Catholic Health Initiatives
FY 2006 CRP EFFECTIVENESS MEASUREMENT TOOL

MBO Name:	**Date Completed:**
Completed by:	**Title:**
Phone Number:	

Program Elements	How To Measure Effectiveness	Results of Measurement	Yes	No
Local Corporate Responsibility Officer (CRO) And Appropriate Governing Bodies				
1. The organization has appointed a local CRO and the appointment has been approved by the entity/respective board or designated committee of the board.	• Documentation of the appointment is supported in the respective minutes.			
2. The CRO is a member of the organization's senior staff and has direct reporting or access to the CEO on compliance matters.	• The MBO organization chart supports this reporting relationship. • Minutes from senior leadership meetings support the attendance and involvement of the CRO.			
3. The CRO job description must reflect the minimum elements of a CRO in addition to other applicable functional responsibilities.	• The CRO job description includes the minimum job requirements as defined in the CHI CRP Manual.			
4. The CRO provides CRP updates to the governing body at least twice yearly (if the CRO reports to the board instead of another governing body, the annual report above satisfies one of these	• The minutes of the governing body reflect the semiannual CRP updates in accordance with the requirements as defined in the CHI CRP Manual.			

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meeting requirements).				
5. An annual CRP report is provided to the board and includes the results of the annual risk and effectiveness measurement assessments, Ethics at Work Line and internal CRP inquiries and reports and other relevant information.	• The MBO board minutes document this presentation and who was in attendance. • The CRO maintains the content of the presentation in his/her records.			
Local Corporate Responsibility Program (CRP) Committee Oversight				
6. The organization has established a local corporate responsibility program committee with authority and responsibility for assisting the local CRO in development and operation of an effective compliance plan at the local operating level.	• A CRP charter or plan has been implemented and approved by the MBO governing body and is on file with the MBO.			
7. There are regular (a minimum of quarterly), ongoing meetings of the facility CRP committee and other activities that document that the facility is actively implementing their compliance plan. Members of the CRP committee are required to attend at least two meetings annually.	• The CRP Committee minutes document quarterly meetings. • The minutes reflect that all CRP Committee members attended at least two meetings annually.			
8. Minutes, agendas and other information are documented to support meeting activities.	• Minutes, agendas and other documentation comply with the minimum requirements as defined in the CHI CRP Manual.			

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9. CRP Committee membership includes at a minimum the following: CEO, CFO, mission, patient financial services, human resources, health information management, nursing, risk, quality, ancillary department representative and any other representative as appropriate (i.e., physician practices, home health, DME, senior services).	• The CRP charter/plan defines the CRP Committee membership and includes the representatives as defined in the program elements.			
10. The CRP committee meetings regularly address the duties and responsibilities of the committee, including monitoring of corrective actions related to compliance auditing and monitoring activities, oversight of Ethics at Work Line activity, compliance education and training activities, implementation of compliance policies and procedures, etc.	• The activities discussed at the CRP Committee meetings are documented in the minutes and include the program elements as defined. • Includes discussion and activities regarding compliance with HIPAA Privacy and IT Security.			
11. The annual effectiveness assessment is completed, distributed to, and discussed with the CRP committee.	• The CRP Committee minutes reflect the presentation and discussion of the annual effectiveness measurement report.			

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Standards and Procedures/Ethics at Work				
12. The Ethics at Work booklet is distributed to all employees, volunteers, medical staff members, board of directors, board subcommittees, medical students and residents, agency staff and any other person as appropriate. Documentation is maintained to evidence receipt and acknowledgment of the Ethics at Work to employees, volunteers, medical students and residents, board members/trustees and board subcommittees. Documentation is maintained to evidence distribution of the Ethics at Work to medical staff members in conjunction with the credentialing and/or recredentialing process and as needed (e.g., when revisions are made).	• Review 10% or 30 randomly selected employee files (whichever is smaller) to verify that the Ethics at Work Acknowledgment and Certification cards are present and signed. • Board and subcommittee members' Acknowledgment and Certification cards are received and maintained in the files. 100% completion is verified by the MBO. • A letter and the Ethics at Work were provided to all credentialed medical staff. • Verify that documentation exists to support the distribution and/or acknowledgment of the Ethics at Work for other persons as appropriate.			
13. The Ethics at Work is provided to all employees upon hire or shortly thereafter (within 30 days). Ethics at Work is redistributed as revisions are made or at a minimum of every three	• Review 10% or 30 randomly selected new employee files (whichever is smaller) to verify that the acknowledgment is signed and dated within 30 days of hire. Files should be from			

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years.	employees hired between July 1st and March 31st. For MBOs with multiple facilities in which distribution of the Ethics at Work was done separately, 10% or 30 new employee files will be randomly selected and reviewed from each facility. If the Ethics at Work distribution was done in a centralized fashion, the review may include a combined sample from all facilities.			
14. Ethics at Work language (Standards of Conduct) is included in staffing contracts.	• Randomly select and review 10% or 10 staffing contracts (whichever is smaller) to verify that the Ethics at Work language (standards of conduct) is included.			
15. HIPAA Privacy standards have been revised and implemented.	• Documentation to support revision and implementation of the HIPAA Privacy standards.			
16. IT Security standards have been adopted and implemented.	• Documentation to support adoption of the IT Security standards.			
Education, Training and Communication				
17. The identity and role of the local CRO and the CHI reporting process has been communicated to employees and	• Documentation to support periodic education is on file with the MBO.			

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medical staff on a periodic basis (at a minimum twice yearly). This may include: posters, newsletters, periodicals, emails, staff training sessions etc.				
18. Mandatory orientation education on the Ethics at Work is provided to all staff within 90 days of hire.	• Review 10% or 30 randomly selected new employee files (whichever is smaller) or review orientation log or sign-in and sign-out sheets to verify that the employee received orientation.			
19. Annual web-based education for required categories is 95% complete.	• Obtain the June 30 web-based completion report and verify that 95% of registered employees have completed their training.			
20. Boards of directors/trustees receive a minimum one hour of CRP education annually.	• The MBO board minutes document annual CRP education.			
Auditing, Monitoring and Risk Assessment				
21. The annual CRP risk assessment has been performed by the designated due date.	• Documentation is on file to support the timely submission of the annual CRP risk assessment.			
22. Action plans are developed to address risk areas identified in the CRP risk assessments. The action plans are implemented within agreed upon timetables.	• The action plan is developed, reviewed and approved by the CRP committee as documented in the minutes. • The implementation dates defined			

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	in the CRP risk assessment action plan are met.			
23. If a CHI IT Security site visit has been completed, an action plan is developed to address risk areas identified in the assessment. The action plan is implemented within agreed upon timetables.	• The action plan is developed, reviewed and approved by the CRP committee and is documented in the minutes. • The implementation dates defined in the action plan are met.			
24. Physician transaction committees, the board or a subcommittee of the board review all new and renewed physician contracts prior to execution.	• The board or committee minutes document the review and approval process. • Review 30 randomly selected physician contracts to ensure this independent review is performed. If less than 30 physician contracts exist, review all physician contracts.			
25. Time sheets for contracted medical directors are filled out appropriately and support payment.	• Randomly select 5 medical directors and review their timesheets for one quarter. If less than 5 medical directors exist, review all the medical director timesheets for the selected quarter.			
26. Billing and coding accuracy is reviewed a minimum of annually. This is done either internally, externally or both. (Note: Coding and billing staff	• Documentation is on file to support that 30 random inpatient and 30 random outpatient billing and coding accuracy reviews are			

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cannot audit their own work.)	completed annually. This random sample should be selected from federal and state funded programs. This may include: CHAN audit reports, other external consultant reports, internal audit reports, etc.			
27. Deficiencies identified as a result of the CHAN benchmark coding audit are corrected and appropriate education is provided to staff.	• Documentation is on file to support action taken to correct deficiencies. • Documentation is on file to support education provided to staff (i.e., department meeting minutes).			
28. Rebills are done when appropriate.	• Randomly select and review 10% or 30 rebills (whichever is smaller) to ensure that any changes in reimbursement are rebilled within 30 days of notification.			
Rewards, Discipline and Enforcement				
29. The MBO has a process in place to recognize and reward employees whose contributions related to CRP activities make a difference in the organization's culture.	• Documentation of how rewards and recognition are integrated into the CRP process.			
30. The MBO employment application includes the exclusionary status	• Verify appropriate verbiage is			

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provision.	included in the application.			
31. The organization's evaluation process includes adherence to the Ethics at Work and an understanding of the corporate responsibility program.	• Review evaluation process to ensure documentation includes this element.			
32. Supporting documentation is maintained of disciplinary action taken in response to violations of the Ethics at Work and the corporate responsibility program.	• The CRO (or his/her designee) maintains a log of any disciplinary actions involving a breech of the standards of conduct as defined in the *Ethics at Work*.			
Hotlines and Other Reporting Mechanisms				
33. Ethics at Work Line calls and issues reported directly to the local CRO are handled in accordance with the CRP Manual.	• The local CRO will review 10% or 10 randomly selected Ethics at Work Line calls (whichever is smaller) to determine that responses and actions comply with the documented process in the CRP Manual. • National CRP Office will randomly select 30 Ethics at Work Line calls from all calls received during the fiscal year, and will verify that the calls are responded to in accordance with the process as defined in the CRP Manual.			

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Background Checks/Exclusions Screening				
34. Background checks/exclusions screening are done for all employees prior to or within 30 days of hire. Documentation of the background checks/exclusions screening is maintained by the organization.	• Review 10% or 30 (whichever is smaller) randomly selected new employee files to ensure documentation exists to support timeliness of background checks/exclusions screenings. • Ensure appropriate actions are taken by the MBO (e.g., termination) when exclusionary status is identified.			
35. Medical staff applicants and other non-credentialed providers are screened for exclusion from participation in Medicare, Medicaid and other federal or state funded health care programs as part of the credentialing process. Documentation of exclusions screening performed for medical staff members is maintained by the organization.	• Review 10% or 30 randomly selected medical staff applicant files (whichever is smaller) and 5% or 10 randomly selected non-credentialed providers ordering services within the MBO (whichever is smaller) to ensure documentation exists to support that exclusions screenings are performed.			
36. Contractors are screened for exclusionary status within 30 days of initiation of contracted service.	• Review 10% or 30 (whichever is smaller) randomly selected new vendors, excluding Group Purchasing Organization and other CHI nationally negotiated contracts, to ensure that documentation is on file supporting timely screening by			

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	the applicable department.			
37. Annual screening of existing employees, physicians and contractors is performed by comparing the facility information to the OIG and GSA exclusion lists.	• Obtain and review internal audit reports to ensure annual screening is performed. • Document the resolution of any potential matches.			