



# **Compliance & Ethics Training Board Member 2020**

# Objectives

By the end of this course, learners will identify appropriate conduct when faced with compliance and/or ethical issues. During the course, learners will:

- Understand the 7 elements of our Compliance Program
- Apply the Code of Conduct when faced with everyday difficult compliance/ethical decisions
- Recognize your ongoing compliance responsibilities
- Know how to contact the Corporate Responsibility (CR) Department

# Message from President and CEO

Monument Health's Compliance Program was built on the foundation of integrity and serves as a reminder of our compliance responsibilities. We are called upon to provide safe, quality care to our patients, and we achieve this by maintaining high standards.

Our organization is ultimately a reflection of each of our actions, decisions, and words. Please keep this in your mind and heart every day as you do your work.

Thank you for your continued commitment to Making a Difference. Every Day.

Best regards,



Paulette Davidson  
President and CEO  
Monument Health

# Compliance Officer

## Monument Health Compliance Officer



Nancy Klunder

Vice President of Corporate Responsibility

- The Compliance Officer is responsible for implementing Monument Health's compliance program.
- Corporate Responsibility reports functionally to the Compliance, Audit and Compensation Committee and administratively to executive leadership.

# Corporate Responsibility

Corporate Responsibility serves the compliance and internal audit needs of Monument Health.

The department reports directly to the Compliance, Audit & Compensation Committee of the Monument Health Board of Trustees, allowing the team to be independent and objective.

## **Compliance & HIPAA**

Mitigate compliance risk by maintaining a program that promotes compliance awareness, prevention, detection, and resolution of conduct that does not conform to legal or policy requirements.

## **Internal Audit**

Mitigate business risk by providing independent review and assurance on organizational governance, risk management, and internal controls needed to achieve the strategic, operational, and financial objectives.

# Elements of an Effective Compliance Program

**Monument Health's Compliance Program is based on the 7 Elements of an Effective Compliance Program, which are:**

1. Implement written policies, procedures, and Code of Conduct
2. Designate a compliance officer and compliance committee
3. Conduct effective training and education
4. Develop effective lines of communication
5. Conduct internal monitoring and auditing
6. Enforce standards through well-publicized disciplinary guidelines
7. Respond promptly to offenses and undertake corrective action

**Policy: Corporate Compliance Program**

# Policies and Code of Conduct

## **Policies and Code of Conduct**

As a condition of employment and in evaluating performance, every caregiver and provider must understand and comply with Monument Health's Code of Conduct and policies.

- **Policies**

- Compliance
- HIPAA Privacy/Security
- Internal Audit

- **Code of Conduct**

- Guidance in upholding our ethical values and responsibilities
- Defines acceptable behaviors to foster a culture of compliance

It is important for you review the contents of the Code of Conduct, please download the PDF booklet.

# Auditing and Monitoring

## **Corporate Responsibility conducts internal monitoring and auditing**

- Performed to review risk areas, determine compliance with legal requirements, and assist in the reduction of risk.
- Examples of the audits conducted by the Corporate Responsibility team include:
  - Physician contracts
  - Billing and coding
  - Research and grant administration
  - Electronic Health Records access
  - Financial
  - Operational

# Disciplinary Action

## **Enforce standards through well-publicized disciplinary guidelines**

- Appropriate and consistent discipline of individuals who violate standards or policies will occur when warranted.
- Enforcing disciplinary standards is important not only to give the Compliance Program credibility, but also to demonstrate Monument Health's integrity, commitment to compliance, and desire to prevent recurrence.

# Corrective Action

## **Respond promptly to offenses and undertake corrective action**

- For a Compliance Program to be effective, all allegations are evaluated and investigated.
- Non-compliant conduct will be immediately addressed and the effects of non-compliance will be mitigated.
- The goal of any corrective action is to address non-compliance and reduce the likelihood of recurrence.

# Fraud, Waste and Abuse

The presence of some dishonest health care providers who exploit the health care system for illegal personal gain has created the need for laws that combat fraud and abuse, along with ensuring appropriate quality medical care. Following are the laws:

## **False Claim Act**

It is illegal to submit claims for payment to Medicare or Medicaid you know or should know are false or fraudulent.

## **Anti-Kickback Statute**

It is a felony to knowingly or willfully offer, pay, solicit, or receive any payment for referrals of items or services reimbursable by a Federal health care program.

## **Physician Self-Referral Law (Stark Law)**

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member of his or her family) has a financial relationship with, unless an exception applies.

# Fraud, Waste, and Abuse

## **Civil Monetary Penalties Law**

*The Government may seek civil penalties for a wide variety of conduct and is authorized to seek different amounts of penalties based on the type of violation. Penalties range from \$10,000 to \$50,000 per violation.*

### **Some examples of violations include:**

- Presenting a claim the person knows or should know is for an item or service not provided as claimed or is false or fraudulent.
- Presenting a claim the person knows or should know is for an item or service for which payment may not be made.
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition or are in labor.

# Fraud, Waste and Abuse

## **Avoiding Fraud, Waste and Abuse**

- Accurate Coding and Billing
  - Correct codes for services provided
- Documentation Compliance
  - Complete and accurate
  - Represents reasonable and necessary services
  - Includes signature, date, and time
  - Signatures that cannot be read include the printed name
- Do not create or participate in the creation of any records intended to mislead or conceal anything improper.

**Monument Health devotes resources to prevent and correct billing errors to Medicare, Medicaid and other government payers.**

# Fraud, Waste and Abuse

Various government agencies/contractors are increasing their audits to protect against fraud, waste, and abuse.

- Notify the Corporate Responsibility department before contacting government payers about issues that are unrelated to routine claims or payments.
- Letters from agencies listed below mandate a very short response time.  
***Please forward these to Corporate Responsibility immediately.***



# Exclusion Statute

Under the **Exclusion Statute**, the Office of Inspector General (OIG) is required to impose exclusions from participation in all Federal Health Care programs on health care providers and suppliers who have been convicted of:

- Medicare or Medicaid fraud
- Patient abuse or neglect
- Felony convictions for health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances

**Excluded providers may not receive Medicare payment.**

# Conflict of Interest

A potential conflict of interest exists when you or a member of your family works for or has a financial relationship with a company:

- Doing business with RH
- Seeking to do business with RH
- Competing with RH

These types of relationships should be reported to Legal Services or Corporate Responsibility.

# Drug Free Workplace and Drug Diversion

## **The Drug Free Workplace/Drug Diversion policy accomplishes two major things:**

- Sends a clear message alcohol and drug use and drug diversion in the workplace is prohibited.
- Encourages providers and caregivers who have problems with alcohol and other drugs to voluntarily seek help.

## **Provider and Caregiver Responsibilities:**

- Do not enable others, cover-up, or make excuses for others when there is suspected abuse or diversion.
- Express concern and encourage the individual to seek help.
  - Guidance Resources Employee Assistance Program (EAP)
- Report suspected drug diversion/abuse to their Director or Supervisor.

## **Signs that a healthcare professional may be diverting drugs:**

- Patients complain of no pain relief from medications documented as given
- Discrepancies on medication administration records
- Has frequent wastage, such as spilling drugs or breaking vials
- Narcotics signed off controlled substance record but not recorded on patient report

## **Policy: Drug Free Workplace and Drug Diversion Guidelines**

# Gifts

**Per policy, nominal gifts (under a \$25 value) may be accepted.**

- Never accept gifts from patients while they are inpatient.
- Never accept cash or cash equivalents from patients or family members.
- If a patient or family member mentions wanting to give a gift, politely decline. If they persist, mention they could make a donation to the foundation or give a modest gift to share with the department, such as bagels.
- If a patient or family shows up with a gift, thank them on behalf of the department, and report to your supervisor.
- Gifts over \$25 may be subject to tax.
- Review the Gifts, Gratuities, and Entertainment policy for more information regarding gifts from patients, vendors, etc.

# Hallway Medicine

Approaching a provider at work for free medical advice may seem harmless, but has concerning complexities. Think of it as a free clinic visit; you would have had to make an appointment in order to obtain that care.

Free care is prohibited by Monument Health policy unless a patient qualifies under our Financial Assistance Program.

We respectfully request caregiver and provider cooperation in refraining from requesting or providing free medical care.

# Identity Theft: Red Flags

“Red Flags” are patterns, practices, or activity that indicates the possible existence of identity theft.

If you suspect identity theft or any patient misidentification, immediately notify your leader.

## **Examples of “Red Flags”:**

- Records are inconsistent with the physical state of the patient or his/her medical history
- Records show substantial discrepancies in age, race, sex, or other physical description
- Documents appear to be forged or altered
- The photograph doesn't match the patient
- The patient cannot readily validate the ID information on file

All registration/intake areas of Monument Health shall review and include in each patient's file a copy of a photo ID issued by a local, state or federal government agency (e.g. driver's license, passport, military ID, etc.).

**If suspicious activity is identified in the Emergency Department,  
do not delay care!**

# HIPAA

## What is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA).

## What does HIPAA do?

- Requires Monument Health to protect and secure our patients' Protected Health Information (PHI).
- Defines how patient information can be used and disclosed.
- Gives patients privacy rights and more control over their own health information.
- Specifies a series of safeguards to assure the confidentiality, integrity, and availability of electronic PHI (e-PHI).
- Requires notification, if warranted, to individuals when their PHI is breached.

# HIPAA – Patient Privacy Rights

**HIPAA provides patients with specific rights related to their PHI:**

- Request restriction of uses & disclosures.
- Request alternative forms of communications .
  - Mail to P.O. Box, not street address
- Obtain a copy of their record.
- Request an accounting of disclosures of PHI.
- Request amendments to their information.

**Policies are in place to ensure  
each of these rights are upheld and respected.**

# HIPAA – Protected Health Information

## What is PHI?

Any information which can be:

- Linked to a specific patient, directly or indirectly.
- Created or received by a covered entity.
- Pertains to a patient's past, present, and/or future treatment and payment.
- Information sent or stored in any form.
  - **Verbal** Discussions
  - **Written** on paper
  - **Electronic**
    - Computer Applications and Systems
    - Computer Hardware/Equipment

# HIPAA - PHI

## 18 PHI identifiers:

- Name
- Address
- Dates
- Phone number
- Fax number
- Email address
- URL address
- IP address
- Social Security number
- Account number
- License number
- Medical record number
- Health plan beneficiary number
- Lab results
- Images
- Biometric identifiers
  - Fingerprint, hand print, etc.
- Full face photos
- Any unique identifiable number, characteristic, or code

# HIPAA – Permitted Uses & Disclosures

## When can you access, use, or share PHI without written authorization from the patient?

- **Treatment** (discussions among providers, sending medical records to primary care providers, etc.)
- **Payment** (billing and collecting activities, review for medical necessity, etc.)
- **Operations** (quality assessments, audits, training/education purposes, peer review, etc.)
- **Exceptions allowed under HIPAA, for example:**
  - Court orders
  - Public health activities
  - Reporting abuse, neglect or domestic violence
  - Worker's Compensation
  - Certain law enforcement activities

## **Policy: HIPAA Privacy – Uses and Disclosures Not Requiring Patient Authorization**

# HIPAA – Permitted Uses & Disclosures

**HIPAA permits PHI to be shared with law enforcement under limited circumstances:**

1. In an attempt to identify or locate a suspect, fugitive, material witness, or missing person.
  - Only specific information is allowed to be disclosed. Review policy prior to releasing information.
2. The patient is a victim of a crime, and is:
  - Alert and cognizant – obtain patient consent to disclose PHI and document this in the medical record.
  - Unable to consent – note this in the medical record.

.....continued

# HIPAA – Permitted Uses & Disclosures

Continued

3. When there is a crime *on Monument Health property*

- The PHI sought by law enforcement is evidence of a possible crime on RH property.

4. When the patient is in lawful custody

- The officer must maintain custody of the patient during treatment.

If an officer drops off a patient and requests to be called when the patient is to be discharged, is it okay to call? **NO**

Law enforcement **must complete** the:

**"Request from Law Enforcement for Release of Protected Health Information"** prior to releasing PHI.

***Policy: HIPAA Privacy – Guidance on Disclosing PHI to Law Enforcement or as Required by Law***

# HIPAA – Incidental Disclosures

“Incidental” means a use or disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a by-product of an otherwise permitted use or disclosure.

- Examples:
  - Communicate and coordinate services at hospital nursing stations.
  - Discuss a patient’s condition quietly in a semi-private room or a waiting room.
  - Discuss a prescription with a patient over the pharmacy counter.
- Incidental uses and disclosures are permitted, so long as reasonable safeguards are used to protect PHI and minimum necessary standards are applied.
  - Speak in lower tone of voice.
  - Take the conversation to a private location, if possible.
- In emergency situations, loud emergency rooms, or where a patient is hearing impaired, precautions may not be practical. In these cases, health care staff are free to engage in communications as required to provide quick, effective, and high quality care.

# HIPAA – Disclosures to Family & Friends

A patient's health information may be verbally disclosed to family, friends, or others involved in the patient's care according to the following guidelines:

- **Patient is present, alert, and capable of making decisions:**
  - Give the patient the opportunity to object; obtain verbal agreement.
  - Infer from circumstances that the patient does not object.
    - Example: Patient asks to have their spouse or friend present in the examination room.
- **Emergency or incapacitated patients:**
  - Refer to the “Guidelines on Patient's Lacking Decision Making Capacity and Surrogate” policy.
  - Use professional judgment to determine whether the disclosure is in the best interests of the patient and, if so, disclose only the information directly relevant to the person's involvement with the patient's health care or related payment.
  - As soon as reasonably possible, the patient will be given the opportunity to agree or object to this practice.

## **Policy:**

**HIPAA Privacy - Disclosure of PHI to Family and Others Involved in Patient's Care**

# HIPAA – Valid Authorizations

**Caregivers and providers may not otherwise access or disclose PHI unless the patient has given written authorization.**

This form can be found on the Intranet under the Forms page or Corporate Responsibility hub page.



**Policy:**

**HIPAA Privacy – Uses and Disclosures Requiring  
Patient Authorization and Authorization Requirements**

# HIPAA - Minimum Necessary & Need to Know

When is it appropriate to:  
Access, View, Use, or Share PHI??

**Only when required for your job!**

You must also only access, view, use, or share the  
“**minimum necessary**” amount of PHI  
you need to do your job.

**Policy:**

**HIPAA Privacy – Handling Confidential Information,  
Reporting Violations and Use of Confidentiality Agreement**

# HIPAA – Facility Directory

## Directory Disclosures:

Patients have the right to restrict the release of their directory information.

- Unless the patient objects, the following PHI may be included in the hospital directory and given to those individuals who inquire about the patient by name:
  - Name
  - Location within the hospital
  - Condition of the patient in general terms (e.g., good, critical, serious)
  - Only members of the clergy may have access to the religious affiliation of the patient, if provided
- If the patient has opted out of the patient directory:
  - Any member of the public seeking information on the location of a patient should be directed to or transferred to the hospital's Guest Service desk or communication center to ensure the patient's directory wishes are upheld.
  - Their information will not be disclosed to any member of the public, including family, friends, florists, clergy, etc.

**Policy: HIPAA Privacy – Patient Directory Guidelines**

# HIPAA Security – Safeguards

## Email Security:

- Use secure email when emailing PHI or other business sensitive information outside of Monument Health.
- **Do Not** use your personal email (Yahoo, Gmail, Hotmail) to send/receive PHI!
- Include “SecureMail” in the subject line



## Policy:

**Information Security – Acceptable Use of  
Information Technology Resources**

# HIPAA – Protecting PHI

## Paper

- Immediately gather documents you sent to a printer. Use “Secure Print” to avoid documents sitting on the printer.
- Turn documents over that contain PHI when in the presence of another person.
- **Double check** when mailing or handing out documents; verify **each page** belongs to that patient.

## Verbal

- Be aware of your surroundings; do not discuss PHI in public areas such as elevators or the cafeteria.
- Do not leave details, such as test results or treatment plans in a voicemail.
  - Message can include your name, healing environment name, and phone number to call back.
  - If the healing environment name identifies type of care, such as Cancer Care Institute, state “Monument Health”.

### Policy:

**HIPAA Privacy – Handling Confidential Information,  
Reporting Violations and Use of Confidentiality Agreement**

# HIPAA –Protecting PHI

## **Social Media**

- Do not share any patient information learned through work on social media.
- Posting patient information without authorization is a violation of the patient's right to privacy and confidentiality.
- Even if you think you've de-identified the information (removed all 18 identifiers), depending on the situation it still might be identifiable to others.

**Policy:  
Social Media**

# HIPAA –Protecting PHI

- **Email**
  - Double check email addressed and attachments before sending PHI to ensure the information is sent to the correct recipient; remember to send securely.
- **Texting/Messaging Apps**
  - Use of standard texting/messaging apps to send PHI is not permitted as it is not secure or encrypted; only Monument Health approved and secure apps, such as Haiku, Canto, and Rover, may be used.
  - Contact the IT Help Desk if you have questions about other secure texting/messaging that may be available.
- **Fax**
  - Double check the fax number before sending PHI to ensure the information is sent to the correct recipient.
- **Patient Photos/Videos**
  - Taking photographs or videos of patients with personal mobile devices, outside a secure app, is prohibited.
  - In situations where photographs are necessary:
    - Use a Monument Health device
    - Use a personal device only when logged into a secure, Monument Health approved app, such as Haiku, Canto, and Rover, because no data/photos are physically stored on the device (smart phone, iPad, iPod, etc.)

**Policy: Information Security – Acceptable Use of Information Technology Resources**

# HIPAA –Protecting PHI

## EMR Access

- Do not access a patient record out of curiosity (no snooping).
- Do not access your own record or the records for your children or other family members.
- Do not access the records of friends or co-workers.
- Do not access records under another user's login.

If you do **not** have a legitimate business purpose (necessary to perform your job function) for accessing a patient's PHI you are **not** allowed to view that information.

Audits are conducted to ensure appropriate access. If inappropriate access is identified, disciplinary action will be taken.

### Policy:

HIPAA Privacy – Handling Confidential Information,  
Reporting Violations and Use of Confidentiality Agreement

# HIPAA – Breaches

**By law, a breach occurs when protected health information is:**

- **Lost, Stolen or Improperly Disposed of**
  - Paper or device upon which the information is recorded cannot be accounted for.
- **“Hacked”** into by people or mechanized programs not authorized to have access.
  - The system in which the information is located is compromised.
- **Communicated or Sent** to others who have no official need to receive it.
  - Medical record is faxed/emailed/mailed to the wrong individual.
  - Posting patient information to social media.

# HIPAA – Breach

## Examples of HIPAA breaches:

- Entering the incorrect ordering/family/attending provider; the report is faxed to the wrong provider.
- Accessing a patient record because you are curious how the patient was doing following the accident reported in the media.
- Contents of a discharge packet weren't reviewed and the patient went home with another patient's progress report.
- Reviewing census information just to see who is admitted into the facility.
- Communicating with a provider about a patient using personal, unsecure texting app.

# HIPAA – Disposal of PHI

## **Disposal of PHI**

- Never dispose of paper or other items containing PHI in the regular trash.
- All paper should be disposed of in the shred bins.
- Non-paper items should be destroyed in the appropriate manner according to your healing environment's process.
- CDs, thumb drives, computers, etc. containing PHI should be sent to the IT Help Desk for appropriate disposal.

**Policy: Disposal of Confidential Information**

# HIPAA – Report Breaches

**Part of your responsibility as a Monument Health caregiver is to report privacy or security breaches involving PHI.**

**Example:** Patient calls and states she received another patient's statement. What do you do?

- **Action:** Ask the recipient to shred or return the information.
- **Report:**
  - Inform your leader of the breach.
  - Complete and submit the “Suspected Breach of Health Information” form to Corporate Responsibility. The form can be found on the Intranet under Forms/Provider Orders located on the left-hand side of the home page and search by “Suspected”.
- **Timeframe:** Report any issues and suspected privacy/security violations immediately.

Any impermissible use or disclosure may trigger breach notification requirements to the patient and the federal government.

**Policy: HIPAA Privacy – Compliance  
with the Breach Notification Rule**

# HIPAA – Consequences of Non-Compliance

- **Sanctions.** Workforce members using PHI inappropriately will be subject to disciplinary action (based on the severity of the violation), which may include:
  - **Education**
  - **Written Warning**
  - **Termination**
- **Penalties.** The Department of Health and Human Services (DHHS), Office for Civil Rights (OCR) is responsible for administering and enforcing the HIPAA standards. They may conduct investigations and reviews to determine compliance with HIPAA and may impose **Civil Monetary Penalties** for both the individual and the organization.

# Non-Retaliation

**Monument Health is committed to protecting those who report problems and concerns in good faith from retaliation, retribution, harassment, intimidation, threats, and/or verbal abuse.**

- No disciplinary action or retaliation will be taken against you when you report a perceived issue, problem, concern, or violation “in good faith.”
  - “In good faith” means you actually believe the information reported is true.
- Retaliation will not be tolerated.
- The Non-Retaliation policy is in place to reassure those who report concerns are protected from retaliation.

# Reporting Options

***Compliance is everyone's responsibility!***

***We all have a duty to report Compliance/HIPAA issues!***

You are encouraged to use the following options to resolve any questions or concerns you may have:

- Discuss the question or concern with your direct supervisor. Give your supervisor a chance to solve the problem. He/she is most familiar with the laws, regulations, and policies that relate to your work.
- If you are not comfortable talking to your supervisor or feel you did not receive an adequate response, contact your supervisor's manager or another member of the management team.
- Contact the Human Resources (HR) office or your HR Business Partner at 755-5510.
- Contact Corporate Responsibility at 755-9020.
- Report anonymously (if requested) through the Compliance Hotline.
  - Call 877-800-6907
  - Submit electronically via the link on the Intranet



# Reporting Concerns

## What Should Be Reported?

- Illegal acts
- Violations of our Code of Conduct
- Patient privacy concerns
- Policy violations
- Provider misconduct
- Quality and safety concerns
- Fraud and falsification of documentation
- Inaccurate billing
- Research misconduct
- Conflicts of Interest
- Misuse of company assets/property
- Retaliation/harassment

## What Should NOT Be Reported to the Hotline?

- Emergencies (Call 911)
- Employment concerns should be addressed with HR at 755-5510
  - Performance evaluations
  - Pay raises
  - Supervisory issues
- IT issues call the IT Help Desk at 755-8131

# Role of Board of Directors

## External Reference

### Board Role

- Oversight
- Ask Questions



- Do the compliance and internal audit programs address significant risks of the organization?
- Are the resources adequate to sustain an effective program?
- Are policies and procedures in place to address risk areas?
- Are risk mitigation responsibilities assigned across appropriate levels?
- What is the scope of compliance education across the organization?
- Is the Board being kept apprised of significant regulatory developments?
- Is the effectiveness of the programs periodically evaluated?
- Are guidelines established for reporting violations to the Board?
- Are resolutions to reported violations verified?

# Role of Compliance Audit & Compensation (CA&C) Committee

- Role of the CA&C Committee
  - Oversee the Compliance & Internal Audit Programs
    - Independence & objectivity, work plans, adequate resources, and program effectiveness
  - Oversee Physician Compensation
    - Fair Market Value/reasonable
  - Oversee Mergers and Acquisitions
    - Fair Market Value/reasonable
  - Oversee business transactions, as needed
    - Potential Conflict of Interests involving Board Members
- Joint roll with the Finance & Investment Committee
  - Oversee the annual, external financial audit

# Corporate Responsibility Hub Page

Visit the Corporate Responsibility hub page on the Intranet for more information!

*Intranet Home Page – Facilities – Corp Svcs the click Corporate Responsibility Hub on left menu*

The screenshot shows the Corporate Responsibility Hub page on the Monum Health Intranet. The page features a dark teal header with the Monum Health logo and 'SharePoint' text. Below the header is a navigation menu with links for Home, Caregiver Hub, Business Hub, Clinical Hub, and Facilities. The main content area is divided into several sections:

- Corporate Responsibility Hub**: A breadcrumb trail showing 'Home', 'Documents', and 'Site Directory'. A search bar is located to the right.
- Welcome to the Corporate Responsibility webpage.**: A large image of hot air balloons with words like 'Compliance', 'Regulation', 'Policy', and 'Transparency' written on them. A 'LEARN MORE →' link is at the bottom.
- WE WANT TO HEAR FROM YOU**: A section with a handwritten-style title and the text 'Hotline 24/7 or Suspected Breach'.
- Corporate Responsibility Policies**: A teal-colored section with the text 'Corporate Responsibility Policies'.
- Code of Conduct**: A section featuring a group photo of diverse employees.
- Education & Resources**: A section with a background of interlocking gears and the text 'SKILL TRAINING', 'KNOWLEDGE', and 'LEARNING'.

At the bottom of the page, there is a 'Specialty areas' link and a 'Get the mobile app' button.

Please record this number for completion:  
575314.