



2026 CA Provider Annual Review Training

General Compliance | Fraud, Waste & Abuse | Drug Diversion | Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) Integrity and Compliance | Special Needs Plan (SNP) Model of Care | Disability Awareness | Cultural Competency and Patient Engagement | Workplace Violence Prevention | Caring Well for LGBTQIA+ Patients at Providence | HazCom



2026 Annual Compliance Training for Providers

Covering Medicare & Medicaid
Fraud and Abuse, Privacy & Security
Awareness *with MSSP ACO*

Table of Contents

Topic Area	Begins at:
1. CME Accreditation Statement	• Slide 3
2. General Compliance	• Slide 4
3. Fraud, Waste & Abuse	• Slide 9
4. Drug Diversion	• Slide 36
5. Gift Giving	• Slide 66
6. Privacy Compliance	• Slide 70
7. Cyber Security	• Slide 109
8. MSSP ACO Integrity & Compliance	• Slide 113

CME Accreditation

Faculty Disclosure Summary

The content of this activity is not related to products or services of an ACCME-defined ineligible company; therefore no one in control of content has a relevant financial relationship to disclose and there is no potential for conflicts of interest. All planners and presenters attested that their content suggestions and/or presentation(s) will provide a balanced view of therapeutic options and will be entirely free of promotional bias. All presentations have been reviewed by a planner with no conflicts of interest to ensure that the content is evidence-based and unbiased.

The information provided addresses several requirements of the Accreditation Council for Continuing Medical Education (ACCME) to help ensure independence in CME activities. Everyone in a position to control the content of a CME activity must disclose all relevant financial relationships with ineligible companies to the CME provider. This information must be disclosed to participants prior to the beginning of the activity. Also, CME providers must mitigate relevant conflicts of interest prior to the educational activity. The ACCME defines “ineligible companies” as those whose primary business is producing, marketing, selling, re-selling or distributing healthcare products used by or on patients. Among the exemptions to this definition are government organizations, non-health care related companies and non-profit organizations that do not advocate for commercial interests. Circumstances create a “conflict of interest” when an individual has an opportunity to affect CME content about products or services of an ineligible company with which he/she has a financial relationship. ACCME focuses on financial relationships with ineligible companies in the 24-month period preceding the time that the individual is being asked to assume a role controlling content of the CME activity. ACCME has not set a minimal dollar amount for relationships to be significant. Inherent in any amount is the incentive to maintain or increase the value of the relationship. The ACCME defines “relevant financial relationships” as financial relationships in any amount occurring within the past 24 months that create a conflict of interest.

Accreditation with Commendation

CME Accreditation Information

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Swedish Medical Center and Providence St. Joseph Health. Swedish Medical Center is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Category 1 Credits [™]

Swedish Medical Center designates this internet enduring material for a maximum of 4.0 *AMA PRA Category 1 Credits* [™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Compliance At Providence

- The Compliance Program sets a framework for adherence to laws, regulations, and organizational policies, as detailed in the approved Compliance Program Description. The Program supports our workforce members in fulfilling their legal, professional, and ethical obligations. A function of the Program is to recognize and prevent regulatory risk.
- The Compliance program applies to all workforce members, including independent physicians.
- Compliance Services manages Providence's Code of Conduct, compliance and privacy policies, the Conflicts of Interest disclosure program, Exclusion Screening program, and educates on various healthcare laws.
- Compliance Services has a presence in each division (North, South, and Central) and at each ministry we serve. [CLICK HERE](#) for a contact list.

Chief Compliance Officer (CCO)

- Providence has designated a CCO who is responsible for oversight of the Compliance Program
- The CCO strives to implement the seven elements of an effective compliance program as outlined in the General Compliance Program Guidance (GCPG) published by the OIG.
 1. Written Policies and Procedures, including a Code of Conduct
 2. Compliance Leadership and Oversight
 3. Training and Education
 4. Effective Lines of Communication and Disclosure Programs
 5. Enforcing Standards: Consequences and Incentives
 6. Risk Assessment, Auditing, and Monitoring
 7. Responding to Detected Offenses and Developing Corrective Action Initiatives
- The CCO is available to workforce members to answer compliance questions.



Chief Compliance Officer,
David Lane, Ph.D.

Code of Conduct (COC)

- The Compliance Program owns and is responsible for the upkeep of our organization's Code of Conduct and the [Code of Conduct policy](#). All providers are asked to review and agree to abide by the COC on an annual basis while working for Providence.
- The COC provides overviews on important topics such as:
 - Culture of diversity and respect
 - Quality of care and patient safety
 - Ethical and legal standards
 - Safeguarding patient information and protecting privacy and confidentiality
 - Compliance with applicable federal and state laws and regulations and policies
 - Duty to report suspected violations and protection from retaliation
- The COC reinforces our organizations values, which drive our actions and the principles that underlines decision making. Therefore, the Code becomes the most important part of the organization's ethical framework.

You can access our COC anytime on our Providence.org site:

[Code of Conduct | Compliance Program | Providence](#)

Doing the Right Thing Right

Our Code of Conduct

Culture of Diversity and Respect

We adhere to all laws and regulations and are committed to a workplace culture where all individuals are treated with respect and dignity, regardless of protected characteristics, as defined by local, state, or federal law, including but not limited to race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), genetic information, marital status, age, sex (which includes pregnancy, childbirth, breastfeeding and related medical conditions), gender, gender identity, gender expression, sexual orientation, and military and veteran status. [POLICY](#)

Quality of Care and Patient Safety

We commit to provide the best, *compassionate* care and service every time and strive to meet and exceed national standards for quality and patient *safety*. Workforce members have the responsibility and obligation to report any Quality of Care and Patient Safety issues. [POLICY](#)

Stewardship of Resources

We commit to effective stewardship of resources in support of patient care and organizational goals and only use resources for legitimate business purposes. [POLICY](#)

Conflicts of Interest (COI) Commitment

We will avoid actual or perceived COI and agree to disclose any outside interests or activities, contracts, and relationships that may be in conflict to the organization. We maintain impartial relationships with vendors, research sponsors, and contracts by not requesting or accepting gifts, cash, or cash equivalents. [POLICY](#)

Ethical and Legal Standards

We conduct ourselves in a professional and ethical manner in support of *justice* and will perform our job duties in accordance with all federal, state, and local laws. [POLICY](#)



Ways to report a compliance, privacy, or other concern

- Discuss the matter or concern with your immediate supervisor
 - Discuss the matter or concern with your department leader
 - Discuss with your HR Partner, HR Service Center, or send report via HR Portal
 - Contact your local or regional compliance or privacy representative
 - Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option
 - For Caregivers in India:
 - From an outside line, dial the direct access number: 000-117
 - At the English prompt dial 888-294-8455
- You may report concerns *anonymously***



To report a quality or patient safety concern

- Discuss the matter or concern with your immediate supervisor
- Discuss the matter or concern with your department leader
- Discuss with your Quality leader or representative
- Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option
- [HRP- High Reliability Platform](#)
 - Must be on organization network to report



Safeguarding Patient Information and Protecting Privacy and Confidentiality

We take every precaution to safeguard patient information, and we will treat protected health information (PHI) of all with special care and follow all federal, state, and local laws. [POLICY](#)

Ethical Conduct of Research

We follow the highest ethical standards and comply with all laws, regulations, guidelines, and ethical directives (where applicable) that govern human, animal, and basic applied science research. [POLICY](#)

Licensure and Certification

We require all health care and education professionals to follow all federal, state, and local laws applicable to licensing, credentialing, and certification requirements. Individuals on the excluded provider lists cannot work for our organization. [POLICY](#)

Compliance with Applicable Federal and State Laws and Regulations, and Policies

We ensure *excellence* by requiring all parties that work for or on behalf of an employer within our family of organizations learn and follow all laws, regulations, and policies. [POLICY](#)

Fair Business Practices

We conduct ourselves ethically, honestly, and with *integrity* at all times. [POLICY](#)

Duty to Report Violations and Protection from Retaliation

It is every workforce member's responsibility to report, in good faith, any violation or suspected violations of our code, fraud, waste, abuse or quality or patient safety concerns as required. Providence's Non-Retaliation policy, and to an extent, government law, protects workforce members from retaliation or harassment for having raised concerns about actual or potential wrongdoing or misconduct ". [POLICY](#)

Our mission, vision, values, and promise provide guidance and inspiration as we deliver quality care, make sound, ethical choices, and meet our organizational goals. As workforce members, we are accountable for the integrity of our decisions and actions on the job. We are obligated to report any suspected violations or concerns. The Code of Conduct provides a foundation of expectations for us as we do our work each day.



A Roadmap for New Physicians

Avoiding Medicare and Medicaid Fraud and Abuse

[CLICK HERE](#) to download your own copy of this Roadmap

Health Care Fraud is a Serious Problem

- The Government spends almost a trillion dollars each year on the Medicare and Medicaid programs.
- Although there is no precise measure of health care fraud, experts estimate that fraudulent billings to the programs are in the range of 3–10 percent.
 - **That means that fraud, waste, and abuse cost taxpayers between \$30 billion to \$100 billion dollars each year.**
- The estimated cost of fraud, waste, and abuse in 2025, was estimated that the taxpayers lost \$14.6 billion in a single “DOJ take down” to \$300 billion annually, to fraud. These figures highlight the substantial impact of fraud and waste on taxpayers.



Fraud, Waste, and Abuse

Fraud includes obtaining a benefit through intentional misrepresentation or concealment of material facts.

Waste includes incurring unnecessary costs as a result of deficient management, practices, or controls.

Abuse includes any practice that is not consistent with the goals of providing patients with services that (1) are medically necessary, (2) meet professionally recognized standards, and (3) are priced fairly.

Fraud and Abuse Laws

Physicians are an important part of protecting the integrity of the Medicare and Medicaid programs. The Government needs physicians to understand the fraud and abuse laws so that they can be partners in preventing fraud, waste, and abuse. There are a number of Federal and State laws to deter and punish those who fraudulently seek to obtain improper payments from Medicare and Medicaid. Federal laws include, but are not limited to, the following:

1. The Health Care Fraud Statute;
2. The False Claims Act;
3. The Anti-Kickback Statute;
4. The Physician Self-Referral Statute
5. Exclusion Provisions; and
6. The Civil Monetary Penalties Law



For more information, click [HERE](#) for a Fact Sheet.

False Claims Act

Prohibits the submission of false or fraudulent claims to the Government.

The Department of Justice obtained more than \$6.8 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, 2025. Over \$5.7 billion related to matters that involved the health care industry.

Claims may be false if the service is not actually rendered to the patient, is provided but already covered under another claim, is miscoded, or is not supported by the medical record.

The [False Claims Act](#) requires a [penalty](#) for each violation. The FCA penalty amount also increases with inflation each year. Currently in 2025, FCA penalties range from \$14,308 to \$28,619 per violation.

For example: a hospital compensated its physicians in a way that violated the Stark Law against physician self-referrals therefore violating the False Claims Act. The hospital had submitted 21,730 false claims to Medicare with a total value of \$39,313,065. The district court assessed 21,730 civil False Claims Act penalties. Ultimately, the hospital was on the hook for **\$119,515,000** in False Claims.

**Deliberate
Ignorance**

You do not have to intend to defraud the Government to violate the False Claims Act. You can be punished if you act with **deliberate ignorance or reckless disregard** of the truth.

Accurate Coding and Billing

Forms of medical billing fraud include duplicate billing, phantom billing, upcoding, under coding, medical equipment fraud, and billing separately for services already included in a global fee.



Accurate medical records are critical

The Medicare and Medicaid programs may review the patient's medical records to verify the claim, as well as the quality of care. If the medical record does not support the claimed service, the claim may be denied.



Good documentation helps ensure quality patient care

Good documentation is also a quality-of-care issue. It helps ensure that patients get the best possible clinical care from you and other providers who may rely on your records.

If you have questions about coding and documentation, please reach out to your [local compliance contact](#).

Participating Physicians...

- Most physicians bill Medicare as participating physicians and receive Medicare's 80 percent directly from Medicare and bill patients for the remaining 20 percent.
- This means that you accept the Medicare payment, plus any copayment or deductible Medicare requires the patient to pay, as the full payment.
- You may not require any extra payment from your patient. In other words, you may not ask Medicare patients to pay a second time for services for which Medicare has already paid.





Non- Participating Physicians...

- Bill directly to patients
- Patients reimbursed by Medicare
- It is illegal to charge more than 15% above the Medicare rate



Incentives to Report Fraud

The False Claims Act also provides a strong financial incentive to whistleblowers to report fraud. Whistleblowers can *receive up to 30 percent* of any False Claims Act recovery.

Often whistleblowers turn out to be ex-business partners, hospital or office staff, competitors, or even patients. Data analytic companies are increasingly becoming whistleblowers. [Check out this press release from January 2026.](#)

PRESS RELEASE

Justice Department Files False Claims Act Complaint Against Priority Hospital Group and Three Long Term Care Hospitals

Wednesday, January 21, 2026

For Immediate Release

2025 judgments exceed \$6.8B - highest in a single year in the history of the False Claims Act

🔦 Healthcare fraud a leading source of False Claims Act settlements & judgments

\$5.7B involved the health care industry, which includes:

Medicare Advantage Provider Seoul Medical Group and Related Parties to Pay Over \$62M to Settle False Claims Act Suit

Renaissance Imaging, a California based radiology group that worked with Seoul Medical, has also agreed to pay \$2.35M

Medicare Advantage Provider Independent Health to Pay Up To \$98M to Settle False Claims Act Suit

Justice Department intervened in a qui tam against national insurers Aetna Inc., Elevance Health Inc., and Humana Inc.

A unanimous jury found Omnicare liable for fraudulently dispensing drugs without valid prescriptions to elderly and disabled people

Types of FCA Violations

The current version of the False Claims Act lists seven types of violations

1. **False Claims** – Presenting, or causing the presentment, of a false claim for payment or approval. [31 U.S.C. §§ 3729\(a\)\(1\)\(A\)](#).
2. **False Records or Statements** – Making, using, or causing others to make or use, a false record or statement that is [material](#) to a false or fraudulent claim. [31 U.S.C. §§ 3729\(a\)\(1\)\(B\)](#).
3. **Conspiracy** – Conspiring to violate the False Claims Act. [31 U.S.C. §§ 3729\(a\)\(1\)\(C\)](#).
4. **Conversion** – Failing to return government property. [31 U.S.C. §§ 3729\(a\)\(1\)\(D\)](#).
5. **False Receipts** – Making or delivering a receipt of government property without completely knowing that the information in it is true. [31 U.S.C. §§ 3729\(a\)\(1\)\(E\)](#).
6. **Unlawful purchase of Government Property** – Buying public property from a government employee who may not lawfully sell it. [31 U.S.C. §§ 3729\(a\)\(1\)\(F\)](#).
7. **Reverse False Claims** – Making, using, or causing to be made or used, a false record or statement material to an obligation to pay money to the government; or conceals, avoids, or decreases an obligation to pay money to the government. [31 U.S.C. §§ 3729\(a\)\(1\)\(G\)](#).

Within these seven categories of violation, there are many ways to run afoul of the False Claims Act. If you are still curious, check out [False Claims Act Violations and Prohibitions Explained](#).

Anti-Kickback Statute (AKS)

The AKS is a federal criminal law and applies to both payers and recipients of kickbacks. The law prohibits obvious kickbacks, such as cash for referrals, as well as more subtle kickbacks, such as free rent, below fair market value rent, free clerical staff, or excessive compensation for medical directorships. The HHS-OIG and the Department of Justice enforce each of these provisions.

As a result, each violation of the AKS is **a felony punishable by a maximum fine of \$100,000, imprisonment up to 10 years, or both.** [42 U.S.C. § 1320a-7b \(b\)](#).

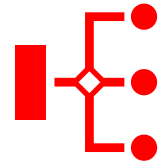
Conviction also will lead to mandatory exclusion from Federal health care programs, including Medicare and Medicaid. [42 U.S.C. § 1320a-7 \(7\)](#).

Violation of the AKS also triggers liability under the Civil Monetary Penalties Law (CMPL). The CMPL carries penalties of **up to \$100,000 per kickback**, in addition to three times the amount of the remuneration. It also makes the resulting bills to the government false under the [False Claims Act](#). As a result, the violator is responsible for three times the value of the bills, and a [False Claims Act Penalty](#) of **up to \$27,894 per bill.** [42 U.S.C. § 1320a-7a \(a\)](#).

Numerous physicians have been sanctioned under the False Claims Act by the Justice Department or by private individuals in a qui tam proceeding for selling their product loyalty to drug or device companies or other vendors.

False Claims Act Liability

A provider submitting a claim to government health care programs implicitly promises to comply with federal and state anti-kickback laws. Therefore, if the provider violates the AKS, **all tainted claims become false** under the federal and state False Claims Acts.



This is because the False Claims Act **pulls in other theories of liability**. When a service rendered by a provider is motivated by kickbacks, the **resulting claims are false or fraudulent as well**. Consequently, civil False Claims Act complaints will often allege a violation of criminal law as grounds for civil liability.



Damages under the False Claims Act **include three times the value** of the tainted claims caused to the Government by the fraud plus a False Claims Act penalty. **The penalty also increases each year**. By February 2024, False Claims Act penalties ranged as high as **\$27,894 per violation**.



Physician Self-Referral Law

[42 U.S.C. § 1395nn] - Commonly referred to as the *Stark Law*

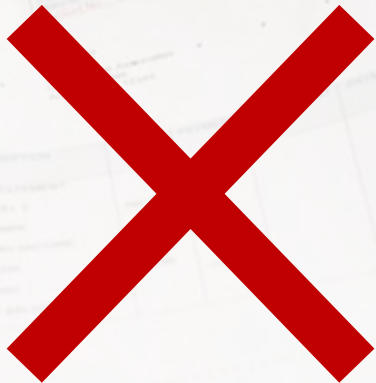
Prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities **with which the physician or an immediate family member has a financial relationship**, unless an exception applies.

- Financial relationships include both ownership/investment interests and compensation arrangements.
 - **For example:** If you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception, or you may not refer patients to the facility, and the entity may not bill for the referred imaging services.
- "Designated health services" include clinical laboratory services, physical therapy, and home health services, among others.



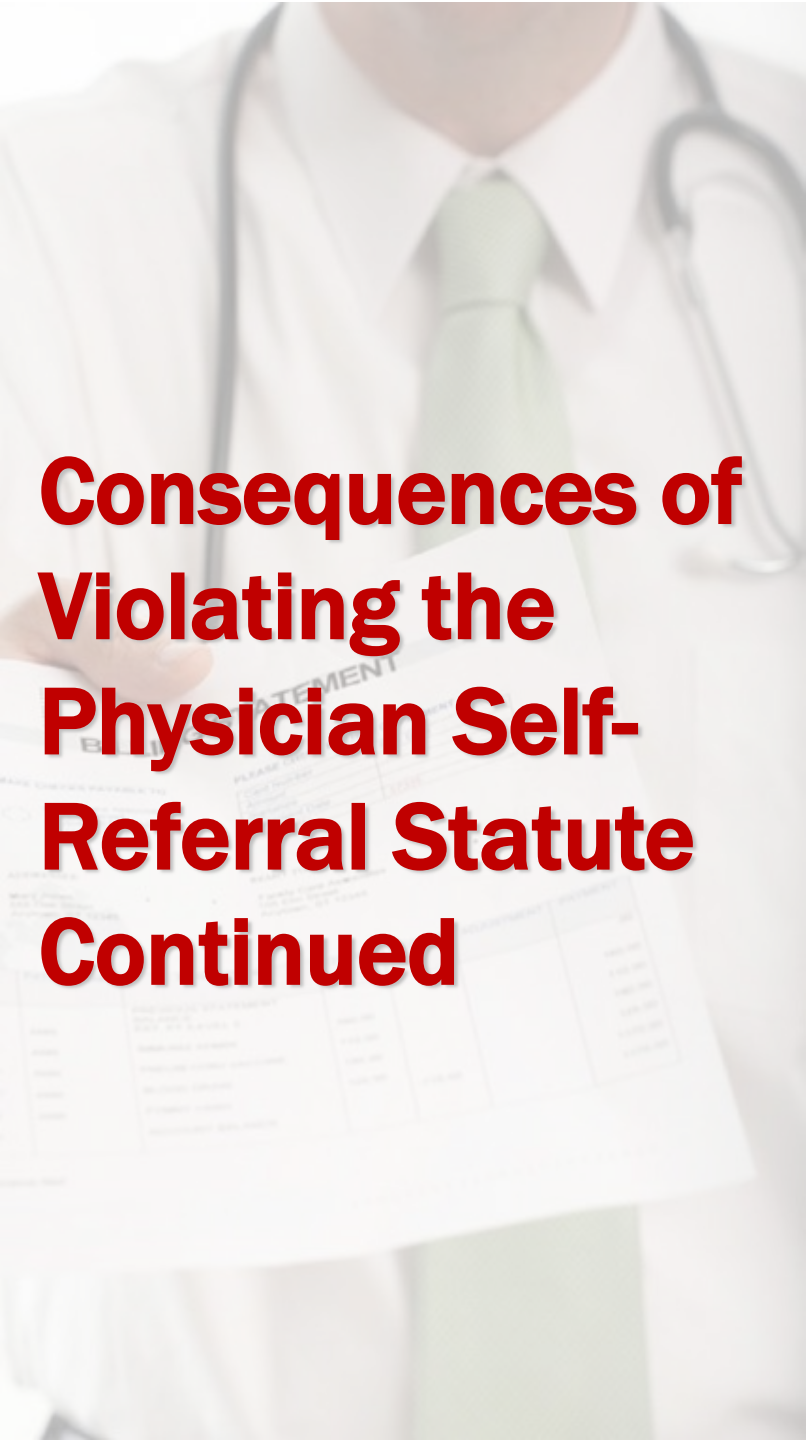
Consequences of Violating the Physician Self-Referral Statute:

- **Payment denial**
- **Monetary penalties**
- **Exclusion**
- **Overpayment/refund obligations**



The Physician Self-Referral Statute is a strict liability law, which means proof of **specific intent to violate the law is not required.**

- The entity submitting improper claims is subject to repayment of all amounts received from Medicare and Medicaid that are connected with the improper relationship and may be subject to additional penalties.
- Physicians who violate the law may be subject to monetary penalties as well as exclusion from participation in the Federal health care programs.
- If a referral is made violating the Stark law and payment is received by the entity providing the designated health service, penalties can include **civil penalties up to \$15,000 for each unlawful referral, exclusion from participation in federal health care programs, denial of payment for services, refunding of payments received, a fine of up to \$100,000 for each illegal cross-referral arrangement, and civil penalties up to \$10,000 per day for failing to report violations.**



Consequences of Violating the Physician Self-Referral Statute Continued

Submitting claims for payment to Medicare or Medicaid that are known or should be known to be false or fraudulent is illegal. **Claims resulting from violations of the Stark Law or AKS may also trigger liability under the [False Claims Act](#).**

The FCA contains a whistleblower provision allowing private individuals to sue on behalf of the United States and are entitled to a percentage of any monetary recoveries.

FCA penalties: Under the civil False Claims Act, no specific intent to defraud is required for a violation to occur.

- **Civil penalties:** Filing false claims may result in fines of up to three times the programs' loss plus \$11,000 per claim filed.
- **Criminal penalties:** There is also a criminal False Claims Act. Criminal penalties for submitting false claims include imprisonment and criminal fines.

Avoid Violating the Anti-Kickback Statute and Physician Self-Referral Statute by Fitting into a “Safe Harbor” or Exception

Many arrangements can be structured to avoid the risk of fraud. Additionally, there are “safe harbors” and exceptions to the Anti-Kickback and Stark Laws, but you must meet required every element and condition of the exception to qualify.

For example, a full-time lease agreement between a physician and a provider to whom the physician refers patients can meet the *space rental safe harbor* if the agreement:

- is set out in writing and signed by the parties;
- covers all the premises rented by the parties;
- is for a term not less than 1 year;
- has an aggregate rental charge set in advance, is consistent with fair market value in arm's length transactions, and does not consider the volume or value of Federal health care program referrals; and,
- the aggregate space rented may not exceed the space that is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

The “Safe Harbor” Regulations [42 CFR 1001.952 (a)-(u)] Describe Protected Business Relationships in the Following Areas

The below examples are not all inclusive:

- **investments in other practices and businesses** (typically up to 40%)
- **rental of space** (at fair market value)
- **rental of equipment** (same limitations as "rental of space," above)
- **personal services and management contracts** (not determined by volume or value of referrals)
- **sale of practices** (cannot make referrals or otherwise generate business)
- **referral services** (cannot exclude any individual or entity)
- **warranties of equipment** (must accurately report any price reductions)
- **discounts** (must be based on purchases of the same good or service fiscally)
- **remuneration to employees** (cannot be considered a kickback)
- **group purchasing organizations** (cannot pay more than a 3% fee to the group purchasing organization)

Exclusion from Medicare and Medicaid

Healthcare agencies that do business with excluded individuals, entities or partners on these lists may be subject to penalties, fines or civil monetary penalties (CMP) and possible suspensions from participation in government health care programs.

Mandatory Exclusions

Imposed based on certain criminal convictions.

Permissive Exclusions

Based on sanctions by other agencies, such as a state medical board suspending or revoking a medical license, or other misconduct including defaulting on health education loans or providing unnecessary or substandard care.

Exclusions are handed down by the OIG and last for periods of typically three to five years in most cases before a potential reinstatement may be made.

If you are excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe. **Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.** In addition, if you furnish services to a patient on a private-pay basis, no order or prescription that you give to that patient will be reimbursable by any Federal health care program.



Some refer to exclusion as a “*financial death sentence*” for any health care provider

Scope & Effect of Exclusion: § 42 CFR 1001.1901

(a) *Scope of exclusion.* Exclusions of individuals and entities under this title will be from Medicare, Medicaid and any of the other Federal health care programs, as defined in [§ 1001.2](#).

(b) *Effect of exclusion on excluded individuals and entities.*

(1) Unless and until an individual or entity is reinstated into the Medicare, Medicaid, and other Federal health care programs in accordance with [subpart F of this part](#), no payment will be made by Medicare, including Medicare Advantage and Prescription Drug Plans, Medicaid, or any other Federal health care program for any item or service furnished, on or after the effective date specified in the notice—

(i) By an excluded individual or entity; or

(ii) At the medical direction or on the prescription of a physician or an authorized individual who is excluded when the person furnishing such item or service knew, or had reason to know, of the exclusion.

(2) This section applies regardless of whether an individual or entity has obtained a program provider number or equivalent, either as an individual or as a member of a group, prior to being reinstated.

(3) An excluded individual or entity may not take assignment of an enrollee's claim on or after the effective date of exclusion.

(4) An excluded individual or entity that submits, or causes to be submitted, claims for items or services furnished during the exclusion period is subject to civil money penalty liability under section 1128A(a)(1)(D) of the Act and criminal liability under section 1128B(a)(3) of the Act and other provisions. In addition, submitting claims, or causing claims to be submitted or payments to be made, for items or services furnished, ordered, or prescribed, including administrative and management services or salary, may serve as the basis for denying reinstatement to the programs.

Providence's Exclusion Screening Program & Requirements

- In accordance with the Medical Staff Excluded Individual Checks policy, Providence **prohibits the credentialing and privileging of Medical Staff members and does not do business with those** who are deemed by a Federal and/or State agency as debarred, excluded or otherwise ineligible for participation in federal or state funded health care programs, or who have been convicted of a criminal offense related to health care.
- **All Medical Staff members are screened before hiring or contracting and then monthly thereafter** against the Office of the Inspector General (OIG)'s List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA)/System for Award Management (SAM), OFAC-SDN, CMS Preclusion, Medicare Opt Out, **and all State Medicaid exclusion lists** to ensure that none of these persons are excluded or become excluded from participation in federal programs.

Civil Monetary Penalties Law

You should also be aware that OIG may seek civil monetary penalties for a wide variety of abusive conduct, including presenting a claim that is false or fraudulent because it is for a medically unnecessary procedure. OIG also may impose civil monetary penalties for violating the Medicare assignment agreement by overcharging or double billing Medicare beneficiaries.

The [adjusted civil penalty amounts](#) updated in 2025 vary depending on the agency and the type of violation. Here are some examples:

1. **Department of Justice:** The adjusted civil penalties assessed or enforced by components of the Department range from **\$7,256 to \$84,852** for violations occurring after November 2, 2015.
2. **Federal Election Commission (FEC):** Violations of federal campaign finance law can result in penalties ranging from **\$7,028 to \$82,188**.
3. **Department of Labor:** The 2025 civil money penalty amounts for labor-related violations are specified in a table published in the Federal Register.
4. **Executive Office of the President:** The inflation-adjusted penalty amount for 2025 is approximately **\$14,308** when rounded to the nearest dollar.

Please note that these amounts apply to *specific violations and agencies*.



No matter your specialty or practice setting, as a physician you may develop relationships with three important groups. Your relationships with these groups will be subject to the provisions of the 5 key fraud and abuse laws.

Reminder!

- **Payers**, like Medicare, Medicaid, patients, and private insurance companies;
- **Other providers**, including physicians and hospitals; and
- **Vendors**, including drug, biologic, and medical device companies.

Future Business Relationships

- Colleagues
- Hospitals
- Nursing Homes
- Medical Companies



Outside Investments

The Office of Inspector General ("OIG") has expressed concern that physician investments in medical device and distribution entities *should be closely scrutinized under the fraud and abuse laws.*

- Physicians are frequently approached with investment opportunities in enterprises related to the delivery of health care.
- Sometimes, you are a legitimate source of capital. Other times, you are a source of patient referrals.
- Because the return on an investment sometimes is used to offer kickbacks in exchange for referrals, you should be vigilant when considering health care business opportunities.
- You should send your patients to the provider that, in your medical judgment, can best meet their medical needs.
- Legal counsel may be helpful in understanding the purpose of the business venture and its associated risks.



Is the Arrangement Legitimate?

To avoid violation of the fraud and abuse laws, test the propriety of any proposed engagement by asking yourself the following questions:

- Does the company really need my particular expertise or input?
- Is the venture promising you high rates of return for little or no financial risk?
- Are you being asked to guarantee that you will refer patients or order services from the venture?
- Does the amount of money the company is offering seem fair and appropriate for what it is asking me to do?
- Is it possible the company is paying me for my loyalty so that I will prescribe its drugs or use its devices?

If you want to pursue an industry relationship but are not sure it is legitimate, take steps to learn whether the arrangement is proper.

Scrutinize Promotional Speaking or Consulting Opportunities!

As a physician, you may have opportunities to consult with or be a promotional speaker for the drug or medical device industry.



Providence Policy Considerations

[PSJH-CPP-718](#) Vendor/Supplier Interactions

Consulting Arrangements

Speaker's Bureau and Educational Events

[PSJH-CPP-719](#) Gifts, Gratuities, and Business

Courtesies

Honoraria/Honorarium and Consultations

Free Drug Samples

If free drug samples are authorized in your clinic by local leadership; there are very specific criteria for use, and there should be a leadership committee at the local level determining if those practices are going to allow to have samples and what policies and procedures govern the sample drug process.

- Free drug samples should be used for the purpose of testing for tolerance or titrating dose; they are not to be used to provide financial assistance.
- Free drug samples should never be commingled with commercial stock drugs.



Drug Diversion

Introduction to Drug Diversion

As part of this course, learners will:

- Have reviewed an overview of Controlled Substances handling and diversion prevention
- Know how to identify potential risks
- Know how to dispose of Controlled Substances
- Understand state/federal regulations
- Prevent drug diversion
- Know how to report drug diversion or suspicion of drug diversion

What is Drug Diversion?

- Drug diversion is the transfer or use of a prescription drug to anyone other than the intended recipient of the medication.
- Misappropriation of medications in any way other than how they are intended for use or prescribed for use. Medications of any kind can be misappropriated or diverted. When medications are misappropriated by a workforce member it is considered theft.
- Drug diversion is a crime that can have negative impacts on our patients, caregivers and health system.
- Patients: Denial of pain relief, exposure to blood borne pathogens, identity theft, fraud & direct patient harm.
- Caregivers: Loss of license, career and professional reputation

Approximately 10-15% of healthcare professionals will struggle with substance use disorders during their career, and many of these turn to drug diversion.

Where Does Drug Diversion Occur?

- Acute care (e.g. hospitals) – main focus of this section
- Retail pharmacies
- Outpatient infusion centers
- Nursing homes
- Hospice
- Home infusion



What are Controlled Substances?

A drug that is regulated by the Drug Enforcement Administration (DEA) because it may be abused or cause addiction

Controlled Substance Schedules

- Drugs and other substances that are considered Controlled Substances under the Controlled Substances Act (CSA) are divided into 5 schedules.
- According to the US Bureau of Labor Statistics, drugs in the highest risk schedules (II, III and IV) account for 94% of abused prescription drugs

Controlled Substance Schedules

Schedule I: No currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

- Examples include heroin, methamphetamine, MDMA (ecstasy)

Schedule II: A high potential for abuse which may lead to severe psychological or physical dependence

- Examples include oxycodone, hydrocodone, amphetamines (Adderall)

Schedule III: Potential for abuse is less than substances in Schedules I or II, and abuse may lead to moderate or low physical dependence or high psychological dependence.

- Examples include buprenorphine, testosterone

Schedule IV: Low potential for abuse, relative to substances in Schedule III

- Examples include alprazolam, carisoprodol

Schedule V: Low potential for abuse relative to substances listed in Schedule IV and consist of primarily of preparations containing limited quantities of certain narcotics.

- Examples include phenergan with codeine, pregabalin

What is the Chain of Custody?

A process that tracks the movement of a product through its lifecycle, to include; documenting each person who handled the medication, the date/time it was collected or transferred, and the purpose for the transfer.

- Drug diversion does not only affect Controlled Substances. Anytime a medication is removed, taken, given, or redirected to someone for whom it was not ordered or intended, this is drug diversion.



How to Identify

Examples of drug diversion

- Personal use of hospital issued drugs on or off hospital property
- Redistribution of hospital issued drugs to unauthorized users (e.g. family members)
- Removal, misuse, stealing, and/or diverting non-controlled medication/drugs (and/or related supplies)
- Self-prescribing of Controlled Substances
- Removing Controlled Substances from a hospital location to be used on patients in another facility




The Facts

Opioid addiction is a major driver of drug diversion.

- More than 822,000 have died since 2015 from a drug overdose. In 2024, 80,391 drug overdose deaths occurred in the United States.
- Among nurses, substance use disorders affect 500,000 individuals nationally
- 87% of physicians have prescribed medications for themselves, and over 55% with painkiller prescriptions wrote them for themselves
- There are an estimated 37,000 drug diverters each year

Common Characteristics of a Diverter

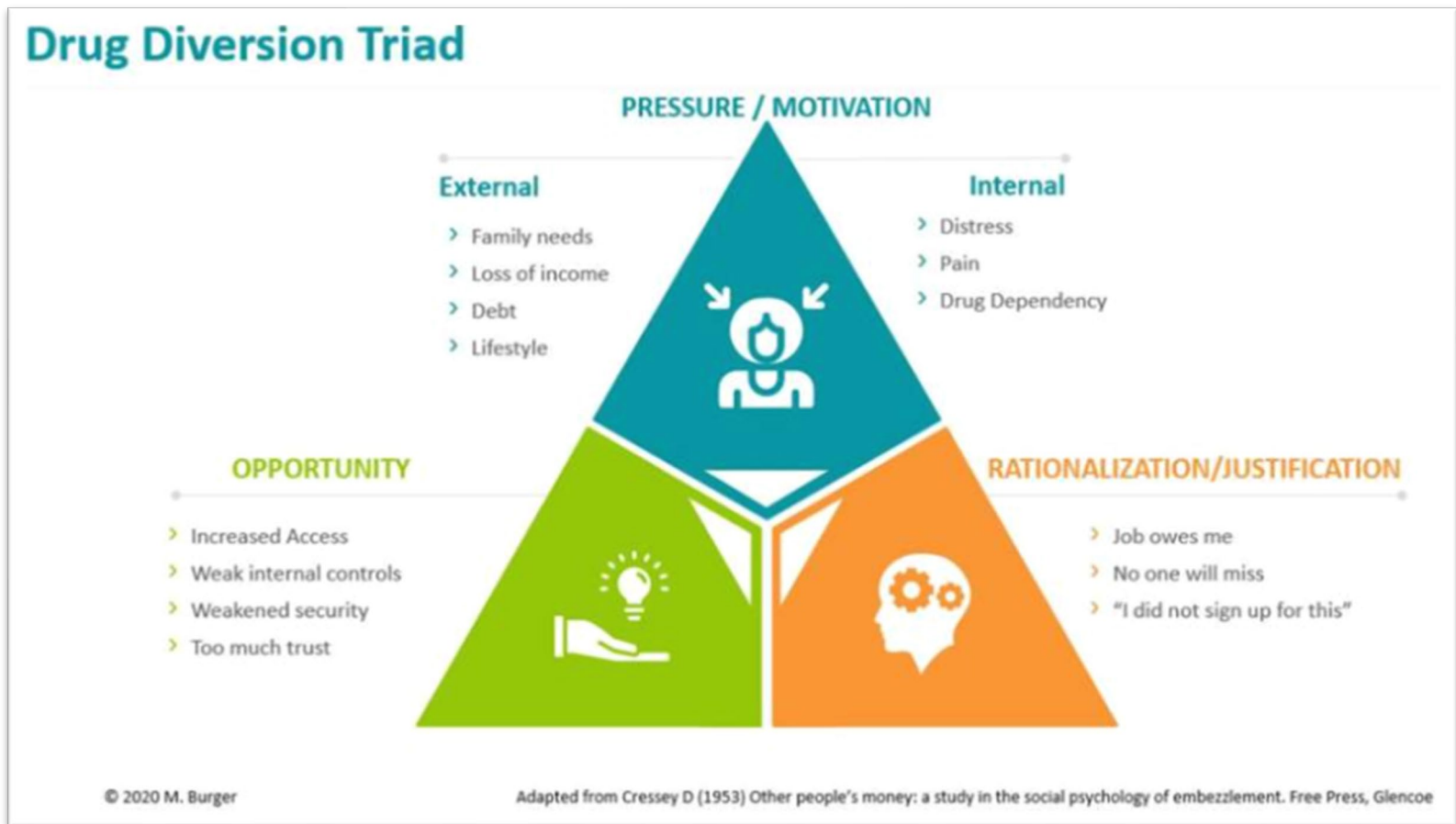
Many diverters appear to be high-functioning professionals who are well-liked by their peers as the diverter may be willing to go “above and beyond” in their roles

-  Frequent volunteering for overtime or shift coverages
-  Come early / stay late or insisting to cover nights, weekends or holidays
-  Offering to administer medications for other nurses and handle waste for Controlled Substances

Contributing Factors for Abuse

Similar to healthcare fraud, drug diversion is typically driven by three factors:

1. Pressure / Motivation to divert
2. Access / Opportunity
3. Rationalization / Justification by the diverter



Commonly Diverted Drugs

Opioids

- HYDRomorphine
- Morphine
- FentaNYL (including patches)
- HYDRocodone
- OxyCODONE
- Methadone

Depressants

- Benzodiazepines (ALPRAZolam, clonazePAM, lorazePAM)

Stimulants

- Dextroamphetamine
- Methylphenidate

Others

- Propofol
- Trazodone
- Nalozone

Classes of Prescription Drugs Commonly Misused

- National Institute on Drug Abuse (NIDA)
 - [Commonly Abused Drugs Chart](#)
- Institute for Safe Medication Practices
- (2023, February 23) Drug diversion and COVID-19. ISMP Medication Safety Alert! Acute Care Edition, 28(4)).
 - [Volume 28, Issue 4 February 23, 2023](#)

Warning Signs

Early Warning Signs

- Overly helpful in certain situations (e.g. medication delivery, offer to medicate colleagues' patients)
- Review medication orders of patients not in their care
- Heavy or no wasting of drugs
- Picking the same colleagues to waste with (waste buddies)
- Pattern of holding waste until end of shift

Later Warning Signs

- Unpredictable work performance
- Recurring mistakes/poor judgment
- Interpersonal relations suffer
- Blames others for errors
- Arrives late to work, no-shows, increased absenteeism
- Frequent personal crises
- Noticeable changes in appearance or hygiene

Red Flags (Report Immediately)

- ❏ Broken or missing tamper seals
- ❏ Damaged or altered packaging
- ❏ Medication or associated supplies (e.g. syringes, needles) found in inappropriate locations or in personal belongings
- ❏ Suspected false documentation medical record or other chain of custody logs (Pyxis, paper, etc.)

Risks

Individual

- Criminal offense
- Loss of career
- Health consequences
 - Overdose
 - Neglected health
 - Infection

Patients

- Compromised safety (e.g. infectious disease exposure)
- Inaccurate documentation leading to poor record of care and potentially fraudulent billing
- Compromised treatment (e.g. inadequate pain relief or neglected care plan)
- Patient privacy (HIPAA violations by caregiver/diverter)

Risks

Hospital

- Loss of reimbursement
- Repayment
- Loss of accreditation
- Drug diversion fines
- Reputational damage and decreased community confidence

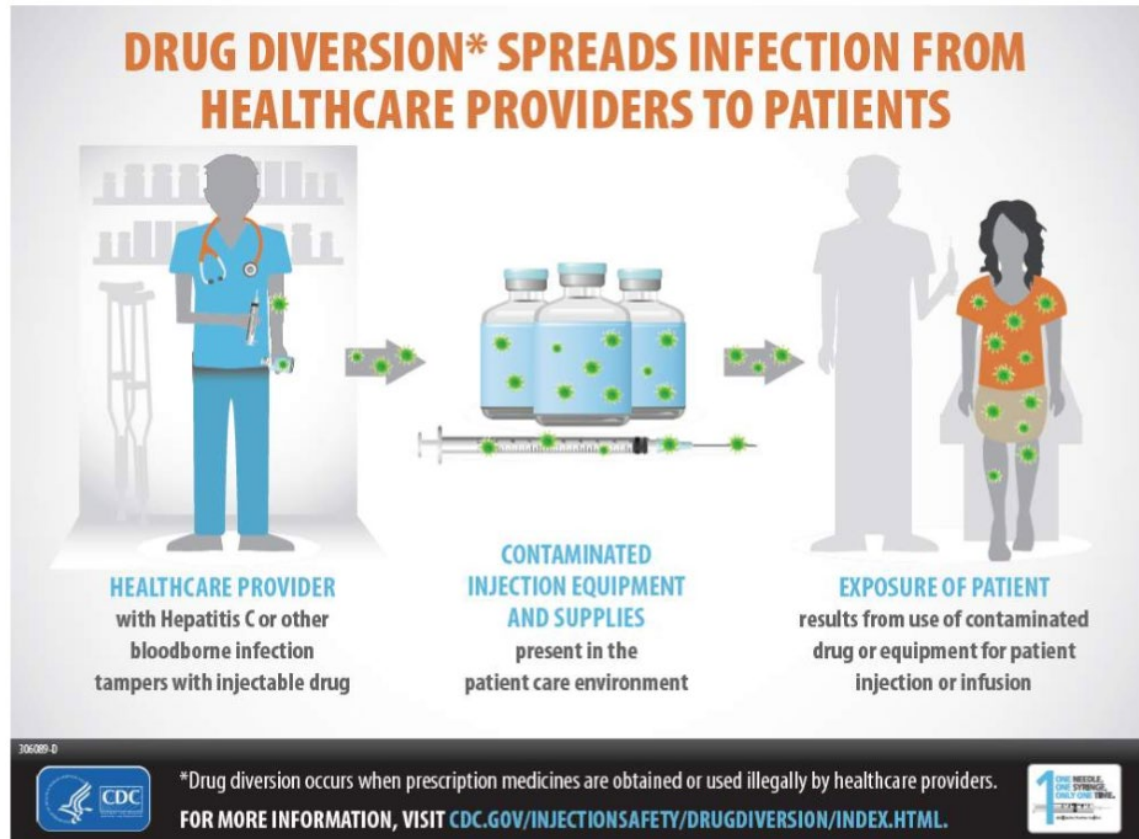
Society

Diversion & Opioid Use Disorder (OUD) is costly to society!

- Increased health expenditures (est. over \$700 billion per year)
- Loss of productivity (est. over \$120 billion per year)

Drug Diversion is Dangerous

Diversion is also costly to the health of patients and healthcare providers



Recent DEA fines related to drug diversion range from \$1 million to \$8 million.

Best practices for Handling Controlled Substances

Eliminate gaps in process

- (e.g. time to administration)
- Remove controlled substances for **one patient at a time**
- Administer CS immediately after removal from Automated Dispensing Machine (ADM; e.g. Pyxis)

Waste on removal

- Partial doses should be wasted at the time of removal, with another caregiver witnessing both the disposal and the ADM entry.
- If a witness is unavailable, return and perform the waste procedure ASAP

30-minute rule

- Removal to Administration/Waste and Documentation process should be

completed within 30 minutes

- Exception: Procedural/trauma cases should be completed by the end of the case

Chain of custody

- Gaps in process or transfer of possession require documentation.
- Ensure a clear chain of custody if you remove a medication but do not administer it
- CS belonging to a patient should only be handled by caregivers in very limited circumstances according to applicable policy/procedure
- CS should NEVER be held or stored in clothing, pockets, or bags/kits belonging to caregivers

Best practices for Handling Controlled Substances

Witness = direct physical observation

- Witnesses must actually see the medication being wasted AND witness the documentation action
- NEVER co-sign a waste in the ADM without seeing the disposal
- Controlled Substances (CS) must be wasted and discarded irretrievably using approved disposal device (e.g. CSRx)

Overrides & discrepancies

- Override removals from ADM can result in a chain of custody gap (no associated patient profile) and should be limited to urgent/emergent situations
- All ADM discrepancies must be resolved

promptly. The Unit Coordinator/Charge Nurse is responsible for ensuring all open discrepancies are resolved before their shift ends

Variances

- Variances warrant investigation. Caregivers should report any deviation from the above practices to their manager and via the High Reliability Platform (HRP)
- Document accurately what you administer and waste, as inaccuracies may initiate an investigation

Questions

- Contact your local pharmacy team

Disposal of Controlled Substances (CS)

Wrong way to Dispose of Controlled Substances

- Drug Diversion occurs when diverters reach in and take out partial vials of Controlled Substances! Some even drain out liquid out of the bottom of sharps containers or trash bins without knowing the risks!



Disposal of Controlled Substances (CS)

Correct way to Dispose of Controlled Substances

Stericycle – CsRx Container

After witnessed waste, dispose as follows:

- Liquids & injectables: Draw up remaining controlled substance and inject contents into CsRx container (solution in container deactivates Controlled Substance)
- Tablets/capsules removed from packaging and dropped into containers
- Patches placed in container



State & Federal Regulations

Legal / Regulatory Oversight

- Drug Enforcement Administration (DEA) – Primary Regulator/Enforcer of the Controlled Substance Act.
- State and/or local law enforcement
- Board of Nursing
- Board of Pharmacy
- Medical Board
- The Joint Commission
- Centers for Medicare and Medicaid Services (CMS)
- Det Norske Veritas National Integrated Accreditation of Healthcare Organizations (DNV NIAHO)

Systems of Prevention



Culture

- The organization expects staff to report any suspected diversion or suspicious behavior

Human Factor

- Vigilance cannot be understated! Every caregiver has a responsibility to safeguard against drug diversion



Proactive Diversion Monitoring

Providence utilizes next generation diversion monitoring software to provide enhanced transparency in Controlled Substance handling.

- Diversion prevention is a multidisciplinary effort. Core Leaders may be asked to review patterns or trends identified by this software.
- Please ensure you continue to practice safe Controlled Substance management and encourage best practices with your peers.
- If you become aware of a Controlled Substance discrepancy or missing Controlled Substance, please report your concerns immediately.

Reporting

Report suspected diversion to a manager/supervisor or the Providence Integrity Hotline

Providence Integrity Hotline (can be reported anonymously):

- Report online or call 1-888-294-8455
- Available 24/7

Do you need help?

These resources listed below can help to protect you and your license:

Substance abuse and mental health services administration (SAMHSA) national helpline: 1-800-662-HELP (4357)

- Free, confidential, 24/7 treatment referral and information service for individuals and families facing mental and/or substance use disorders

National Drug Helpline: 1-844-289-0879

- Free, confidential, 24/7 information about substance use, treatment options, and support resources

Professional Recovery Programs by State

State	Board of Medicine Licenses	Board of Nursing Licenses	Board of Pharmacy Licenses	All Others
AK				AK Office of Substance Misuse & Addiction Prevention (OSMAP) Office of Substance Misuse and Addiction Prevention (OSMAP) State of Alaska Department of Health
WA	WA Physicians Health Program Phone: 206-583-0127 https://wphp.org	WA Health Professional Services (WHPS) Phone: 360-236-2880, Option 1 https://nursing.wa.gov/whps	WA Recovery Assistance Program for Pharmacy (WRAPP) Phone: 800-446-7220 https://www.wsparx.org/page/WRAPP/WRAPP.htm	WA Recovery & Monitoring Program (WRAMP) Phone: 360-236-2880, Option 2 https://doh.wa.gov/wramp
MT	Montana Recovery Program www.montanarecoveryprogram.com	Montana Recovery Program www.montanarecoveryprogram.com	Montana Recovery Program www.montanarecoveryprogram.com	
OR	Health Professionals' Services Program (HPSP) Phone: 888-802-2843 Oregon Medical Board: Health Professionals' Services Program	Health Professionals' Services Program (HPSP) Phone: 888-802-2843 Oregon Medical Board: Health Professionals' Services Program	Health Professionals' Services Program (HPSP) Phone: 888-802-2843 Oregon Medical Board: Health Professionals' Services Program	
CA	Diversion Program Administered by Premier Health Group Phone: 800-522-9198	Diversion Program Administered by Premier Health Group Phone: 800-522-9198 https://www.rm.ca.gov/intervention/index.shtml	Diversion Program Administered by Premier Health Group Phone: 800-522-9198 https://www.pharmacy.ca.gov/licensees/personal/pharmacist_recovery.shtml	
TX	Texas Physician Health Program (TXPHP) Phone: 512-305-7462 https://www.txphp.state.tx.us/	Texas Peer Assistance Program for Nurses (TPAPN) https://www.texasnurses.org/mpage/TPAPN	Professional Recovery Network Phone: 800-727-5152 http://www.txprn.com/	
NM		Diversion Program Administered by RecoveryTrek Phone: 505-841-9091 https://www.bon.nm.gov/diversion		

Do You Think Someone Needs Help?

We have a duty to respond to diversion in a manner that promotes the safety of our patients and caregivers. Help is available!

- Reach out to any core leader
- Call Human Resources
- Caregiver Assistance is available 24/7 through Lyra:
 - 844-311-6223, Confidential & free

Medical Directorships & Substantive Responsibility Requirements



Medical Director Agreement Considerations

- **Government Scrutiny:** Given the potential impact on referrals, government agencies closely examine medical director compensation arrangements.
- **Fair Market Value (FMV):** When establishing medical directorships, it's essential to ensure that compensation is fair and reasonable.
- **Substantive and Well-Defined Roles:** Medical directorships should have clear responsibilities and expectations. These roles should be substantive, meaning they contribute significantly to the organization's functioning.
- **Uniform Contracts:** Consistency in contract terms is crucial. Standardized agreements for medical directorships must be used to maintain transparency and fairness.
- **Timekeeping:** If timesheets are required, they should include time spent and work performed so that the hours listed and activities performed can be confirmed as legitimate, necessary services for the facility, activities do not overlap with other roles, and that compensation is aligned with actual work performed.

Gift Reporting Requirements

Although some physicians believe that free lunches, subsidized trips, and gifts do not affect their professional judgment, research shows that these types of perquisites and humans' natural desire to reciprocate can influence prescribing practices and generally affect how physicians act.

The Sunshine law requires public disclosure of gifts and limiting the types of gifts physicians may accept. This law ensure that certain activities are conducted openly and ethically, allowing public observation, participation, and access to records.

The Patient Protection and Affordable Care Act of 2010 requires drug, device, and biologic companies to publicly report nearly all gifts or payments they make to physicians since 2013. This information is posted on the Internet so the public will know what gifts and payments a physician receives from industry!

The "Internet test" is important to use in your relationships with the health care industry. *"How would I feel if this arrangement were trending on the internet?"*

Giving Gifts to Providence Caregivers

Per [Providence policy](#) (PSJH-CPP-719 Gifts, Gratuities, and Business Courtesies), directly employed caregivers of Providence are not permitted to accept gifts from independent physicians, even as a *Thank You* or around the holidays. **Examples of gifts include but are not limited to:**

- *Frequent* meals (breakfast, lunch, dinners)
- Tickets to events/shows
- Gift cards/Certificates/Vouchers
- Gifts that cannot be shared with the department
 - Electronics
 - Jewelry
 - Clothing items/accessories



Providence's Disclosure Program - *Reporting Concerns*

The purpose of the *Providence Disclosure Program* is to foster a culture of integrity, transparency, and accountability within our family of organizations. This program is designed to support the identification, correction, and prevention of compliance and quality issues, helping ensure the highest standards of ethical and legal conduct and patient care. It aims to empower all workforce members to speak up and report compliance and quality of care related issues and concerns confidentially and without fear of retaliation. *PSJH-CPP-741 Disclosure Program*

[Integrity Hotline](#)

1-888-294-8455



[High Reliability Platform \(HRP\)](#)



*Found in the My Apps portal via Providence network.
Must be on Providence network to create a report.*

More Ways to Report FWA Concerns



You can also report suspected cases of fraud, waste, or abuse in Federal HHS programs with the U.S. Department of Health and Human Services, Office of Inspector General electronically through the Office of Inspector General's Complaint Portal, available at <https://oig.hhs.gov/fraud/report-fraud/index.asp>, or by mail or phone at:

U.S. Department of Health and Human Services, Office of Inspector General,
ATTN: OIG HOTLINE OPERATIONS, P.O. Box 23489, Washington, DC 20026.

Phone: 1-800-HHS-TIPS (1-800-447-8477) or 1-800-377-4950 (TTY)

Privacy Compliance at Providence



➤ **Mission and Values:** Privacy compliance is about respecting individuals - Safeguarding information is the “right thing to do”.



➤ **Legal and Regulatory:** The risk of civil monetary penalties and litigation is reduced when we comply with privacy requirements.

➤ **Quality of Care:** Patient confidence that their information is safeguarded promotes communication/transparency for higher quality of care.



➤ **Reputation:** Patients expect their information is going to be safeguarded. When we protect their information, it creates an environment of trust.

Know the 18 Patient Identifiers

1. Names
2. Geographic subdivisions smaller than a state (address, zip code, etc.)
3. All elements of dates (birth date, admission date, discharge date, date of death)
4. Telephone Number
5. Fax numbers
6. E-mail address
7. Social security numbers
8. Medical record numbers
9. Health plan numbers
10. Account numbers
11. Certificate/License number
12. Vehicle numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URL)
15. Internet Protocol (IP)
16. Biometric Identifiers (fingerprint, voice)
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code (tattoos, birthmarks, scars, initials, tax ID #, radiology and surgical procedure images)

Using PHI for Treatment

You may use and disclose PHI to provide the patient with appropriate treatment and may disclose PHI to other health care professionals that have a care relationship with the patient (Examples: nurses, labs, technicians, etc.)

- PHI **may not** be shared in any format, including electronic, paper or verbal with clinicians who are **not involved** with the patient's care.
- A former care relationship with the patient, curiosity purposes or a personal relationship, **does not** qualify as meeting the definition of treatment.

Examples of Appropriate Disclosures



A physician may discuss a patient's treatment with the patient in the presence of a family member/friend when the patient brings them to a medical appointment and asks if they can come into the treatment room.
*Physicians should use caution with sensitive information.



A physician may discuss the after-care plans with an individual who has accompanied the patient to a medical appointment. The information must be "need to know" for the person supporting the patient.



A pharmacist may give a prescription to a patient's friend who the patient has sent to pick up the prescription.



A health care provider may give information regarding a patient's drug dosage to the patient's health aide who calls the provider with questions about a prescription.

Epic Privacy Education

As a provider with access to Epic, it is important to understand and follow Providence's policies regarding its access and use.

If you access any aspect of a patient's record when you don't have a legitimate business reason to access the record, this leads to privacy policy violations.

This next section will provide an overview of appropriate Epic use.

Epic and PHI

All patient information in Epic is considered Protected Health Information (PHI) and this includes but is not limited to PHI on track boards, the status bard, census reports, demographic information on Patient Lookup, or using the hover feature.

Providers may only view PHI, whether access is made by clicking on or hovering over it, for Providence related business purposes based on your role and being part of the patient's care team.

All clicks, hover activity, downloading, printing or other activity in Epic is monitored on a 24/7 basis.

Epic Privacy Education

Having a Business Purpose

Having a "business purpose" to access information in Epic means that the provider accesses PHI for reasons related to their job functions but not for their own personal reasons or for reasons related to tasks that are not part of the provider's role at Providence.

Having a business purpose to access PHI in any part of Epic will always include completing role-based tasks related to treatment, payment, and/or healthcare operations, also referred to as TPO.

- Providing healthcare to a patient (documenting in the record)
- Consulting with another provider
- Looking at historical encounters because doing so is necessary to treat the patient

Epic Privacy Education

Minimum Necessary

When using or disclosing PHI, a covered entity must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Access only what's necessary: If it is not necessary to look at previous encounters that a current patient may have had, or certain information about the patient contained within the media tab when providing current patient care, then it should not be viewed by you.

Limit sharing of information: When using or disclosing PHI for payment or internal healthcare operations purposes (i.e. quality improvement) use only that which is necessary for the intended purpose.

Access to EPIC & Other Information Systems

Can I access my family, friend or co-worker's medical record?

If you are not part of the care team, you may not access a patient's medical record for any reason. Privacy laws and Providence policies only allow access to a patient's medical record for treatment, payment, and healthcare operations purposes. There are no exceptions to this, even if someone requests that you access their record when you are not involved in their care.

Is EHR access monitored?

Providence monitors workforce member access to its systems 24/7. All activity, including clicks and hovering, are recorded and suspicious access is investigated. This includes but is not limited to access to identity look-up, ED track boards, census lists, etc.

Can I access my own medical record?

Providence policy prohibits workforce members, including physicians, from using their work provided credentials to access their own medical record in Providence's systems. Workforce members must request access and/or copies of their medical records the same way any other patient would, through the patient portal or by contacting HIM/medical records or their physician's office

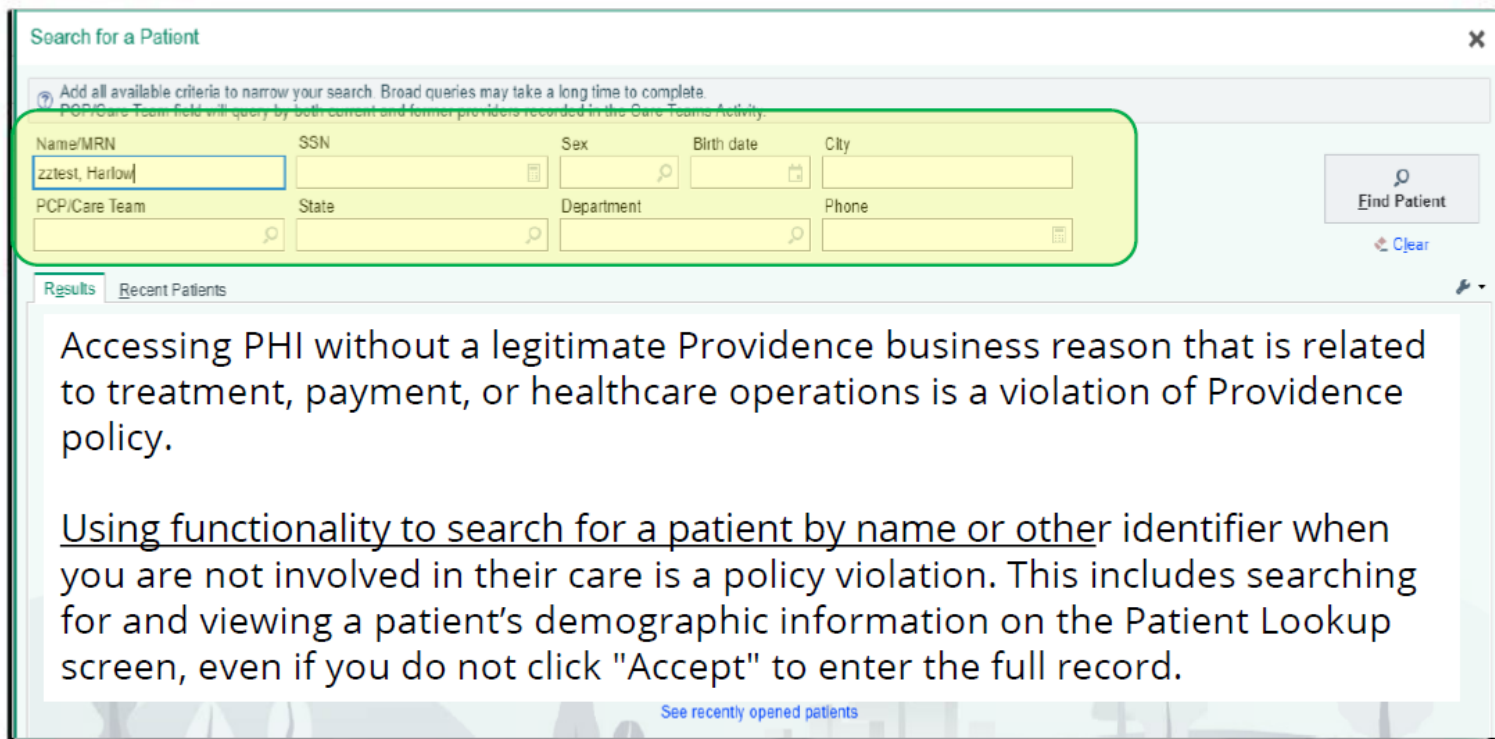
What happens if I violate privacy policies?

Privacy violations will be leveled in accordance with Providence's privacy sanction policy & appropriate corrective action taken.

Employed physicians may be subject to disciplinary actions up to and including termination.

Prohibited Uses of Epic

Searching For a Patient You are Not Caring For



Search for a Patient

Add all available criteria to narrow your search. Broad queries may take a long time to complete.
PCP/Care Team field will query by both current and former providers recorded in the Care Teams Activity.

Name/MRN	SSN	Sex	Birth date	City
zztest, Harlow				
PCP/Care Team	State	Department	Phone	

Find Patient

Clear

Results Recent Patients

Accessing PHI without a legitimate Providence business reason that is related to treatment, payment, or healthcare operations is a violation of Providence policy.

Using functionality to search for a patient by name or other identifier when you are not involved in their care is a policy violation. This includes searching for and viewing a patient's demographic information on the Patient Lookup screen, even if you do not click "Accept" to enter the full record.

[See recently opened patients](#)

Prohibited Uses of Epic

Searching For a Patient You are Not Caring For


Results Recent Patients

Match	Patient Name	MRN	Date Of Birth	Legal Sex	Address	City	State	Zip Code	SSN
17.98	ZZTEST,HARLOW	20018682920	10/09/2003	F	2319 DISNE...	ANAHEIM	CA	92806	xxx-xx-0001


Unauthorized access to patient demographic information is a policy violation. Always ensure that you are using appropriate patient search methods and that your access to patient information is justified and within the permitted business purposes.


Zztest, Harlow - 20018682920


This patient's name is an exact match to what was entered.


 Born 10/9/2003 (21 y.o.)

Female


 2319 DISNEY WAY
ANAHEIM CA 92806

 No PCP on file

 xxx-xx-0001

 858-867-5309 (H)

858-867-5309 (M)

 ilovedisney143@gmail.com

Language: English

Ethnicity: Unknown

Race: Unknown to patient

[→ Create New Patient](#)

Accept Cancel

Use of Hovering

Note: This screenshot is test data from Epic. It is NOT real patient information

Workforce members must not use the hover feature in Epic to view patient information unless they have a specific Providence business reason to do so.

All hover activity is monitored and recorded.

The screenshot displays the Epic ED Track Board interface. At the top, there is a navigation bar with various icons and a search bar. Below this is a table of patient records. The table has columns for patient ID, name, age, gender, and other clinical data. A tooltip is visible over one of the rows, showing a comment: "Comments (through 12/12/24 0910) Nurse Inpatient, RN 06/01/17 1207 Stroke call at 10:55". At the bottom of the screen, there is a summary bar with various metrics and counts.

Patient ID	Name	Age	Gender	Chief Complaint	Admission Time	Disposition
ED01	McIntosh, John	45	M	chest pain	08/01/17 1207	Admitted
ED02	Park, Kim	32	F	back pain	08/01/17 1207	Admitted
ED03	Lee, David	55	M	stroke symptoms	08/01/17 1207	Admitted
ED04	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED05	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED06	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED07	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED08	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED09	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED10	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED11	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED12	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED13	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED14	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED15	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED16	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED17	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED18	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED19	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED20	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED21	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED22	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED23	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED24	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED25	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED26	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED27	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED28	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED29	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted
ED30	Kim, Sarah	28	F	back pain	08/01/17 1207	Admitted

Use of Hovering

Note: This screenshot is test data from Epic. It is NOT real patient information

Hovering is not permitted unless the workforce member has a business reason to do so.

Hovering means holding your cursor over a patient name or other identifier resulting in additional patient health information becoming visible to the workforce member for that patient.

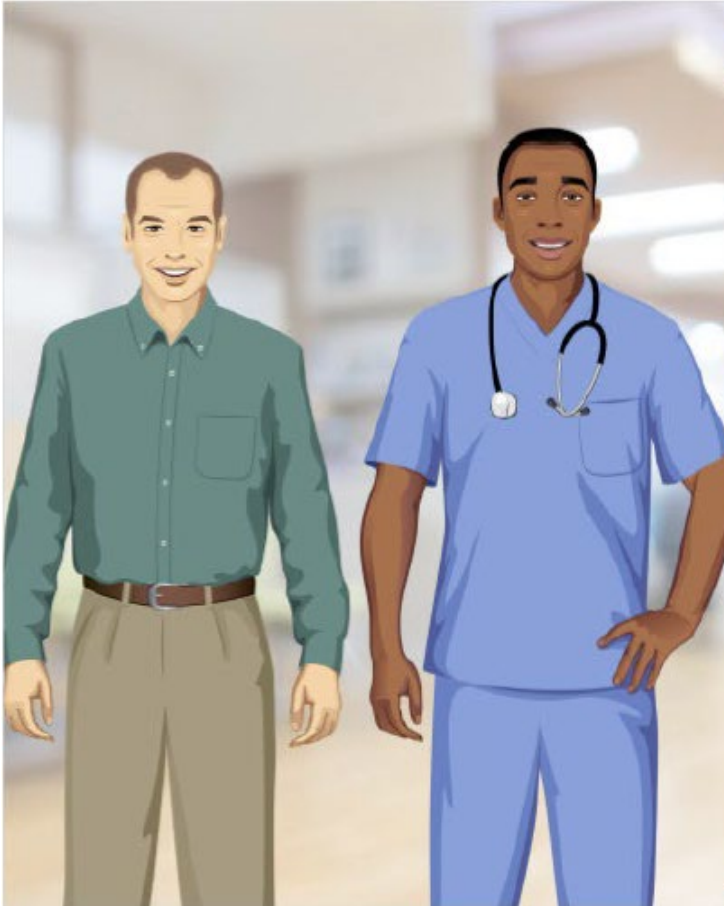
Adhering to these policy requirements is vital to maintaining patient confidentiality and compliance with Providence policy.

The screenshot displays the Epic ED Track Board interface for Providence LCOM Torrance Emergency Center. The main area shows a list of patients with columns for patient name, age, gender, symptoms, and vital signs. A tooltip is visible over the patient 'Parvashia, Pooja', displaying a comment: 'Comments (through 12/12/24 0910) Nurse Inpatient, RN 06/01/17 1207 Stroke call at 10:55'. The bottom of the screen features a 'All Pts Metrics' bar with various status indicators.

Patient Name	Age	Gender	Symptoms	Vitals
Parvashia, Pooja	71 y.o.	F	fever	8094.09
Oliver, Catalina	51 y.o.	F	drinking symptoms	8094.47
Oh, Deborah	87 y.o.	F	back pain	8094.31
Espinosa, Ethel	81 y.o.	F	Chest Pain	8094.29
Farrar, Pamela	47 y.o.	F	Respiratory Emphyse	8094.28
Murphy, Margaret	22 y.o.	F	Abdominal Pain	8094.24
Mills, Wally	21 y.o.	F	back pain	8094.23
Reedling, Marie	32 y.o.	F		7493.68
Shelton, Indira	36 y.o.	F		7206.13
Test, Overdose	39 y.o.	F	Overdose (Intentional)	6985.30
McDermott, David	62 y.o.	F		6720.38
John, Test Data	51 y.o.	F	Intoxicated	6798.10

Sharing EPIC Credentials

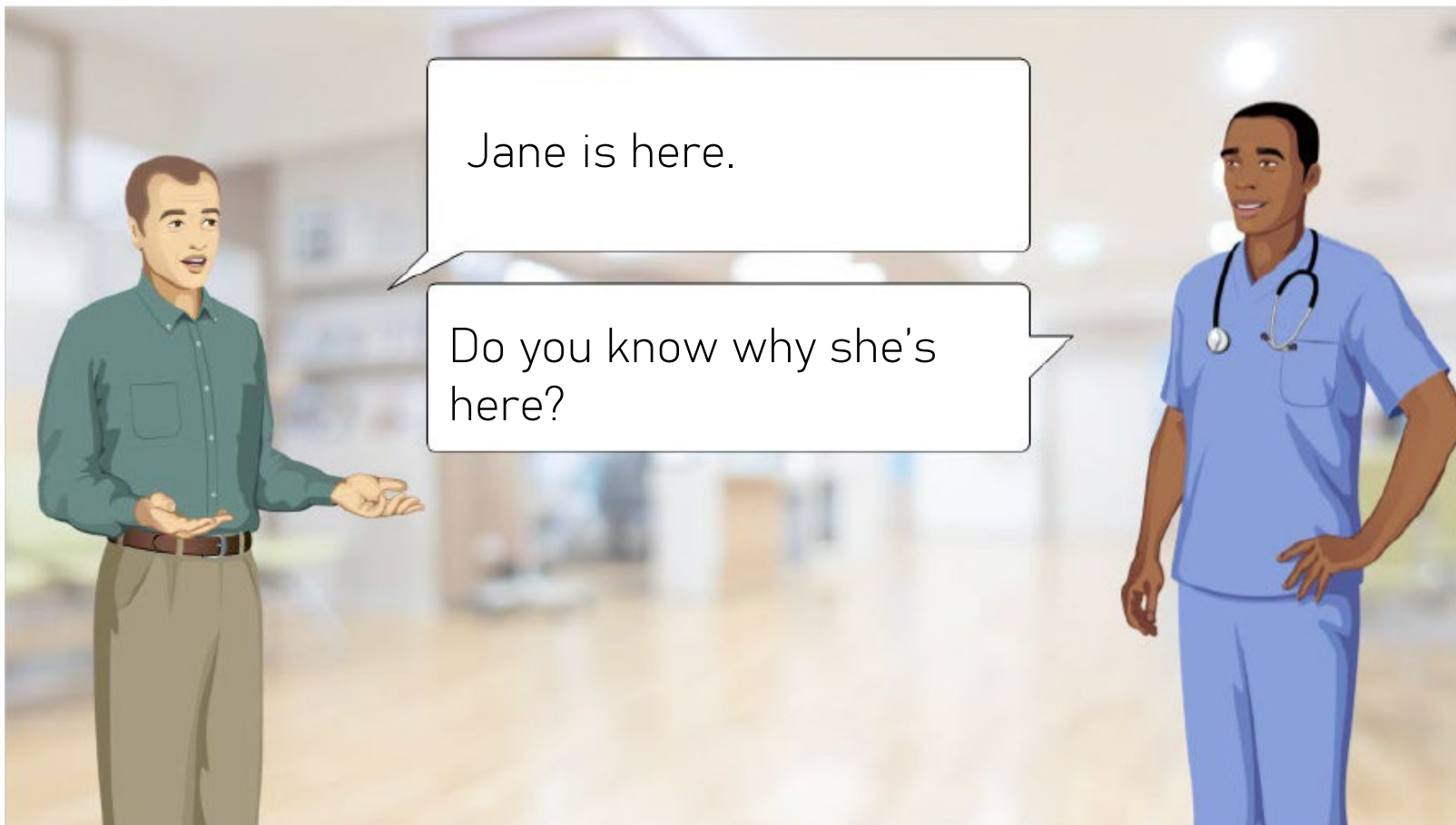




Bob and Jake are physicians who were involved in Jane's hospitalization last year and got to know Jane and her family very well.

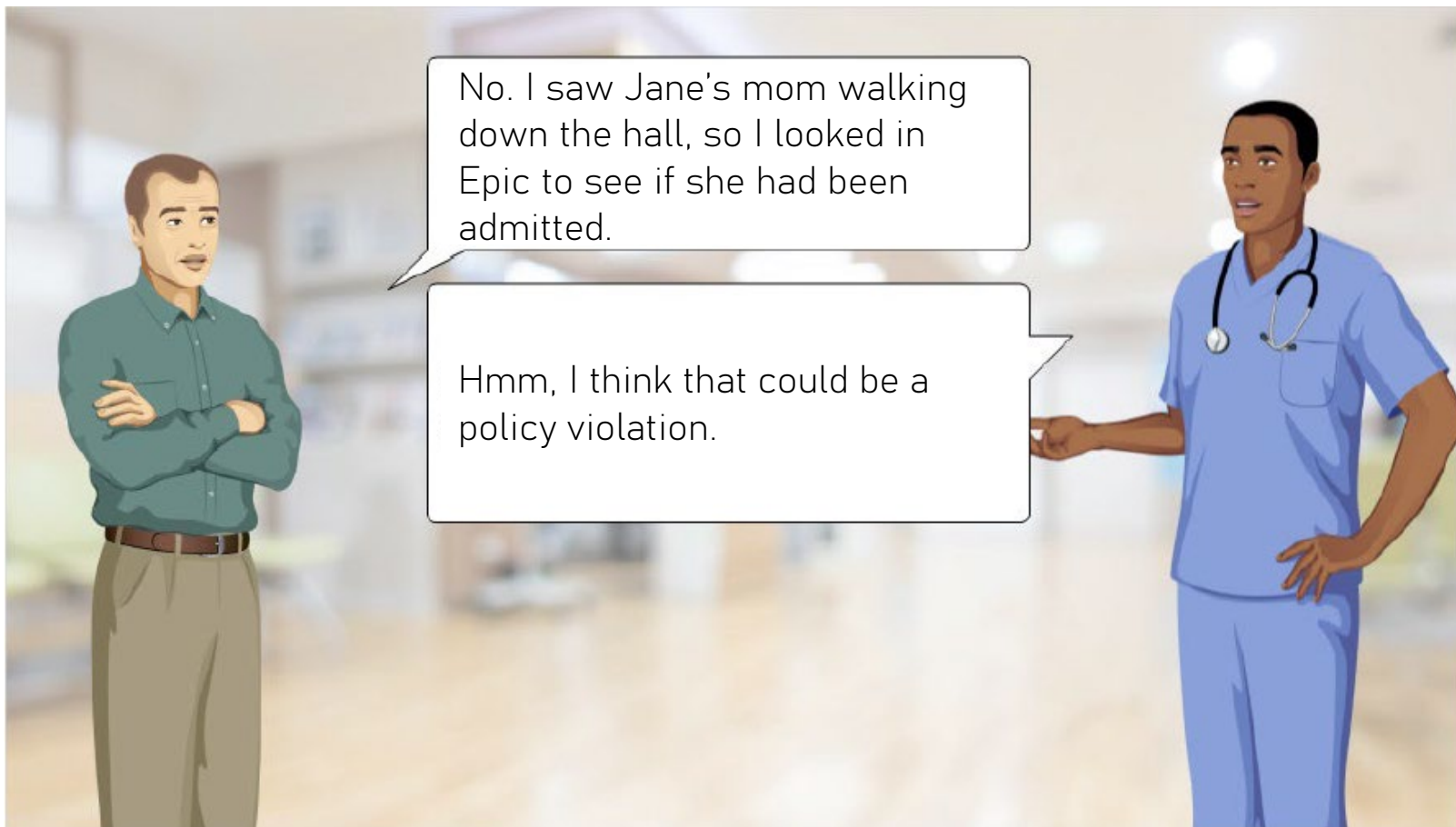
Jane has recently been admitted to the hospital.

Bob is concerned about the patient and accesses her medical record to find her location in the hospital.



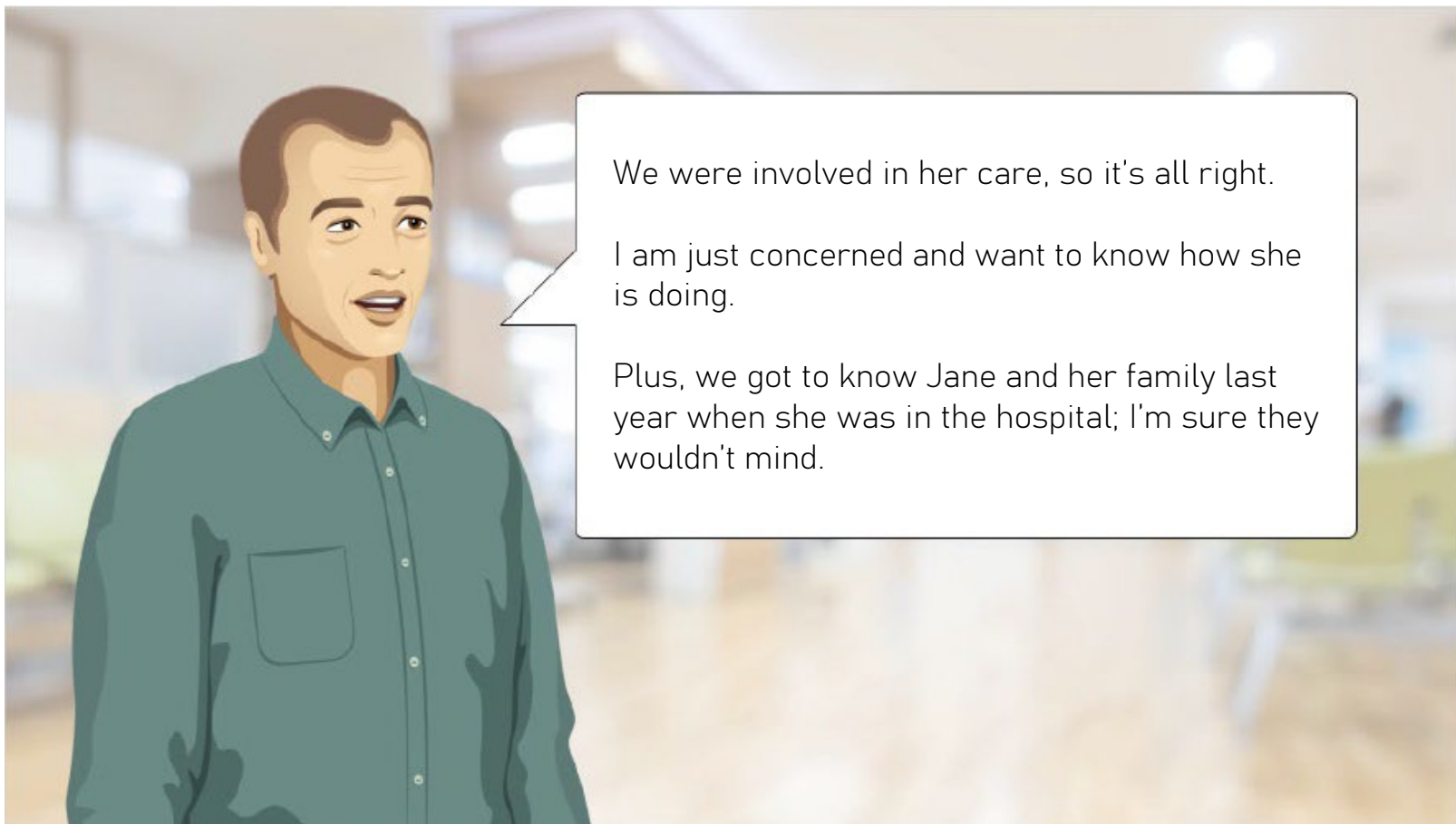
Jane is here.

Do you know why she's here?



No. I saw Jane's mom walking down the hall, so I looked in Epic to see if she had been admitted.

Hmm, I think that could be a policy violation.



We were involved in her care, so it's all right.

I am just concerned and want to know how she is doing.

Plus, we got to know Jane and her family last year when she was in the hospital; I'm sure they wouldn't mind.

Is Bob correct in thinking that because he was involved in the patient's previous care that he is still able to view the patient's medical records?

NO

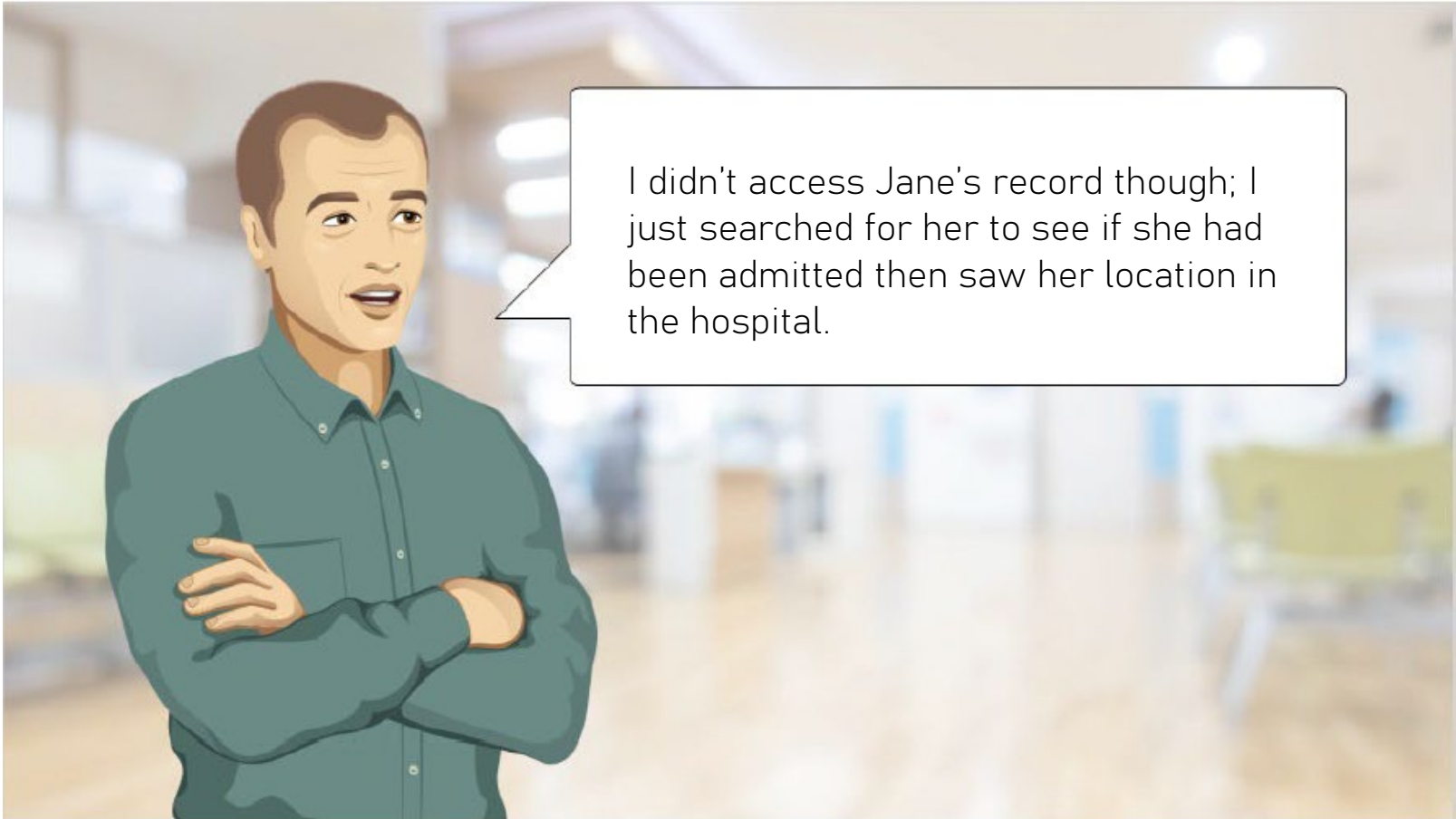
Bob is not correct in thinking that because he was part of the patient's prior care that he can continue to review the patient's medical record.

Yeah, but you aren't part of her current stay.

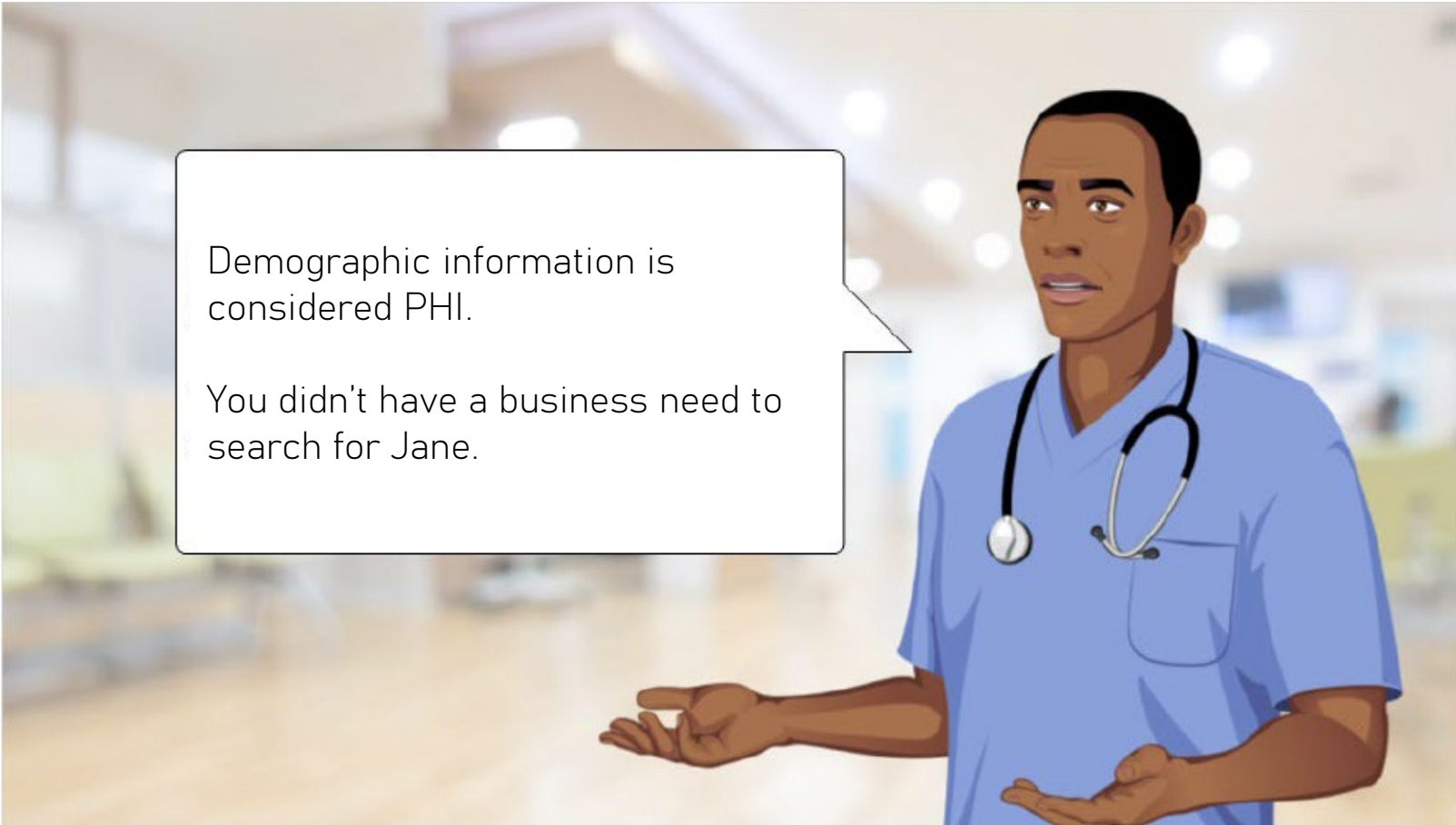
I am pretty sure privacy education teaches that a former care relationship, curiosity, personal relationship and even concern about a patient's well-being does not qualify as being involved with the patient's care.

I think accessing Jane's record is a policy violation.





I didn't access Jane's record though; I just searched for her to see if she had been admitted then saw her location in the hospital.



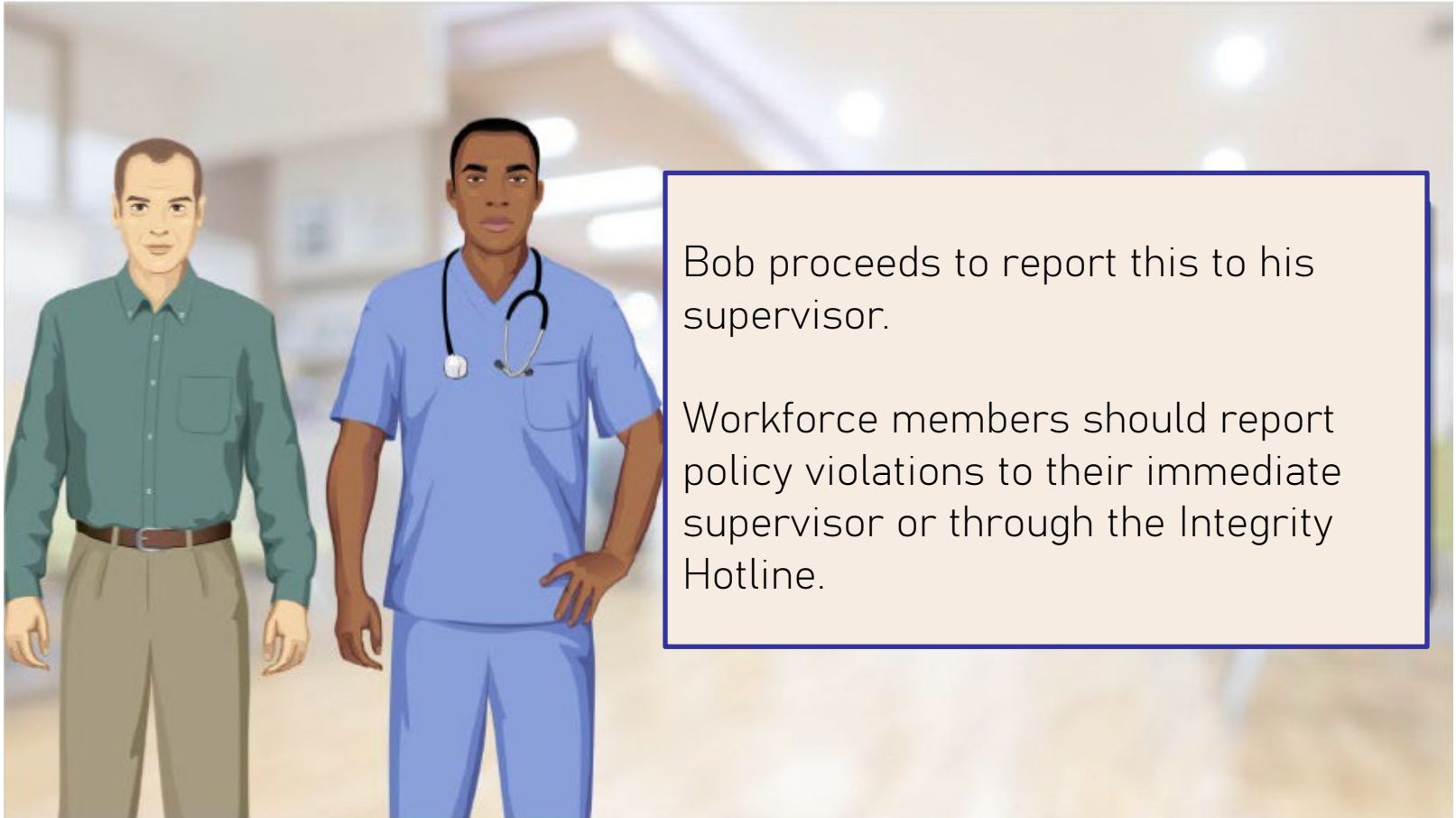
Demographic information is considered PHI.

You didn't have a business need to search for Jane.



Wow, thanks for letting me know! I'll not do that in the future.

I should self-report that I looked her up, and that I now know not to do that in the future.



Bob proceeds to report this to his supervisor.

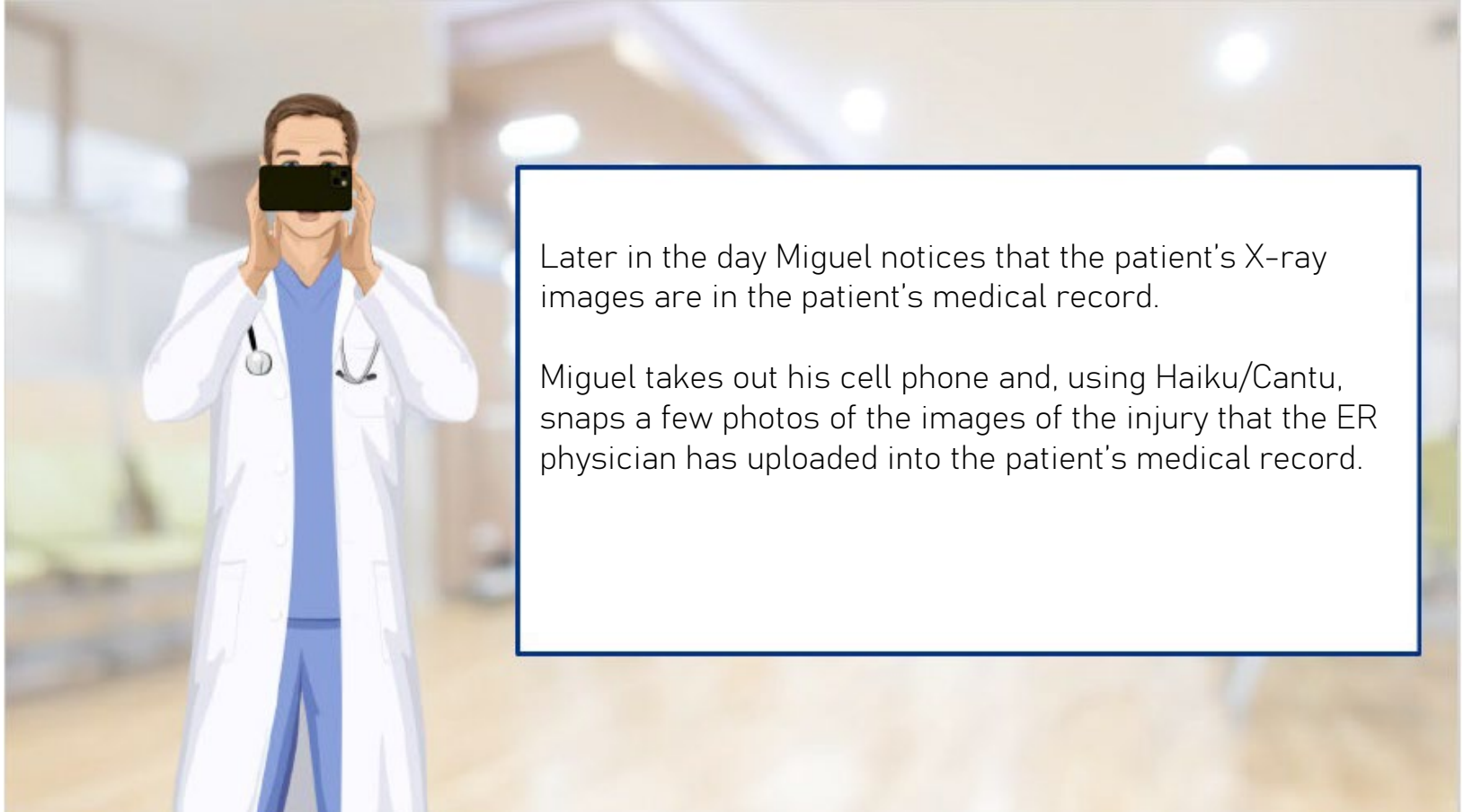
Workforce members should report policy violations to their immediate supervisor or through the Integrity Hotline.



While driving to work, Miguel passed a serious automobile crash.

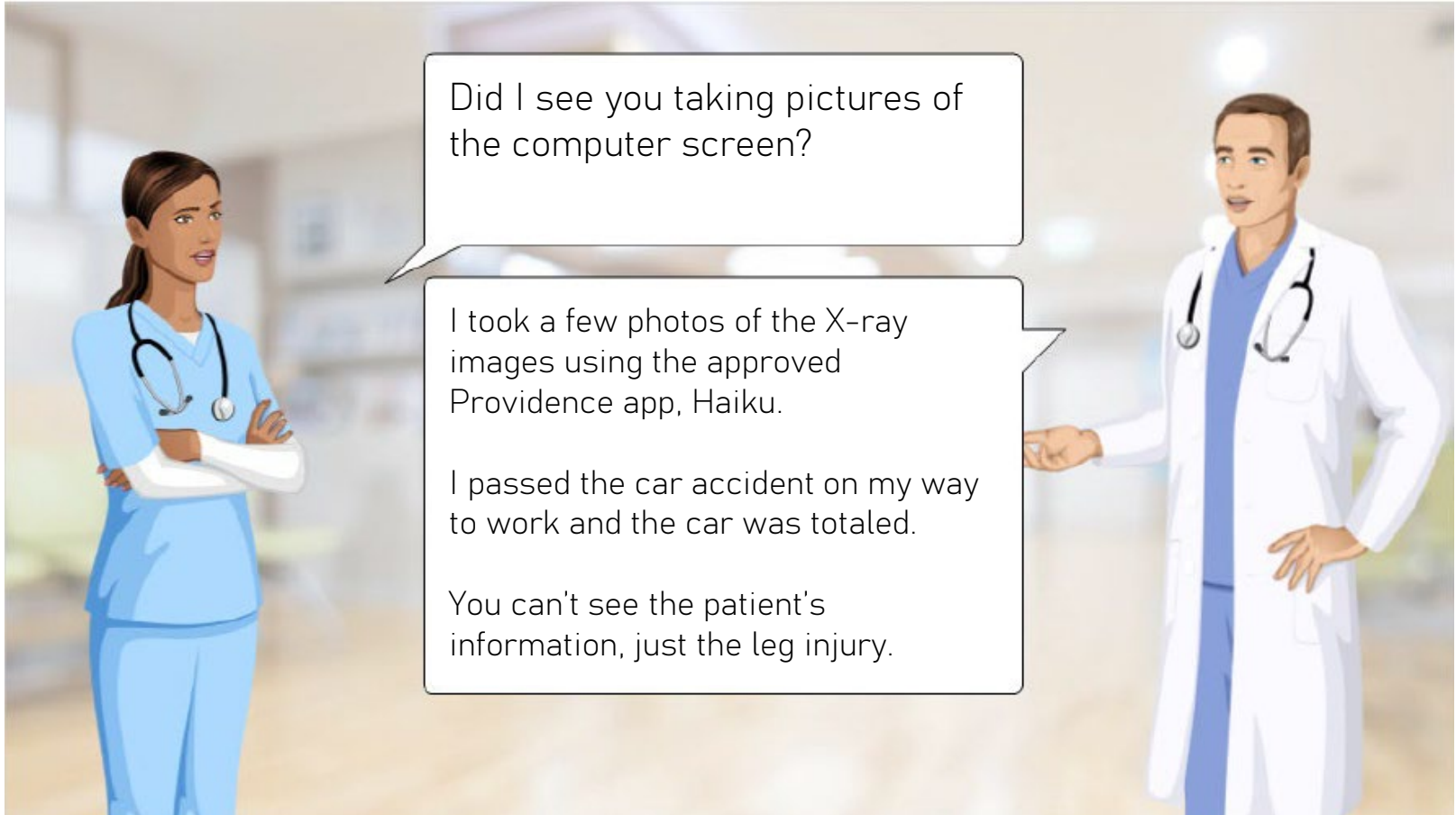
As Miguel arrives at the hospital he notices the ambulance outside the Emergency Department entrance.

As the day progresses, Miguel realizes that he is assigned to the care of this patient and that it is the patient from the accident he witnessed.



Later in the day Miguel notices that the patient's X-ray images are in the patient's medical record.

Miguel takes out his cell phone and, using Haiku/Cantu, snaps a few photos of the images of the injury that the ER physician has uploaded into the patient's medical record.

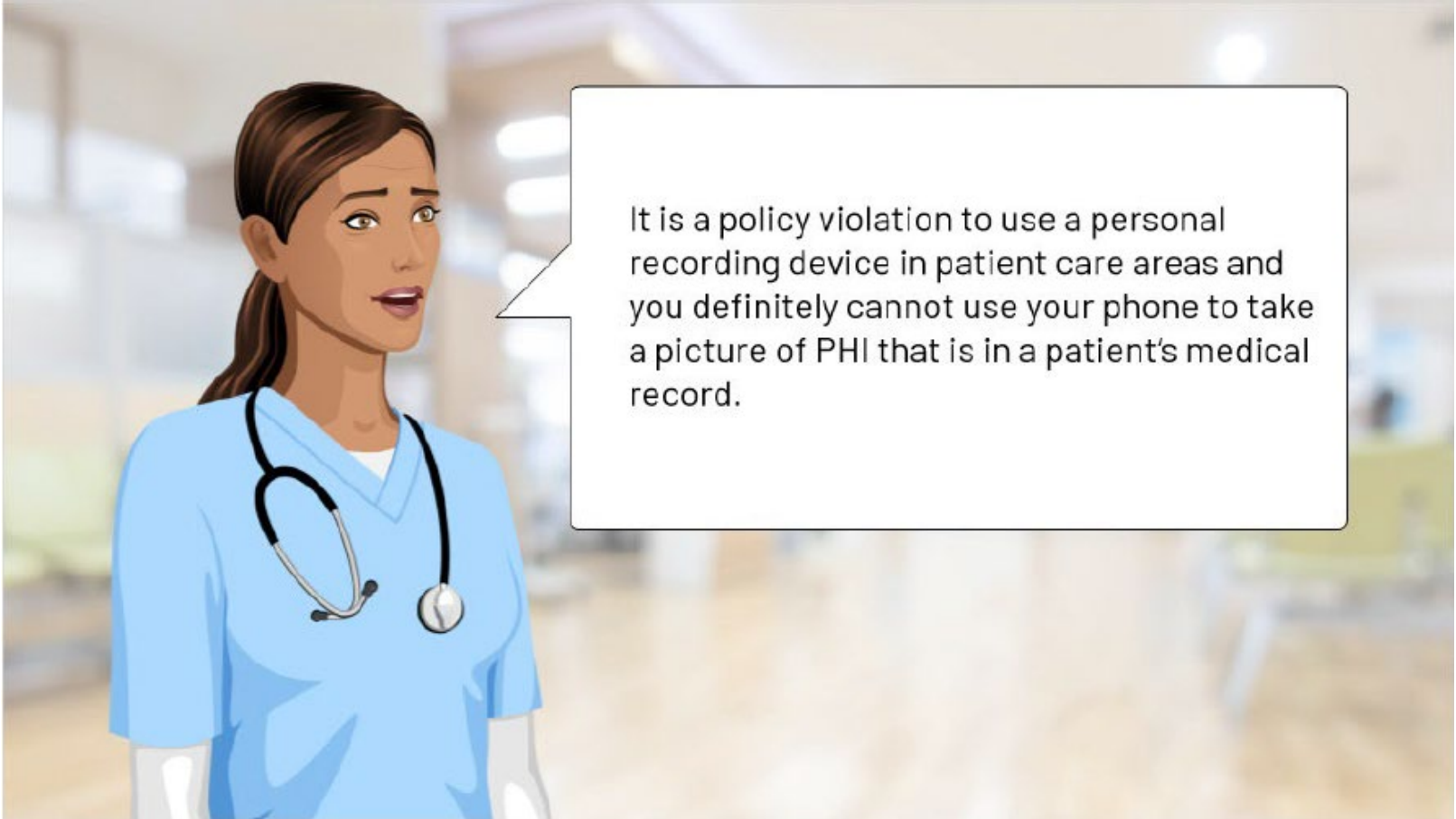


Did I see you taking pictures of the computer screen?

I took a few photos of the X-ray images using the approved Providence app, Haiku.

I passed the car accident on my way to work and the car was totaled.

You can't see the patient's information, just the leg injury.



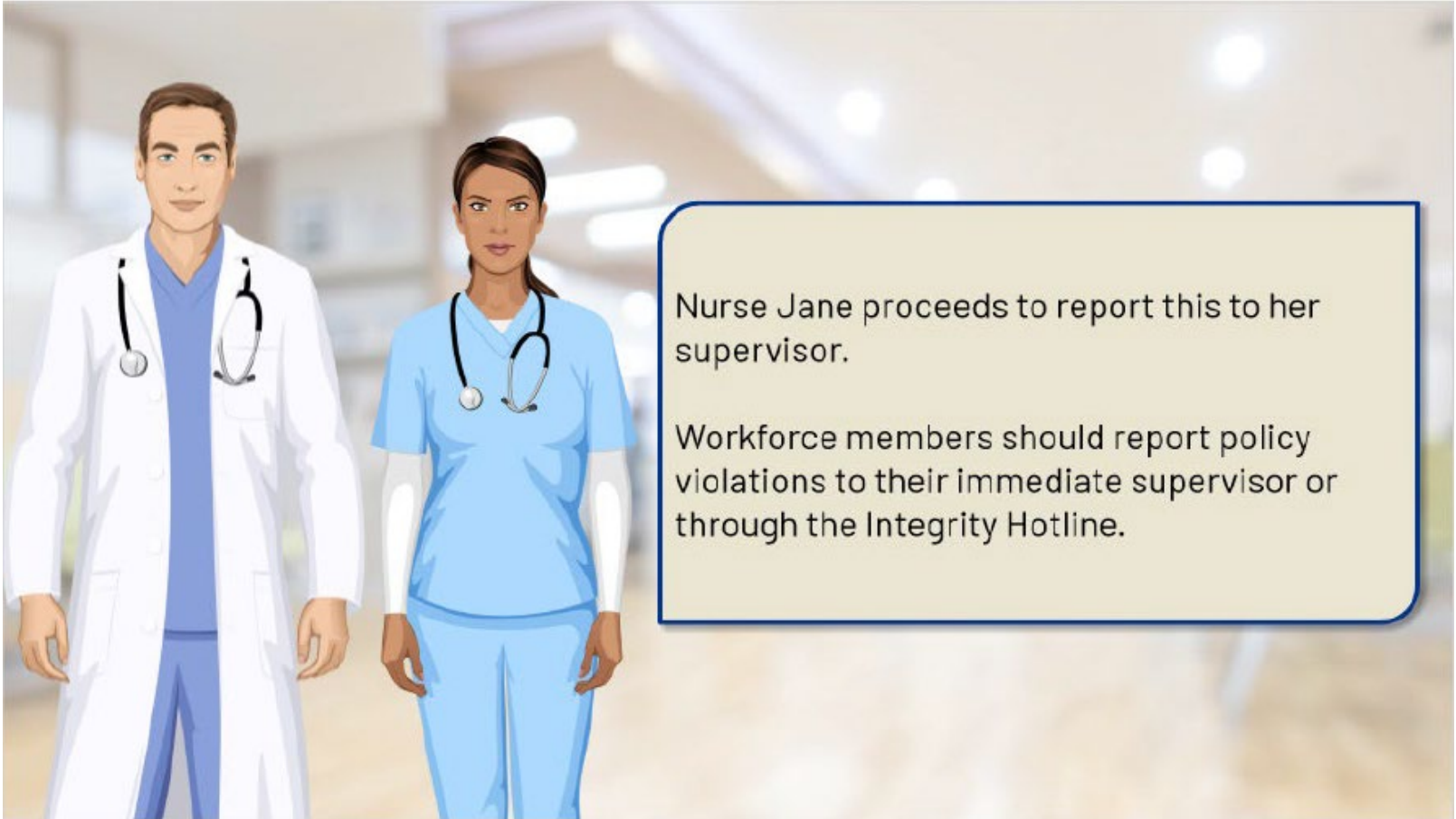
It is a policy violation to use a personal recording device in patient care areas and you definitely cannot use your phone to take a picture of PHI that is in a patient's medical record.

Oh, I didn't think it'd be a violation because the photo doesn't identify the patient.





You don't know that for sure and either way, it's not appropriate and you are violating policy and patient privacy by taking that picture and using your personal recording device in a patient care area.



Nurse Jane proceeds to report this to her supervisor.

Workforce members should report policy violations to their immediate supervisor or through the Integrity Hotline.

Use of Portable Devices

It is a policy violation to transmit or communicate PHI (including images/pictures) through any mechanism except through a Providence approved secured technology or application, even when using a Providence issued cell phone.

Please talk to your core leader to learn what specific Providence approved secured technologies or applications are available to you to message, capture and/or upload images into the patient's medical record for treatment purposes.

Please call the integrity hotline for guidance

Remember: Even if you are using a Providence owned cell phone, you still must use the secured technologies or applications to send secure PHI.

Personal Electronic Devices in Patient Care Areas

It is a violation of policy for workforce members to utilize any personal photography or recording devices in patient care areas (even if no patients are present) or where patients are present including, but not limited to, operating rooms, nursing stations, patient rooms, hallways, and elevators.









For example, all below are prohibited:

- Recording social media videos (for fun or educational purposes)
- Selfies or pictures with staff members
- Pictures with patients even when they give their approval
- Partial pictures of covered patients in the OR
- Pictures related to patient care/procedures
 - Medical trays in Operating Rooms
 - Medical waste in ER Rooms

Using Email for Providence Tasks

Personal email addresses must not be used to send or receive PHI.

- Providence policy PSJH-CYBR-950.08 Acceptable Use Standard prohibits the “use of third-party e-mail providers (e.g., personal e-mail accounts) to conduct Providence business”.
- Providers are prohibited from using their personal email address or a non-Providence email address to conduct business for/with Providence.
- Even if you think it is deidentified information, you may not send it via third party email accounts.

ACCEPTABLE	NOT ACCEPTABLE
 PHI and PII that IS YOUR OWN	 PHI and PII that is NOT your own
 Your Tax documents and Paystubs	 Passwords and logins to Providence-related systems
 Your personal information (<i>education related, PSLF forms, resume etc.</i>)	 Providence Work Product (<i>anything you were paid to create at Providence e.g. code, project plans, financial reports etc.</i>)
 Your HR related documents (<i>performance reviews, salary information, benefits etc.</i>)	 EPIC Intellectual Property (<i>e.g. screenshots, templates, smart phrases etc.</i>)

Privacy and Patient Rights Safeguards: *What Should You Do?*



Verify patient identity by using 3 identifiers. Many patients share full names and dates of birth and errors cause significant billing issues for patients along with privacy concerns. (Verify w Lindsay)



Be cautious with verbal conversations whether in treatment areas or in public areas. Know the audience listening.



Escalate all requests by patients promptly to avoid missing legal deadlines (i.e.; requests for medical record access or changes to medical records). Store portable devices and other electronic media in a secure location—your car is not a secure location!



Keep all papers/electronics with PHI out of view of the public. Secure your computer, voicemail and other passwords—lock and don't share! Ensure that screens are secured from being viewed by unauthorized individuals.



Ensure that treatment related communications or treatment photography is done via Providence secure applications.



Ensure you are not using a third-party email application to send PHI.

Law Enforcement and Government Oversight Agencies

If approached by law enforcement while on shift for Providence, immediately connect with the unit/department supervisor.

Disclosures of a patient's personal or medical information to law enforcement or government agents must be handled by Health Information Management or the designated operations area, even if they have a subpoena or a warrant for medical records.

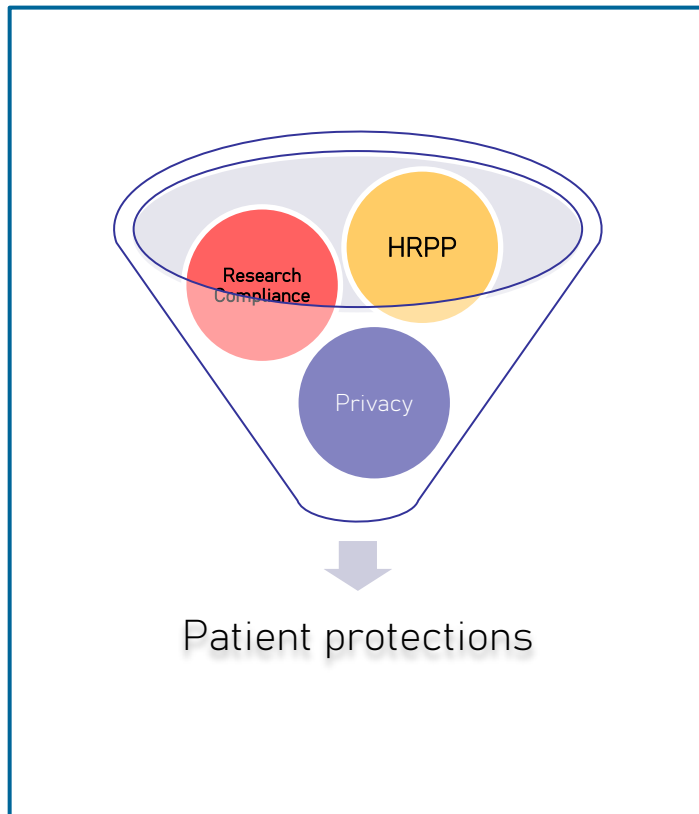
It is important to note that Providence will always cooperate with requests from government agencies, our response will be clear and truthful, and no alteration or destruction of records will occur.

Media Requests

- If contacted by a reporter or the media about a patient, you should notify a Providence core leader or the house supervisor (politely declining requests for information).
- Only designated individuals within Providence are authorized as public spokespeople to speak with the media.
- The media should never be permitted within patient care areas and are treated as general visitors to the hospital (unless appropriately authorized by senior leadership) and appropriate patient consents and authorizations are in place.

Intersection of Research and Patient Information

When it comes to research there are 3 distinct areas at Providence that are set up to protect the well-being of patients.



If you are planning to be involved in research here at Providence, ensure you are familiar with:

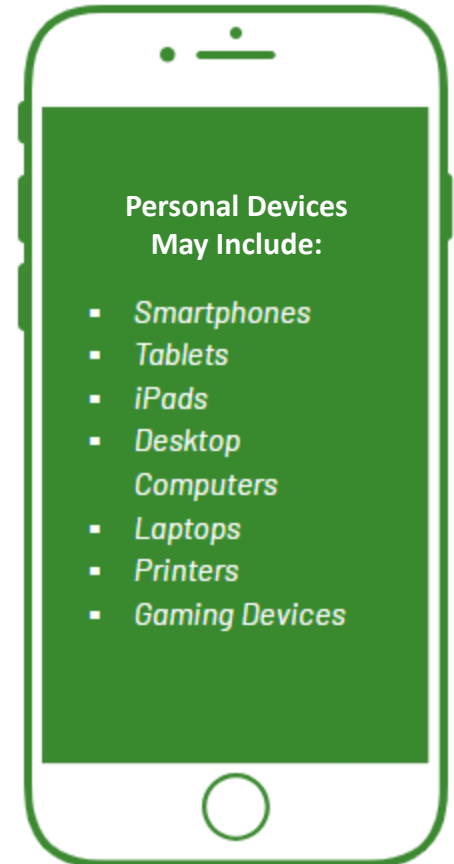
- [The Providence Human Research Protections Program](#)
- [Research Compliance at Providence](#)
- [Required study documentation](#) such as an Informed Consent form, Study Protocol and others.

Below are two publicly available NIDPOEs (“reprimands”) the FDA cited researchers on:

[NIDPOE issued for lack of IRB Approval](#)
[NIDPOE issued for failure to obtain consent \(among other violations\)](#)

Cyber Security at Providence

- Providence monitors the use of all information systems, all access to electronic data, and all devices that are used to access our systems or data.
- Personal device use must comply with all security policies (password protected, updated Operating System, patches, anti-virus, etc.) and the Use of Personal Device HR policy.
- Personal devices that contain Providence applications, programs, and apps are not to be used by anyone else or shared with anyone else.
- Any attempt to circumvent Providence security controls or non-compliance with policies can result in disciplinary action up to including termination of contract/partnership.



Artificial Intelligence (AI) Governance at Providence

Workforce members should only use Providence approved AI solutions for Providence work and on Providence devices

Policy: PSJH-EIS-908 Use of Providence-Approved AI Solutions

- Providence prohibits the use of non-approved AI systems by workforce members while working within the Providence IT systems/assets. Since *ProvidenceChat* was retired, Copilot is Providence's main AI system that is integrated with M365 for those who have the license.
- If there is an AI system not already approved that you want to use at Providence, it must be formally approved through the appropriate enterprise guardrails processes. The current processes are explained at [Enterprise AI Guardrails Program Management](#)
 - For AI systems *related to patient care or clinical decision-making*, specific approval from the Providence Clinical AI Review Council is required for both internally developed and third-party solutions. This Council is accountable for certifying that the appropriate guardrails have been followed and the Clinical AI system can go to production deployment.
- All data collected or generated through Providence-approved AI systems must be used ethically and securely, accessed only by authorized workforce members, and handled in accordance with existing privacy policies, with use beyond product improvement requiring approval from the Providence Data Protection Council and Board.
- Caregivers who fail to comply with these requirements will be subject to disciplinary actions up to and including termination as outlined in PSJH-CPP-851 Privacy Sanctions Policy as well as the Counseling and Corrective Actions Policy (located on the Caregiver Services Portal).

Copilot for M365: Compliance & Usage Restrictions

At Providence, IS Cybersecurity has approved Copilot and it is integrated into Microsoft 365 and is automatically subject to all Providence policies, including but not limited to policies related to confidentiality, security, privacy, acceptable use, and Minimum Necessary Use of Protected Health Information (PHI) and Personally Identifiable Information (PII).

- Copilot for M365 must NOT be used for patient care or clinical decision making.
 - Users will be required to attest to NOT using Copilot for M365 for patient care or clinical decision making during the license request process.
- Copilot for M365 can be used with PHI/PII and Providence internal and confidential information, in accordance with Providence policy.
 - **IMPORTANT:** Use of PHI should be limited to the minimum necessary to accomplish the intended purpose. This means that in most cases caregiver (i.e. names, addresses) or patient identifiers (i.e. names, MRNs) should not be typed into Copilot for M365 input fields.
- Caregivers are responsible for how they use Copilot for M365 results.
 - Information should be reviewed to make sure it is accurate.
 - Copilot for M365 is for Providence business purposes only; it should not be used for personal reasons.

If you use Copilot, check out this [Copilot for M365 Tip Sheet](#) for helpful best practices.

Cyber Security Best Practices

- Keep all passwords private and secure. Do not share with anyone, **ever!**
- Lock or log off your computer when you walk away.
- To avoid phishing schemes, work related or personal, do not click on suspicious links or download attachments from unfamiliar senders, especially from email addresses you've never encountered before.



Health Connect Partners, LLC MSSP ACO Integrity & Compliance Training

Why Do I Need ACO Compliance Training?

Why do I need ACO compliance training?

- Compliance training is required by CMS for all MSSP ACOs – including employees, providers, and suppliers
- Your organization has chosen to participate in the HCP MSSP ACO. This means that *you* are now participating in the MSSP ACO too
- There are a few things you need to know to help ensure HCP complies with CMS requirements

What Am I Going to Learn & is it Important?

This compliance training program will address:

- Specific compliance requirements of MSSP ACOs
- Compliance issues, including fraud, waste, and abuse
- HCP's Integrity & Compliance Program
- Who to contact with questions or concerns

Compliance training is important; non-compliance can be very serious and result in:

- Termination of HCP's contract with CMS
- Loss of substantial amounts of funding
- Possible civil and/or criminal penalties for serious or intentional violations

What is a Medicare Shared Savings Program (“MSSP”) Accountable Care Organization (“ACO”)?

MSSP ACOs are groups of doctors, hospitals, and other health care providers who voluntarily work together to coordinate care for Medicare fee-for-service beneficiaries.

MSSP ACOs share in savings that result from providing beneficiaries with coordinated, high-quality care.

MSSP ACOs are not managed care organizations, do not use closed networks of providers, and do not limit a Medicare beneficiary's freedom to choose his or her providers.

MSSP ACOs must meet specific requirements established by the Centers for Medicare and Medicaid Services (“CMS”)

Health Connect Partners, LLC (HCP) is the Providence MSSP ACO for Alaska, Washington, Montana, Oregon, and California.

MSSP ACO Compliance Requirements

CMS has established specific compliance requirements for all MSSP participants that go beyond those that otherwise apply to health care providers including:

- Medically necessary and appropriate care
- At-risk beneficiaries
- Beneficiary choice
- Beneficiary notices
- Communications with beneficiaries
- Marketing materials
- Gifts to beneficiaries
- Other MSSP requirements



Let's look at each of these areas further

Medically Necessary & Appropriate Care

- Your MSSP ACO is committed to achieving the goals of:
 - Better health
 - Better care
 - Lower costs
- Health care that is **medically necessary** and **appropriate**
- MSSP participants may not:
 - Deny, reduce, or limit medically necessary services
 - Over-utilize services provided to non-MSSP beneficiaries to offset reduced revenues
 - Condition participation in the MSSP ACO on referrals of non-ACO business



At Risk Beneficiaries

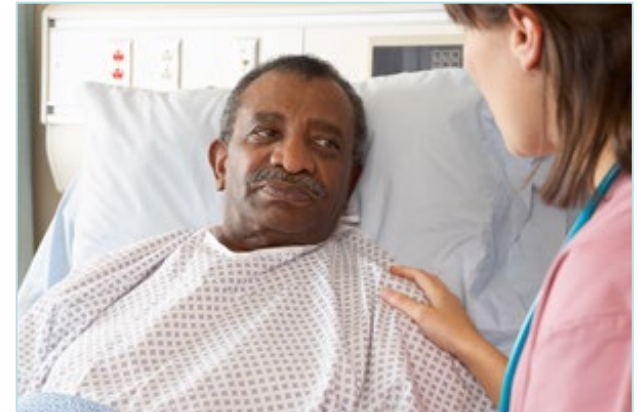
- MSSP participants may not avoid beneficiaries with high-cost medical needs
- An "at risk" beneficiary is a patient who:
 - Has a high CMS risk score on the CMS-HCC risk adjustment model;
 - Is considered high cost due to having two or more hospitalizations or emergency room visits each year
 - Is dually eligible for Medicare and Medicaid;
 - Has a high utilization pattern
 - Has one or more chronic conditions;
 - Has had a recent diagnosis that is expected to result in increased cost;
 - Is entitled to Medicaid because of disability; or
 - is diagnosed with a mental health or substance abuse disorder.



Beneficiary Choice

Can the MSSP ACO limit Medicare beneficiaries to seeing only other ACO providers?

- No – HCP is not a managed care plan or a closed network program.
- Medicare fee-for-service beneficiaries are free to seek care from providers outside of Providence organizations and its affiliate organizations participating in the MSSP ACO.
- MSSP participants may not engage in practices or adopt policies that restrict or limit the right of Medicare fee-for-service beneficiaries to obtain health care services from providers they choose.



Communications with Beneficiaries

Are there other MSSP ACO requirements for communications with Medicare beneficiaries?

Yes – CMS has placed significant limitations on MSSP ACO communications (also referred to as “Marketing Materials”) with Medicare beneficiaries:

“Marketing Materials” include

Beneficiary notices

Brochures

Websites

Advertisements

Outreach events

Mailings

Social media

“Marketing Materials” do not include

Billing and claims information

Materials on other specific individual health related issues

Educational materials on health care conditions

Materials customized or limited to a subset of beneficiaries

Materials that do not contain information about the ACO, its participants, or providers

Written referrals for health care services

MSSP ACO Materials – CMS Requirements

- All ACO marketing and communication materials for actual or potential Medicare beneficiaries require advance approval by CMS
- ACOs are prohibited from using incorrect or misleading information in marketing materials
- ACOs may not modify template marketing materials provided by CMS without approval of CMS
- Medicare and ACO contact information must be included in all materials developed or distributed to Medicare beneficiaries
- CMS prohibits the use of certain specific language, phrases, and terms in MSSP ACO marketing materials

MSSP ACO Materials – CMS Requirements

ACO-created materials may not contain:

- Language suggesting beneficiaries are required to see only ACO providers, or are in any way prohibited from seeing providers outside the ACO
- Language suggesting beneficiaries enroll or are participating in ACOs; wording should be clear the provider, not the beneficiary, has chosen to participate in the ACO
- Language suggesting CMS endorses one ACO over another
- Language suggesting an ACO is in any way superior to other ACOs, or other types of ACOs, or that providers participating in the ACO are superior to other providers participating in other ACOs or CMS initiatives

MSSP ACO Materials: CMS Requirements

CMS prohibits the use of certain terms and phrases in ACO-created materials:

Prohibited	CMS Suggested Alternative
"Managed care" or "care management"	"Coordinated care" or "care coordination"
Beneficiaries "enroll" or "enrollment"	Providers "participate"
"You have been selected to participate"	"Your provider has chosen to participate"

Refer to CMS' *Guidelines for MSSP ACO Marketing Materials* for additional information

MSSP ACO Materials – CMS

Requirements Beneficiary Notifications

- **Initial Notification:** MSSP ACOs must provide beneficiaries with a Beneficiary Notification Letter at or before their first primary care visit of the year for each five-year agreement period. Any new beneficiaries added throughout the agreement period will also need the initial Beneficiary Notification.
- **Follow-Up Notification:** MSSP ACOs must also furnish a follow-up communication at the beneficiary's next primary care visit or within 180 –days of the beneficiary receiving the first notification. This notification is intended to provide the beneficiary with a meaningful opportunity to ask any outstanding questions they might have and serve as a tool to reduce beneficiary confusion and increase comprehension of the ACO program and cannot be simply resending the first notification.
- **Signage:** All MSSP ACO facilities must post the current CMS MSSP Poster in an area viewable to patients.
- **Templates:** CMS provides templates that must be used for notifications and signage and may not be altered.

Gifts to Beneficiaries

Can an MSSP ACO participant offer free or discounted services to Medicare beneficiaries?

Yes – but strict limitations apply. Organizations are allowed to provide Medicare beneficiaries free or below market value items and services to encourage care coordination and beneficiary health awareness when it meets all of the following requirements:

- “In-kind” (e.g. goods, commodities, and services, but not cash);
- Reasonably connected to the medical care of the beneficiary;
- Either preventive care items or services or intended to advance one or more of the following clinical goals:
 - Adherence to a treatment regime
 - Adherence to a follow-up care plan; and/or
 - Management of a chronic disease or condition
- Not a Medicare covered item or service.

Gifts to Beneficiaries

MSSP ACO participants may not give Medicare beneficiaries:

- Cash or items unrelated to health care under any circumstances (e.g. sporting event tickets, gift certificates for non-health care items)
- Items or services as a reward for receiving services from the organization
- Items or services to persuade a Medicare beneficiary to remain in the ACO or with a particular ACO provider



Appropriate

An ACO may provide a blood pressure monitor to a patient with hypertension to encourage regular blood pressure monitoring

Inappropriate

An ACO may not waive or reduce Medicare copayments or deductibles unless based on a beneficiary's financial need. This would be considered a financial incentive, not "in-kind" goods and services

Other MSSP ACO Requirements

MSSP ACO participants must also adhere to additional requirements of the MSSP ACO program including:

- Development of processes supporting evidence-based medicine, quality assurance, and patient engagement
- Periodic submission of quality data, certifications, and other information in accordance with CMS requirements
- Retention of all records related to MSSP for a minimum of 10 years after the ACO agreement period ends

All HCP participant organizations are expected to cooperate in the gathering, recording, and submitting of data in a timely, accurate, and complete manner, and assist in meeting all other requirements

Seeking Answers to Your Questions

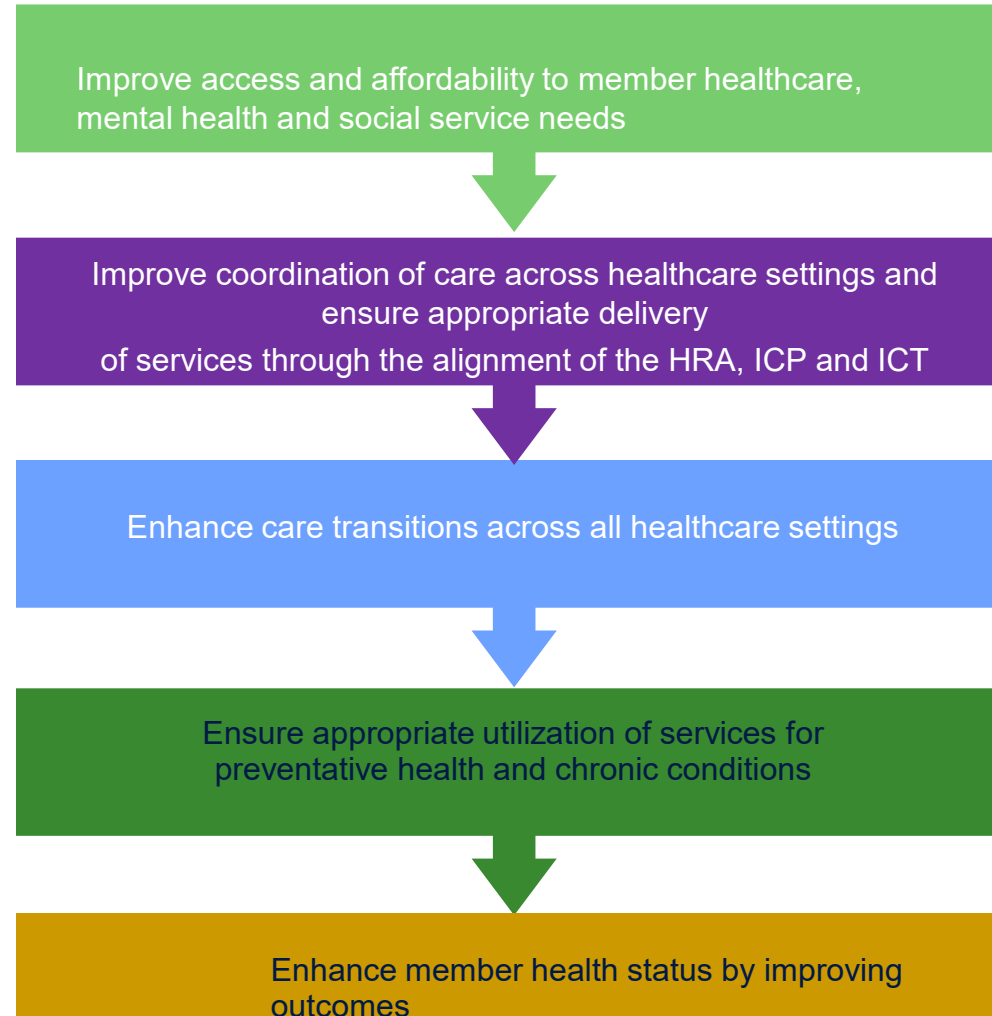
- All HCP participants are encouraged to seek answers to questions and report issues and concerns
- HCP participants are expected to report, in good faith, any actual or suspected fraud, waste, and abuse, violations of law or regulations, or MSSP policies
- You may choose one or more of the following options for reporting:
 - *A manager, supervisor, or compliance officer in your organization*
 - *MSSP ACO Compliance Officer (Amy Riedel): amy.riedel@providence.org*
 - *Providence Compliance Hotline: 888-294-8455*



**Annual
Special Needs Plan (SNP)
Model of Care Training**

Ambulatory Care Management

Special Needs Plan: Goals



Special Needs Plan: MOC

- ▶ Model of Care (MOC): CMS requires SNP Plans to develop a MOC that describes their approach to caring for their target population. The SNP MOC is a working framework on how the SNP proposes to coordinate the care of the SNP enrollees.
- ▶ Required Training: CMS requires all employed and contracted staff, who provide direct and indirect care coordination services to SNP members, to complete initial SNP MOC training and annually thereafter. Delegates this requirement to each medical group to provide initial and annual training for all employed and contracted staff and maintain the documentation of that training.





Types and Eligibility

Chronic Special Needs Plan (C-SNP)

- Eligibility Verification within 30 days post enrollment
 - Balance-Heart First: Chronic Heart Failure, Cardiovascular Disease or Diabetes
 - Village Health: End Stage Renal Disease (ESRD)

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP/DSNP)

- Eligibility Verification Monthly and eligible to receive all Medicare and Medi-Cal benefits
 - Connections
 - Connections at Home: In addition, will meet Nursing Facility Level of Care (NFLOC) which qualifies them for home and community-based services.

Institutional Special Needs Plan (I-SNP)

- Eligibility Verification Annually
 - Embrace Plan

D-SNP Focus: Connections & Connections at Home

Connections:

Designed for people who have both Medicare and Medi-Cal

Including Medicare benefits, all Medi-Cal benefits, plus drug coverage and extra benefits like transportation, dental, vision coverage, acupuncture, hearing and more.

Connections at Home:

Designed for people who have both Medicare and Medi-Cal, and meet the State of California criteria for nursing facility level of care and live in their own home or nursing facility

As the only FIDE SNP in California, SCAN provides and administers all the Medicare benefits, all Medi-Cal benefits, drug coverage, including Long Term Services and Supports (LTSS) in designated counties (below).



California - LA, RV, SB, SD

Only FIDE SNP in CA

Connections at Home: LTSS Qualifying Criteria

Criteria:

- Chronic medical conditions that affect member's daily functioning
- Activity of Daily Living (ADL) deficits (requires physical assistance with at least 1 ADL)
- Skilled need- requires intermittent or constant nursing monitoring of health conditions
- Live in the service area (LA, Riverside, San Bernardino & San Diego)
- Members are assessed every year to ensure that they continue to qualify to receive services.

Services include:

- Care coordination
- Personal Care and light homemaking
- Travel Escort for medical appointments
- Home delivered meals
- Incontinence and hygiene supplies
- Bathroom DME
- Nutritional supplements (Rx required, not as sole source of nutrition)

For More Information:

- If you have a member who may qualify for LTSS, please contact us via Member Services: 800-559-3500, or our LTSS Call Center: 800-887-8695.

D-SNP Requirements

Alzheimer's Disease and Related Dementias (ADRD) Training

Dementia care training is an integral part of the Interdisciplinary Care Team (ICT) component to ensure an understanding of Alzheimer's Disease and Related Dementias (ADRD) including symptoms and progression, behaviors and communication problems caused by and/or related to ADRD, caregiver stress and management, and community resources available for those affected by ADRD.



D-SNP Requirements

Enhanced Care Management

SCAN provides ECM services to members identified as meeting the criteria for the following 4 ECM populations:

1. Adults Living in the Community and at Risk for Long-Term Care Institutionalization
 2. Adult Nursing Facility Residents Transitioning to the Community
 3. Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
 4. Adults At Risk of Avoidable Hospital or ED Utilization
- Enhanced Care Management services include but are not limited to: outreach and engagement, enhanced coordination of care, health promotion, comprehensive transitional care, member and family supports; coordination of and referral to community and social support services, and comprehensive assessment and care management plan: through primarily in-person contact or if in-person contact is unavailable or does not meet the needs of the Member, alternative methods (i.e., telehealth) will be used in accordance with Member choice.



The 4 Elements of Model of Care

Overall Special Needs Plan

Population Type

- Chronic SNP (**C-SNP**)
- Fully Integrated Dual Eligible SNP (**FIDE-SNP**)
- Institutional SNP (**I-SNP**)

MOC 1: Description of SNP Population

Subpopulation – most vulnerable



MOC 3: Provider Network

- Specialized Expertise
- Use of Clinical Practice Guidelines and Care Transition Protocols
- MOC Training for Provider Network with signed attestation
- Staff/Providers deliver care to SNP members must complete annual MOC training



Population

Care
Coordination

Provider
Network

Quality
Measurement
and
Performance

MOC 2: Care Coordination

- Health Risk Assessment (**HRA**)
- Face to Face Encounter
- Individual Care Plan (**ICP**)
- Interdisciplinary Care Team (**ICT**)
- Care Transition Protocols (**CT/TOC**)



MOC 4: Quality Measurement and Performance

- Quality Performance Improvement Plan
- Measurable Goals and Health Outcomes
- Measuring Patient Experience of Care
- Ongoing Performance Improvement Evaluation
- Dissemination of SNP Quality Performance
- Quality Measure Monitoring
- SNP model of care program evaluation process
- Quality Improvement Plan



Face to Face Encounters

Face to Face Encounter - New Requirements

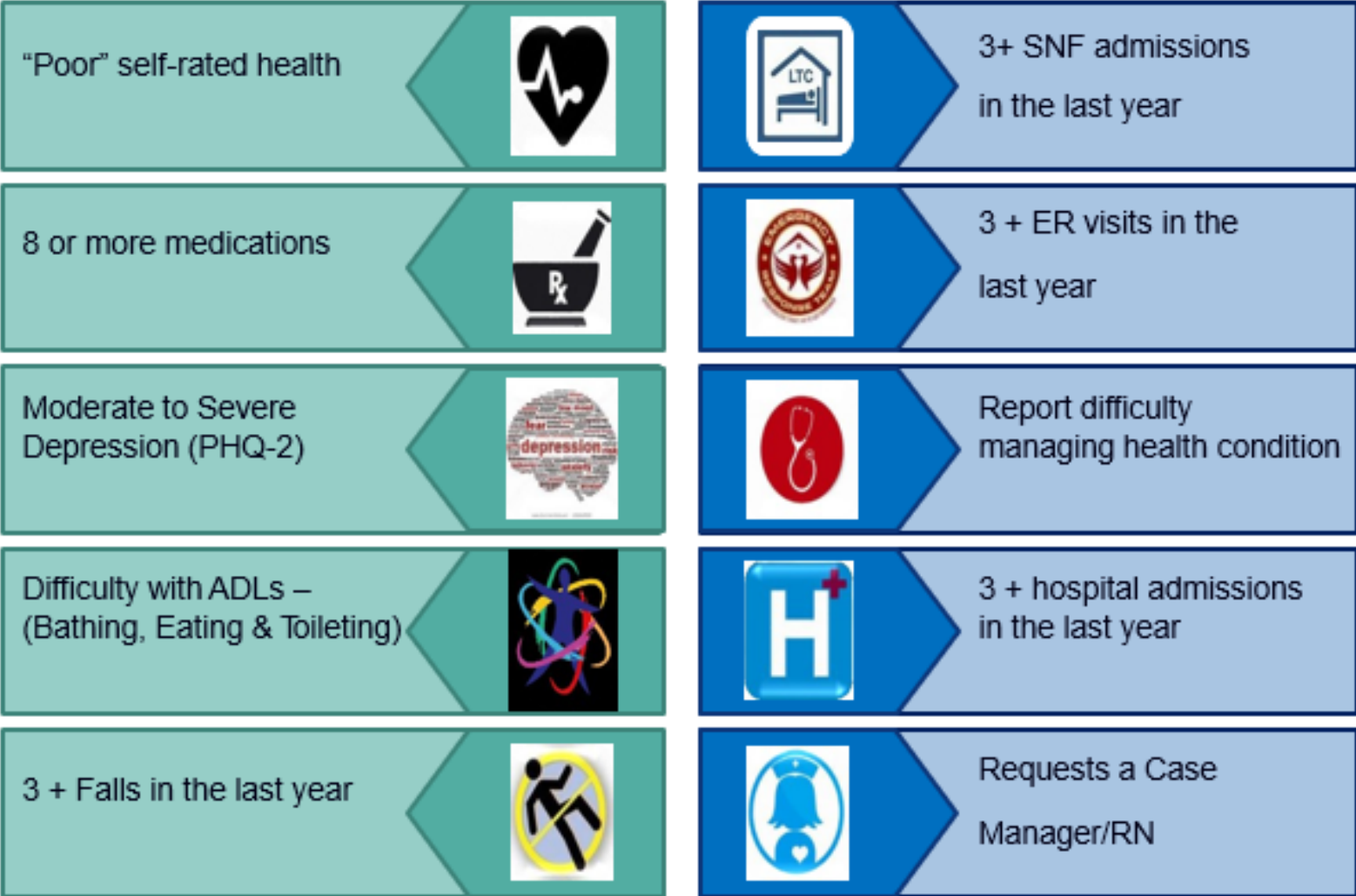
Within the first 12 months of enrollment, as feasible and with the member's consent, the organization conducts face-to-face encounters to deliver health care, care management or care coordination services.

A face-for-face encounter must be either in person or through a visual, real-time, interactive telehealth encounter.

The encounter must be between the member and representative from any of the following:

- A member of the ICT
- Organization's case management and coordination staff.
- A healthcare provider contracted with the health plan.

Health Risk Assessment (HRA) Triggers



Member Benefits



Health Risk Assessment (HRA)-Health Plan performs an initial HRA



Transportation—the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region



In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides** or lower costs for items such as **Diabetic Monitoring supplies, Cardiac Rehabilitation**. **CSNP Focus – Balance** includes **\$0 insulin benefit, including coverage through the gap**. These benefits vary by region and type of SNP.

Individualized Care Plan (ICP)



- Review Health Risk Assessment/SCAN's Individual Care Plan for triggered patients
- Complete Clinical Review
- Outreach to member: Outreach to member, documenting attempts and outcome within 30 days of receipt of trigger report
- Review all triggers with the member on your outreach and assess for any other concerns, determine acuity level and need for case management.
- Review all findings in your Interdisciplinary Rounds
 - Developed based on the patient's assessment and identified problems
 - Includes patient's self-management plans and goals
 - Includes barriers and progress towards goals
- Shared with patient/caregiver, PCP, and any settings where the patient has a transition of care: Hospital, Skilled Nursing Facility
- Updated with changes to health such as new diagnosis, hospitalization, or at least annually and communicated to ICT and patient
- Must be completed within 30 days of notification by Health Plan trigger and/ or change of health status per CMS/Health Plan requirement

When to Update the Care Plan:

Clinical review identifies a change of health status not reflected on the SCAN care plan

During member outreach/assessment, a new concern is identified

As a result of Interdisciplinary Team review

A change of health status that occurs at any point during the member journey (e.g. admit/discharge from a facility)



Send the revised care plan to the member and PCP

Interdisciplinary Care Team (ICT)

- All SNP members require interdisciplinary care
- **Interdisciplinary care can be formal or informal**
- Our ***formal*** ICT team meets weekly and consists of Medical Director, Social Worker and SNP Care Management nurse
 - Patients/caregivers are invited to ICT during the initial assessment and care plan sign-off. They have the right to opt in or out of participation.
 - The PCP is invited to join the weekly ICTs
- ***Informal*** ICT can occur in person, over the phone or electronically between any two members of the patient's care team



Transition of care (TOC)

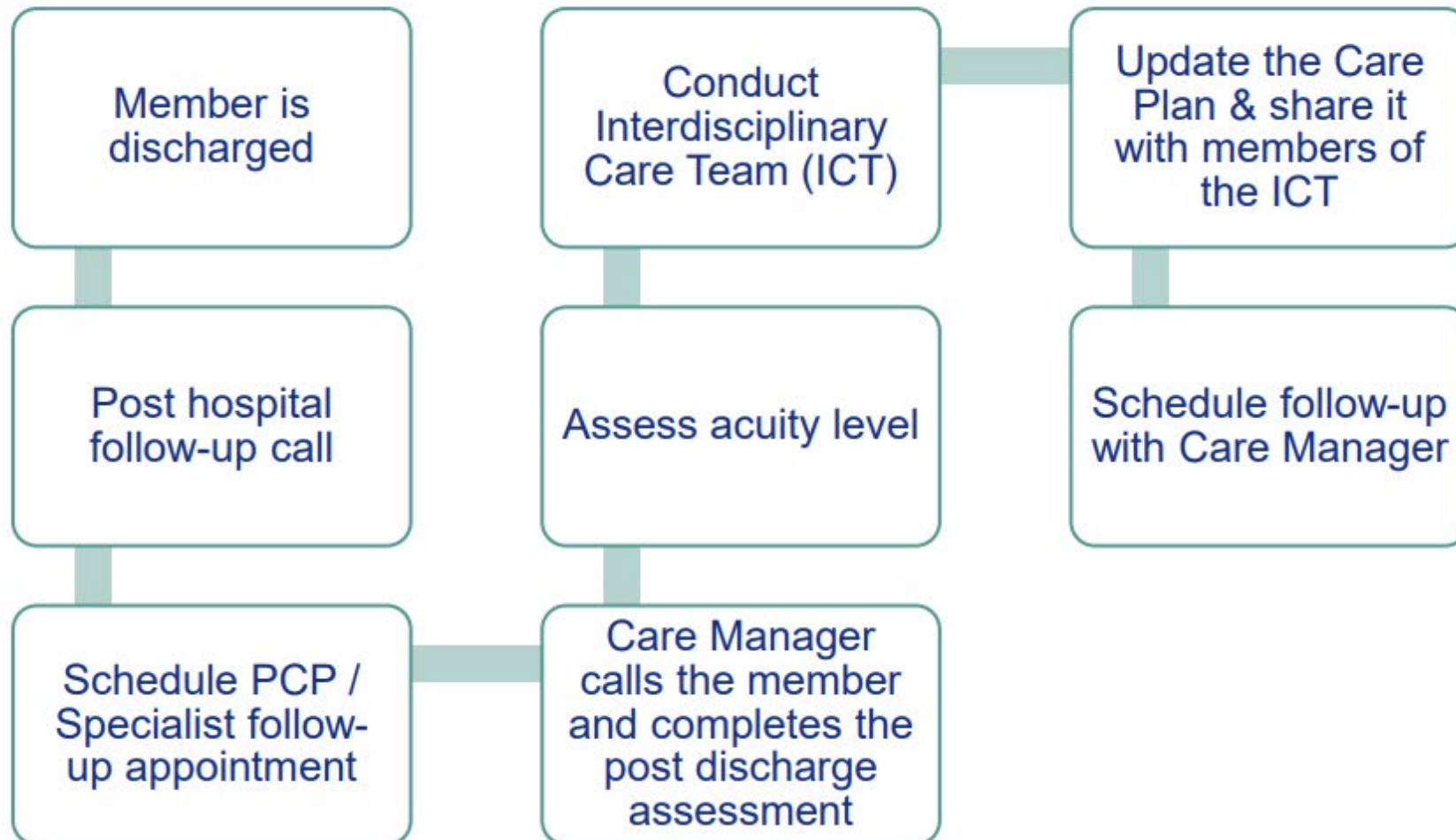
- Patients are at risk of adverse outcomes when there is a transition between settings
- Patients experiencing an inpatient transition are identified
- The patient's care plan is shared between care settings upon admission
- PCP is notified of patient's discharge



Discharge follow up call is made to patient;
Care Manager to review the following:

- Discharge instructions and verify understanding
- Medications and ensure new prescriptions have been filled and picked up
- Follow-up appointments in place
- Home Health start date and confirm they have been in touch with the patient (if applicable)
- Durable medical equipment has been delivered (if applicable)
- Additional education around diagnosis, symptoms, when to call the doctor
- Nurse Advice Line and Urgent Care Center information provided
- Questions the patient/family/caregiver may have

Coordinating Care Transitions



Care Transitions (CT) Documentation

Care Transitions documentation must include:

- “Patient outreach was completed/attempted within 5 business days of discharge from one setting to another”.
- Notification to PCP within five business days of discharge
- Ensure follow-up services and appointments are scheduled within 5 business days of transition
- The team ensures there is an identified provider directing the member’s care and any other providers who need to be aware of the transition are notified.
- Care plan transferred between settings before, during, after transition of care
- Member coaching occurred
- Members of the ICT and members/caregivers have access to the plan of care

Advance Directive

Advance Directive is an ongoing conversation that:

- Involves *shared decision making* to clarify and document an individual's wishes, preferences, and goals regarding future medical care.
- This comprehensive process is critically important to ensuring patients receive the medical care they want in the event they lose the capacity to make their own decisions.
- PCPs are required to educate and should encourage each Member to complete an advance directive and document in the Member's medical record
- Completed advance directives must be placed in a prominent place in the Member's medical record (See 42 CFR 422.128(b)(1)(ii)(E)).

SNP MOC Oversight (Annual Audit)



Schedule and timely submission

Scheduled Annually – SCAN will coordinate with Compliance and Ambulatory Care Management teams

Request for audit document

Timely Submission of audit documents

Corrective Action Plan – Creating a Successful Response

This includes MOC training with proof of attestation for the Primary Care Physicians/Specialty Providers of selected patient files.

Audit Performed

Ensure appropriate participants available for case review

Notification of Audit Outcome

Pass

CAP

Once CAP is issued, we cannot change audit results for untimely submission of documents

Correction Action Plan Process

Perform Root Cause Analysis - the “why” deficiency occurred.

Corrective Action Plan - Group plan for correcting deficiency including Implementation Date(s)

Responsible Individual- Must be a person not a department

Repeat Deficiencies

Each repeat deficiency requires new Root Cause

Analysis and Corrective Action Plan.

File Review Deficiencies

File Review Deficiencies require Root Cause

Analysis and Corrective Action Plan including implementation of any process change (**including staff training, etc.**)

Role of SNP Care Manager

- Reviews Health Risk Assessment (HRA) from Health Plan
- Performs an assessment of medical, psychosocial, cognitive and functional status
- Develops a comprehensive individualized care plan with member input
- Identifies barriers to goals and strategies to address
- Discusses member care at Interdisciplinary Care Team (ICT) meetings
- Facilitates transitions of care calls after an ED visit or acute hospitalization
- Provides personalized education for optimal wellness
- Encourages preventive care such as flu vaccines and mammograms
- Reviews and educates on medication regimen
- Promotes appropriate utilization of benefits
- Assists member to access community resources
- Assesses cultural and linguistic needs and preference

Your Role as the Physician

- ✓ Review comprehensive and individualized care plans created for each patient
- ✓ Encourage your patients to engage with their assigned SNP Care Managers and take advantage of the benefits.
- ✓ Participate in ICT meetings for your patient if necessitated
- ✓ Collaborate with patient care during Transitions to reduce gaps in care and readmission risk
- ✓ Provide medical documentation necessary to the SNP Care Manager for the assessment and care planning process
- ✓ Encourage and support your patients to complete their Annual Wellness visits with you and your team



MOC training attestation documentation

*Friendly reminder to complete both attestations as evidence that you completed this training:

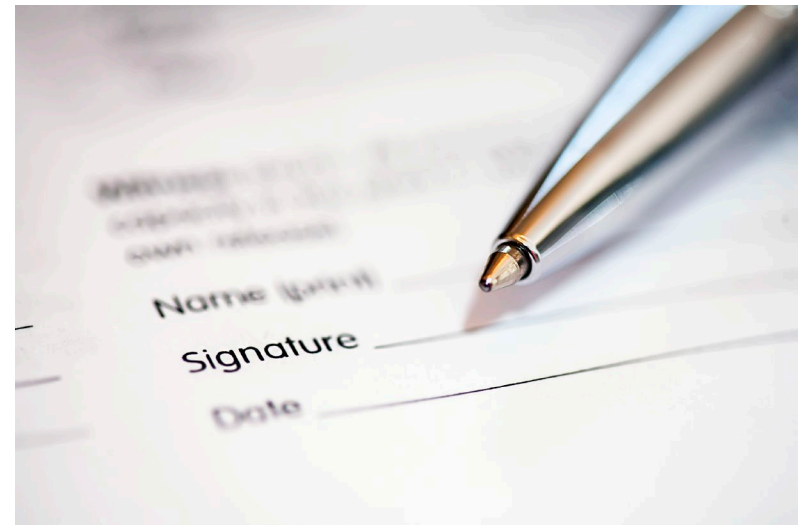
1. **Providence Attestation:**

- "Provider Education/Attestation" (on MS Forms)

2. **SCAN Sr Attestation:**

- "Attestation of Special Needs Plan Training"

Thank you for your time!





Disability Awareness

2026

Objectives

- Explain the prevalence and types of disabilities within Providence's population
- Identify and explain the legal requirements related to access for person with disabilities
- Define the basic rights of persons with disabilities
- Identify the physical accessibility components at a provider's office that are assessed and reported.
- Define your responsibilities in interacting with members, visitors, patients & their companions with disabilities.
- Use appropriate terminology and proper etiquette when interacting with people with disabilities
- Identify available resources and community resources.

Definitions: Impairment vs Disability

Functional Limitations

- Difficulty completing basic or complex activities because of a physical, mental, or emotional restriction.
- May be due to behavioral and/or chronic health conditions.

Functional Capabilities

- Strengths of a person with a disability to perform certain activities, with or without accommodations.

Impairment

- Alteration of a person's health status as assessed by medical means
- Typically identified with an organ or body part
- Ranges from mild (pinky amputation) to severe (tetraplegia)
- Does not include impact on person's ability to function in society

Disability

- A physical or mental impairment that substantially limits one or more of the major life activities (mobility, cognitive, vision, speech, or hearing)
- Birth (congenital) to acquired over lifetime
- Visible or hidden

Americans with Disabilities Act (ADA)

The ADA requires:

- Medical care providers make their services available in an accessible manner.
- Policies, procedures and guidelines be in place regarding non-discrimination based on disability.
- Providence is committed to providing equal access for members and their companions with disabilities.

“No individual shall be discriminated against on the basis of disability...”

Most important legislation for disability rights

Prohibits discrimination

Fundamental Values:
Equal Opportunity
Integration
Full participation

The Rehabilitation Act of 1973

Section 504- Prohibits discrimination due to disabilities in programs that receive federal funding

“No qualified individual with a disability ...shall be excluded from, denied the benefits of, or be subjected to discrimination under” any program activity.

Program accessibility

Effective communication

Accessible construction and alterations

Section 508- Requires electronic and information technology to be accessible to people with disabilities including employees and members of the public

Visual and audio outputs, optical aids

Accessibility- related software: Jaws (job access with speech)

The Olmstead Decision

Olmstead, or Olmstead v. LC, is the name of the most important civil rights decision for people with disabilities in our country's history. This 1999 United States Supreme Court decision was based on the Americans with Disabilities Act. The Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions when the following three-part test is met:

- The person's treatment professionals determine that community supports are appropriate;
- The person does not object to living in the community; and
- The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.



Most Integrated Setting

Integrated setting

- Refers to a setting that, “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible”
- Term means services and benefits to persons with disabilities should not be separate or different from a person without disabilities unless the separate programs are necessary to ensure that benefits services are equally effective

Least restrictive

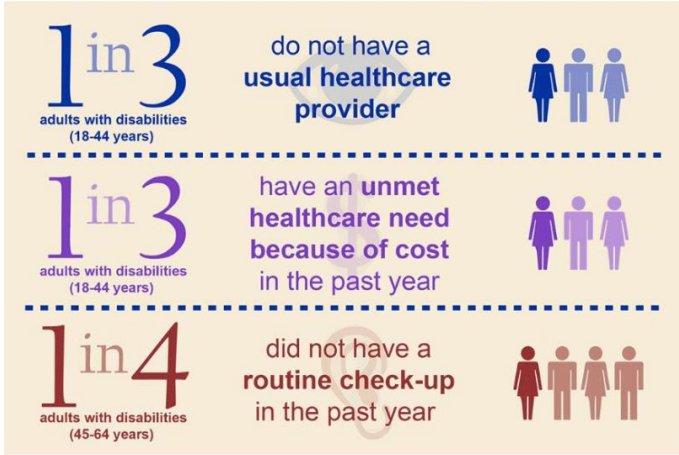
- Least restrictive environment is terminology for education settings
- All other settings use the term “integrated setting”
- A “least restrictive environment/setting possible” means members are treated in an environment and manner that respects individual worth, dignity, privacy and enhances their personal autonomy.

Disabilities and Healthcare Access

- Persons with disabilities and functional limitations may encounter environmental barriers to care.
- Most difficult barriers to overcome are attitudes.
- Focus on individual's ability rather than on disability.

Physical Access	Communication Access	Program Access
Ability to get: <ul style="list-style-type: none">• To• Into• Through• Onto	Ability to:: <ul style="list-style-type: none">• Understand what is being asked• Use the information given• Result in effective communication	Participate in: <ul style="list-style-type: none">• Health education• Prevention & treatment• Community-based programs

Healthcare access barriers for working-age adults include



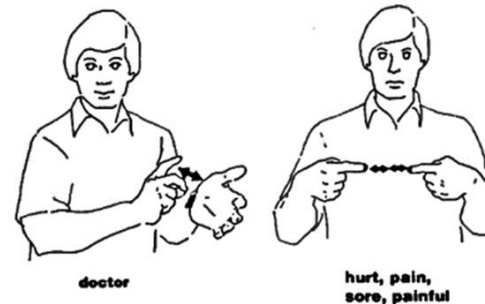
Accessibility Requirements for Providers

- Intended to meet the needs of any patient to improve program access and health outcomes
- Department of Health Care Services (DHCS) requirement MMCD PL 12-006 requires California plans “to assess the physical accessibility of provider sites, including specialist and ancillary service providers that serve high volume of seniors and persons with disabilities.”
- Required for all Medi-Cal contracted providers

Physical access



Effective communication



Reasons for Accommodations

Functional limitations may create a need for accommodations such as:

- Physical accessibility.
- Changes to provider office policies.
- Accessible exam or medical equipment.
- Effective communication.
- Member and health education materials in alternate formats.
- Physical disabilities may be more obvious, but unseen mobility issues are more common.
- For example, a member may experience an issue with physical ability to move around or walk a distance due to hip or knee problems, breathing issues, weakness, etc.

Never assume to know the member's disability

Types of Physical Accommodations

- Put yourself in the position of a person who is sight impaired, uses a wheelchair or is hard of hearing. Then think about what you would need to access information or simply enter an office
- Can you think of additional common types of physical accommodations? There are many barriers to access that are often overlooked by people who don't need them.
- These are everyday things we use, including: elevator, doors, doorways, hallways, restrooms, parking lots, telephones, forms and documents



Speech Disabilities

Members with speech disabilities may use:

- Their own voice
- Letter board
- Pen and paper
- Augmentative and alternative communication devices
- Speech generating devices (SGDs) “talk” when certain letters, words, pictures, or symbols are selected
- Speech-to-speech relay services (STS)
- A call that uses a specially-trained communications assistant

Speech disabilities can be:

- Developmental
- Result of illness or injury
- No speech
- Difficult to understand

Communication Tips

When talking about a disability or with a person with disabilities, focus on the person, not the disability, avoid negative language and use people-first language

If you have trouble communicating:

Ask the member how he or she wants to communicate

Speak slowly, clearly and patiently, and give time to respond

Don't:

Assume — which also includes not assuming someone from another culture understands American Sign Language.

Rush or ask the member to hurry.

Use People-First Language

Person with a disability

Person who is deaf

Person who uses a wheelchair

Person with an intellectual disability

Avoid Negative Language:

Handicapped person, blind person, wheelchair-bound or mentally retarded

Communication Tips

Members with mental health and/or substance abuse conditions may need consideration:

- Know how to get help in the event of a crisis, remain calm and offer support
- Keep stress levels to a minimum
- Change words you use
- Ask what environment they are most comfortable in

DON'T:

- Finish their sentences or cut them off
- Mimic or mock their speech
- Assume you know what they are saying
- Be patronizing

Resources and Authorities

- Contact the member's assigned health plan for interpreting services
- Centers for Disease Control and Prevention, [Disability and Health Promotion | Disability and Health | CDC](#)
- Deaf and disabled telecommunications program (DDTP) 1-800-806-1191 <http://ddtp.cpuc.ca.gov>
- California telephone access program <https://www.youtube.com/watch?v=9j3lwGUvS0c>
- California relay services (CRS) <http://ddtp.cpuc.ca.gov/default1.aspx?id=1482>
- Title 29, The United States Code, Section 794 (section 504 of The Rehabilitation Act of 1973)
- Americans with Disabilities Act of 1990
- DHCS Facility Site Review (FSR), Physical Accessibility Review Survey (Attachment C- "29 elements")
- Department of Health Care Services (DHCS)

Cultural Competency and Patient Engagement

What is Culture?

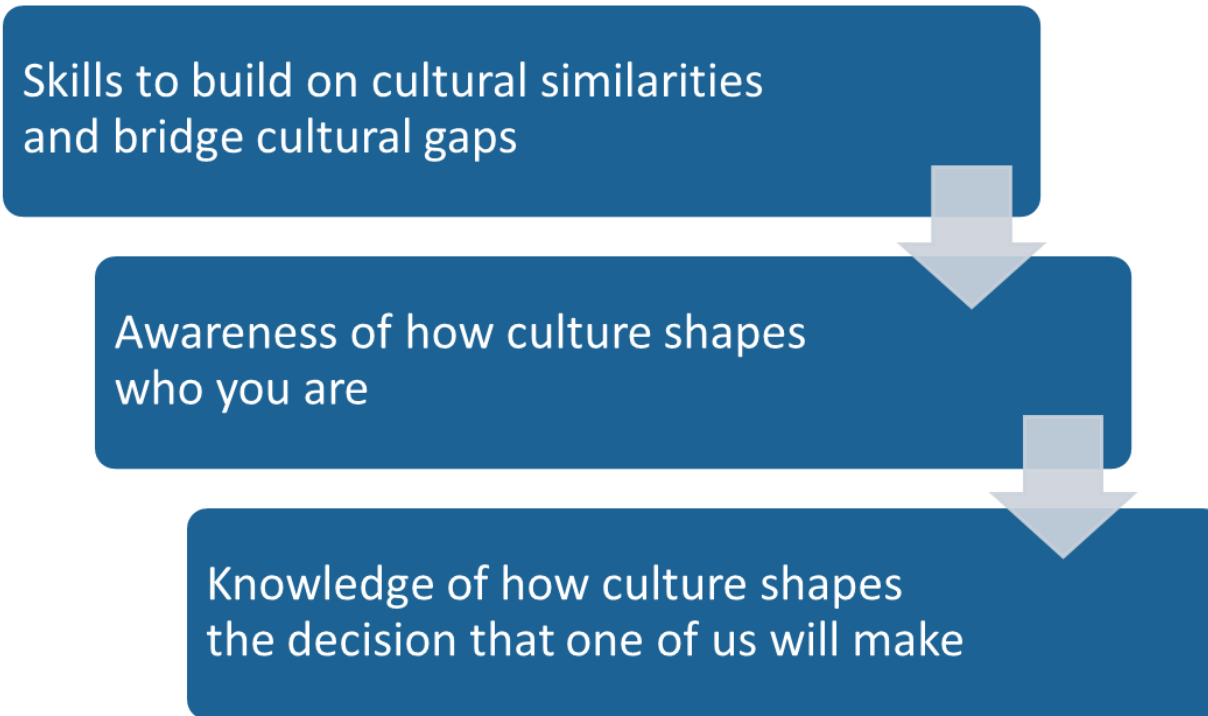
- Culture refers to integrated patterns of human behavior that includes language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.
- We use it to create standards for how we act and behave socially.



¹Source from <http://minorityhealth.hhs.gov> and The Cross Cultural Health Care Program

Building Cultural Engagement

Culture is not only learned but it is shared, adaptive, and is constantly changing.



Individual Culture

- Our view of illness and what causes it.
- Our attitudes toward doctors, dentists, and other health care providers.
- When we decide to seek our health care provider.
- Our attitudes about seniors and persons with disabilities.
- The role of caregivers in our society.
- Culture is a unique representation of the variation that exists within our society.

The Health Care Encounter

- It is important to keep in mind, everyone brings their cultural background with them.
- There are many cultures at work in each health care visit.
- Our personal culture includes what we find meaningful-beliefs, values, perceptions, assumptions and explanatory framework about reality.
- These are present in every communication.

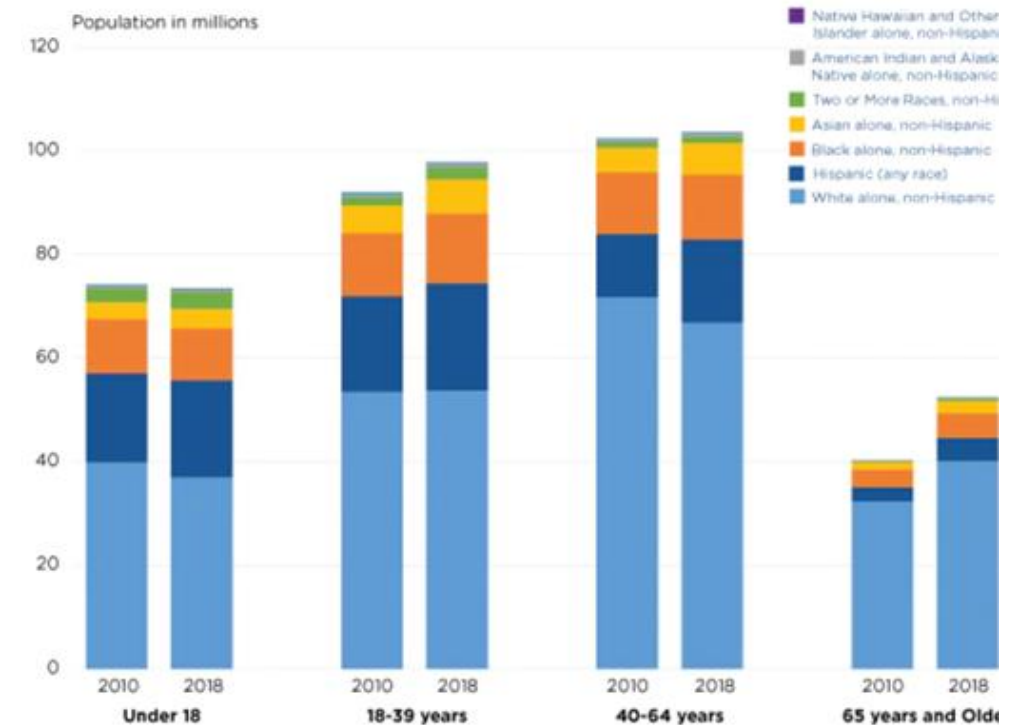


Did You Know?

- 1 in 6 people living in the US are Hispanic (almost 57 million)
- By 2035, this could be nearly 1 in 4. (CDC, 2015)
- 20% of people living in the U.S. speak a language other than English at home (CIS, 2014).
- Latino population in the U.S. has grown by 43% between 2000 and 2010 (Census, 2011)
- 17% of the foreign-born population in the U.S. are classified as newly arrived (arriving in 2005 or later). (Census, 2011)

A More Diverse Nation

Distribution of Race and Hispanic Origin by Age Groups



Barriers vs. Benefits

Barriers to communication	Benefits of clear communication
Speech patterns, accents or different languages may be used (Linguistic)	Safety & Adherence
Many people are getting health care coverage for the first time (Limited Experience)	Physician & Patient
Cultural Barriers	Satisfaction
Each person brings their own cultural background and frame of reference to the conversation (Cultural)	Office Process
Health system have specialized vocabulary and jargon (systemic Barriers)	Saves Time & Money

Clear Communication

Possible patient thoughts...

- I tell you I forgot my glasses because I am ashamed to admit I don't read very well.
- I don't know what to ask and I am hesitant to ask you.
- When I leave your office, I often don't know what I should do next.
- I'm very good at concealing my limited reading skills.



Here's what your team can do...

- Use a variety of instruction methods.
- Encourage open-ended questions
- Use Teach Back Method or "Show Me" method.
- Use symbols, color on large print direction or instructional signs.
- Create a shame free environment by helping with materials.

Clear Communication

Possible patient thoughts...

- I put medication into my ear instead of my mouth to treat an ear infection because the instructions said, "*For Oral Use Only*".
- I am confused about risk and information given in numbers like % or ratios. How do I decide what I should do?



Here's what your team can do...

- Explain how to use the medications that are being prescribed.
- Use specific, clear & plain language on prescriptions.
- Use plain language to describe risks and benefits, avoid using just numbers.

Clear Communication

Possible patient thoughts...

- I am more comfortable waiting to make a health care decision until I can talk with my family.
- I am sometimes more comfortable with a doctor of my same gender.
- It's important for me to have a relationship with my doctor.



Here's what your team can do...

- Confirm decision-making preferences.
- Office staff should confirm preferences during scheduling.

Clear Communication: Limited English Proficiency

Possible patient thoughts...

- My English is pretty good but at times I need an Interpreter.
- Some days it's harder for me to speak English.
- When I don't seem to understand, talking louder in English intimidates me.
- If I look surprised, confused or upset I may have misinterpreted your nonverbal cues.

Things the provider team can do :

- Office staff should confirm language preferences during scheduling.
- Consider offering an Interpreter for every visit.
- Consider the volume and speed of the patient's speech
- Mirror body language, position and eye contact.
- Ask the patient if they're unsure.



Language Assistance Services

Language assistance is available at no cost

- Interpreter support available.
- Sign language Interpreters.
- Speech to text interpretation for hearing loss in patients who do not sign.
- Member informing materials in alternative formats (i.e., large print, audio, and Braille).

Contact the health plan for assistance with language services



Use Professionally Trained Interpreters

Hold a brief introductory discussion with the Interpreter to ...

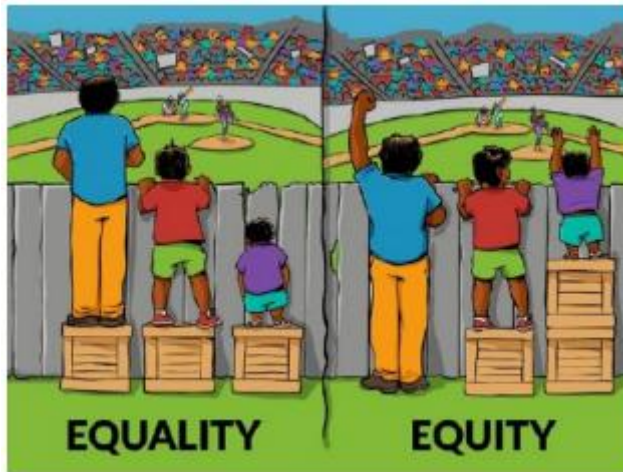
- Introduce yourself and give a brief nature of the call/visit.
- Reassure the patient about your confidentiality practices.
- Be prepared to pace your discussion with the patient to allow time for interpretation and avoid interrupting during interpretation.

Alternate Formats Are Required

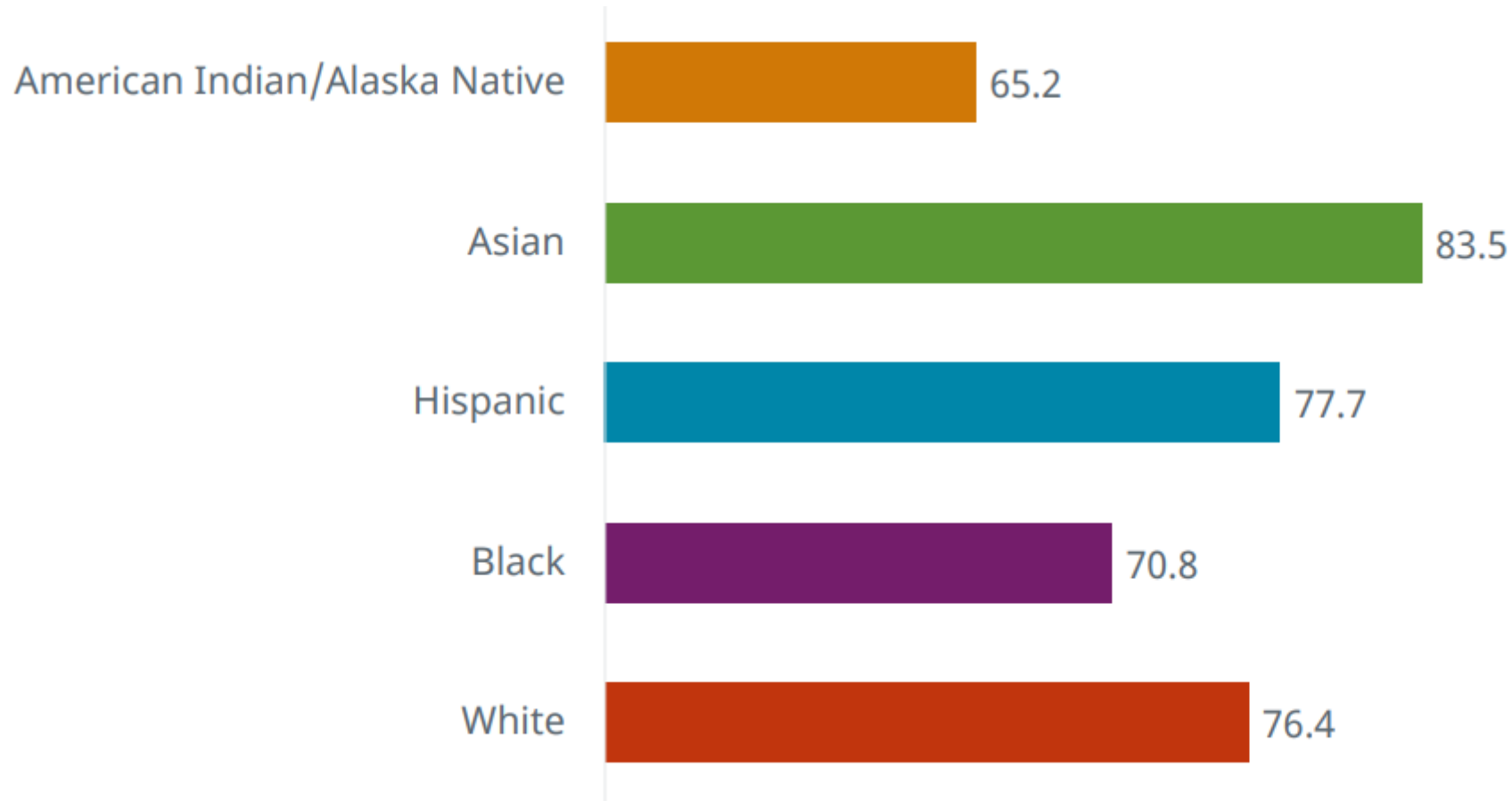
- Under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication.
- Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under the act, a physician and surgeon is required to demonstrate satisfaction of continuing education requirements, including cultural and linguistic competency in the practice of medicine, as specified.
- Effective communication means to communicate with people with disabilities as effectively as communicating with others. Alternative communications that support a patient encounter include Sign Language Interpreters, Tactile Interpreters, captioning and assisted listening devices.

Health Equity vs. Equality

- Health Equity is “the attainment of the highest level of health for all people.” Inequities exist when groups are unable to attain this level of health.
- Equality means everyone gets the same resources while equity means everyone has the same outcome.
- Newer models of health justice focus on self-determination, recognizing that individuals have a right to determine their own destiny, and this may mean choosing different outcomes based on their values.



Inequities in National Life Expectancy by Race/Ethnicity



Hill, L, Ndugga, N, and Artiga, S. 2023. Key Data on Health and Health Care by Race and Ethnicity.

Retrieved from:

<https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/:~:text=Provisional%20data%20from%202021%20show,77.7%20years%20for%20Hispanic%20people>

Inequities in Late-Stage Cancer Diagnosis

- Successful treatment of cancer increases with early-stage diagnosis, and late-stage diagnosis means cancer is harder to overcome.
- Data showed that across 4 cancer types (breast, cervical, colorectal and lung), in comparison to the size of their member population:
 - Asian members were overrepresented in late-stage diagnosis
 - Black members were overrepresented for cervical cancer
 - White members were overrepresented for breast, colorectal and cervical cancers

Addressing Inequities

- The 2023 PNA report found that two cancer screening measures showed meaningful inequities:
 - Breast cancer screening rate among Chinese members was the lowest group at 46.71%
 - Cervical cancer screening rate among Korean members was the lowest at 42.24%
- Comprehensive Community Cancer Screening and Support Program partners with external stakeholders to fight against cancer. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses
 - Breast Cancer Screening pilot with City of Hope
 - Joined Orange County Cancer Coalition
 - Sharing information about local mobile mammography community events
 - Digital and print advertisement; social media campaigns

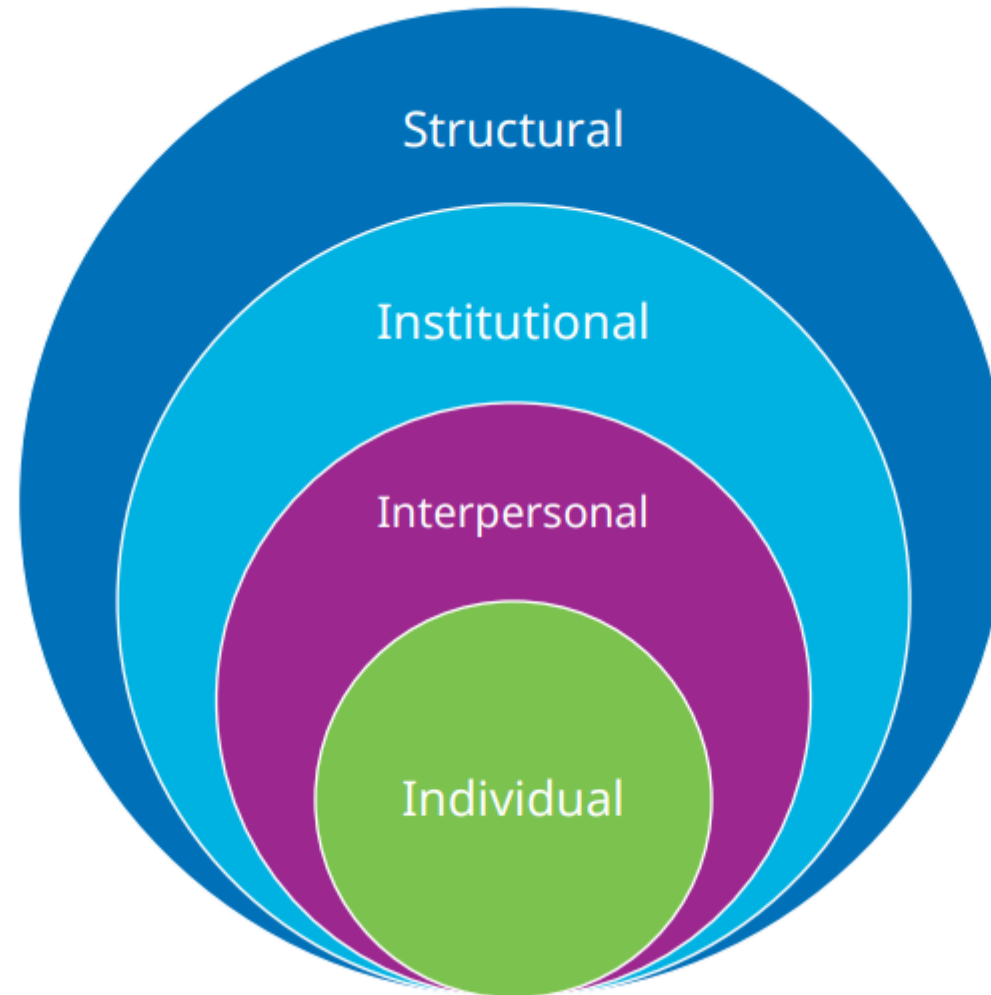
Levels of Racism

Individual Racism:

Pre-judgement, bias or discrimination based on race by an individual

Interpersonal Racism:

Occurs between individuals. Once we bring our private beliefs into interaction with others, racism becomes interpersonal



Institutional Racism:

Policies, practices and procedures that work better for white people than for people of color, often unintentionally

Structural Racism:

A history and current reality of institutional racism across all institutions, combining to create systems that negatively impact communities of color

Institutional Racism and Implicit Bias in Health Care

- Various research studies have highlighted how institutional racism and bias can lead to reduced quality of care for Black patients
- Three research articles showed how clinician misperception led to Black patients receiving lower quality care for pain compared to White counterparts
- These findings highlight the importance of acknowledging and overcoming bias

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman^{a,1}, Sophie Trawalter^a, Jordan R. Axt^a, and M. Norman Oliver^{b,c}

^aDepartment of Psychology, University of Virginia, Charlottesville, VA 22904; ^bDepartment of Family Medicine, University of Virginia, Charlottesville, VA 22908; and ^cDepartment of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities In Pain

Carmen R. Green, MD,^a Karen O. Anderson, PhD,^b Tamara A. Baker, PhD,^c Lisa C. Campbell, PhD,^d Sheila Decker, PhD,^e Roger B. Fillingim, PhD,^f Donna A. Kaloupek, MD, MPH,^g Kathryn E. Lasch, PhD,^h Cynthia Myers, PhD,ⁱ Raymond C. Tait, PhD^j

Are Pain Beliefs, Cognitions, and Behaviors Influenced by Race, Ethnicity, and Culture in Patients with Chronic Musculoskeletal Pain: A Systematic Review

Ceren Orhan, PhD^{1,2}, Eveline Van Looveren, MSc^{2,3}, Barbara Cagnie, PhD², Naziru Bashir Mukhtar, MSc², Dorine Lenoir, MSc^{2,3}, and Mira Meeus, PhD^{2,4}

Consider the Impact of Institutional Racism and Implicit Bias on the Health Care System

Providence Staff

- How does Providence mitigate the impacts of institutional racism and biases through equitable hiring practices and promotional opportunities?
- What mentorship opportunities develop staff that aspire to lead?
- How are diverse voices at the table invited to guide program development that benefits the communities that they are from and serve?

Network Providers

- How do providers' implicit biases impact clinical decision-making and care?
- How are provider offices welcoming to people from different backgrounds?
- Are providers and their staff reflective of the community they serve?

Contractors, Subcontractors and Downstream Subcontractors

- Do services unintentionally exclude or disadvantage certain groups?
- Are contractors thoughtful about designing products in an inclusive manner?

Workforce Diversity

- Having a diverse workforce means having health care professionals, trainees, educators and researchers of varied race, ethnicity, gender, disability, social class, socioeconomic status, sexual orientation, gender identity, primary spoken language and geographic region
- While the U.S. patient population has grown in diversity, physician workforce diversification is occurring at a much slower rate. This is especially true among Black, Latin, and Native American physicians.
- Institutional racism is experienced in places of higher education, where Black, Latin and Native American aspiring clinicians face discrimination that makes achieving advanced education harder

Togioka BM, Duvivier D, Young E. Diversity and Discrimination in Healthcare. [Updated 2023 Aug 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK568721/>

Salsberg E, Richwine C, Westergaard S, et al. Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce. JAMA Netw Open. 2021;4(3):e213789. doi:10.1001/jamanetworkopen.2021.3789

Intersectionality

Intersectionality refers to the overlap of various identity factors, such as race, ethnicity, social class, nationality, gender, sexuality and ability

Examples:

- Indigenous women who are missing
- Persian transgender men
- Disabled lesbians in rural communities
- Black veteran entrepreneurs
- Older adults with ADHD on Medi-Cal
- White people living in poverty

Honoring Differences and Similarities

- All people, regardless of differences or similarities, should be served with excellence and dignity, respecting the value and needs of each person.
- Providence staff have similarities and differences within our organization, just like we have with our members—this is an asset.
- Ensure that programs, policies and practices recognize and reflect the diversity of our membership.
- Workforce diversity is an important factor to improving patient outcomes because having a provider who understands you and your experience increases patient experience.
 - Literature has shown that especially with Black patients, satisfaction and communication are improve with patient-provider race concordance

Diversity Within Groups

- Middle Eastern and North African (MENA) people have historically been identified as “white” by the US Census. However, this group is diverse:
 - **Nationality:** Israeli, Palestinian, Egyptian, Iranian
 - **Ethnicity:** Hebrew, Arab, Persian
 - **Language:** Farsi, Hebrew, Arabic
 - **Religion:** Jewish, Muslim, Christian, Areligious
- When understanding characteristics of other cultures, it is important to treat each person as an individual and use “person-centered care” principles that focus on centering the member’s/patient’s needs in their own care.

Perceptions of Health and Death

- Cultural health beliefs affect the way members view health, illness and death.
- Dignity should be given to members' beliefs, experiences and values as it relates to their health.
- Some cultures consider discussion of impending death to be inappropriate and insensitive.
- At end-of-life, some patients may rely heavily on medical care, some rely on faith and spirituality, and others rely on both.

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- Weiss, B. D. (2007). Health literacy and patient safety: Help patients understand; Manual for clinicians (2nd ed.). Chicago, IL: American Medical Association Foundation. Retrieved from http://med.fsu.edu/userFiles/file/ahec_health_clinicians_manual.pdf
- National Patient Safety Foundation: Ask Me 3 materials for providers. Retrieved from <http://www.npsf.org/?page=askme3>



Providence Clinical Network South Division

Workplace Violence Prevention

2026

Agenda

Background on Workplace Violence Prevention

Foundation Providers:

- Responding to an Event
- Resources Available

Affiliate Providers



Our Healing Environment

Providence is committed to ensuring a safe and healing environment for all the people we serve and for our care teams.

We believe that healing is best nurtured with **compassion and respect**, and in the absence of intimidation, fear or violence.

We are dedicated to keeping you as **informed and comfortable** as possible.

You are an important part of keeping our environment safe by treating others with **dignity, respect, and compassion**.



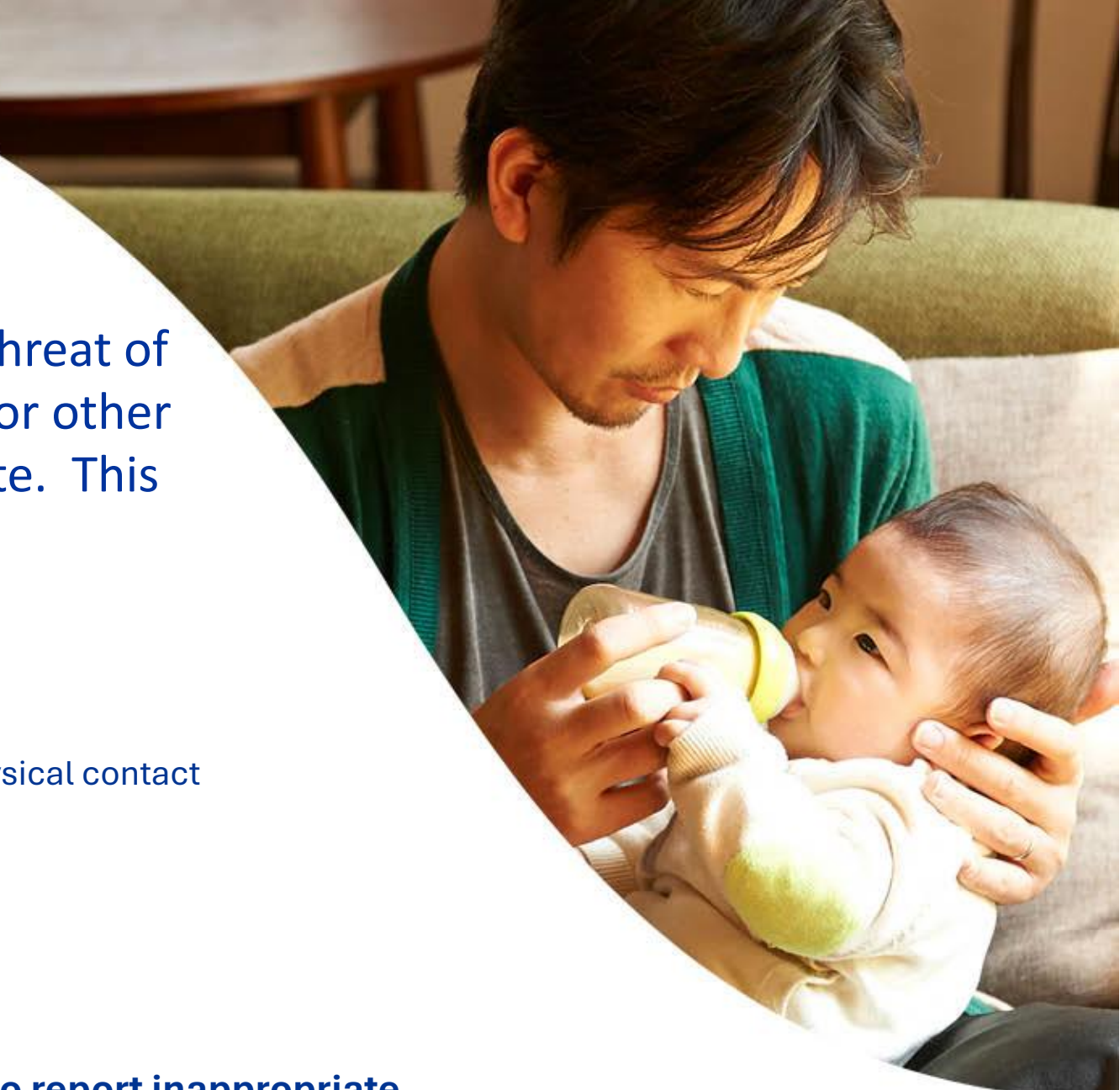


Workplace violence is defined as any act or threat of physical violence, harassment, intimidation, or other disruptive behaviour occurring at the worksite. This includes in-person and any written or verbal communication.

Unacceptable behaviors include

- Grabbing, hitting, kicking, spitting or any unwanted physical contact
- Abusive, threatening, or inflammatory language
- Remarks of a racial or discriminatory nature
- Behavior that disrupts care
- Any illegal behavior

If you ever feel concerned for your safety or wish to report inappropriate behavior, please talk with a member of your care team immediately



Foundation Providers responding to an event:

- Ensure all impacted individuals are safe.
- Compassion is key before going into details and learning from an event.
- Provider, Caregiver, or Manager can submit a HRP report via Speak Up for Safety on your desktop.
- Alternatively, can submit via EPIC via Patients record



Ensure that the correct patient encounter is open for the incident before starting the report.

1. From a patient's encounter, click the **More Activities drop down arrow**.
2. Click the **Speak Up For Safety** link.
 - **Tip:** To save this link as a favorite, hover over the link and click the pin that appears.



PressGaney | Providence Health & Services - Providence Health & Services

Reporter Falls Team Device HAPI Medication Safety Workplace Violence

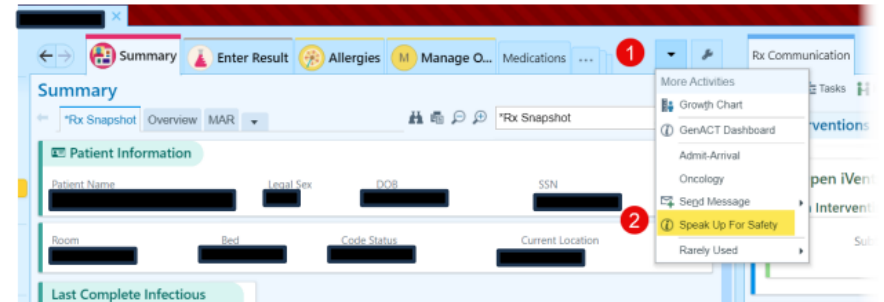
- Patient Safety
- Workforce Safety**
- Service Feedback

Patient Safety - Includes patient related events. This module also includes visitor related events.

Workforce Safety - At this time, this module is only for reporting Workforce Violence events.

Service Feedback - This would be events for a complaint from a patient/family, or even a compliment.

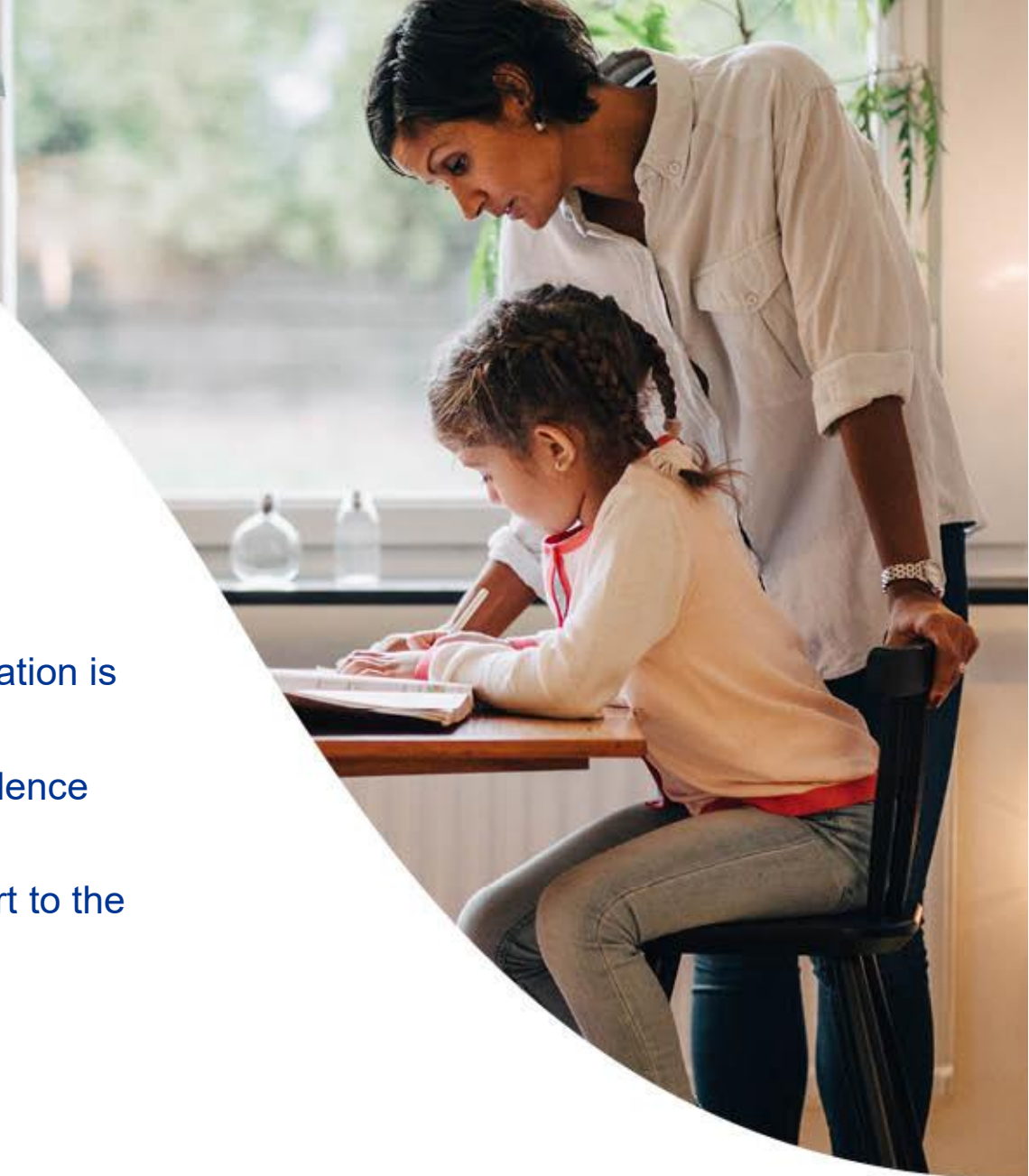
Click the **Green button** to the left to launch a new event





Foundation Providers Responding to Incidents:

- After an HRP incident has been submitted, a care team of professionals will review and provide next steps.
- Incidents reported will not be shared with perpetrator and retaliation is prohibited.
- Workplace Violence Prevention team will assess workplace violence hazards and mitigate where possible.
- If you would like to report a concern anonymously, please report to the Integrity Hotline at 888-294-8455 or by visiting www.Providence.org/IntegrityOnline

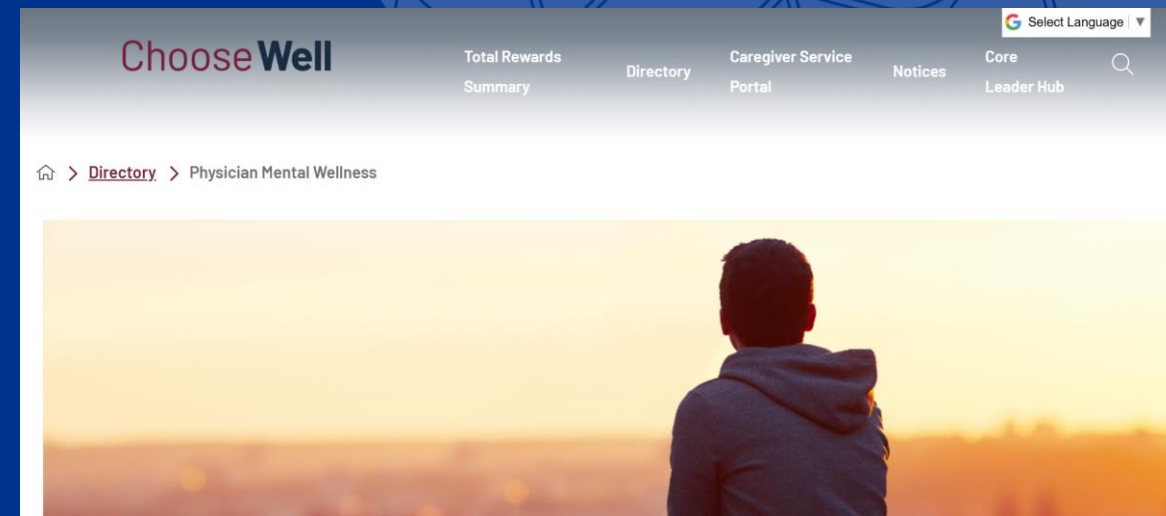
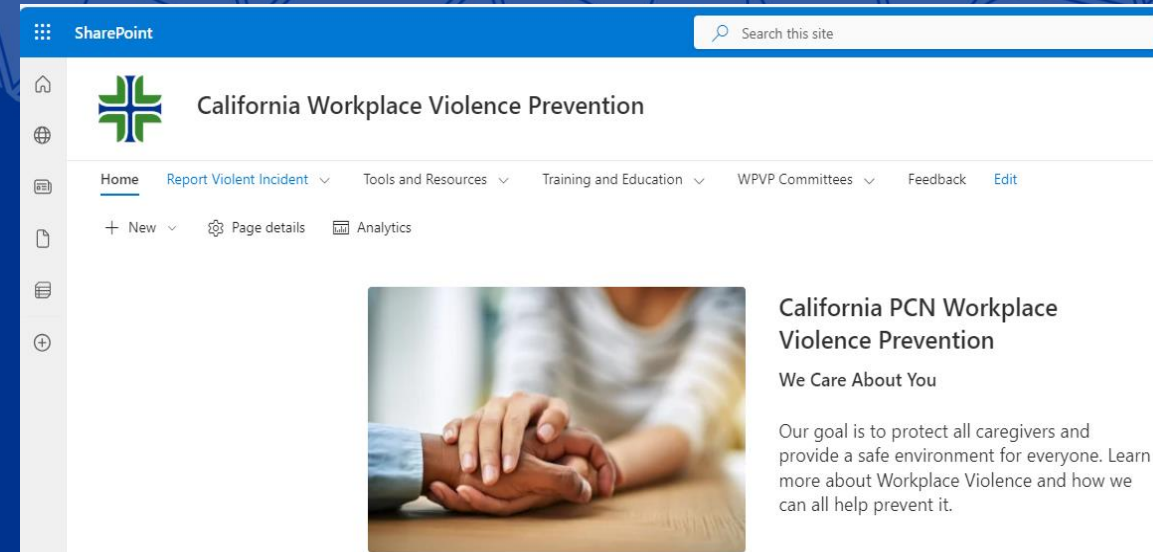


Foundation Providers Resources

- Providence has Safety Professionals dedicated to providing a safe and healing environment for all the people we serve and for our care teams.

To reach our 24/7 security team please call 714-712-3500 or email PCNSouthsecurity@Providence.org

- AVADE De-Escalation Training Available for Clinic Staff
- [California Workplace Violence Prevention - Home \(sharepoint.com\)](#)
- Choose Well Resources for Physicians.
 - [All Resources | Choose Well \(mychoosewell.org\)](#)



Support for Affiliate Providers

- [California Senate Bill 553 \(SB 553\)](#), signed into law on September 30, 2023. require employers to develop and implement a workplace violence prevention plan in accordance with newly codified Labor Code section 6401.9
- Starting July 1, 2024 employers in California with 10 or more employees must establish, implement, and maintain a Workplace Violence Prevention Plan that includes:
 - Prohibiting employee retaliation.
 - Accepting and responding to reports of workplace violence.
 - Employee workplace violence training and communication.
 - Emergency response.
 - Workplace violence hazard assessments.
 - Other requirements, such as maintaining a Violent Incident Log

If you have any questions on establishing your own plan or questions on Workplace Violence Prevention please reach out to our team and we can advise how best to keep your Caregiver, Patients and Practices safe.

Regional Workforce Safety Manager:

Orange County/High Desert (SJU, SJO, MHM, SMHD)

- Lindsay Kung, Lindsay.Kung@providence.org

Los Angeles (Facey, PMI, SJPP)

- Steve Yahner, Steve.Yahner@providence.org

Northern California (PMG)

- Justin Hallstrom, justin.hallstrom@providence.org

Security Operations Center 24/7

714-712-3500

Email: PCNSouthsecurity@Providence.org



Caring Well for LGBTQIA+ Patients at Providence

***Creating a Welcoming Environment for Trans+
Patients***

Objectives



- Understand how caring well for trans+ patients aligns with Providence's mission
- Get comfortable with terminology and definitions, affirmative language skills
- Build empathy for our patients
- For the purposes of this training, trans+ is an umbrella term that encompasses transgender, gender diverse, and intersex patients. Note: not all intersex people identify as transgender.

| Providence Mission and Values – Our Professional Responsibilities and Commitments |

 **Mission:** As expressions of God’s healing love, we are steadfast in serving all, especially those who are poor and vulnerable.

 **Values:** Compassion | Dignity | Justice | Excellence | Integrity



Vision: Health for a Better World



Promise: Know me, care for me, ease my way



Caring well for LGBTQIA+ people is in direct alignment with our mission, values, and promise.

It is our professional responsibility to care well for our LGBTQIA+ patients at Providence.

Providence recognizes Caregiver personal values are diverse;
at the Providence workplace it is expected that professional care align with Mission, Values, and Promise.

LGBTQIA+ History and Background

- LGBTQIA+ people have always been part of society – transgender people were acknowledged, accepted, and celebrated in ancient societies.
- Persecution, harassment and abuse of transgender people is more prevalent in recent history (1900s-present day)
- Transgender people are now starting to be more widely accepted again, but still face tremendous amounts of persecution, violence, and stigma – especially transgender femmes and people of color.
- Approximately 20 million adults identify as lesbian, gay, bisexual or transgender people (2020).
- LGBTQIA+ people are in every town, every city, every zip code. California and Texas have the largest number of LGBTQIA+ adult residents (2020).



Health Disparities and Inequities of the LGBTQIA+ Community



- LGBTQ+ youth are **more than four times as likely** to attempt suicide than their peers¹
- Transgender and nonbinary youth were **2 to 2.5 times** as likely to experience depressive symptoms, seriously consider suicide, and attempt suicide compared to their cisgender LGBTQ peers³
- Transgender and nonbinary youth who reported gender identity acceptance from adults and peers had significantly lower odds of attempting suicide in the past year⁴
- Transgender people are also more likely to attempt suicide as a result of this and other stressors: 4.6% lifetime suicide attempt rate among general population, 42-46% among transgender and gender diverse population.
- LGBTQIA+ patients face significant community and family discrimination, which contributes to these disparities.

Why is This Important in Healthcare?



Discrimination of LGBTQIA+ patients:

22% of transgender patients avoided or postponed seeking needed medical care because of disrespect or discrimination from health care staff

41% of LGBTQ people who lived in a nonmetro area said it would be “very difficult” or “not possible” to find the same type of service at a different hospital

29% of transgender patients surveyed said a doctor or other health care provider refused to see them because of their actual or perceived gender identity

Patient Experience: Discrimination in Health Care, Disparities and Inequities

The California Transgender Advisory Council - Transgender, Gender Diverse or Intersex Workgroup (CTGI Workgroup) participants expressed several challenges accessing healthcare, including:

- Lack of competent care
- Absence of safe gender-affirming care
- Providers not recognizing TGI identities
- Patient difficulty changing names and pronouns within medical systems and EHR
- Confusion among providers regarding providing preventive care procedures
- Absence of integrated TGI care
- Lack of TGI-affirming HIV care
- Safety concerns and a scarcity of doctors in rural areas.

Providence Patient and Family Advisory Council (PFAC) patients confirmed these same concerns. PFAC members, like the CTGI Workgroup, also highlighted that patients experience intersectional barriers to care related to race, socioeconomic status, age, disability, body size, and immigration status. These identity factors compound health disparities amongst TGI individuals.

Citations:

- Providence Patient and Family Advisory Council
- [TGI Final Report 2024](#)

—

Patient Experience: Barriers to Care, Disparities and Inequities

The CTGI and Providence's PFAC have also highlighted that trans+ patients experience:

- Difficulty with navigation to begin gender-affirming care.
- The feeling from the community that many doctors just didn't "care" about them.
- There is systemic discrimination and consistent misgendering of people seeking services. There were reports of doctors setting requirements before TGI individuals can receive gender affirming care that are more stringent or inconsistent with the current standards of care (i.e. requiring more letters for surgery than necessary).
- There is a lack of follow-up on referrals made to fellow practitioners.
- Enrollees and insureds are hesitant to seek services due to a history of high denial levels.
- Lack of insurance coverage of needed prescriptions and proper equipment (i.e., hormones and syringes of the correct gauge and length).
- Lack of adequate and competent in-network providers for referrals to care.
- The assumptions of femininity and masculinity are reflected in denials of surgical procedures (i.e., breast augmentation or facial feminization).
- Insurance coverage does not include financial support for recovery from surgical procedures.

Citations:

- Providence Patient and Family Advisory Council

- [TGI Final Report 2024](#)

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| What are pronouns and why are they important?

Pronoun Reference Sheet

She	Her	Her	Hers	Herself
He	Him	His	His	Himself
They	Them	Their	Theirs	Themselves

These are some examples – there are many more.

If you don't know someone's pronouns, ask! And remember, mistakes happen – apologize, correct yourself, and move on.

Integrating pronouns into introductions, patient appointments, and work environments can be simple.

For example: *“Hi, I’m Juan and my pronouns are he/him. What name do you go by, and what are your pronouns?”*

You can also do this in meetings: *“Hi everyone. I’m Allie. I’m an MA and I go by she/her.”*

Add them to your email signature next to your name: D. Marshall (pronouns they/them/theirs)

When checking someone in, ask someone’s full legal name, pronouns, and what they like to be called (these might be different than what you assume!)

- Example: "Welcome. Can you please tell me your legal name as it shows up on your insurance?" (let patient respond)
"Thank you. How do you like to be called, and what are your pronouns?"

It’s also a good idea to verify someone’s name, pronouns by stating what you see written in their chart and asking if those are correct. It gives people an opportunity to check in on name/pronouns and verify

What if I make a mistake?

- Despite a person's best efforts, mistakenly using the wrong pronouns can happen. If you mistakenly use the wrong pronouns, simply apologize, correct the pronouns, and move on.
- Do not over-apologize – this can be harmful.
- In some situations, if a person feels comfortable and safe doing so, they may correct another person's mistake using the wrong pronouns – the same way you'd correct someone mistakenly using the wrong name.
- Example: "In our conversation, I learned that she – I'm sorry, he – had some additional questions for the nurse"
- Example: Person 1: "I walked into his room - " Person 2: "THEIR room" Person 1: "Thank you. I walked into their room and was glad to see they were improving".

Basic LGBTQIA+ Terminology



Gender



**Gender
Expression**



**Sex
Assigned
at Birth**



**Sexual
Orientation**



Gender

Gender identity | One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Gender may be related to the pronouns people would like to use as well (e.g., she/her, he/him, they/them, etc.)



Gender Expression

Gender expression | External appearance of one's gender identity, usually expressed through behavior, clothing, body characteristics or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being masculine, feminine, or androgynous.

These are informed by social context.



Sex Assigned at Birth

Sex Assigned at Birth | The sex (male or female) assigned to a child at birth, most often based on the physical characteristics of reproductive organs, secondary sexual characteristics, chromosomes, and hormones of the child's external anatomy. Also referred to as birth sex, natal sex, biological sex, or sex. Commonly abbreviated as AFAB (assigned female at birth) or AMAB (assigned male at birth).

Sex assigned at birth is completely independent of gender identity.



Sexual Orientation

Sexual orientation | An inherent or enduring emotional, romantic or sexual attraction to other people. Examples include heterosexual, bisexual, pansexual, gay, lesbian, queer, asexual, etc.

Note: an individual's sexual orientation is independent of their gender identity.

Key Takeaways

- Using medically accurate and appropriate terminology, as well as terminology indicated by the patient, helps facilitate more effective communication with patients
- Using this terminology and people's names and pronouns as they have indicated (even if those names/pronouns have not been indicated in their records or legal documents) can ensure communication is LGBTQIA+ inclusive and creates a welcoming environment, especially for trans+ patients.
- Avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender or gender conforming, or non-intersex
- Do not use language, whether verbal or nonverbal, that demeans, ridicules, or condemns trans, gender diverse, intersex or other LGBTQIA+ individuals

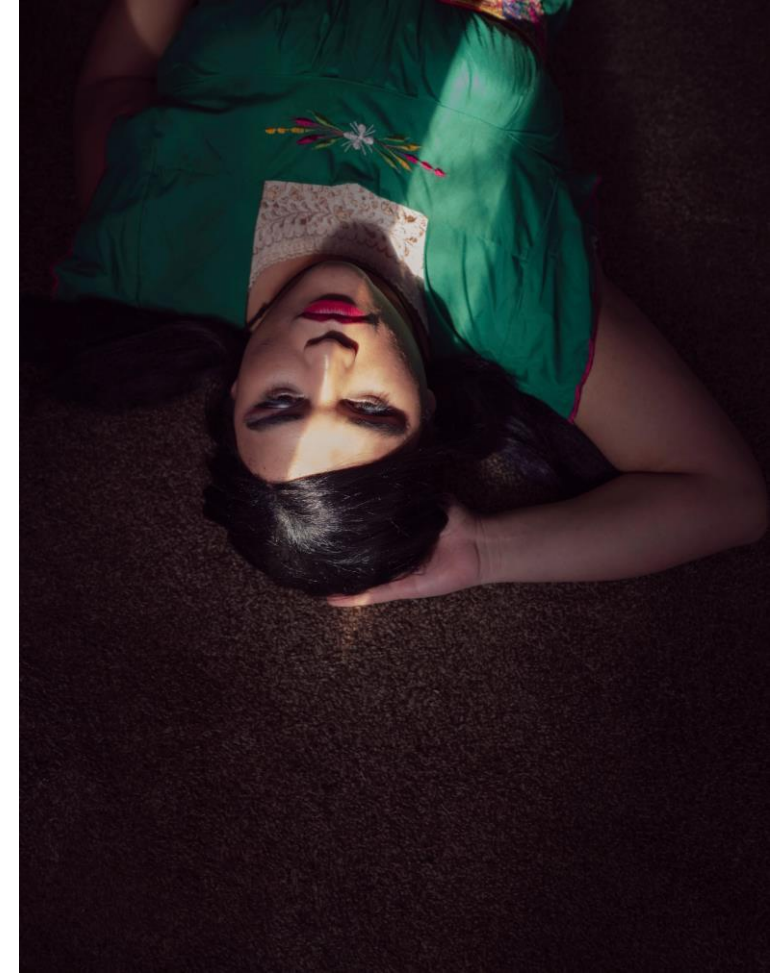
Examples of bias and microaggressions against transgender and gender diverse people (and what to avoid!)

Use of transphobic wording, such as incorrect gender pronouns, belittling language, and publicly questioning a person's gender

- "But she's not a REAL woman"
- Using different pronouns than what a person has indicated as the pronouns they use for themselves
- "Why can't you just be a butch lesbian?"

Assumptions that all trans people are the same, such as assuming all trans people undergo gender-affirming surgeries.

- "Oh, my uncle is trans – he had surgery last year. When are you having surgery?"
- "When are you going to REALLY transition?"



Examples of bias and microaggressions against transgender and gender diverse people (and what to avoid!)



Upholding the gender normative and binary culture that denies a transgender identity.

- "Boys don't wear dresses"
- "You're so pretty for a trans woman!"
- "There are only two genders –I don't get how you can feel like a man and a woman."

Denying the existence of transphobic experiences.

- "I was confused about this stuff too, when I was their age. They'll get over it, it's just a phase."
- "They're only dressing like that to get attention. If they didn't dress like that, then they wouldn't have any problems!"

Examples of bias and microaggressions against transgender and gender diverse people (and what to avoid!)

Denial of personal body privacy, such as asking intrusive medical questions or questions about appearance.

- "Have you had bottom surgery?"
- "You're not going to let them take puberty blockers, are you?"
- "If you're really a girl, why don't you shave?"

Not seeing trans people as humans.

- Referring to transgender/gender diverse people as "it" or "thing"



Examples of bias and microaggressions against transgender and gender diverse people (and what to avoid!)

Assumptions that trans people have a mental illness.

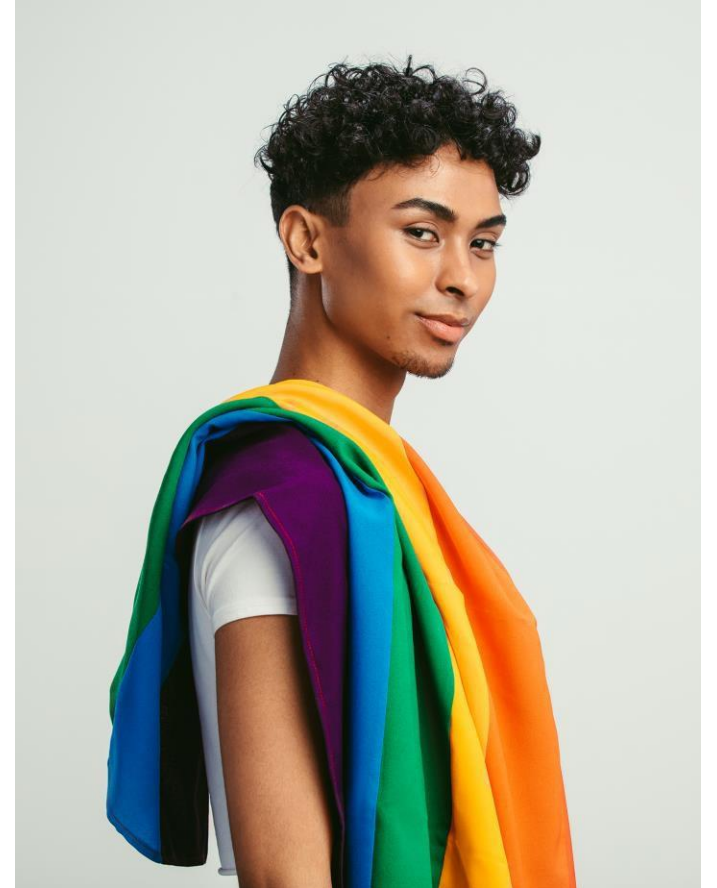


- The medical system pathologizes transgender people – transgender people are required to have mental health assessments and letters of permissions before receiving many kinds of affirming treatment.
- Cis-gender people are not required to get these same assessments for similar surgical or hormonal interventions.
- This reinforces that transgender people must have a mental illness to seek care, and cis people who seek similar care do not.
- Example: Gender affirming care, specifically surgery often requires letter(s) of approval from a mental health therapist. Breast augmentation or reduction, hormone replacement therapy, hair transplants, elective plastic surgery for cis-gendered people does not.

10 Additional Tips for Improving Care to Trans+ Patients

Providence | Tips for Improving Care for Transgender People

1. Welcome transgender people by getting the word out about your services and displaying transgender-positive cues (signs!) in your office
2. Treat transgender people as THEY would want to be treated (platinum rule!)
3. Remember to always refer to transgender people by their name and pronoun that corresponds with their gender identity
4. If you are unsure about person's gender identity or how they wish to be addressed, ask politely for clarification.
5. Establish an effective policy for addressing discriminatory comments and behavior in your office or organization.



Providence | 10 Tips for Improving Services for Transgender People

6. Remember to keep the focus on care rather than indulging in questions out of curiosity
7. Keep in mind that the presence of a transgender person in your treatment room is not always an appropriate "training opportunity" for other health care providers
8. It is inappropriate to ask transgender patients about their genital status
9. if it is unrelated to their care.
10. Never disclose a person's transgender status to anyone who does not explicitly need that information for care.
11. Become knowledgeable about transgender health care issues.



- Emotional, Behavioral, and Cognitive Reactions to Microaggressions: Transgender Perspectives; [Kevin L. Nadal, Kristin C. Davidoff, Lindsey Davis, Yinglee Wong](#):
https://www.researchgate.net/publication/263918101_Emotional_Behavioral_and_Cognitive_Reactions_to_Microaggressions_Transgender_Perspectives
- Microaggressions towards lesbian and transgender women: Biased information gathering when working alongside gender and sexual minorities; [Annalisa Anzani](#), ¹[Simona Sacchi](#), ¹and [Antonio Prunas](#) ¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8453726/>
- Common Trans and/or non-binary based microaggressions <https://www.ed.ac.uk/equality-diversity/students/microaggressions/lgbtq-microaggressions/trans-and-or-non-binary-microaggressions/commontrans-and-non-binary-based-microaggression>
- GLAAD Launches Trans microaggressions photo project <https://www.glaad.org/blog/glaad-launches-trans-microaggressions-photo-project-transwk>
- National LGBT Health Education Center: Learning to Address Implicit Bias Towards LGBTQ Patients https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/10/Implicit-Bias-Guide-2018_Final.pdf
- Addressing the Elephant in the Room: Microaggressions in Medicine Melanie F. Molina, MD;* Adaira I. Landry, MD, MEd; Anita N. Chary, MD, PhD; Sherri-Ann M. Burnett-Bowie, MD, MPH <https://www.fammed.wisc.edu/files/webfm-uploads/documents/diversity/microaggressions-everyday-life.pdf>

- Providence Swedish LGBTQIA+ Program
<https://providence4.sharepoint.com/sites/SHSLGBTQI>
- Trans Student Educational Resources, 2015. “The Gender Unicorn.” <http://www.transstudent.org/gender>.
- The Teaching Transgender Toolkit. By Eli Green and Luca Maurer. 2015.
- Transgender Law Center, 2016. "10 Tips." <http://transgenderlawcenter.org/wp-content/uploads/2011/12/01.06.2016-tips-healthcare.pdf>
- <https://www.glaad.org/reference/transgender>
- UCSF Transgender Center for Excellence
- Fenway Health

Providence | Additional Resources

- <https://www.glaad.org/transgender/resources>
- <https://www.lgbtqiahealtheducation.org/resources/in/transgender-health/>
- <https://transgenderlawcenter.org/resources/health>
- <https://www.thehrcfoundation.org/professional-resources/transgender-patient-services-support-resources-for-providers-and-hospital-administrators>
- <https://www.thetrevorproject.org/resources/category/gender-identity/>
- <https://www.lavenderrightsproject.org/>
- <https://thegalap.org/>
- <https://straightforequality.org/transmaterials>
- <https://transequality.org/>
- <https://icath.info/>



HazCom - The Right to Understand

2026

Hazcom—The Right to Understand

What is the GHS?

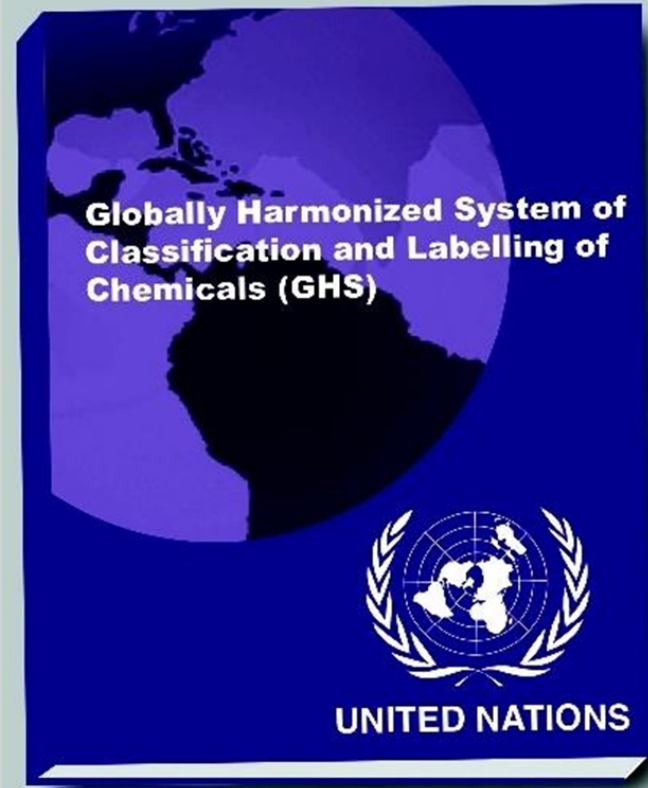
The GHS is an acronym for The Globally Harmonized System of Classification and Labeling of Chemicals.

The GHS is a system for standardizing and harmonizing the classification and labeling of chemicals. It is a logical and comprehensive approach to:

Defining health, physical and environmental hazards of chemicals;

Creating classification processes that use available data on chemicals for comparison with the defined hazard criteria; and

Communicating hazard information, as well as protective measures, on labels and Safety Data Sheets (SDS).



So, what does that mean for you?

Hazcom– The Right to Understand

There are 5 New Elements You Need to Understand Within OSHA'S New HazCom Standard.

1 - Signal Words:

Danger = Highest Hazard Chemicals

Warning = Lower (Medium) Hazard Chemicals

No Signal Word = Low Hazard Chemicals

2 – Hazard Classification:

Manufacturers are now required to “classify” their products according to the “intrinsic hazards of the ingredients that make up that product.” Things like Flammable Liquids, Corrosive to Metals, Explosive, etc.

3 – Pictograms:

A graphic (pictorial) representation of the hazard (see slide 6)

4 – Hazard Statements:

“Standardized,” “assigned” phrases that describe the hazard. Things like “Extremely Flammable Aerosol and Vapor,” or Toxic and Corrosive Liquids.”

5 – Precautionary Statements:

Additional information that provides measures to be taken to minimize or prevent adverse effects of the hazard. There are 4 types of Precautionary Statements – Prevention, Storage, Disposal and Response to exposure or spillage of a Hazardous Material.

What are the GHS Hazard Classifications?

Physical Hazards:

- Explosives
- Flammable Gases
- Flammable Aerosols
- Oxidizing Gases
- Gases Under Pressure
- Flammable Liquids
- Flammable Solids
- Self-Reactive Substances
- Pyrophoric Liquids
- Pyrophoric Solids
- Self-Heating Substances
- Substances which, in contact with water emit flammable gases
- Oxidizing Liquids
- Oxidizing Solids
- Organic Peroxides
- Corrosive to Metals

Health Hazards:

- Acute Toxicity
- Skin Corrosion/Irritation
- Serious Eye Damage/Eye Irritation
- Respiratory or Skin Sensitization
- Germ Cell Mutagenicity
- Carcinogenicity
- Reproductive Toxicology
- Target Organ Systemic Toxicity-Single Exposure
- Target Organ Systemic Toxicity-Repeated Exposure
- Aspiration Toxicity

Environmental Hazards:

- Hazardous to the Aquatic Environment
 - Acute aquatic toxicity
 - Chronic aquatic toxicity
 - Bioaccumulation potential
 - Rapid degradability

Classification is the starting point for the GHS

Once a chemical has been classified, the hazard(s) must be communicated to target audiences. As in existing systems, **labels** and **Safety Data Sheets** are the main tools for chemical hazard communication.

What are the required Label Elements (Official OSHA Definitions)?

Product Identifier (ingredient disclosure): Name or number used for a hazardous product on a label or in the SDS.

Supplier identification: The name, address and telephone number should be provided on the label.

Signal Words:

The signal word indicates the relative degree of severity of a hazard. The signal words used in the GHS are:

"Danger" for the more severe hazards, and

"Warning" for the less severe hazards.

Signal words are standardized and assigned to the hazard categories within endpoints. Some lower level hazard categories do not use signal words. Only one signal word corresponding to the class of the most severe hazard should be used on a label.

Hazcom—The Right to Understand

Hazard Statements: Hazard statements are standardized and assigned phrases that describe the hazard(s) as determined by hazard classification. An appropriate statement for each GHS hazard should be included on the label for products possessing more than one hazard.

Precautionary Statements: Precautionary information supplements the hazard information by briefly providing measures to be taken to minimize or prevent adverse effects from physical, health or environmental hazards. First aid is included in precautionary information.

There are four types of precautionary statements covering: prevention, response in cases of accidental spillage or exposure, storage, and disposal

Pictograms: A composition that is intended to convey specific information about the hazards of a chemical. Eight pictograms are designated under this standard for application to a hazard category.

Hazcom—The Right to Understand

HCS Pictograms and Hazards

As of June 1, 2015, the Hazard Communication Standard (HCS) will require pictograms on labels to alert users of the chemical hazards to which they may be exposed.

Each pictogram consists of a symbol on a white background framed within a red border and represents a distinct hazard(s).

The pictogram on the label is determined by the chemical hazard classification.

Health Hazard



- Carcinogen
- Mutagenicity
- Reproductive Toxicity
- Respiratory Sensitizer
- Target Organ Toxicity
- Aspiration Toxicity

Flame



- Flammables
- Pyrophorics
- Self-Heating
- Emits Flammable Gas
- Self-Reactives
- Organic Peroxides

Exclamation Mark



- Irritant (skin and eye)
- Skin Sensitizer
- Acute Toxicity
- Narcotic Effects
- Respiratory Tract Irritant
- Hazardous to Ozone Layer (Non-Mandatory)

Gas Cylinder



- Gases Under Pressure

Corrosion



- Skin Corrosion/Burns

Exploding Bomb



- Explosives
- Self-Reactives
- Organic Peroxides

Flame Over Circle



- Oxidizers

Environment (Non-Mandatory)



- Aquatic Toxicity

Skull and Crossbones



- Acute Toxicity (fatal or toxic)


Hazcom—The Right to Understand

Hazard Communication Standard Labels:

OSHA has updated the requirements for labeling of hazardous chemicals under its Hazard Communication Standard (HCS). As of June 1, 2015, all labels will be required to have:

- Pictograms
- A Signal Word
- Hazard & Precautionary Statements
- Product Identifier
- Supplier Identification.

A sample revised HCS label, identifying the required label elements, is shown on the right. Supplemental information can also be provided on the label as needed.

SAMPLE LABEL	
PRODUCT IDENTIFIER	HAZARD PICTOGRAMS
CODE _____	
Product Name _____	SIGNAL WORD
SUPPLIER IDENTIFICATION	Danger
Company Name _____	HAZARD STATEMENT
Street Address _____	Highly flammable liquid and vapor. May cause liver and kidney damage.
City _____ State _____	SUPPLEMENTAL INFORMATION
Postal Code _____ Country _____	Directions for use
Emergency Phone Number _____	_____
PRECAUTIONARY STATEMENTS	_____
Keep container tightly closed. Store in cool, well ventilated place that is locked.	_____
Keep away from heat/sparks/open flame. No smoking.	_____
Only use non-sparking tools.	Fill weight: _____ Lot Number _____
Use explosion-proof electrical equipment.	_____
Take precautionary measure against static discharge.	Gross weight: _____ Fill Date: _____
Ground and bond container and receiving equipment.	_____
Do not breathe vapors.	Expiration Date: _____
Wear Protective gloves.	
Do not eat, drink or smoke when using this product.	
Wash hands thoroughly after handling.	
Dispose of in accordance with local, regional, national, international regulations as specified.	
In Case of Fire: use dry chemical (BC) or Carbon dioxide (CO ₂) fire extinguisher to extinguish.	
First Aid	
If exposed call Poison Center.	
If on skin (on hair): Take off immediately any contaminated clothing. Rinse skin with water.	

Hazcom—The Right to Understand

Does all of this apply to “Workplace” or “Secondary Container” Labels?
Here’s what OSHA says:

1910.1200(f)(6):

Workplace labeling. Except as provided in paragraphs (f)(7) and (f)(8) of this section, the employer shall ensure that each container of hazardous chemicals in the workplace is labeled, tagged or marked with either:

1910.1200(f)(6)(i)

The information specified under paragraphs (f)(1)(i) through (v) of this section for labels on shipped containers; or,

1910.1200(f)(6)(ii)

Product identifier and words, pictures, symbols, or combination thereof, which provide at least general information regarding the hazards of the chemicals, and which, in conjunction with the other information immediately available to employees under the hazard communication program, will provide employees with the specific information regarding the physical and health hazards of the hazardous chemical.

Meaning, “Workplace” or “Secondary Container” labels can be the same as the shipping label or can contain only Product Identifier and “Words, pictures, symbols or combination thereof” that provide general information about the hazards of the chemicals.

Hazcom—The Right to Understand

Now, let's talk about the new Safety Data Sheets (SDS).

- No longer known as MSDS.
- Sixteen Standardized Sections
- Specific Information required in each section.
- Rather than simplified, most SDS will be longer and more technical in nature.



Hazcom—The Right to Understand

Hazard Communication Safety Data Sheets:

The Hazard Communication Standard (HCS) requires chemical manufacturers, distributors, or importers to provide Safety Data Sheets (SDSs) (formerly known as Material Safety Data Sheets or MSDSs) to communicate the hazards of hazardous chemical products.

As of June 1, 2015, the HCS will require new SDSs to be in a uniform format, and include the section numbers, the headings, and associated information under the headings listed on the right:

Section 1, Identification includes product identifier; manufacturer or distributor name, address, phone number; emergency phone number; recommended use; restrictions on use.

Section 2, Hazard(s) identification includes all hazards regarding the chemical; required label elements.

Section 3, Composition/information on ingredients includes information on chemical ingredients; trade secret claims.

Section 4, First-aid measures includes important symptoms/ effects, acute, delayed; required treatment.

Section 5, Fire-fighting measures lists suitable extinguishing techniques, equipment; chemical hazards from fire.

Section 6, Accidental release measures lists emergency procedures; protective equipment; proper methods of containment and cleanup.

Section 7, Handling and storage lists precautions for safe handling and storage, including incompatibilities.

Section 8, Exposure controls/personal protection lists OSHA's Permissible Exposure Limits (PELs); Threshold Limit Values (TLVs); appropriate engineering controls; personal protective equipment (PPE).

Section 9, Physical and chemical properties lists the chemical's characteristics.

Section 10, Stability and reactivity lists chemical stability and possibility of hazardous reactions.

Section 11, Toxicological information includes routes of exposure; related symptoms, acute and chronic effects; numerical measures of toxicity.

Section 12, Ecological information*

Section 13, Disposal considerations*

Section 14, Transport information*

Section 15, Regulatory information*

Section 16, Other information, includes the date of preparation or last revision.

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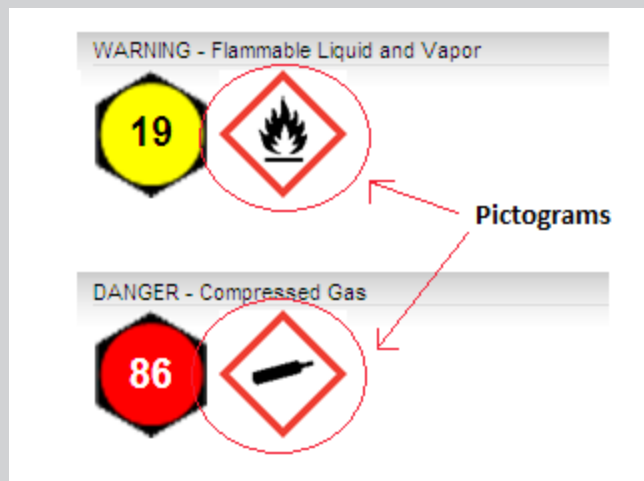
What is the first thing I need to do to satisfy the OSHA training requirement?

The first compliance date of the revised HCS was December 1, 2013. From that date forward, all employees must be trained on the new label elements and the SDS format.

- **Training on label elements must include information on:**
 - Type of information the employee would expect to see on the new labels:
 - Product Identifier
 - Signal Word
 - Pictogram
 - Hazard Statements
 - Precautionary Statements
 - Name, Address and Phone Number of Manufacturer, Supplier or Importer
 - How an employee might use the labels in the workplace.
 - General understanding of how the elements work together on a label.
- **Training on the format of the SDS must include information on:**
 - Standardized 16-section format, including the type of information found in the various sections.
 - How the information on the label is related to the SDS

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Feeling a little overwhelmed? Don't worry, the MaxCom|Incora system has it all covered!



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And more:

Hazard Statements

Contains gas under pressure; may explode if heated

Precautionary Statements

Administer oxygen for difficult breathing. Call 911 or Emergency Medical Services.
Do not enter low-lying areas. Do not remove clothing if adhered to.

Secondary Container Label

Acetone



DANGER

Highly Flammable Liquid and Vapor

Hazards: Irritant, Toxic Decomposition Products

Routes of Exposure: Inhalation, Ingestion, Skin Absorption, Eyes, Skin Contact

Target Organs: Liver, Kidneys, Brain CNS PNS, Lungs Respiratory System, Eyes, Cutaneous Hazard

PPE: **Eye/Face** - Use Face Shield; **Resp** - Utilize Vent Hood; **Other** - Use Protective Gloves

Label Notes: Test Note

Sigma-Aldrich - +18003255832

Hazcom–The Right to Understand

HazCom GHS required elements for chemicals in use at Providence--and its family of organizations--are available on the MaxCom|Incora-HazCom system.

The MaxCom|Incora-HazCom system is accessible through the MyApps portal and the link is located on the SharePoint pages for the System and Regions.

Instructions:

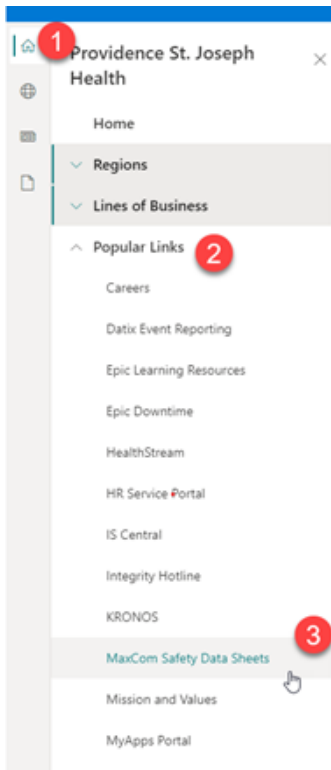
Open the MyApps Portal.

Open SharePoint and choose the System or a Regional SharePoint page:

- * Click on the Home/Global Navigation icon on left-hand side**
- * Click on Popular Links**
- * Click on MaxCom Safety Data Sheets**

The MaxCom|Incora-HazCom link has the login and password information embedded in the link, so no login credentials are required to access the system and its information.

Below is a visual representation of the instructions on the prior slide AFTER opening a System or Regional SharePoint page:



If you need SDS information and do not have access to the MyApps portal -

Ask a Providence caregiver or manager to assist by accessing the system and pulling the relevant chemical SDS for you.

Education Completion Attestation

STOP!

[Completion Attestation](#)  *Please click the link to fill out the attestation to receive credit for completing this education.*

Please note that the link will take you outside of this education.

Once you complete the attestation, you will receive a certificate of completion at the email address you provided. **For CME information, please go to the next slide.**

STEP 1

The link to claim your credits will be provided in the Certificate of Completion email that is sent to you once you've completed the attestation form on the prior slide.

STEP 2

Complete and submit the evaluation

Use the link provided at the end of the evaluation to access Swedish CME Portal. Log-in or create a profile to claim credit.

STEP 3

Claim credit and download CME certificate

This is in the "Past Certificates" area of *My Portal*

For help contact:
cme@swedish.org