El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

# AGENDA
## CORPORATE COMPLIANCE/PRIVACY AND INTERNAL AUDIT COMMITTEE MEETING OF THE EL CAMINO HOSPITAL BOARD

**Thursday, August 18, 2016 – 5:00 pm**

El Camino Hospital, Conference Room F (ground floor)
2500 Grant Road, Mountain View, CA 94040

Dennis Chiu will be participating via teleconference from Best Western Inn at the Vines, 100 Soscol Ave, Napa, CA 94559

**PURPOSE:** The Corporate Compliance/Privacy and Internal Audit Committee is responsible for providing direction for both the Corporate Compliance and Internal Audit programs at all locations of El Camino Hospital (ECH). Responsibilities include providing oversight on compliance issues requiring executive-level interaction, assessing physician relationship risk as it relates to compliance, reviewing HIPAA/Privacy laws as they relate to compliance, and directing ECH on compliance strategies. The Committee also serves as the ad-hoc mobilization team for any external investigations and/or actions. Further, additional responsibilities include providing direction and oversight to ongoing internal audit activity and determining appropriate organizational response in order to identify and mitigate organizational risk.

| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|---|
| **1.** | **CALL TO ORDER / ROLL CALL** | John Zoglin, Chair | | **5:00 – 5:01 pm** |
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| **2.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | John Zoglin, Chair | | **5:01 – 5:02** |
| | | | | |
| **3.** | **PUBLIC COMMUNICATION**<br>a. Oral Comments<br>*This opportunity is provided for persons in the audience to make a brief statement on issues or concerns not covered by the agenda.*<br>b. Written Correspondence | John Zoglin, Chair | | **information**<br>**5:02 – 5:05** |
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| **4.** | **CONSENT CALENDAR**<br>*Any Committee Member or member of the public may remove an item for discussion before a motion is made.*<br>***Approval***<br>a. Meeting Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee (5/19/16)<br>***Information***<br>b. Status of FY17 Committee Goals<br>c. Article of Interest | John Zoglin, Chair | *public comment* | **motion required**<br>**5:07 – 5:10** |
| | | | | |
| **5.** | **REPORT ON BOARD ACTIONS**<br>**ATTACHMENT 5** | John Zoglin, Chair | | **information**<br>**5:10 – 5:15** |
| | | | | |
| **6.** | **FY17 INTERNAL AUDIT WORK PLAN**<br>**ATTACHMENT 6** | Diane Wigglesworth, Compliance/Privacy Officer | *public comment* | **motion required**<br>**5:15 – 5:25** |
| | | | | |
| **7.** | **KEY PERFORMANCE INDICATORS, SCORECARD AND TRENDS**<br>Memo, Scorecard, and Trend Graphs<br>**ATTACHMENT 7** | Diane Wigglesworth, Compliance/Privacy Officer | | **information**<br>**5:25 – 5:30** |

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| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
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| **8.** | **ADJOURN TO CLOSED SESSION** | John Zoglin, Chair | | **motion required 5:30 – 5:31** |
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| **9.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | John Zoglin, Chair | | **5:31 – 5:32** |
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| **10.** | **CONSENT CALENDAR**<br>*Any Committee Member may remove an item for discussion before a motion is made.*<br>***Approval***<br>*Gov't Code Section 54957.2*<br>a. Meeting Minutes of the Closed Session of the Corporate Compliance/Privacy and Internal Audit Committee (5/19/16)<br>***Information***<br>*Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation.<br>b. Compliance and Privacy Logs<br>c. Internal Audit Follow Up<br>d. Internal Audit Work Plan | John Zoglin, Chair | | **motion required 5:32 – 5:36** |
| | | | | |
| **11.** | Discussion involving *Gov't Code Sections 54957* and *54957.6* for discussion and report on personnel matters:<br>- Report on Committee Recruitment | John Zoglin, Chair | | **discussion 5:36 – 5:56** |
| | | | | |
| **12.** | Report involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation:<br>- Report on FY16 Patient Safety/Claims | Sheetal Shah, Director of Risk Management & Patient Safety | | **possible motion 5:56 – 6:11** |
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| **13.** | Report involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation:<br>- Report on Internal Audit Activity | Diane Wigglesworth, Compliance/Privacy Officer | | **information 6:11 – 6:46** |
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| **14.** | Discussion involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation:<br>- Discussion on IT Security | Hassnain Malik, Chief Information Security Officer | | **information 6:46 – 7:06** |
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| **15.** | Report involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation:<br>- Report on FY16 Compliance Program | Diane Wigglesworth, Compliance/Privacy Officer | | **possible motion 7:06 – 7:13** |
| | | | | |
| **16.** | Discussion involving *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets:<br>- Pacing Plan | John Zoglin, Chair | | **information 7:13 – 7:16** |
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| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
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| **17.** | Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters:<br>- Executive Session | John Zoglin, Chair | | **discussion 7:16 – 7:26** |
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| **18.** | **ADJOURN TO OPEN SESSION** | John Zoglin, Chair | | **motion required 7:26 – 7:27** |
| | | | | |
| **19.** | **RECONVENE OPEN SESSION / REPORT OUT** | John Zoglin, Chair | | **7:27 – 7:28** |
| | To report any required disclosures regarding permissible actions taken during Closed Session. | | | |
| | | | | |
| **20.** | **ADJOURNMENT** | John Zoglin, Chair | | **motion required 7:28 – 7:29 pm** |

**Upcoming Corporate Compliance Committee Meetings:**

- September 29, 2016
- October 26, 2016 (*Semi-Annual Board and Committee Educational Gathering*)
- November 9, 2016 (*Joint Session of Compliance Committee and Hospital Board*)
- November 17, 2016

# a. Meeting Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee (5/19/16)

**Minutes of the Open Session of the**
**Corporate Compliance/Privacy and Internal Audit Committee**
**Thursday, May 19, 2016**
**El Camino Hospital, 2500 Grant Road, Mountain View, CA 94040**
**Conference Room E**

| Members Present | Members Absent | Others Present |
|---|---|---|
| John Zoglin, Chair (via teleconference) | None | Tomi Ryba |
| Sharon Anolik Shakked, Vice Chair | | Mary Rotunno |
| Christine Sublett | | Diane Wigglesworth |
| Jeffrey Davis, MD | | Joann McNutt (arrived at 5:25pm) |

| Agenda Item | Comments/Discussion | Approvals/Action |
|---|---|---|
| **1. CALL TO ORDER/ROLL CALL** | The Open Session meeting of the Corporate Compliance/ Privacy and Internal Audit ("CCPIA") Committee of El Camino Hospital (the "Committee") was called to order at 5:02 pm by Ms. Anolik Shakked. A silent roll call was taken. Chair Zoglin joined the meeting by web conference; all Committee members were present. | |
| **2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Vice Chair Anolik Shakked asked if any Committee members may have a conflict of interest on any of the items on the agenda. No conflicts were noted. | |
| **3. PUBLIC COMMUNICATION** | None. | |
| **4. COMMITTEE RECRUITMENT** | Diane Wigglesworth, Compliance/Privacy Officer, reported that to fill the two vacancies on the Committee, staff advertised to candidates through leadership, in local print media and on LinkedIn. Staff received three resumes, but only one candidate may meet the criteria requested by the Committee (with a healthcare background).<br><br>The Committee discussed whether or not to pursue formal recruitment and how many members to recruit. Discussions highlighted that the Committee is looking for skills in ERM and financial audits.<br><br>Tomi Ryba, Chief Executive Officer, noted that Jeff Hodge is a recruiter the Hospital has retained previously for similar searches. Ms. Ryba will provide a cost estimate to Chair Zoglin, who will confirm the cost with Chair Cohen.<br><br>**Motion:** To appoint Committee members Sharon Anolik Shakked and Christine Sublett to an Ad Hoc Committee for the purpose of recruiting 1-2 Committee members.<br><br>**Movant:** Sublett | ***Motion passed to form ad hoc committee; Recruiter to be engaged*** |

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| | **Second:** Davis<br>**Ayes:** Anolik Shakked, Davis, Sublett, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None | |
| **5. CONSENT CALENDAR** | Vice Chair Anolik Shakked asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed.<br><br>**Motion:** To approve the consent calendar: Minutes from March 17, 2016.<br><br>**Movant:** Sublett<br>**Second:** Davis<br>**Ayes:** Anolik Shakked, Davis, Sublett, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None | ***Consent calendar approved*** |
| **6. POLICIES FOR APPROVAL** | One new policy regarding electronic signature, and how they will be accepted by ECH. One policy with minor revisions regarding HR Educational Programs.<br><br>Ms. Rotunno noted that this is the first electronic signature/authentication policy of this kind at ECH.<br><br>**Motion:** To recommend approve the following policies: Electronic Signature and HR – Educational Programs.<br><br>**Movant:** Davis<br>**Second:** Sublett<br>**Ayes:** Anolik Shakked, Davis, Sublett, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None | ***Policies approved*** |
| **7. REVIEW COMMITTEE CHARTER** | As required every two years, the Committee reviewed its charter to ensure purpose and duties accurately reflect the work of the Committee.<br><br>Chair Zoglin highlighted discussions of Stark laws and anti-kickback statutes in the charter, which Ms. Ryba recommended as updates for the Committee (provided by Ms. Rotunno) and an education area for the Board.<br><br>The Committee discussed how best to formally educate the Board about current acute risks on an annual basis. Currently, annual compliance training is not completed by the Board. The Committee requested a memo addressing the following points:<br><br>- Legal review: Is there a legal requirement for Board members to complete annual compliance | ***Charter approved; education plan to be discussed and developed*** |

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| | training like ECH staff members do?<br>- Design Recommendations: What should the format of annual education for the Board look like? Considerations include: balancing the current state of affairs at ECH as well as overarching developments and trends (e.g. ransomware), incorporate into Board Retreat?<br><br>**Motion:** To recommend approval of the Committee's charter as presented.<br><br>**Movant:** Sublett<br>**Second:** Davis<br>**Ayes:** Anolik Shakked, Davis, Sublett, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None | |
| **8. KEY PERFORMANCE INDICATORS SCORECARDS AND TRENDS** | Ms. Wigglesworth described how investigations continue to be on the rise and have been since Epic Go-Live. While the software is behaving appropriately and acting as designed, there are still process issues. Compliance reports these problems to the iCare team and is working with key stakeholders to mitigate issues going forward. Ms. Wigglesworth complimented staff and physicians for their awareness and responsiveness in reporting both minor and major problems. For any valid problems brought forward, Compliance investigates whether an issue is an isolated incident or a pattern of behavior to resolve. She explained billing integrity is major focus, especially ensuring that documentation will support an audit.<br><br>Ms. Wigglesworth reported that the first three Epic RAC claims were requested for government review. Results are currently pending.<br><br>Ms. Wigglesworth noted that most issues reported primarily revolve around HIPAA concerns or billing/claims, rather than EMTALA or Anti-Kickback/Stark. She also highlighted the decrease in number of required breach reports to Department of Health since Epic Go-Live.<br><br>Dr. Davis recommended including a glossary with definitions when bringing these metrics to the Board. | |
| **9. NEW ARTICLES** | Ms. Wigglesworth presented an article describing comparable organizations' efforts to boost IT security to meet compliance needs and prepare for cyberattacks. | |
| **10. ADJOURN TO CLOSED SESSION** | **Motion:** To adjourn to closed session at 5:38pm.<br><br>**Movant:** Davis<br>**Second:** Sublett | |

*DRAFT*

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| | **Ayes:** Anolik Shakked, Davis, Sublett, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None | |
| **11. AGENDA ITEM 20: RECONVENE OPEN SESSION/ REPORT ON BOARD ACTIONS** | Open session was reconvened at 7:58 pm. The Minutes of the Closed Session of the Committee Meeting of January 21, 2016 were approved by a vote in favor by all members present (Anolik Shakked, Davis, Sublett, Zoglin).<br><br>Chair Zoglin and Dr. Davis deferred their report on Board actions. | |
| **12. AGENDA ITEM 21: STATUS OF FY16 COMMITTEE GOALS** | The Committee is on track to meet its goals. The last goal to be completed is a monitoring plan presented to the full Board. | |
| **13. AGENDA ITEM 22: COMMITTEE COMMENTS** | There were no additional Committee comments. | |
| **13. AGENDA ITEM 23: ADJOURNMENT** | **Motion**: To adjourn at 8:00 pm.<br><br>**Movant**: Davis<br>**Second**: Sublett<br>**Ayes**: Anolik Shakked, Davis, Sublett, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Meeting adjourned at 8:00 pm.*** |

**Attest as to the approval of the foregoing minutes by the Corporate Compliance/Privacy, and Internal Audit Committee of El Camino Hospital:**

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John Zoglin
Chair, CCPIA Committee

# Status of FY17 Committee Goals

# Corporate Compliance/Privacy and Audit Committee
# Goals FY 2017

## Purpose

The purpose of the Corporate Compliance/Privacy and Audit Committee ("Compliance and Audit Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its exercise of oversight by monitoring the compliance policies, controls and processes of the organization and the engagement, independence and performance of the internal auditor and external auditor. The Compliance and Audit Committee assists the Board in oversight of any regulatory audit and in assuring the organizational integrity of ECH in a manner consistent with its mission and purpose.

### Staff: Diane Wigglesworth, Director of Corporate Compliance

*The Director, Corporate Compliance/Privacy and Audit Committee shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chairs consideration. Additional members of the executive team or outside consultants may participate in the Committee meetings upon the recommendation of the Director, Corporate Compliance/Privacy and Internal Audit Committee and at the discretion of the Committee Chair.*

| Goals | Timeline by Fiscal Year<br>(Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.) | Metrics of Success Achieved |
|---|---|---|
| ▪ Review and evaluate Hospitals Information Security Risk Management Plan | ▪ Preliminary report in Q2 2017 and Final report in Q3 | ▪ Committee reviews and approves plan. |
| ▪ Review and evaluate risk assessment of Patient Centered Medical Home (PCMH) Compliance and any corrective action plans | ▪ Q3 2017 | ▪ Committee reviews and approves plan. |
| ▪ Review plan and evaluate ERM activities, performance and execution of program | ▪ Q4 2017 | ▪ Committee reviews and approves plan. |

**Submitted by:**
John Zoglin, Chair, Corporate Compliance/Privacy and Audit Committee
Diane Wigglesworth, Executive Sponsor, Corporate Compliance/Privacy and Audit Committee

# Article of Interest

# 2010 FEDERAL SENTENCING GUIDELINES MANUAL

## CHAPTER EIGHT - SENTENCING OF ORGANIZATIONS

## PART B - REMEDYING HARM FROM CRIMINAL CONDUCT, AND EFFECTIVE COMPLIANCE AND ETHICS PROGRAM

### 2. EFFECTIVE COMPLIANCE AND ETHICS PROGRAM

Historical Note: Effective November 1, 2004 (see Appendix C, amendment 673).

**§8B2.1. Effective Compliance and Ethics Program**

(a) To have an effective compliance and ethics program, for purposes of subsection (f) of §8C2.5 (Culpability Score) and subsection (c)(1) of §8D1.4 (Recommended Conditions of Probation - Organizations), an organization shall –

(1) exercise due diligence to prevent and detect criminal conduct; and

(2) otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

Such compliance and ethics program shall be reasonably designed, implemented, and enforced so that the program is generally effective in preventing and detecting criminal conduct. The failure to prevent or detect the instant offense does not necessarily mean that the program is not generally effective in preventing and detecting criminal conduct.

(b) Due diligence and the promotion of an organizational culture that encourages ethical conduct and a commitment to compliance with the law within the meaning of subsection (a) minimally require the following:

(1) The organization shall establish standards and procedures to prevent and detect criminal conduct.

Board

(2) (A) The organization's governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program.

Management

(B) High-level personnel of the organization shall ensure that the organization has an effective compliance and ethics program, as described in this guideline. Specific individual(s) within high-level personnel shall be assigned overall responsibility for the compliance and ethics program.

Compliance Officer

(C) Specific individual(s) within the organization shall be delegated day-to-day operational responsibility for the compliance and ethics program. Individual(s) with operational responsibility shall report periodically to high-level personnel and, as appropriate, to the governing authority, or an appropriate subgroup of the governing authority, on the effectiveness of the compliance and ethics program. To carry out such operational responsibility, such individual(s) shall be given adequate resources, appropriate authority, and direct access to the governing authority or an appropriate subgroup of the governing authority.

(3) The organization shall use reasonable efforts not to include within the substantial authority personnel of the organization any individual whom the organization knew, or should have known through the exercise of due diligence, has engaged in illegal activities or other conduct inconsistent with an effective compliance and ethics program.

(4) (A) The organization shall take reasonable steps to communicate periodically and in a practical manner its standards and procedures, and other aspects of the compliance and ethics program, to the individuals referred to

in subparagraph (B) by conducting effective training programs and otherwise disseminating information appropriate to such individuals' respective roles and responsibilities.

(B) The individuals referred to in subparagraph (A) are the members of the governing authority, high-level personnel, substantial authority personnel, the organization's employees, and, as appropriate, the organization's agents.

(5) The organization shall take reasonable steps—

(A) to ensure that the organization's compliance and ethics program is followed, including monitoring and auditing to detect criminal conduct;

(B) to evaluate periodically the effectiveness of the organization's compliance and ethics program; and

(C) to have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization's employees and agents may report or seek guidance regarding potential or actual criminal conduct without fear of retaliation.

(6) The organization's compliance and ethics program shall be promoted and enforced consistently throughout the organization through (A) appropriate incentives to perform in accordance with the compliance and ethics program; and (B) appropriate disciplinary measures for engaging in criminal conduct and for failing to take reasonable steps to prevent or detect criminal conduct.

(7) After criminal conduct has been detected, the organization shall take reasonable steps to respond appropriately to the criminal conduct and to prevent further similar criminal conduct, including making any necessary modifications to the organization's compliance and ethics program.

(c) In implementing subsection (b), the organization shall periodically assess the risk of criminal conduct and shall take appropriate steps to design, implement, or modify each requirement set forth in subsection (b) to reduce the risk of criminal conduct identified through this process.

*Commentary*

*Application Notes:*

1. *Definitions.—For purposes of this guideline:*

*"Compliance and ethics program" means a program designed to prevent and detect criminal conduct.*

*"Governing authority" means the (A) the Board of Directors; or (B) if the organization does not have a Board of Directors, the highest-level governing body of the organization.*

*"High-level personnel of the organization" and "substantial authority personnel" have the meaning given those terms in the Commentary to §8A1.2 (Application Instructions - Organizations).*

*"Standards and procedures" means standards of conduct and internal controls that are reasonably capable of reducing the likelihood of criminal conduct.*

2. *Factors to Consider in Meeting Requirements of this Guideline.—*

*(A) In General.—Each of the requirements set forth in this guideline shall be met by an organization; however, in determining what specific actions are necessary to meet those requirements, factors that shall be considered include: (i) applicable industry practice or the standards called for by any applicable governmental regulation; (ii) the size of the organization; and (iii) similar misconduct.*

*(B) Applicable Governmental Regulation and Industry Practice.—An organization's failure to incorporate and follow applicable industry practice or the standards called for by any applicable governmental regulation weighs against a finding of an effective compliance and ethics program.*

*(C) The Size of the Organization.—*

*(i) In General.—The formality and scope of actions that an organization shall take to meet the requirements of this guideline, including the necessary features of the organization's standards and procedures, depend on the size of the organization.*

# ATTACHMENT 5

# ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

| | | |
|---|---|---|
| | **Item:** | Report on Board Actions<br>Compliance Committee Meeting<br>Meeting Date: August 18, 2016 |
| | **Responsible party:** | Cindy Murphy, Board Liaison |
| | **Action requested:** | For Information |
| | **Background:**<br>In FY16, staff added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. Recently, staff was asked to supplement the Chair's verbal report with the attached written report. | |
| | **Other Board Advisory Committees that reviewed the issue and recommendation, if any:**<br>None. | |
| | **Summary and session objectives** :<br>To inform the Committee about recent Board actions. | |
| | **Suggested discussion questions:**<br>None. | |
| | **Proposed Committee motion, if any:**<br>None. This is an informational item. | |
| | **LIST OF ATTACHMENTS:**<br>Report on May and June 2016 Board Actions | |

# Report on May and June 2016 Board Actions

1. May 11, 2016 El Camino Hospital Board Meeting Approvals
    a. FY 16 Period 9 Financial Report
    b. Recognized Tehila and Saul Eisenstat, MD were for their years of service to the Hospital and patients
    c. Hospital Bylaws amended to provide consistent rules for contracting/employment relationships between El Camino Hospital and Board member who are members of the District Board and those who are not.
2. June 8, 2016 El Camino Hospital Board Meeting Approvals
    a. Recognized Michele Kirsch and Nahid Aliniazee for Co-Chairing the 2016 Sapphire Soiree which generated the highest yield in revenue over the history of the event. Over $520,000 will go directly to the ECH Cancer Center.
    b. FY2017 Operating and Capital Budget
    c. Over $3 million in Community Benefit Grants
    d. Disbanded its iCare Ad hoc Committee of the Board
    e. The FY17 Organizational and Individual Executive Incentive Goals. Important Changes this year were
        i. Removing Joint Commission Certification as a trigger goal
        ii. Reducing the number of individual goals for each executive
        iii. Making individual goals more specific to each executive's area of accountability
    f. Incremental funding for Women's Hospital Renovations and new Behavioral Health Services Building
    g. Final Funding for the North Parking Garage Expansion
    h. Epic 2015 and 2016 Upgrades
    i. FY16 Committee Goals
    j. Minor Revisions to the Finance Committee and Executive Compensation Committee Charters
    k. 6 Physician Contract Renewals
    l. Approved the Board Chair's slate of Committee members and Chairs for FY17. Some Board member assignments were changed. Director Chen was appointed as Chair of the Executive Compensation Committee.
3. June 14, 2016 El Camino Healthcare District Board meeting Approvals
    a. Approved Amendment (above to the ECH Bylaws)
    b. Approved Revised Process for Election and Re-Election of Non-District Board Members to the Hospital Board (Provides for appointment of Chair of the Committee and clarifies that a member of the ECH Governance Committee serves as member of the Committee)
    c. Approved the FY17 District and Hospital Budgets

d. Designated $9.3 million of tax revenue from the FY 2014 and FY 2015 funds in its Capital Appropriation Fund to the Women's Hospital Expansion Renovation/Reconstruction Project.
e. Approved $6.4 million in Community Benefit Grants
f. Authorized the Mountain View Campus Development Proposal (North Parking Garage, Behavioral Health Services Building, Integrated Medical Office Building, Central Utility Plant Upgrades, Women's Hospital Expansion, Demolition of Old Main Hospital and Associated Work). This was approval to build on District owned land as required by the ground lease. Funding approval will come later where required.
g. Appointed Director Reeder (Chair), Director Miller and Gary Kalbach as members of the ECH Board Member Election Ad hoc Committee for FY17.

*This list is not meant to be exhaustive, but includes agenda items the Board s voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

# ATTACHMENT 6

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

# Internal Audit Risk Assessment: FY 2017

Diane Wigglesworth
Corporate Compliance Officer
Prepared: August 8, 2016

# Executive Summary

A number of factors were considered when forming the risk map and proposed internal audit plan. Considerations included the current healthcare regulated environment, the Office of Inspector General (OIG) 2016 Work Plan, risks common to the healthcare industry, findings from previously completed audits, and feedback from the executive leadership team.

**Some of the business conditions and changes at El Camino hospital since the last risk assessment include:**

- Implementation of Epic
- Implementation of ICD-10 Coding
- Payment tied to quality and government bundled payment initiative
- Opening of a new primary care clinic and development of Urgent Care Clinics
- Development of new outpatient wound care services
- Continued decline of Medicare reimbursement
- Significantly expanded government enforcement (RAC's, MAC's, etc.)
- Financial challenges to contain costs
- Upcoming major capital projects and bond acquisition
- Increased scrutiny of the OIG on clinical documentation and billing
- Growing consulting and professional fees related to physician and medical directorships.

# Executive Summary

The risk assessment was conducted to proactively address potential organizational risks, vulnerabilities and weaknesses. Areas reviewed included:

- The strategic plan and targeted growth areas
- Financial risk
- Revenue cycle risks
- New technology and IT security risk
- Compliance risk
- Risk themes identified by the executive leadership team

Also considered were risks inherent to the industry and information gathered from third party resources such as HCCA, HFMA, AHIA OIG, and regulatory agencies. Common themes identified during those assessments included:

- General IT: Access to and integrity of data
- IT security exposures
- Clinical coding and documentation accuracy
- Physician contract compliance
- Case management competence
- Charge capture and verification
- Cost containment and management
- Competing priorities

# Other Key Compliance and Emerging Risk Areas for Audit

**(listed in no particular order of priority)**

- Privacy and Data Security
- Meaningful Use Compliance/Readiness
- Release of Patient Health Information
- Business Information Analytics
- Completeness and Adequacy of Data Reporting
- Enterprise Risk Management
- Provider Based Billing
- RAC Program Effectiveness Reviews
- Privacy and Security Assessments HITECH / HIPAA
- Case Management / Length of Stay Management
- Patient Status Determination (IP,OP, Observation)
- Physician Contracting Reviews
- Fair Market Value Compensation/Payments
- Pharmacy Operations and Medication Security
- Accountable Care Organization (ACO) definition and readiness
- Adequacy of clinical documentation to support levels of care
- Payments Tied to Quality (BPCI)
- Declining Reimbursement / Cost Containment
- Charity Care and Community Benefit Determination
- Pricing Transparency and Collection Activity
- IT Governance
- Revenue Cycle Assessment
- Charge Capture Process Reviews
- IRB and Clinical Trial Billing
- Supply Chain Cost Management Review
- Compliance Program Effectiveness Reviews
- Pricing Assessments
- Fair Labor Standards Act
- Pay for Performance / Core Measures Reporting Effectiveness
- Joint Venture and Management Agreements
- Credentialing/Re-Credentialing
- ICD-10 Documentation and Coding

# Historical Risk Areas Audited by Fiscal Year

| Risk Area | Report Title | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 |
|---|---|---|---|---|---|---|---|---|---|---|
| Accounting | Accounts Payable & Spend Controls | X | | | | X | | X | | |
| | Construction in Progress Accounting | | | | | | | | | X |
| | Controls Audits (Petty Cash, A/P & Payroll) | | | | X | | | | | |
| | Vendor Payments: Purchasing / Accounting | | | | | | | X | | |
| Administration | Business Continuity/Disaster Recovery Preparedness | | | | | | X | | | |
| | ECH District Insurance Program Review | | | | X | | | | | |
| | EMTALA Compliance | | | | | | | X | | |
| | External Audit of Consolidated Financial Statements | X | X | X | X | X | X | X | X | X |
| | HIPAA Compliance | | | | | | | | X | |
| | HR Employee Termination Process | X | | | | | | X | | |
| | Marketing Assessment | X | | | | | | | | |
| | Strategic Project Valuation | | | X | | | | | | |
| Finance | Case Management & Length of Stay | | X | | | | | | | |
| | Risk Management | | | | | | | | X | |
| | Charge Capture | | | | | | | | | X |
| | Charge Capture: Emergency Dept. | | X | | | | | | | |
| | Charge Description Master Accuracy | | | | | X | | | X | |
| | Charge Description Master Maintenance | X | | | | | | | | |
| | Contract Compliance: Cardinal | | | | | | | | | X |
| | Contract Compliance: Eclipsys | | | | | | | | | X |
| | Contract: Lucile Packard Operating Agreement | | | | | X | | | | |
| | Internal Controls Over Financial Reporting | | | X | | | | | | |
| | Pharmacy Operations Review | | | X | | | | | | |

| Risk Area | Report Title | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 |
|---|---|---|---|---|---|---|---|---|---|---|
| HIM | Coding: Clinical Accuracy | | | X | X | | X | | | |
| | Medical Records: Duplicate Records | | | X | | | | | | |
| | Release of Protected Health Information | | | | | X | | | | |
| IT | IT Asset Management | | | | X | | | | | |
| | IT Data Security Incident Management | | | | X | | | | | |
| | IT General Controls | | | | | | | | | X |
| | IT Vendor Management | | | | | | | | | X |
| | IT Vendor Security | | X | | | | | | | |
| | IT: HIPAA Security Rule | | X | | | | | | | |
| | Vendor - Business Associate Agreement Validation | | | | | X | | | | |
| Patient Accounts | Admit and Registration | | | | | | | | X | |
| | Billing: Accuracy for Transfers | | | X | | | | | | |
| | Billing: Charity Care | | X | | | | | | | |
| | Billing: Clinical Trials | | | | X | | | | | |
| | Billing: OB ED Charges | X | | | | | | | | |
| | Billing: OR Charges - Revenue Cycle | | | | X | | | | | |
| | Billing: Provider Based | | X | | | | | | | |
| | Billing: Radiology Revenue Cycle | | | | | | X | | | |
| | Billing: Revenue Cycle Senior Health Center | | | | X | | | | | |
| | Billing: Warranty Device | | | X | | | | | | |
| | Contracting Audit: Managed Care & Contract Validation For Claims Collection | X | | | | | | | | |
| | Denial Claims Management & Reporting | | | | X | | | | | |
| | Medicare Secondary Payer Review | X | | | | | | | | |
| Payroll | Payroll: E-Time Post Implementation Review | | | | X | | | | | |
| | Payroll: Manual Timekeeping | | | | | | | X | | |
| Physician Contracts | Real Estate: Physician Real Estate Lease | X | | | X | | | | | |
| | Contracting Audit: Payments to Physicians | | X | | | X | | | X | |

# Prioritizing Audits

Other key themes highlighted by the ECH leadership during interviews included:

- The inherent risk associated with the end to end revenue cycle process
- The need to continue focusing on cost containment due to expected future decreases in reimbursement from Medicare and other third party payers
- Management of the electronic health record and security of PHI
- Data integrity, data analytics, and data governance
- Improving patient safety and patient satisfaction

To assist in prioritizing the potential audits, emphasis was placed on audits that focused on one or more of the following:

- Issues that could result in significant, adverse financial impact
- Incidents of non-compliance with regulations that could result in fines and/or impair the hospital's reputation
- Issues that are so significant the hospital would conclude immediate attention is required

Based on the information from the assessment, our current risks and priorities, and the results of historical audits, the following proposed audits and prioritization map were created.

# Proposed Internal Audits

## ICD-10 Coding

Risk of non–compliance with Medicare criteria for coding and risk of externally reporting inaccurate data. RAC has increased reviews for DRG assignment prior to the ICD-10 conversion and, with the complexity of new ICD-10 coding, more government scrutiny is anticipated.

## Case Management Two – Midnight Rule

Risk of non-compliance with Medicare criteria for inpatient vs. outpatient designations could result in the need to re-pay reimbursement as well as loss of future revenues due to continuing issues with incorrect assignment. Continued modifications to the CMS outpatient prospective payment system (OPPS Final Rule) makes compliance a challenge.

## Patient Centered Medical Home (PCMH)

Risk of not maintaining PCMH and NCQA standards and accreditation. Must validate chart documentation and operational processes to maintain accreditation and alignment with Meaningful Use Stage 2 requirements.

## OCR IT Audit Readiness

The hospital received and completed the pre-audit questionnaire in preparation for the potential selection by OCR for an audit. Risk not being prepared or able to demonstrate compliance within required timeframe if selected for audit.

## Financial Cash Controls

Risk that lack of proper internal controls could lead to theft, inaccurate information and/or financial misstatements.

# Proposed Internal Audits *(continued)*

**Release of Protected Health Information (PHI)**

Risk of non-compliance with regulations regarding the release of protected health information which could result in fines, lawsuits and/or damage to reputation. With the implementation of Epic, internal controls and compliance with HIPAA requirements regarding release of PHI need to be validated.

**EMTALA Compliance**

Risk of sanctions or exclusions if the Hospital does not adhere to EMTALA guidelines by having good processes in place. Must validate whether stipulations in EMTALA are being complied with by the Hospital.

**IRS Governance Standards for Insured Revenue Bonds**

Risk of not being prepared for greater scrutiny regarding tax-exempt status. When securing new bonds, not-for-profit hospitals may be subjected to an IRS evaluation to evaluate the governance of tax-exempt organizations.

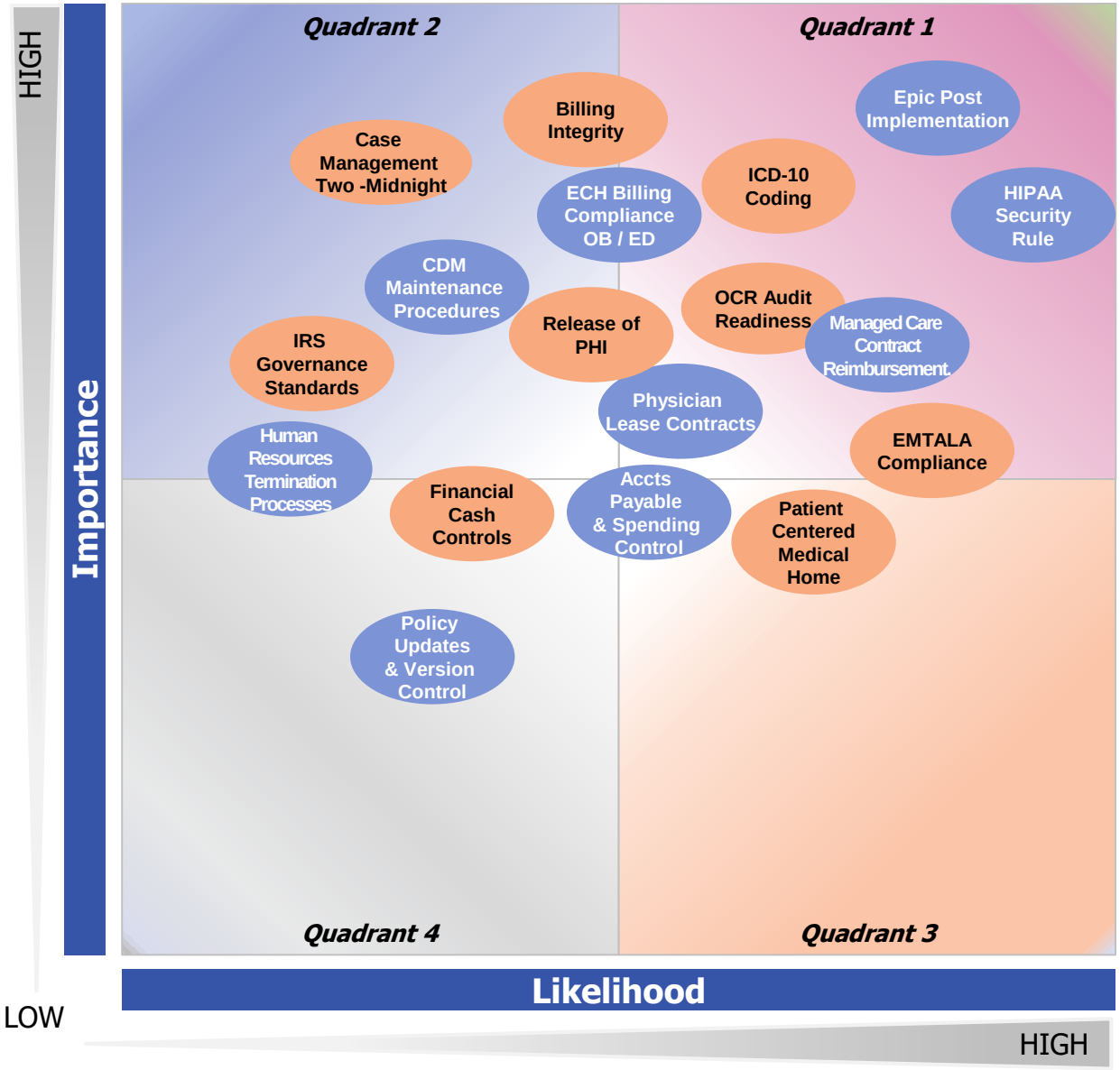
**Billing Integrity**

Risk that inadequate billing process can result in lost revenue or payments. Risk of not being prepared for OIG areas of focus could lead to poor results. The most recent OIG work plan recommends that organizations validate processes and accuracy of billing for Intensity Modulated Radiation Therapy (IMRT) as well as billing compliance for Part B Outpatient claims provided during inpatient stay.

# Risk Assessment Process: Prioritization Map

FY 2016 — **Risk areas addressed by audits performed in FY 2016**

FY 2017 — **Risk areas addressed by audits proposed for FY 2017**



# ATTACHMENT 7

# COMMITTEE MEETING AGENDA ITEM COVER SHEET

| | | |
|---|---|---|
| | **Item:** | Key Performance Indicators<br>Compliance Committee Meeting<br>Meeting Date: August 18, 2016 |
| | **Responsibility party:** | Diane Wigglesworth, Sr. Director Corporate Compliance |
| | **Action requested:** | Information only |
| | **Background:**<br>Key performance indicators were developed to track required elements from the Federal Sentencing Guidelines. These indicators help the committee monitor activity and review organizational trends. | |
| | **Committees that reviewed the issue and recommendation, if any:** N/A | |
| | **Summary and session objectives** :<br>Objective is to review the trending of key indicators. Compliance validated some billing issues and Epic documentation errors reported by patients and staff. Issues were resolved by the Epic i-Care team. Compliance will continue ongoing monitoring of billing integrity. HIPAA related questions and reported issues YTD are up over the previous year however self-reported violations to CDPH have trended down from the previous year. | |
| | **Suggested discussion questions:**<br>1. Are there any areas of concern? | |
| | **Proposed board motion, if any:**<br>None | |
| | **LIST OF ATTACHMENTS:**<br>1. Corporate Compliance Scorecard<br>2. KPI 2-year Trend Graph | |

# Corporate Compliance Scorecard FY15

**El Camino Hospital**

| Key Performance Indicator | FY:16 Current Month | Current YTD Actual | Prior YTD Actual |
|---|---|---|---|
| ***Total Number of Hospital Discharges (excluding normal newborn)*** | ***1,527*** | ***18,618*** | ***19,081*** |
| **Core Elements** | | | |
| **Policies and Procedures** | Jun. 2016 | *Jul - Jun FY:2016* | *Jul - Jun FY:2015* |
| Number of reported instance when policies not followed | 3 | 37 | 46 |
| Number of disciplinary actions due to Investigations | 2 | 14 | 11 |
| **Education and Training** | Jun. 2016 | *Jul - Jun FY:2016* | *Jul - Apr FY:2015* |
| Percentage of new employees trained within 30 days of start date | 100% | 100% | 100% |
| **Investigations** | Jun. 2016 | *Jul - Jun FY:2016* | *Jul - Apr FY:2015* |
| Total number of investigations | 27 | 260 | 188 |
| Investigations open | 0 | 0 | 0 |
| Investigations closed | 27 | 251 | 186 |
| Hotline concerns substantiated | 2 | 21 | 34 |
| Hotline concerns not substantiated | 0 | 24 | 13 |
| Average number of days to investigate concerns | 6 | 7 | 5 |
| **Reporting Trends** | Jun. 2016 | *Jul - Jun FY:2016* | *Jul - Apr FY:2015* |
| Anti-Kickback/Stark | 6 | 45 | 48 |
| EMTALA | 0 | 4 | 2 |
| HIPAA Reports | 14 | 185 | 149 |
| HIPAA Security Breaches | 0 | 4 | 0 |
| Billing or Claims | 11 | 104 | 50 |
| Conflict of Interest | 1 | 5 | 1 |
| **Reported Events to CMS** | Jun. 2016 | *Jul - Jun FY:2016* | *FY:2015 Actual* |
| Number of total events self reported by ECH | 0 | 0 | 1 |
| Number of self reported events followed up by CMS | 0 | 0 | 1 |
| CMS initiated visits (separate from ECH self reported events) | 0 | 0 | 0 |
| Number of statement of deficiencies issued to ECH | 0 | 0 | 0 |
| Number of Actual Sanctions, fines or penalties | 0 | 0 | 0 |
| **Reported Events to CDPH** | Jun. 2016 | *Jul - Jun FY:2016* | *FY:2015 Actual* |
| Number of total regulator events self reported by ECH | 1 | 11 | 5 |
| Number of self reported events followed up by CDPH | 0 | 5 | 8 |
| Number of total privacy breaches self reported by ECH | 0 | 18 | 23 |
| CDPH initiated visits (separate from ECH self reported events) | 0 | 7 | 19 |
| Number of statement of deficiencies issued to ECH | 0 | 3 | 6 |
| Number of Actual/Realized Sanctions, fines or penalties | 0 | 0 | 0 |
| **Monitoring and Audit Findings** | Jun. 2016 | *Jul - Jun FY:2016* | *FY:2015 Actual* |
| Total number of Audit Findings | 14 | 47 | 42 |
| Number of findings identified has high severity | 0 | 6 | 15 |
| **Monitoring and Audit Findings** | Jun. 2016 | *Jul - Jun FY:2016* | *FY:2015 Actual* |
| Number of Open Liability Claims | 10 | *10* | *13* |
| Number of Open Liability Lawsuits | 6 | *7* | *8* |

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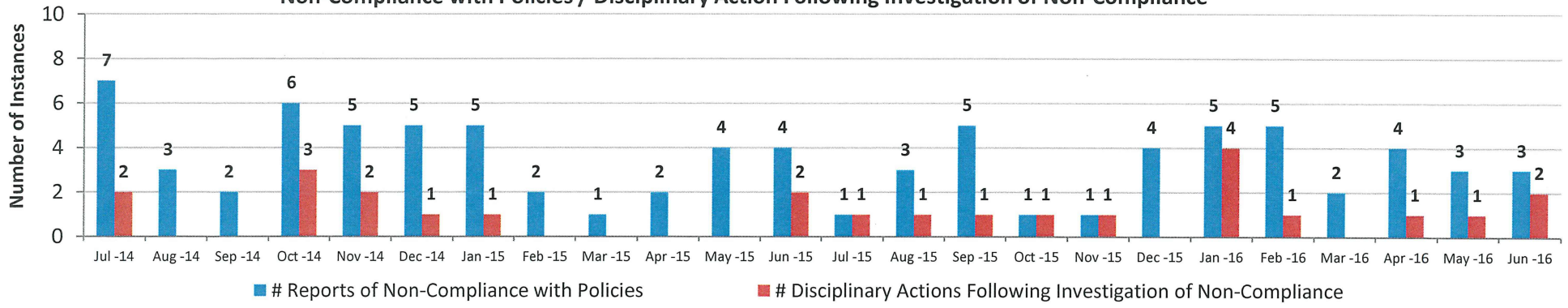
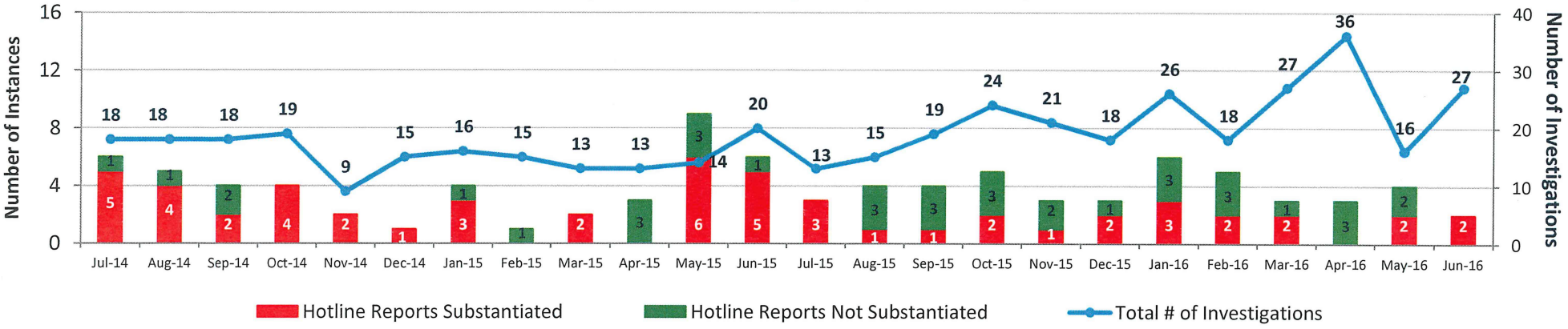
# Corporate Compliance

## Policies & Procedures

### Non-Compliance with Policies / Disciplinary Action Following Investigation of Non-Compliance




### Investigations: Total Investigations / Hotline Activity




### Privacy Breaches Requiring Report to Outside Entity