employee or independent contractor if the person discloses information about the employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official. This includes actions that would discriminate against an employee or former employee or adversely impact a former employee's current or future employment.

#### New York Labor Law §741

Under this law, a healthcare employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care.

*LAUNCH's Non-Intimidation and Non-Retaliation Policy(Policy #520) is attached hereto on the Agency Public Drive.*

#### NYS Medicaid Inspector General Act of 2006

This legislation (Chapter 442 §363-d) requires that medical assistance providers must have a corporate compliance program minimally applicable to billings to and payments from Medicaid. This Compliance Plan complies with NYS Medicaid Inspector General Act of 2006. Employees are to be encouraged to participate in the corporate compliance program with policies of both non-retaliation and non-intimidation for coming forward and disciplinary action for failing to do so.

## **Privacy & Confidentiality**

### *Health Insurance Portability and Accountability Act of 1996*

This legislation was intended to enhance the privacy and security of medical information while streamlining the health insurance industry. It applies to all medical providers, insurance companies, and all other entities with access to 'protected health information.' Medicaid has released the code sets to be used in New York State.

LAUNCH is committed to complying with all laws protecting the confidentiality of all individuals' health information, including the Health Insurance Portability and Accountability Act (HIPAA) and HITECH Omnibus Rule, the Family Educational Rights and Privacy Act (FERPA), and the Stop Hacks and Improve Electronic Data Security Act (SHIELD). All employees, interns, volunteers, students, contractors, Business Associates and Board members are expected to adhere to the agency's HIPAA and FERPA standards and procedures. The Associate Executive Director of Quality and Performance has been designated as the agency's Privacy Officer. The Privacy Officer is responsible for monitoring disclosures of individual's PHI (Protected Health Information) and ensuring that the agency's HIPAA and FERPA procedures are followed. All individuals receiving services are given a copy of the agency's Privacy Practices notice during the intake process. The agency's Privacy Practices notice is also available on LAUNCH's website and individuals may request a written copy from a supervisor or the Privacy Officer at any time.

*Agency Confidentiality Policy (Policy #507) is located herein on the Agency Public Drive.*

## **Exclusion Screening and Background Checks**

LAUNCH will ensure compliance with all federal and state laws and regulations regarding exclusion screening. LAUNCH will not employ, contract with or conduct business with an individual or entity excluded from participation in state or federally sponsored health care programs such as Medicare and Medicaid. LAUNCH will conduct exclusion screening checks on all employees, consultants, vendors, and Board members initially and monthly to ensure compliance with all federal and state laws and regulations regarding exclusion screening.

*The Exclusion Screening policy(Policy #512) is contained herein on Agency Public Drive.*

## **Self-Disclosure**

LAUNCH is committed to ensuring that the agency's documentation, coding and billing practices comply with all federal and state laws and regulations. LAUNCH prohibits the intentional submission for reimbursement of any claim that is false, fraudulent or fictitious.

Upon identification of a Medicaid overpayment, LAUNCH will promptly investigate, quantify, report, and return the overpayment in accordance with applicable federal and New York State requirements.

An overpayment is defined as any funds received or retained under the Medicaid program to which LAUNCH is not entitled.

## Self-Disclosure Requirement

At times, LAUNCH may receive overpayment for services. LAUNCH will utilize the self-disclosure process established by the New York State Office of the Medicaid Inspector General for the reporting of Medicaid overpayments.

LAUNCH will not rely solely on claim adjustments or voiding to satisfy its obligation to report and return overpayments when the overpayment is identified through internal review, audit, investigation, or other compliance activities.

Instead, LAUNCH will:

- Submit either an **Abbreviated Self-Disclosure** or a **Full Self-Disclosure**, as appropriate, for all identified overpayments, including those corrected through claims adjustment or voiding.
- Ensure all disclosures include, at a minimum:
  - A description of the issue and how it was identified
  - The time period involved
  - The methodology used to calculate the overpayment
  - Root cause analysis
  - Corrective actions implemented to prevent recurrence

## Determination of Disclosure Type

LAUNCH will determine the appropriate level of disclosure as follows:

- **Abbreviated Self-Disclosure** may be used when the overpayment is routine, non-systemic, and readily quantifiable.
- **Full Self-Disclosure** will be submitted when the overpayment involves systemic issues, patterns of errors, control failures, or potential fraud, waste, or abuse.

Examples of issues appropriate for full self-disclosure include, but are not limited to:

- Systemic errors
- Repeated or patterned billing issues
- Control or compliance program failures
- Potential violations of fraud and abuse laws

## Return of Overpayments (60-Day Rule)

In accordance with Affordable Care Act Section 6402(a) and New York Social Services Law §363-d, LAUNCH will report and return identified overpayments by the later of:

- Sixty (60) days after the date on which the overpayment was identified; or
- The date any corresponding cost report is due, if applicable.

For purposes of this policy, an overpayment is considered “identified” when LAUNCH has determined, or should have determined through the exercise of reasonable diligence, that an overpayment was received and has quantified the amount.

*The Self Disclosure policy(Policy #515) is contained herein on Agency Public Drive.*

### **Billing and Financial Reporting and Records**

LAUNCH is committed to ensuring that the agency’s documentation, coding and billing practices comply with all federal and state laws, regulations and guidelines. Furthermore, LAUNCH is committed to ensuring against the accidental submission of any claim that is false or inaccurate. All LAUNCH employees and contractors must prepare and submit documentation and billing that is honest and accurate. Billing will only be submitted for actual services provided, which also includes documentation containing all required elements to support the billing. LAUNCH has developed systems to ensure that LAUNCH only bills and receives payment for services provided and supported by the required documentation. Any employee or contractor who knowingly presents or causes to be presented, claims for payment or approval which are false, fraudulent, or fictitious, will be subject to disciplinary action up to termination and/or prosecution.

LAUNCH is committed to creating and maintaining complete and accurate financial records and reports. LAUNCH’s financial statements and reports are prepared in accordance with applicable laws, with accepted accounting principles, and are subject to external audits by an independent auditing firm.

*\*\*LAUNCH will follow any updated guidance that OMIG releases regarding disclosures.*

### **Conflict of Interest**

LAUNCH is committed to ensuring compliance with all required federal and state laws regarding making transparent and ethical business decisions. All employees and members of the Board will disclose real and potential conflicts of interest and refrain from participation in any decisions on matters that involve a real conflict of interest or the appearance of a conflict pursuant to the Agency Conflict of Interest Policy.

*The Agency Conflict of Interest Policy(Policy #1001) is located herein on Agency Public Drive.*

## **Job Description**

### **Director, Quality Enhancement for AccessCNY**

#### **Main Function:**

In conjunction with assigned Agency leadership teams, facilitate an ongoing regulatory compliance and quality improvement program, for all Agency departments.

#### **Duties:**

- **Corporate Compliance Officer**
    - Act as the focal point for the Agency's required compliance plan, and be responsible for the day-to-day operations of the compliance program
    - Design and implement the Agency's compliance plan; monitor the plan and evaluate the effectiveness of it
    - Incorporate compliance plan changes based on the Agency's organizational experience and/or changes to laws and regulations, policies and standards
    - Implement and monitor the Agency's Risk Assessment System
    - Report on the progress of adopting, implementing, and maintaining, the Agency's compliance program to the: Board of Directors, Compliance Committee, and the CEO
    - Coordinate the implementation of the Agency's fraud, waste, and abuse prevention programs
    - Liaison with the HR Department regarding corporate compliance issues
    - Oversee corporate compliance: reporting, investigations, and management, for the Agency
    - Investigate alleged compliance guideline violations, work with the HR department to handle violations promptly, consistently, and effectively
    - Serve as the confidential "whistle-blower" contact person regarding potential fraud and abuse; investigate alleged violations
    - Ensure that HIPAA policy and procedures are followed inclusive of business agreements, privacy officer duties, and recording of approved disclosures
  
  - **Supervision**
    - Responsible for the supervision of assigned staff in the program
    - In conjunction with the Sr Director, MH Community Based Services and/or HR; recruit, interview, and hire staff to fill approved (funded) vacancies
    - Orient, train, and direct staff regarding specific job duties
    - Provide ongoing direction, support, and regular one on one supervision to staff
    - Conduct performance evaluations of staff-initial, 6 month, and annual; document performance concerns and follow-up with disciplinary action, if necessary
    - Share pertinent service, departmental, and Agency wide information; encourage staff participation in Agency functions, trainings, events, etc.
    - Be available after hours to ensure emergency support for reportable incidents and safeguard implementation

Oversees the Quality Enhancement (QE) Department in the absence of the Chief Quality Officer
  
  - **Incident Investigations**
    - Oversee participant incident reporting, investigation, and management, for the entire Agency consistent with the Office for People with Developmental Disabilities (OPWDD) 624 regulations,
-

Office of Mental Health (OMH) 524 regulations and Department of Health (DOH) regulations, to include data entry into IRMA and NIMRS electronic records

- Analyze trend data and present to the Board of Directors annually
- Conduct compliance and HIPAA breach investigations, as assigned
- Serve as chair and convener of the Special Review Committee (regarding participant incidents), and ensure that the committee discharges its duties in compliance with OPWDD, OMH, DOH and NYS Justice Center regulations

- Compliance & Quality Improvement Audits

- Implement regularly, scheduled, program audits
- Observe various Agency services to ensure regulatory compliance and adherence to quality standards
- Review other Agency systems, including: training, incidents, personal allowance, etc.
- Prepare internal audit reports, as directed by the Chief Quality Officer
- Make recommendations to the Chief Quality Officer for program specific, systemic, improvements

- Self-Auditing Program

- Design, implement, and monitor, an ongoing self-audit program, tailored to each Agency service and funding stream; to be implemented by assigned staff
- Attend exit interviews with all external quality assurance auditors, i.e. OPWDD Bureau of Program Certification, OMH, DOH Program Review; when at Agency
- Ensure the QE team observes staff service delivery, reviews service documentation, and audits billing
- Develop, and implement systems, to ensure regulatory compliance
- Regularly review participant records for compliance
- Collaborate with other agencies and consultants to keep current with best practices in the QE field

- Participant Satisfaction

- Implement a system to monitor participant satisfaction in Agency programs
- Implement a system to measure quality initiative outcomes in Agency programs
- Assist the Chief Quality Officer to analyze data

- Community and Teamwork

- Facilitate positive communication with other departments and accept assignments in other areas as requested by supervisor
- Work collaboratively with participants, families, program staff, co-workers, and supervisor
- Conduct self in a professional manner
- Serve as a member of the Leadership Team
- Attend staff meetings and other meetings as directed by supervisor
- Participate in Agency-wide events, advocacy, and/or, community education

- Follows Agency Standards and Procedures

- Provide person-centered, quality, services
- Demonstrate effective time management skills
- Observe confidentiality and safeguards regarding all participant related information

- Follow Agency standards and procedures
- Maintain compliance with applicable program rules and regulations
- Contribute to department and Agency quality improvement initiatives
- Ensure compliance with federal, state, and local employment laws and regulations, as well as with company policies

- Perform Other Duties as Assigned

**Education & Experience:**

Bachelor degree in a human services field plus five years' experience working with people with disabilities, required. Minimum of three years' supervisory experience, required. Minimum of two years' of knowledge and experience with OPWDD, OMH, NYS Justice Center, and compliance regulations, preferred. Position requires good communication and facilitation skills. Must be detail-oriented and have strong organizational skills.

**Scope of Responsibility:**

Position involves access to confidential information, which must be respected. Errors can have legal and financial consequences for the Agency, participants, and employees. With moderate supervision, work independently to investigate allegations, assess participant satisfaction, and enhance service delivery. Use one's own experience and judgment to assess and carry out assigned responsibilities, in keeping with Agency goals and philosophy. Contact with the public is moderate.

**Conditions of Employment:**

Must have a valid NYS Driver License in accordance with the Agency Vehicle and Driving policy and transportation necessary to meet program needs. Must respect confidentiality. Must be able to demonstrate teamwork and professionalism. Must have flexible schedule able to accommodate occasional early morning, evening, or weekend, commitments. Must participate and meet established requirements in a database check through the Division of Criminal Justice Services as defined by the State of New York, Office for People with Developmental Disabilities, Chapter 575 of the Laws of 2004. Must participate in successful database checks through the State Central Registry of Child Abuse and Maltreatment, HHS Office of Inspector General, Excluded Parties List System, New York Office of Medicaid Inspector General and Specially Designated Nationals.

**Reports to:**

Chief Innovation Officer

