El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA
CORPORATE COMPLIANCE/PRIVACY AND INTERNAL AUDIT COMMITTEE MEETING OF THE EL CAMINO HOSPITAL BOARD
Wednesday, October 5, 2016 – 5:00 pm
El Camino Hospital, Conference Room A & B (ground floor)
2500 Grant Road, Mountain View, CA 94040

Christine Sublett will be participating via teleconference from 27A Boopasandra Main Rd, Boopasandra, Bengaluru 560094 India

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 – 5:02 pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	John Zoglin, Chair		**5:02 – 5:03**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement on issues or concerns not covered by the agenda.* b. Written Correspondence	John Zoglin, Chair		**information** **5:03 – 5:06**
4.	**CONSENT CALENDAR** Any Committee Member or member of the public may remove an item for discussion before a motion is made. ***Approval*** a. Meeting Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee (8/18/16) ***Information*** b. Status of FY17 Committee Goals	John Zoglin, Chair	*public comment*	**motion required** **5:06 – 5:10**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	John Zoglin, Chair		**information** **5:10 – 5:15**
6.	**POLICIES FOR APPROVAL** *Policies with Major Revisions* a. HR - Student Educational Experience *Policies with Minor Revisions* b. HIMS – Patient Access to Protected Health Information c. HR – Discrimination in Employment d. HR – Harassment *Policies with No Revisions* e. HIMS – Retention and Destruction of Records **ATTACHMENT 6**	Diane Wigglesworth, Sr. Director, Corporate Compliance	*public comment*	**motion for recommendation required** **5:15 – 5:18**

A copy of the agenda for the Regular Committee Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at 650-988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
7.	**KEY PERFORMANCE INDICATORS, SCORECARD AND TRENDS** Memo, Scorecard, and Trend Graphs **ATTACHMENT 7**	Diane Wigglesworth, Sr. Director, Corporate Compliance		**information** **5:18 – 5:28**
8.	**ADJOURN TO CLOSED SESSION**	John Zoglin, Chair		**motion required** **5:28 – 5:29**
9.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	John Zoglin, Chair		**5:29 – 5:30**
10.	**CONSENT CALENDAR** *Any Committee Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2* a. Meeting Minutes of the Closed Session of the Corporate Compliance/Privacy and Internal Audit Committee (8/18/16) ***Information*** *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation. b. Compliance Activity Log c. Privacy Activity Log d. Internal Audit Follow Up	John Zoglin, Chair		**motion required** **5:30 – 5:36**
11.	Discussion involving *Gov't Code Sections 54957* and *54957.6* for discussion and report on personnel matters: - Report on Committee Recruitment	Sharon Anolik Shakked and Christine Sublett, Recruitment Ad Hoc Committee		**discussion** **5:36 – 5:46**
12.	Report involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation: - Results of Consolidated Financial Statements, 403(b), and Cash Balance Audit	Brian Conner, Joelle Pulver, and Bertha Minnihan, Moss Adams, LLP		**motion for recommendation required** **5:46 – 6:15**
13.	Report involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation: - Report on Internal Audit Activity	Diane Wigglesworth, Sr. Director, Corporate Compliance		**information** **6:15 – 6:25**
14.	Discussion involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation: - Discussion on IT Security	Deb Muro, Interim CIO		**information** **6:25 – 6:40**
15.	Report involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation: - Report on FY16 Summary of Physician Payments	Diane Wigglesworth, Sr. Director, Corporate Compliance		**motion for recommendation required** **6:40 – 6:50**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
16.	Discussion involving *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets: - Pacing Plan	John Zoglin, Chair		**information 6:50 – 6:52**
17.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters: - Executive Session	John Zoglin, Chair		**discussion 6:52 – 6:57**
18.	**ADJOURN TO OPEN SESSION**	John Zoglin, Chair		**motion required 6:57 – 6:58**
19.	**RECONVENE OPEN SESSION / REPORT OUT**	John Zoglin, Chair		**6:58 – 6:59**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
20.	**ADJOURNMENT**	John Zoglin, Chair		**motion required 6:59 – 7:00 pm**

Upcoming Corporate Compliance Committee Meetings:

- October 26, 2016 (*Semi-Annual Board and Committee Educational Gathering*)
- November 9, 2016 (*Compliance Committee Meeting, followed by Joint Session of Compliance Committee and Hospital Board*)
- January 19, 2017
- March 16, 2017
- May 18, 2017

a. Meeting Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee (8/18/16)

Minutes of the Open Session of the
Corporate Compliance/Privacy and Internal Audit Committee
Thursday, August 18, 2016
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040
Conference Room F (ground floor)

Members Present
John Zoglin, Chair
Sharon Anolik Shakked, Vice Chair
Dennis Chiu (via phone)
Christine Sublett

Members Absent
None

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 4:59 pm by Chair Zoglin. A verbal roll call was taken. All Committee members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Zoglin 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. CONSENT CALENDAR	Dennis Chiu joined the meeting at 5:02 pm. Chair Zoglin asked if any member of the Committee or the public wished to remove an item from the consent calendar. Ms. Anolik Shakked requested that Item B (Status of FY17 Committee Goals) be pulled. Diane Wigglesworth, Sr. Director of Corporate Compliance, provided updated copies of the agenda, noting that the Committee Recruitment discussion was moved to closed session. In response to Ms. Anolik Shakked's question regarding the Information Security Committee goal, Ms. Wigglesworth clarified that for the preliminary report in Q2 FY17, the Committee can expect a detailed update from the CIO on the Information Security Roadmap. **Motion:** To approve the consent calendar: Minutes of the Open Session of CCPIA Meeting of May 19, 2016, Status of FY17 Committee Goals, and Article of Interest. **Movant:** Sublett **Second:** Anolik Shakked **Ayes:** Anolik Shakked, Chiu, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Consent calendar approved***
5. REPORT ON BOARD ACTIONS	Chair Zoglin highlighted the funding approvals for upcoming construction projects and physical investments. There has been	

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	no report yet to the Board regarding ERM program and IT Security; this topic is currently paced for a joint meeting in November, pending Committee member availability.	
6. FY17 INTERNAL AUDIT WORK PLAN	Ms. Wigglesworth provided a summary of a risk map and proposed internal audits for this fiscal year. A number of factors were considered in putting the summary together including: third party recommendations (OIG, HCCA, HFMA, AHIA, and regulatory agencies), common risks for healthcare organizations, findings from previous audits, and interviews with the executive leadership team. Ms. Wigglesworth noted that she prioritized audits that would emphasize issues that could have adverse financial or regulatory impacts on the organization. Proposed audits included: 1) Financial Risk: ICD-10 Coding, Financial Cash Controls, IRS Governance Standards; 2) Revenue Cycle Risk: Case Management, Billing Integrity, OIG-focus; 3) New Technology and IT Security Risk: OCR Audit Readiness, PHI Release; and 4) Compliance Risk: Patient Centered Medical Home, EMTALA Compliance. She reported that Chair Zoglin suggested adding an audit that would examine whether ECH's systems are effectively designed to execute and support the outpatient strategic plan. She explained that Epic is currently working on the ambulatory build to bring on Pathways, clinics, and other primary care clinics. In response to Ms. Anolik Shakked's question, Ms. Wigglesworth described her methodology in developing the risk prioritization map and the grid she used to evaluate risks identified in interviews with the executive leadership team. In response to Ms. Sublett's question, Ms. Wigglesworth explained that the timeline for these audits is still being developed. She recommended completing the IRS Governance Standards audit first, given ECH's bond pursuits. Iftikhar Hussain, CFO, explained that the IRS' audit of ECH in 2008 had a good outcome. Ms. Wigglesworth asked the Committee for recommendations on audit prioritization. Ms. Sublett suggested OCR Audit Readiness be addressed soon, given their requests so far and the Coalfire report. Ms. Wigglesworth reported that she also would also prioritize ICD-10 Coding, as 6,000 more codes will be added on October 1st. Ms. Wigglesworth explained that she was not prioritizing business information analytics or RAC program effectiveness review this year because of the available bandwidth of the organization and tools in Epic that may capture similar information. She reported that there are two upcoming upgrades to Epic (in 2017), so it would be worth waiting until those are complete. Alex Robison from Protiviti commented that audits that are not being prioritized as highly may still be covered under the current work being done. **Motion:** To approve the recommended audit work plan with one additional audit to review the strategic plan and targeted growth areas. **Movant:** Anolik Shakked	***FY17 Internal Audit Work Plan approved***

	Second: Sublett **Ayes:** Anolik Shakked, Chiu, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
7. KEY PERFORMANCE INDICATORS SCORECARDS AND TRENDS	Ms. Wigglesworth reported an increase in investigations, with areas of focus including billing, documentation issues, and claims activity. She described work queues in Epic where claims can be held until issues or documentation discrepancies are reviewed and resolved. Compliance will continue ongoing monitoring of billing integrity.	
8. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 5:25pm. **Movant:** Anolik Shakked **Second:** Sublett **Ayes:** Anolik Shakked, Chen, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
9. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:27 pm. During the closed session, the Committee approved the closed session minutes of the Corporate Compliance/Privacy and Internal Audit Committee meeting of May 19, 2016 by a vote in favor of all members present (Anolik Shakked, Chiu, Sublett, Zoglin).	
13. AGENDA ITEM 20: ADJOURNMENT	**Motion**: To adjourn at 7:28 pm. **Movant**: Davis **Second**: Sublett **Ayes**: Anolik Shakked, Sublett, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chiu **Recused**: None	***Meeting adjourned at 7:28 pm.***

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

_____

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 (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 FY 2017 and Final report Q3 FY 2017	▪ Committee reviews and approves plan.
▪ Review and evaluate risk assessment of Patient Centered Medical Home (PCMH) Compliance and any corrective action plans	▪ Q3 FY 2017	▪ Committee reviews and approves plan.
▪ Review plan and evaluate ERM activities, performance and execution of program	▪ Q4 FY 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

ATTACHMENT 5

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on Board Actions Compliance Committee September 26, 2016
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	For Information
	Background: 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: None.	
	Summary and session objectives : To inform the Committee about recent Board actions.	
	Suggested discussion questions: None.	
	Proposed Committee motion, if any: None. This is an informational item.	
	LIST OF ATTACHMENTS: Report on August and September 2016 Board Actions	

August and September 2016 Board Actions*

1. August 10, 2016 El Camino Hospital Board Approvals
    a. FY 16 Period 12 Financials (FY16 Budget was met)
    b. Approved final funding for the following projects:
        i. Behavioral Health Services Building - $72,5000,000
        ii. Integrated Medical Office Building - $247,000,000
        iii. Central Plant Upgrades (to support new construction) - $7,500,000
    c. Appointed two new members to the Finance Committee – Joseph Chow and Boyd Faust
    d. Disbanded the Board's iCare Ad Hoc Committee
    e. Recommended the District Board adopt the following as the highest priority Hospital Board member competencies for FY2017 –
        i. Understanding of complex market partnerships
        ii. Long-range strategic planning
        iii. Healthcare insurance industry experience
        iv. Finance experience/entrepreneurship
        v. Experience in clinical integration/continuum of care
2. August 10, 2016 El Camino Healthcare District Board meeting Approvals: Approved final funding for the following projects that exceeded $25,000,000 in a single transaction.
    a. Behavioral Health Services Building - $72,5000,000
    b. Integrated Medical Office Building - $247,000,000
3. August 27, 2016 – El Camino Hospital Board voted not to renew the CEO's contract. Ms. Ryba's last day of employment will be October 31, 2016.
4. September 14, 2016 El Camino Hospital Board Actions
    a. FY 16Organizational Goal Achievement @ 67% (slightly above target)
    b. FY17 Organizational Goal Metrics
    c. ED Gastroenterology and Neuro-Interventional On-Call Panel Agreements
    d. CEO Search Ad Hoc Committee of the Board
    e. FY17 Internal Audit Work Plan
    f. Silicon Valley Medical Development Primary Care Clinic and Physician Contracts
    g. FY 16 CEO Incentive Plan Payment
    h. FY 17 CEO Salary Range

*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

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Policy Approval Compliance Committee October 5, 2016
	Responsibility party:	Diane Wigglesworth, Sr. Director, Corporate Compliance
	Action requested:	Approval of Policies
	Background: As required by Title 22 and the Joint Commission, the Hospital's governing body must review and approve all organizational policies at least every three years, if there are no changes, and if a policy is new or revised, it must be approved by the Board before the Hospital can adopt it. Policies are being brought to the appropriate Board Advisory Committee for review and recommendation before being placed on the Hospital Board consent calendar for approval. All policies have been internal reviewed and have received appropriate approvals before being presented to a Board Committee.	
	Committees that reviewed the issue and recommendation, if any: N/A	
	Summary and session objectives : • Review policies and recommend for Board approval	
	Suggested discussion questions: None.	
	Proposed board motion, if any: To recommend that the Hospital Board approve the policies.	
	LIST OF ATTACHMENTS: 1. Summary of Policy Changes 2. Policies	

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES				
Policy Number	**Policy Name**	**Department**	**Revised Date**	**Summary of Policy Changes**
POLICIES WITH MAJOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Student Educational Experience	HR	9/22	1.Name changed from "Students, Interns & Instructors"2.Policy: Clarifies the responsibilities of both the school and the institution in regards to meeting the requirements of the student placement agreement (contract) 3.Clarifies the student scope of practice 4.Appendix A-defines roles and responsibilities of all parties involved in a clinical placement 5.Appendix B-Define limitations to specifically to the nursing scope of practices well as, skills that they are able to practice under supervision. Due to the volume of changes made to the policy the final version instead of the redline was included in the packet for easy of reviewing.
POLICIES WITH MINOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Discrimination in Employment	HR	9/22	Added "gender identity" as a clarification to the policy. The hospital is modifying and clarifying in order to submit this policy along with other information to be recognized by the Health Equality index in October. The hospital's operational practice remains consistent with this clarification.
	Harassment	HR	9/22	Added "gender identity" as a clarification to the policy. The hospital is modifying and clarifying in order to submit this policy along with other information to be recognized by the Health Equality index in October. The hospital's operational practice remains consistent with this clarification.
	Retention and Destruction of Records	HIMS	9/22	Changed name to "Retention and Destruction of Organization Records"
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	
	Patient Access to Protected Health Information	HIMS	9/22	Hospital has two policies with the same information. One is assigned under HIPAA and another was under HIMS department. Since the primary owner is HIM the HIPAA policy is being archived and this policy will be retained.

Att. 06a HR - Students Interns and Instructors

POLICY/PROCEDURE TITLE: **Student Educational Experience**

CATEGORY: Human Resources
LAST APPROVAL DATE: 9/2015

SUB-CATEGORY: **Human Resources**
ORIGINAL DATE: **5/13/1998**

COVERAGE:

All students and faculty of academic institutions (clinical or non-clinical) that participate in educational experiences (including preceptorship, internship, externship, , observation or independent study) which are covered by a current signed agreement between the educational facility and El Camino Hospital. In addition, the Hospital has established specific rules and procedures for educational experiences in order to maintain and safeguard the high standards of patient care and safety established by the Hospital. The rules and procedures set forth in this policy are administered by Clinical Education/Talent Development

PURPOSE:

1. Stipulates requirements to be met by students and faculty prior to the student educational experience whether a group rotation, individual practicum or preceptorship
2. Insure that patient care standards and/or other professional and business standards are maintained in all student learning situations.
3. Define responsibility and accountability for assignment of students and the patient care or other work products they provide
4. Clearly delineate any limitations on students clinical practice

POLICY:

All participants in academic educational experiences (including preceptorship, internship, externship, observation or independent study) at El Camino Hospital must be covered by a current signed agreement between the educational institution/organization and El Camino Hospital, which is drafted by El Camino Hospital. This agreement must be submitted to the educational institution for review and signature. Agreements will be forwarded to the Chief of Human Resources for review and final approval.
The agreement must include the following:

a. Statement of purpose (including student course of study)
b. Responsibilities of the parties
c. Designation of an individual from the educational institution/ organization who will supervise and/or who is directly responsible for student placement and monitoring.
d. Statement that required health documentation and background checks for affected students must be on file at the educational facility and that the educational facility must be able to deliver copies to the Hospital upon request.
e. Required insurance coverage (plus insurance certificate documents evidencing all required insurance coverage to be provided by the educational facility or the student):
    - General liability
    - Professional or malpractice liability

f. Statement that students and instructors must comply with all policies and procedures of El Camino Hospital.

g. Statement that the Hospital reserves the right to deny access to any student, non-employee, volunteer or instructor that does not comply with its' policies and procedures.

El Camino Hospital retains the responsibility of the care of the patient, including those assigned to a student. The ECH clinical professional assigned to manage the care of a patient for a given shift retains ultimate accountability for the decisions regarding patient care.

4. During a clinical rotation, the student practices under the supervision and direction of the clinical faculty identified by the educational institution and the assigned El Camino Hospital clinical professional (ex. RN, therapist, etc.). During a preceptorship, the student functions under the supervision and direction of the assigned preceptor.

5. The student placement coordinator and the Department Managers are responsible to:

- Ensure that the terms of the agreement are followed and properly completed in a timely manner.
- Report student and instructor non-compliance issues to the Director of Clinical Education or the Director of Talent Development, as appropriate.

6. El Camino Hospital reserves the right to determine the number of students assigned to a particular area or areas of the Hospital at any time to insure that patient care or safety standards are not compromised.

7. The educational institution is responsible for assuring that students are prepared to carry out assigned responsibilities commensurate with their course objectives, before assigning such responsibilities in the clinical setting.

POLICY/PROCEDURE TITLE: Student Educational Experience

PROCEDURE:

1... All students scheduling must be coordinated through Clinical Education Services/Talent Development. Any student who has not been scheduled through one of these departments will be denied access to the designated area of experience. Director of Clinical Education and/or Director of Talent Development may delegate this responsibility to a department designee.

2... Compliance with Hospital immunization, background check and drug screening requirements outlined in the Infection Prevention policy must be documented by providing date completed prior to the start of the educational experience. School representative must affirm in writing that the information has been reviewed, the student meets all the requirements for eligibility and that documentation of such can be provided upon request from the hospital. These affirmation records will be maintained in Clinical Education/Talent Development.

3. Clinical Education/Talent Development or department designee will make copies of all applicable El Camino Hospital policies and procedures available to the educational facility prior to the start of the educational experience. New and/or updated policies and procedures will also be made available to the educational facility as appropriate.

4... Clinical Education/Talent Development, in partnership with the educational facility, will provide orientation materials to the students prior to the commencement of the educational experience regarding applicable safety training, emergency paging codes, confidentiality, etc.

5. Student Injury/Exposure Guidelines

   a. Follow school policy for non-emergency injury/exposure sustained by a student during an educational experience (including preceptorship, internship, externship, volunteer internship or independent study).

POLICY/PROCEDURE TITLE: Student Educational Experience

The Hospital will make available, whenever possible, emergency health care for the assigned student in case of accident or illness while on hospital premises. Any student receiving such emergency services shall be financially responsible for the charges therefore. The student shall otherwise be responsible for his or her own health care.11.

6. Student Scope of Practice

a. Pre-licensure students may perform skills normally associated with the performance of role /job which they are preparing and that are deemed appropriate to the student's level of knowledge and skill by their facility. See Appendix B- Limitations to student scope of practice.
b. All students who engage in an evidence-based project, research study or quality improvement project as part of their degree requirement must consult with the hospital prior to seeking approval from their academic Institutional Review Board (IRB) and /or El Camino Hospital IRB.

POLICY/PROCEDURE TITLE: Student Educational Experience

APPROVAL	DATES
Originating Committee or UPC Committee:	05/2015
_____Medical Committee (if applicable):	
ePolicy Committee:	8/2015
Pharmacy and Therapeutics (if applicable):	
Corporate Compliance Committee:	8/2015
Board of Directors:	9/2015

Historical Approvals: 5/13/98, 11/15/00 (formerly numbered 20.10), 11/19/03, 11/06, 06/09, 11/12

REFERENCES: (*as applicable*)

Title 16 CCR, Division 14, Board of Registered Nursing, Section 1426.1, 1427

ATTACHMENTS: ADDENDUMS: EXHIBITS: OR APPENDICES:

Appendix A – Roles and Responsibilities of Parties involved in Student Educational Experiences

Appendix B – Limitation to the Student Scope of Practice

POLICY/PROCEDURE TITLE: Student Educational Experience

Appendix A- Roles and Responsibilities of Parties Involved in Student Educational Experiences

Director of Clinical Education/Director of Talent Management or designee

1. Validates that a current agreement for Student Educational Experience is in place with the academic institution. Agreements are kept by Clinical Education/Talent Development Services
2. Approves educational experiences (including group rotations, preceptorship, internship, externship, volunteer internship or independent study)
3. Facilitates hospital and unit orientation for students and faculty. Facilitates all aspects of iCare access and training.
4. Prior to the start of the educational experience, validates compliance with required health screening, immunizations, background checks, drug testing and pre-clinical compliance training materials.
5. Communicate with affiliating schools regularly to discuss learning experiences, to elicit feedback from faculty and student on the quality of the student experiences and provide updates on facilities policies and initiatives.

Manager or designee (educator)

1. Refer all requests for student clinical placement to the Director of Clinical Education/Talent Development or designee.
2. Facilitate unit orientation of clinical faculty, as needed.
3. Provide clinical facility any unit specific policies and procedures relevant to the student clinical experience.
4. Foster collaboration through ongoing communication with faculty to achieve the best learning outcomes and positive relationship between El Camino and affiliating schools.

Clinical Faculty

1. During a clinical rotation, is responsible to provide a level of supervision commensurate with the level of the student in the nursing curriculum and must be available to the students and staff at all times during the students' clinical hours.
2. Collaborates with RN or clinical staff member, charge nurse/charge person and unit manager to determine student assignments focused on clinical objectives. Post student assignments on unit per unit preferences.
3. Reviews documentation with student and verifies the entries using the cosign smart phrase. By prior arrangement, this may be relinquished to the RN or clinical staff member to whom the patients are assigned.
4. Supplementary assignments and schedules in specialty areas (i.e. operating room, outpatient clinics, etc.) are approved by the manager prior to the beginning of the semester.
5. Is responsible for assessing and evaluating student competence and clinical performance.

6. Promptly informs department manager and hospital student coordinator of any patient care problem involving a student and submits appropriate documentation.

El Camino Hospital Staff supervising student(s)

1. Retains responsibility for patient assessment, documentation, and provision of appropriate patient care.
2. Exchanges information regarding care of the student's assigned patients at the beginning, throughout and at the completion of the shift or clinical assignment.
3. Maintains open lines of communication with student and faculty in order to help identify experience that will enhance the student experience.
4. In collaboration with clinical faculty, may directly supervise students in the performance of and documentation of clinical responsibilities for which a student has received instruction for in their curriculum.

Student (clinical rotation)

1. Performs patient care in accordance with El Camino Hospital policies and procedures.
2. Performs clinical care responsibilities within the scope of practice commensurate with the course objectives and their level in school.
3. Complies with school and hospital dress code, acts in a professional manner when interacting with staff and during patient care.
4. Displays facility specific ID badge with school designation at all times while on the hospital properties.
5. Reports to assigned unit/dept. on time to verify patient assignment and received bedside report with the staff nurse, if appropriate.
6. Maintains patient and hospital confidentially following HIPAA and CA state law
7. May not print or photocopy from the EHR any patient specific information.
8. Performs ALL new skills under the supervision of the clinical staff.
9. Promptly reports changes in the patient's condition to the assigned RN and the clinical faculty.
10. Completes all required documentation for the patient assignment as agreed upon with the assigned nurse. All documentation is reviewed and co-signed by the clinical instructor or assigned El Camino Hospital preceptor.
11. Completes an evaluation of the clinical experience at the end of the semester which is turned in to the hospital.

Student Preceptorships

1. Precepting student functions under the direction and supervision of the assigned RN or clinical staff member
2. Clinical Faculty is not required to be onsite while the student is providing care but must be available to students and staff at all times during the student's clinical hours and maintain accountability for the student's clinical performance. Faculty must also have periodic face-to-face visits with the preceptor.

3. Students may not assume responsibility for patient care when the preceptor is absent from the nursing or clinical unit. Students must not be assigned to care for patients independently but are expected to work as a team with the preceptor.
4. El Camino Hospital Staff Preceptor provides ongoing feedback to the student and instructor throughout the semester about student performance and progress in meeting the learning objectives. The preceptor is responsible for communicating to the clinical faculty and department manager the lack of progress or other performance problems as soon as they are identified.
5. All documentation by the student during a preceptorship is verified by the El Camino Hospital staff preceptor using the EHR smart phrase.

POLICY/PROCEDURE TITLE: Student Educational Experience

Appendix B- Limitation to the Nursing Student Scope of Practice

RN and LVN students may NOT perform the following nursing responsibilities:

1. Receive verbal or telephone orders
2. Receive or report critical test value to the physician
3. Acknowledge or sign off physician orders
4. Have unsupervised access to the medication Pyxis
5. Serve as one of the two authorized staff performing the independent double check at the patient's bedside when preparing and administering high alert medication by any route
6. Serve as one of the two authorized staff when obtaining blood products or identifying those to receive blood products.
7. During a Code Blue or other emergency situation, defibrillate or mix, hang or push emergency medications.
8. Be the primary initial contact informing the patient/families of a change in the patients status or emerging health problems.
9. Insert a feeding tube with a metal stylet
10. Perform arterial sticks
11. Administer chemotherapy
12. Perform a blood glucose check

LVN Students: In addition to those area identified above, LVN students may NOT perform the following clinical procedures or tasks:

1. Perform venipuncture for collection of laboratory specimens and /or establish IV therapy
2. Flush or withdraw blood from a central venous catheter or arterial line
3. Hang or monitor intravenous therapy containing medication, including TPN or PPN
4. Central venous catheter site care.

RN Students MAY perform, ONLY with DIRECT OBSERVATION by a licensed staff RN or their clinical faculty, the follow clinical procedures/tasks:

1. Report changes in condition, test results, provide status updates to the physician and answer queries from the physician
2. Following the identification of correct blood products and match with correct patient by two licensed staff RN's administer blood products.
3. Administer, but not independently sign out, narcotics. Narcotics must be obtained from the Pyxis by the staff RN and administration observed
4. Administer IV push Medication
5. Initiate, make/rate adjustments, and reload narcotics for Patient Controlled Analgesia (PCA) or continuous narcotic infusions.

6. Perform venipuncture for collection of laboratory specimens and/or to establish IV therapy
7. Perform central venous catheter site care, catheter flush and withdrawal of blood

Att. 06b HR - Discrimination in Employment

POLICY/PROCEDURE TITLE: HR- Discrimination in Employment

CATEGORY: Human Resources
LAST APPROVAL DATE: 02/2016

SUB-CATEGORY: Human Resources
ORIGINAL DATE: 9/11/1994

COVERAGE:

El Camino Hospital employees. If there is a conflict between the Hospital policy and the applicable MOU, the applicable MOU will prevail.

PURPOSE:

El Camino Hospital is an equal opportunity employer and makes employment decisions on the basis of qualifications and competencies. El Camino Hospital prohibits unlawful discrimination in employment based on race, ancestry, national origin, color, sex, sexual orientation, gender identity, religion, disability (including AIDS and HIV diagnosis), marital status, age (40 and over), medical condition (rehabilitated cancer and genetic characteristics), refusal of Family Care Leave, refusal of leave for an employee's serious health condition, denial of pregnancy disability leave, retaliation for reporting patient abuse in tax supported institutions, or any other status protected by federal, state or local laws. All such discrimination is unlawful and will not be tolerated.

This commitment applies to all persons involved in the operations of El Camino Hospital, including supervisors and co-workers, and applies to all employment practices, including advertisements; applications and interviews; licensing or certification; referrals by employment agencies; salary, classifications and duties; hiring, transferring, promoting or leaving a job; working conditions; participation in a training or apprenticeship program, employee organization or union.

POLICY/PROCEDURE TITLE:HR- Discrimination in Employment

STATEMENT:
This policy is written to insure understanding of and compliance with California and Federal laws which prohibits discrimination in employment.

DEFINITIONS:

1. It is the responsibility of every employee, regardless of supervisory status, to adhere to these policies. An employee who is found to have violated the Discrimination in Employment policy shall be subject to disciplinary action up to and including termination.

2. To assure the dignity and worth of each individual, El Camino Hospital managers and supervisors are responsible to provide an environment which is committed to this policy.

PROCEDURE:

Individuals with a Disability - Reasonable Accommodation
(*See* California Government Code ɜ 12926 and the federal Americans with Disabilities Act 42 U.S.C. 12101, *et seq,*)

1. The manager will make good faith attempts to provide reasonable accommodation for the known physical or mental limitations of an individual with a disability who is an applicant or employee, unless an undue hardship would result.

2. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job will contact Human Resources and/or the appropriate manager and specify the restrictions on job duties and what accommodation is being requested to perform the essential functions of the job. Employee Health Services, together with Human Resources and the appropriate manager, will conduct an interactive process to identify any barrier(s) that would make it difficult for the applicant or employee to perform her/his essential job functions, and potential accommodations which would allow the essential functions of the job to be performed . If the accommodation is deemed reasonable and will not impose an undue hardship, the manager in consultation with Human Resources will make the accommodation.

3. If an applicant or employee believes she/he has been subject to any form of unlawful discrimination, she/he must provide a written complaint to Human Resources or the manager.

F. Procedure for Discrimination Complaints

1. An individual who believes that she/he has not received equal opportunity in employment must report the incident to her/his direct supervisor, manager, department director or to a Human Resources Business Partner or the Director of Human Resources Operations immediately. The report should be submitted in writing. If the incident involves the employee's direct supervisor, manager or department director, the employee must report the incident immediately to the Human Resources Department. Employees are to be assured that their doing so will not result in any reprisal or retaliation.

2. The written complaint must be specific and include the dates of the alleged incident, names of the individuals involved, names of any witnesses, and as much information as possible regarding the complaint. El Camino Hospital will timely initiate an effective, thorough and objective investigation and attempt to resolve the situation.

3. Any department director/manager/supervisor who receives a report or complaint of a violation of this policy must report it immediately to a Human Resources Business Partner or the Director of Human Resources Operations.

4. If El Camino Hospital determines that unlawful discrimination has occurred, effective remedial action will be taken, commensurate with the severity of the offense. Appropriate action will also be taken to deter any future discrimination.

5. El Camino Hospital will not retaliate against any employee for filing a complaint and will not knowingly permit retaliation by management or coworkers.

POLICY/PROCEDURE TITLE:HR- Discrimination in Employment

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee:	12/2015
Pharmacy and Therapeutics (if applicable):	
Compliance Committee:	01/2016
Board of Directors:	02/2016

Historical Approvals: 9/11/94, 5/1/98, 3/14/01 (formerly titled “11.02 Equal Employment Opportunity Practices;” also 11.06 Americans with Disabilities Act now included herein), 11/03, 12/06, 2/09, 11/12

Att. 06c HR - Harassment

POLICY/PROCEDURE TITLE:HR- Harassment

CATEGORY: Human Resources
LAST APPROVAL DATE: 11/12

SUB-CATEGORY: Human Resources
ORIGINAL DATE: 9/1994

COVERAGE:

All El Camino Hospital Employees

PURPOSE:

El Camino Hospital is committed to providing a work environment free of all forms of discrimination and harassment. El Camino Hospital considers discrimination and harassment of any nature (physical, racial, sexual, verbal, etc.) to be misconduct and it will not be tolerated.

El Camino Hospital prohibits harassment in the workplace because of race, ancestry, national origin, color, sex, sexual orientation, gender identity, religion, disability (including AIDS and HIV diagnosis), marital status, age, medical condition (rehabilitated cancer and genetic characteristics), refusal of Family Care Leave, refusal of leave for an employee's serious health condition, denial of pregnancy disability leave, retaliation for reporting patient abuse in tax supported institutions, or any other status protected by federal, state or local law, ordinance or regulation. All such harassment is strictly prohibited. El Camino Hospital's anti-harassment policy applies to all persons involved in the operations of El Camino Hospital, including supervisors and co-workers.

In order to quickly and fairly resolve complaints, El Camino Hospital requires all employees to report any incidents of harassment in the workplace immediately to her/his manager or to any other manager that is readily available, or to the Manager of Employee and Labor Relations or to any Human Resources representative. The requirement to report includes incidents that involve the employee's direct supervisor or manager.

STATEMENT:

This policy is written to insure compliance with the laws and regulations of Title VII of the Civil Rights Act of 1964, the California Fair Employment and Housing Act,

specifically Government Code §12940(a), (h) and (i), and the Ralph Civil Rights Act, which prohibits hate violence.

PROCEDURE:

Sexual Harassment Defined

1. California law defines sexual harassment as unwanted sexual advances or visual, verbal or physical conduct of a sexual nature. This definition includes many forms of offensive behavior. The following is a partial list:

a. Unwanted sexual advances;
b. Offering employment benefits in exchange for sexual favors;
c. Making or threatening reprisals after a negative response to sexual advances;
d. Visual conduct such as leering, making sexual gestures, displaying sexually suggestive objects or pictures, cartoons or posters;
f. Verbal conduct such as making or using derogatory comments, epithets, slurs, and jokes;
g. Verbal sexual advances or propositions;
h. Verbal abuse of a sexual nature or use of sexually degrading words to describe an individual;
i. Suggestive or obscene letters, notes or invitations or, graphic verbal commentary about an individual's body;
j. Physical conduct such as touching, assault, impeding or blocking movements.

2. It is unlawful for males to sexually harass females or other males, and for females to sexually harass males or other females. Sexual harassment on the job is unlawful whether it involves co-worker harassment, harassment by a supervisor or manager, harassment by patients or visitors, or by persons doing business with or for El Camino Hospital.

F. Complaint Procedure

1. The complaint procedure is established to allow for an immediate, thorough and objective investigation of sexual or other harassment claims, appropriate disciplinary action against one found to have engaged in prohibited harassment, and appropriate remedies to any victim of harassment.

2. Employees who believe they have been harassed on the job, including by persons doing business with or for El Camino Hospital, must provide a written or verbal complaint to their manager or to any other manager readily available, or to the Manager of Employee and Labor Relations or any Human Resources representative, as soon as possible. The complaint should include details of the incident(s), names of individuals involved, and the names of any witnesses. Managers must immediately refer all harassment complaints to the Manager of Employee and Labor Relations.

3. All incidents of sexual or other harassment that are reported must be investigated. The Manager of Employee and Labor Relations, or designated representative, will promptly undertake an effective, thorough and objective investigation of the harassment allegations. The investigation will be completed and a determination regarding the harassment alleged will be made.

4. If the Manager of Employee and Labor Relations determines that harassment has occurred, the Manager of Employee and Labor Relations will take effective remedial action commensurate with the circumstances. Appropriate action will also be taken to deter any future harassment. If a complaint of harassment is substantiated, appropriate disciplinary action, up to and including termination, will be taken.

5. The employee who made the complaint will be informed of the progress of
the investigation, and if it is determined that harassment did occur, what actions are being taken to prevent further incidents of harassment.

G. Protection Against Retaliation

1. In accordance with applicable laws, El Camino Hospital prohibits retaliation against any employee by another employee or by El Camino Hospital for using this complaint procedure or for filing, testifying, assisting or participating in any manner in any investigation, proceeding or hearing conducted by a federal or state enforcement agency. Prohibited retaliation includes, but is not limited to, demotion, suspension, failure to hire or consider for hire, failure to give equal consideration in making employment decisions,

failure to make employment recommendations impartially, adversely affecting working conditions or otherwise denying any employment benefit the employee may otherwise be entitled to.

2. Once El Camino Hospital knows of the occurrence of harassment, action will be taken to prevent further harassment, and El Camino Hospital will not knowingly permit any retaliation against any employee who complains of harassment or who participates in an investigation.

3. In accordance with applicable laws, El Camino Hospital also prohibits retaliation against any employee who opposes harassment. Opposition includes, but is not limited to: seeking advice or assisting or advising any person in seeking advice of an enforcement agency regardless of whether a complaint is filed or, if filed, substantiated; opposing employment practices that an employee reasonably believes to be unlawful; participating in an activity perceived to be opposition to discrimination by an employer covered by the law; or contacting, communicating with or participating in any federal, state, or local human rights or civil rights agency proceedings.

4. Any report of retaliation by the one accused of harassment, or by coworkers, supervisors or managers, will also be immediately, effectively and thoroughly investigated in accordance with El Camino Hospital's investigation procedure outlined above. If a complaint of retaliation is substantiated, appropriate disciplinary action, up to and including termination, may be taken.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:HR- Harassment

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	11/2012
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: 09/94, 05/98, 03/01 (formerly numbered 11.04), 11/03, 11/06, 05/08, 06/09, 11/12

Att. 06d HIMS - Retention and Destruction of Records

POLICY/PROCEDURE TITLE: HIMS-Retention and Destruction of Records ~~HIMS-Retention and Destruction of Organization Records~~

CATEGORY: Administrative
LAST APPROVAL DATE: 6/13

SUB-CATEGORY: ADMINISTRATIVE
ORIGINAL DATE: 4/03

COVERAGE:

All El Camino Hospital staff

PURPOSE:

It is El Camino Hospital's policy to maintain effective and cost efficient management techniques in the retention and destruction of all hospital business and medical records and information in accordance with all applicable state and federal laws and regulations.

Legal requirements and considerations, frequency of use and fiscal or clinical pertinence of records, space constraints, department structure, technological advancements, and historical or research uses for records have been taken into consideration in the creation of this policy.

STATEMENT:

- *It is the policy of El Camino Hospital to comply with all mandatory reporting requirements for health insurance portability and accountability act (HIPPA)*
- *It is the procedure of El Camino Hospital regarding health insurance portability and accountability act (HIPPA) to ensure patient safety*

PROCEDURE:

A. Retention Policy:

Information may be created or retained on paper, film, microfilm, photograph, electronic media, etc., as an original record or reproduction thereof.

1. Retention of electronic media must meet the following conditions:
   - An off-site storage backup system is employed;
   - When signatures are required, an imaging system is employed that can copy signed documents;
   - Once put in electronic form, the information is unalterable;

- Safeguards are in place to maintain the confidentiality and limit access by unauthorized persons;
- Mechanisms are established which allow electronic authentication; and
- System maintenance procedures are in place.

2. Records or information retained on paper, film, microfilm, or photograph must meet the following requirements:
   - Records must be easily retrievable to meet intended use;
   - Redundancy of records must be minimized in order to maintain cost efficiency;
   - Records must be maintained in a manner which protects them from defacement, damage, or loss;
   - Medical records must be available within a reasonable timeframe to facilitate patient care;
   - Confidentiality of protected health information must be maintained to assure compliance with all applicable state and federal requirements;
   - Records stored off-site must meet the same retention and confidentiality requirements as records stored within hospital facilities.

~~3. See HIM Policy 9.01 Medical Record Retention and Destruction~~

~~It is the policy of El Camino Hospital to maintain a retention period in close alignment with recommendations of the California Healthcare Association as set forth in the following tables. While every document is not listed, it is our intent to provide a categorical guide to encompass all current and future documentation.~~

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ADMINISTRATIVE RECORDS	
Record	**Retention Period**
Accident or incident reports	10 years
Annual reports to California Department of Health Services	Permanent
Appraisal reports	Permanent
Audit reports	Permanent
Census (daily)	6 years
Communicable disease reports to state and local health departments	3 years
Construction projects	Permanent
Contracts	Life of contract plus 6 years (unless contract specifies longer retention)
Corporate records, including: Articles of Incorporation, bylaws of the governing body, bylaws of the medical staff, minutes of meetings of the board of directors, executive committee, medical staff.	Permanent
Correspondence of continuing interest	6 years
Deeds or titles to property	Permanent
Departmental reports • Annual • Non-annual	 Permanent 6 years
Endowments, trusts, bequests	Permanent
Financial reports	Permanent
Hazard communications records (pesticides)	5 years
Health and Human Services grants	3 years
HIPAA privacy related documents	6 years
Incident reports	10 years
Infection control committee minutes and reports	6 years
Inspection reports by local, federal or state agencies	6 years
Insurance policies, current and expired	Permanent
Leases	Life of lease plus 6 years
Licenses or certificates	Life of license or certificate plus 6 ~~yrs~~yrs.
Medical device reports (MDR) and records of MDR reportable events	6 years
Medical device tracking records	6 years
Permits	Life of permit plus 6 years
Policy and procedure manuals	Life of manual plus 6 years
Reports of unusual occurrences	2 years
Statistics on admissions and services	Permanent

Survey reports ((TJC) JOINT COMMISSION, etc.)	6 years

ADMITTING RECORDS	
Records	**Retention Period**
Admission and discharge reports	6 years

BUSINESS RECORDS	
Record	**Retention Period**
Audit reports	7 years
Bank deposits	6 years
Budgets	6 years
Cash receipts	6 years
Cashiers tapes from bookkeeping machines	2 years
Charge slips to patients	6 years
Check registers	6 years
Checks – cancelled • Payroll • Taxes, capital, purchases, important contracts • Other	 6 years Permanent 7 years
Claims and charges to patients, fiscal intermediaries, third party payers, etc.	6 years
Collective bargaining agreements	Permanent
Correspondence: • General • Credits and Collections • Insurance	 6 years 6 years 6 years
Disbursements – unclaimed, returned	3 years
Equipment depreciation records	Life of equipment plus 6 years
Income – daily summary	6 years
Income tax returns	Permanent
Invoices • Fixed assets • Accounts receivable/payable	Life of equipment plus 6 years 6 years
Journals – general	6 years
Ledgers – general	6 years
Medicare cost reports: • Billing material referring to specific claims • Cost report material including all data necessary to	

support accuracy of entries on cost report • Medical record material including utilization review committee reports, physicians' certification reports, and other records relating to health insurance claims	6 years
Patient accounts	6 years
Patient cash and valuables receipts	2 years
Payroll records	2 years
Social security reports	4 years after taxes are paid
Unemployment tax records	4 years
Vouchers Capital expenditures Cash Other checks	 Life of item plus 6 years 6 years 7 years
Welfare agency records	7 years
Withholding tax exemption certificates (w-4 forms)	4 years after taxes are paid
Workers' compensation records, ~~self insured~~self-insured claims files and claims logs	Claim files must be kept 5 years from date of injury or date on which last compensation benefit paid. Must keep indefinitely if open future medical benefits due (may be microfilmed after 2 years)

CONCERN: EMPLOYEE ASSISTANCE PROGRAM / CAMINO COUNSELING SERVICES	
Records	**Retention Period**
Psychotherapy notes	Adults 7 years, Minors until age 19 or 7 years, whichever is greater
Member records including (but not limited to): Consent forms Consultation reports Intake assessment summaries and mental status reports Member histories Member identification information Psychological testing reports Summary at case closing and final diagnosis Treatment request and authorization forms	Adults 7 years, Minors until age 19 or 7 years, whichever is greater

DIETARY DEPARTMENT RECORDS	
Records	**Retention Period**
Bacteriological testing of ice	2 years
Dietetic service personnel, number of	2 years
Food costs	3 years
Food purchased	3 years
In-service training records	6 years
Meal counts	2 years
Menus	3 months

ENGINEERING RECORDS	
Records	**Retention Period**
Air filter maintenance records	Life of air filter plus 6 years
Blueprints of buildings	Permanent
Calibration records	6 years
Emergency generator records, inspection, performance, exercising period and repairs	Life of generator plus 6 years
Equipment operating instructions	Life of equipment plus 6 years
Equipment records on inspection and maintenance	6 years
Inspection reports of grounds and buildings	1 year
Maintenance logs (heating, air conditioning, ventilation)	3 years
Purchase orders	6 years
Thermometer charts and monthly bacteriological tests for autoclaves and sterilizers	3 years
Watchman clock dials	2 years
Work orders	2 years

HOUSEKEEPING RECORDS	
Records	**Retention Period**
Checkout, transfer, isolation records	2 years
Cleaning records, policies and procedures	2 years
Contract files	Life of contract plus 6 years

Exterminator records	6 years

HUMAN RESOURCES RECORDS	
Records	**Retention Period**
Applications – employees, permanent and temporary, and non-employees	2 years after date of personnel action
Employee health records • Employees not subject to OSHA regulations • Employees subject to OSHA regulations	 • 6 years • Duration of employment plus 30 years
Employee personnel records, including acknowledgement of child abuse and neglect reporting requirement, and elder and dependent adult abuse reporting requirement	6 years after termination of employment
Equal Pay Act records	2 years
Exposure records – OSHA	Duration of employment plus 30 years (with limited exceptions)
Garnishment records	7 years
Hazardous waste training records	6 years after termination of employment
Job classifications	6 years
Labor / management reporting records	5 years after filing report
Labor / management collective bargaining agreements, including: • Certificates • Notices • Memoranda • Related written agreements • Other related documents	5 years from last effective date
OSHA logs, summaries and reports; OSHA form 300 Log/301 Incident Reports	6 years
Overtime reports	5 years
Payroll records, including: • Hours worked • Leaves of absence • Overtime, vacation, sick leave entries • Time cards • Wage rates and wages paid • Wage statements, itemized	Permanent
Pension records	Permanent
Personnel records for employees and applicants required by Title VII of the Civil Rights Act, the Americans with Disabilities Act and the Age Discrimination in Employment Act.	2 years after date of employment action
Pesticide training program records	2 years

Volunteer personnel records	6 years after termination of volunteer status
W-2, W-4 forms	4 years
Worker's compensation documents	6 years

INDIVIDUAL DEPARTMENT RECORDS	
Record	**Retention Period**
Budget and budget data	2 years
Correspondence, general	2 years
Incident and accident reports	Discretionary
Memoranda received	Discretionary
Memoranda sent	2 years
Minutes of departmental meetings	2 years
Personnel records	2 years
Policy and procedure manuals • Departmental • Other departments	 6 years Discretionary
Requisitions	Discretionary
Statistics and reports	6 years

LABORATORY, PATHOLOGY AND IMAGING RECORDS	
It is the policy of the Laboratory and Pathology Departments to adhere to the specific department policies on record and specimen retention in compliance with accrediting agencies. Refer to both Laboratory and Pathology policies. Below are general guidelines:	
Record	**Retention Period**
Blood and blood product testing records	Adults 10 years, Minors until age 25 Records must be kept at least 5 years after processing or 6 months after the latest expiration date for the individual product, whichever is later.
Blood donor histories and pertinent records	Adults 10 years, Minors until age 25 Records must be kept at least 5 years after processing or 6 months after the latest expiration date for the individual product, whichever is later.
Blood transfusion records	Adults 10 years, Minors until age 25 Records must be kept at least 5 years.
Cytology reports	Records must be kept at least 10 years.

Electrocardiograms Electroencephalograms Electromyograms	Adults 10 years, Minors until age 25 Retain only those portions that are specifically selected by the physician to accompany the report in the patient's medical record.
Equipment inspection, validation, calibration, repair and replacement records	6 years. Must be kept at least 3 years.
LABORATORY, PATHOLOGY AND IMAGING RECORDS (cont'd)	
Errors in test results	3 years. Retain original report and corrected report.
Fetal heart monitor strips	25 years. Retain only those portions that are specifically selected by the physician to accompany the report in the patient's medical records.
Histopathology	10 years. Stained slides must be kept at least 10 years; specimen blocks must be kept at least 2 years from date of examination.
Immunohematology records and reports	2 years. ~~must~~Must be kept at least 5 years.
Mammography films and reports	Adults 10 years, Minors until age 25 Must be kept in a permanent medical record of the patient for not less than 5 years, or not less than 10 years if no additional mammograms are performed at the facility, or longer as required by state law, unless the original mammogram is transferred to a health care provided of the patient or to the patient directly.
Mammography personnel records	6 years after termination of employment. Documentation of qualifications of interpreting physicians, radiologic technologists and medical physicist must be kept during the term of employment and, following employment, until the next annual inspection has been completed and the FDA has determined that the Mammography Quality Standards Act personnel requirements.
Mammography quality assurance records	6 years. Must be kept until the next annual inspection has been completed and the FDA

	has determined that the facility is in compliance with the quality assurance requirements, or until the test has been performed two additional times at the required frequency, whichever is longer.
Pathology: refer to Pathology policy regarding retention and destruction of documents, tissue blocks, slide and tissues. Reports	Adults 10 years; Minors until age 25 Retain unusual case reports permanently. Reports must be kept at least 10 years.
LABORATORY, PATHOLOGY AND IMAGING RECORDS (cont'd)	
Patient testing specimen records (including personnel performing the test and, if applicable, instrument printouts)	6 years. Must be kept at least 3 years.
Procedure manuals; method of validation	6 years. Must be kept at least 3 years.
Quality control reports	6 years. Must be kept at least 3 years. However, immunohematology quality control records must be kept at least 5 years. Quality control records for blood and blood products must be kept at least 5 years after processing or 6 months after expiration date, whichever is later. Records of histologic or clinical confirmation of cytologic findings on abnormal cases and false negative and false positive results for each category of specimens (which such results are made available) must be kept 10 years.
Radioisotopes – receipt, transfer, use, storage, delivery, disposal and reports of overexposure	Permanent
Registers of tests (chronological log books)	10 years
Requests for tests	3 years. Must be kept at least 3 years.
Research papers published	Permanent.
Specimen records	6 years. Must be kept at least 3 years.
Test reports not otherwise specifically mentioned, preliminary and final	10 years. Reports must be kept at least 3 years.
Video records of diagnostic tests (e.g. arthroscopies)	Adults 10 years, Minors until age 25 Retain only those portions that are specifically selected by the physician to accompany the report in the patient's medical record.

Radiology / X-ray films / images	Adults 10 years, Minors until age 25 X-ray films should be retained for time prescribed for retention of medical records.

MEDICAL RECORDS	
Record	**Retention Period**
Anatomical gift	Permanent
Birth room record	Permanent
Cancer registry files	Permanent
Index to patients' medical records	Permanent
Patient medical records including, but not limited to: • Admission records • Autopsy reports • Consent forms • Consultation reports • Emergency department records • Labor and delivery records • Laboratory and other test results • Nurses' notes and flow sheets • Pathologists' reports • Patient histories • Patient identification information • Physical examinations • Physical therapy notes • Physicians' orders • Radiological examinations and reports • Summary at discharge and final diagnoses • Surgical records including: anesthetic records findings operative procedures pre and ~~post operative~~post-operative diagnoses tissue diagnoses • Temperature charts • Transfer to or from the hospital • Vital sign records • Research records	Adults 10 years, Minors until age 25 or 10 years, whichever is greater
Psychotherapy notes (office notes not included in the medical record)	Adults 7 years, Minors until age 19 or 7 years, whichever is greater
Psychiatric reports to State Health Department	6 years
Social service confidential case histories	5 years
Transfer records related to patient transfers to or from the hospital not contained in the medical record	5 years

Surgery • Register of operations Operating room logs	10 years
Emergency department logs	10 years

MEDICAL STAFF RECORDS	
Record	**Retention Period**
Allied health professional files, non-employee	Permanent
Continuing education record	Permanent
Medical staff applications, rejected	Permanent
Medical staff committee records, including minutes, reports and other records	Permanent
Medical staff credentialing files	Permanent
On-call lists	5 years
Residents, interns and fellows records	Permanent

NUCLEAR MEDICINE RECORDS	
Records	**Retention Period**
Calibration records	3 years
Exposure records	Permanent
Film body records	6 years
Interpretations, consultations and procedures reports	6 years
Radiation dose records	Permanent
Receipt and disposition of radiopharmaceuticals	6 years
Reports of overexposure	Permanent
Utilization records	6 years

NURSING RECORDS	
Records	**Retention Period**
Minutes of meetings	6 years
Nursing education and training records	6 years
Policies and procedures	6 years after revision
Private duty name files	6 years after last use
Staffing patterns, including methodology used	6 years

PHARMACEUTICAL RECORDS	
Record	**Retention Period**
Controlled substances dispensed	3 years
Methadone dispensing – record of drug dispensed for each patient	3 years
Prescriptions	3 years

PUBLIC RELATIONS RECORDS	
Records	**Retention Period**
Clippings (historical)	Permanent
Contributor records	Permanent
Permission to release information / photographs	7 years
Photographs – institutional	Permanent
Press releases	2 years
Publications (~~inhouse~~in-house)	Permanent

PURCHASING AND RECEIVING RECORDS	
Records	**Retention Period**
Packing slips	3 months
Purchase orders	2 years
Purchase requisitions	2 years
Receiving reports	2 years
Returned goods credits	2 years

RESEARCH RECORDS	
Records	**Retention Period**
Human experimentation records (experimental drugs and devices)	30 years beyond experiment
Other research reports	6 years

B. Retention Procedure:

1. Business records

a. On-site storage

All records that are able to be stored within the physical confines of a hospital department, or on the premises of the hospital, should be so stored in accordance with the retention guidelines set forth above. Storage of confidential business records, such as personnel records, contracts, financial information or billing records containing protected patient health information, must be stored in a manner which will preserve the confidentiality of the information. This may be storage within a locked cabinet, or locked office or storage space.

b. Off-site storage

The Compliance Officer must approve off-site storage for all records requiring long term storage.

All records must be stored using approved storage boxes or containers, and must be clearly marked with a brief description of the contents, date ranges of contents, the responsible department, and the intended destruction date. Containers not meeting these requirements may not be sent to off-site storage.

2. Patient medical records and psychotherapy notes

a. Active medical records and psychotherapy notes

All medical records of patients under active treatment must be stored in a manner that preserves the confidentiality of the information while still providing appropriate accessibility that facilitates excellent quality of care. This means that medical records must not be visible to the public in patient rooms, nurses stations, treatment areas, offices, or while transporting the patients or records.

b. Inactive medical records and psychotherapy notes

All medical records and psychotherapy notes of patients not under active treatment that are able to be stored within the physical confines of a hospital department, or on the physical premises of the hospital, should be so stored in accordance with the retention guidelines set forth above. Records must be stored in a manner that will preserve the confidentiality of the information, such as a locked cabinet, or locked office or storage space. Medical records must be logged or indexed in a manner that will facilitate retrieval within a reasonable period of time for continuing patient care.

The Director of Health Information Management must approve off-site storage for medical records requiring long term storage.

Medical records must be stored using approved storage boxes or containers, and must be clearly marked with a brief description of the contents, date ranges of contents, the responsible department, and the intended destruction date. Containers not meeting these requirements may not be sent to off-site storage.

F. Destruction Policy:

It is the policy of El Camino Hospital to isolate paper records designated for destruction in a manner that maintains the confidential nature of the information. Containers for material to be destroyed must be located in non-public areas and must remain in a locked room when ~~staff are~~staff is not in attendance. Paper records designated for destruction will be shredded prior to disposal in order to render the information unidentifiable. Microfilm, x-ray film, tracings, etc. will also be disposed of in a manner that renders the information unidentifiable. Electronic media will be erased or otherwise disposed of in a manner that will render the information permanently unreadable, and unable to be reproduced or retrieved.

G. Destruction Procedure

Records will be destroyed at least annually. The Compliance Officer or Director of Health Information Management will be notified in writing by the department who owns the records prior to destruction. The Compliance Officer or Director of Health Information Management will maintain a permanent destruction log listing records and dates of destruction.

1. Confidential paper records

All types of paper records containing confidential business records, such as personnel records, contracts, financial information or billing records containing protected patient health information, or patient medical records, including psychotherapy notes, must be shredded or disposed of in designated containers for shredding.
Shredding containers will be emptied into designated bins which are to remain locked at all times. Contents of bins will be shredded by a contracted service that will maintain protection of confidentiality until all records are shredded.

2. Confidential films, tracings, etc.

   Confidential films, tracings, strips, etc. will also be shredded or otherwise disposed of in a manner that will render the information unidentifiable. Confidentiality of these records will also be strictly maintained until destruction is complete.

3. Electronic media

   All electronic media will be securely destroyed via contract with data storage contractor.

POLICY/PROCEDURE TITLE:HIMS-Retention and Destruction of Records

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee:	9/2016
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: 4/03, 03/05, 11/06, 07/08, 06/09, 10/10, 06/13 (by him)

REFERENCES: (*as applicable*)

"Records Retention Guide," California Healthcare Association, September 2002.

"The California Patient Privacy Manual," California Healthcare Association, October 2002, Second Edition.

Title 45, Code of Federal Regulations, Parts 160 and 1

Att. 06e HIMS - Patient Access to Protected Health Information

POLICY/PROCEDURE TITLE:HIMS -Patient Access to Protected Health Information

CATEGORY: Patient Care Services
LAST APPROVAL DATE: 10/2012

SUB-CATEGORY: Patient Care Services
ORIGINAL DATE: 4/03

COVERAGE:

All El Camino Hospital staff

PURPOSE:

Individuals who wish to access their own protected health information may do so only in accordance with applicable state and federal laws. Requests for access and copying must be in writing and signed by the patient or legal representative unless during a period of active care. This policy and procedure establishes the process for handling patient requests, circumstances where the hospital may deny access, the patient's right to appeal a denial, the time frame within which requests will be processed, and fees for making requested copies available.

STATEMENT:

- *It is the policy of El Camino Hospital to comply with all mandatory reporting requirements for health insurance portability and accountability act (HIPPA)*
- *It is the procedure of El Camino Hospital regarding health insurance portability and accountability act (HIPPA) to ensure patient safety*

DEFINITIONS *(as applicable)*:

Note: The definitions below are in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1. *Protected Health Information*: Individually identifiable health information that is transmitted or maintained by electronic or any other medium.

2. *Designated Record Set:* Medical records, behavioral health records (including psychiatric, alcohol and drug treatment records), and billing records about an individual patient maintained by the hospital and used to make decisions in the process of healthcare delivery. Medical records created by another provider filed with records of El Camino Hospital are included.

3. *Psychotherapy Notes:* Notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session which are separated from the rest of the individual's medical record. Medication prescription and monitoring, counseling start and stop times, modalities and frequencies of treatment, and a summary of diagnosis, functional status, treatment plan, symptoms, prognosis or progress are not considered to be psychotherapy notes and are, therefore, open to patient access.

PROCEDURE:

A. Policy for patient access to protected health information during period of care:

Pertinent information may be provided to patients and their personal representatives to share with other providers for treatment purposes. Patients may review their medical records (without addition or correction) during the period of active care. Corrections or additions must be handled in accordance with the administrative policy "Patient Request for Amendment of Protected Health Information." The patient's attending physician should be notified if the patient has questions about the documentation or feels that information may be in error. These disclosures do not require authorization or written request. (Access to Behavioral Health records should be handled in accordance with California State law.)

B. Policy for patient access to protected health information after patient has left the hospital:

1. Information available to the patient:

Upon appropriate written request, access will be permitted to the individual patient's protected health information, including medical records and billing records unless the information falls into one of the categories which may be denied as discussed below. Peer review, quality assurance, and information created and maintained for business purposes of the hospital not used to make

decisions about an individual patient in the process of healthcare delivery are *not* considered part of the designated record set and are not subject to review or copying by the patient or legal representative.

In addition, patients do *not* have the right to access and obtain copies of:

- Psychotherapy notes;
- Information compiled for use in civil, criminal, or administrative actions;
- Information subject to prohibition by the Clinical Laboratory Improvements Act (CLIA); or
- Information that is not part of the designated record set.

2. Request must be in writing:

Individual patients or legal representative must request access to their own protected health information in writing. The request must be signed and dated by the patient or legal representative.

3. Time frame for response to patient request:

Access to inspect medical and billing records will be provided within five (5) working days of receipt of the written request. Copies will be provided within fifteen (15) working days of receipt of the written request.

4. Manner of access:

El Camino Hospital will arrange with the individual a convenient time and location in the hospital to inspect or obtain copies of the protected health information. Individuals reviewing records must provide identification upon request.

Inspection will be attended by a hospital staff member. The patient or legal representative will be referred to the patient's physician for discussion of clinical questions. Copies of the records may be mailed in lieu of inspection at the hospital upon patient request.

5. Fees:

No fee will be charged for retrieving a patient's records and allowing the patient or his legal representative to review them.

Reasonable cost-based fees will be charged by the hospital for providing copies of protected health information, other than those forms signed by the patient or legal representative with a copy designated for the patient (e.g., Conditions of Admission, consent forms, etc.).

- The fees will include the costs of copying (including supplies and labor) and postage (if the individual has requested that the records be mailed). A current fee schedule will be provided upon request.

- A reasonable deposit fee may be charged for original x-ray films in order to assure return.

- Copies will be provided at no charge when records are needed to prove eligibility for a public benefit program (e.g., Medi-Cal, Social Security disability insurance benefits, and Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled [SSI/SSP] benefits).

6. Denial of patient access:

A request for access or copies may be denied in the following situations:

- The request is for records that are not available for inspection (see Subsection E of this policy, "Information Available to the Patient");

- The hospital is acting under the direction of a correctional institution to deny access to an inmate;

- The protected health information has been created or obtained during an active research project and the patient agreed that access would not be permitted while the research project was active ;

- The protected health information contains information obtained from someone other than a healthcare provider under a promise of confidentiality and the requested access would reveal the source of the information;

- The requested information has been compiled in anticipation of a civil, criminal or administrative proceeding;

- The request is for behavioral health records, which may contain reference to another person, and the Medical Director for Behavioral Health Services has determined that the information may endanger the life or safety of the patient or the other person referenced; or

- The request is from the patient's legal representative for behavioral health records which makes reference to another person, and the Medical Director for Behavioral Health Services has determined that access to the information is likely to endanger the life or safety of such other person.

If access or copies are denied, a written explanation of the basis for denial will be provided to the patient or legal representative within five (5) working days of receipt of the request. This explanation will include information regarding whether or not an appeal to the hospital may be made, the process for placing and handling such an appeal, and how to register a complaint with the Secretary of the Department of Health and Human Services.

7. Appeal of denial:

If access is denied, it must first be determined whether the denial may be appealed.

a. Unreviewable grounds for denial –

No appeal process exists under state or federal law in the following circumstances:

- the protected health information is exempted from the right of access;

- the hospital is acting under the direction of a correctional institution to deny access to an inmate, and the information could jeopardize the health, safety, security, custody, or rehabilitation of the inmate, any officer, employee, or other inmates;

- a patient's right to protected health information created or obtained in the course of research may be temporarily suspended while the research is in progress, provided the

patient has agreed to the denial of access when agreeing to participate. The right of access will be reinstated upon completion of the research; or

- the protected health information contains information obtained from someone other than a healthcare provider under a promise of confidentiality and the requested access would reveal the source of the information.

b. Reviewable grounds for denial –

The individual may appeal a denial under the following circumstances:

- The Medical Director of Behavioral Health Services has determined that the access is likely to endanger the life or safety of the individual;

- The records contain reference to anther individual and the Medical Director of Behavioral Health Services has determined that the access is likely to endanger the life or safety of such other person; or

- The request is made by the individual's legal representative and the Medical Director of Behavioral Health Services has determined that the access is likely to endanger the life or safety of the individual or another person.

8. Appeal for review of a denial of access:

If access is denied based on reviewable grounds, an appeal must be made in writing and signed and dated by the patient or legal representative who made the original request.

If an appeal is made, the review must be performed within a reasonable period of time by a licensed healthcare professional designated by the hospital who did not participate in the original decision to deny access.

The reviewer will determine whether or not to deny access based on the items listed above under "Reviewable grounds for denial." The reviewer will promptly report his decision to the Director of Health Information

Management Services, who will provide written notice to the individual of the determination and initiate any appropriate action.

9. Retention of documentation:

All documentation related to an individual's, or legal representative's, request for access, and any documentation related to a denial process, will be filed with the medical record and retained in accordance with the policy for retention of medical records.

C. Procedure for patient access to protected health information:

All requests for access to protected health information by an individual patient or legal representative will be assessed in accordance with this policy. Appropriate response will follow promptly.

1. Written request:

All requests for access of copies of protected health information must be in writing and must be signed and dated by the individual patient or legal representative. Incomplete requests will be considered invalid and will be returned to the requestor immediately.

2. Reply to request:

Unless denied, access to inspect medical, behavioral health, and billing records will be permitted within five (5) working days of receipt of the written request. Copies will be provided within fifteen (15) working days of receipt of the written request.

Patient requests for access to behavioral health information will be referred to the Medical Director of Behavioral Health Services and the requestor will be so notified immediately upon receipt of the request.

If access or copies are denied under conditions listed above in this policy, the Director of Health Information Management Services, Risk Manager, or designee, will be so notified. A written explanation of the basis for denial will be provided to the patient or legal representative within five (5) working days of receipt of the request.

3. The process for appeal:

   Upon receipt of a written appeal for review of the denial, the Director of Health Information Management Services, Risk Manager, or designee, will be notified.

   Administrative arrangements will be made promptly to secure the services of a licensed healthcare professional not previously involved in the denial process.

   The requestor will be notified promptly of the determination of the reviewer. If access is to be permitted, arrangements will be made to permit inspection within five (5) days of the determination. If copies are to be provided, the copies will be provided within fifteen (15) days of the determination.

4. Retention of documentation:

   All documentation relating to the request, or any denial or appeal will be filed with the medical record and retained in accordance with the policy on retention of medical records.

POLICY/PROCEDURE TITLE:HIMS -Patient Access to Protected Health Information

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee:	9/2016
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: 4/03, 03/05, 11/06, 06/09, 10/12

REFERENCES: (*as applicable*)

"The California Patient Privacy Manual," California Healthcare Association, October 2002, Second Edition.

Title 45, Code of Federal Regulations, Parts 160 and 164, August 14, 2002.

ATTACHMENT 7

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Key Performance Indicators
	Responsibility party:	Diane Wigglesworth, Sr. Director Corporate Compliance Compliance Committee October 5, 2016
	Action requested:	Information Only
	Background: 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 : Objective is to review the trending of key indicators. Compliance was notified of two IT Security issues that required immediate response and are continuing to be investigated. Also received a report of some pharmacy charges that had incorrectly been charged and Compliance validated that corrective actions were taken and rebilling occurred. Compliance received some hotline calls from patients that were investigated and ultimately resolved. There were no reportable privacy violations to CDPH in the last two months.	
	Suggested discussion questions: 1. Are there any trends of concern?	
	Proposed board motion, if any: None, this is an informational item.	
	LIST OF ATTACHMENTS: 1. Corporate Compliance Scorecard 2. KPI 2 year Trend Graph	

Att. 07b Corporate Compliance Scorecard FY17 (Totals as of Aug. 2016)

Corporate Compliance Scorecard FY15

El Camino Hospital

Key Performance Indicator	FY17 Current Month	Current YTD Actual	Prior YTD Actual
Total Number of Hospital Discharges (excluding normal newborn)	***1,592***	***3,116***	***3,095***
Core Elements			
Policies and Procedures	**Aug. 2017**	***Jul - Aug FY2017***	***Jul - Aug FY2016***
Number of reported instance when policies not followed	4	8	4
Number of disciplinary actions due to Investigations	2	4	2
Education and Training	**Aug. 2017**	***Jul - Aug FY2017***	***Jul - Aug FY2016***
Percentage of new employees trained within 30 days of start date	100%	100%	100%
Investigations	**Aug. 2017**	***Jul - Aug FY2017***	***Jul - Aug FY2016***
Total number of investigations	21	44	28
Investigations open	0	0	0
Investigations closed	21	44	28
Hotline concerns substantiated	2	5	4
Hotline concerns not substantiated	3	4	3
Average number of days to investigate concerns	7	7	5
Reporting Trends	**Aug. 2017**	***Jul - Aug FY2017***	***Jul - Aug FY2016***
Anti-Kickback/Stark	7	12	8
EMTALA	0	0	2
HIPAA Reports	13	22	30
HIPAA Security Breaches	1	2	0
Billing or Claims	9	20	13
Conflict of Interest	0	0	1
Reported Events to CMS	**Aug. 2017**	***Jul - Aug FY2017***	***FY2016 Actual***
Number of total events self reported by ECH	0	0	0
Number of self reported events followed up by CMS	0	0	0
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	**Aug. 2017**	***Jul - Aug FY2017***	***FY2016 Actual***
Number of total regulator events self reported by ECH	3	3	11
Number of self reported events followed up by CDPH	3	3	5
Number of total privacy breaches self reported by ECH	0	0	18
CDPH initiated visits (separate from ECH self reported events)	0	7	7
Number of statement of deficiencies issued to ECH	0	0	3
Number of Actual/Realized Sanctions, fines or penalties	0	0	0
Monitoring and Audit Findings	**Aug. 2017**	***Jul - Aug FY2017***	***FY2016 Actual***
Total number of Audit Findings	11	11	47
Number of findings identified has high severity	1	1	6
Monitoring and Audit Findings	**Aug. 2017**	***Jul - Aug FY2017***	***FY2016 Actual***
Number of Open Liability Claims	11	*10*	*10*
Number of Open Liability Lawsuits	5	*6*	*7*

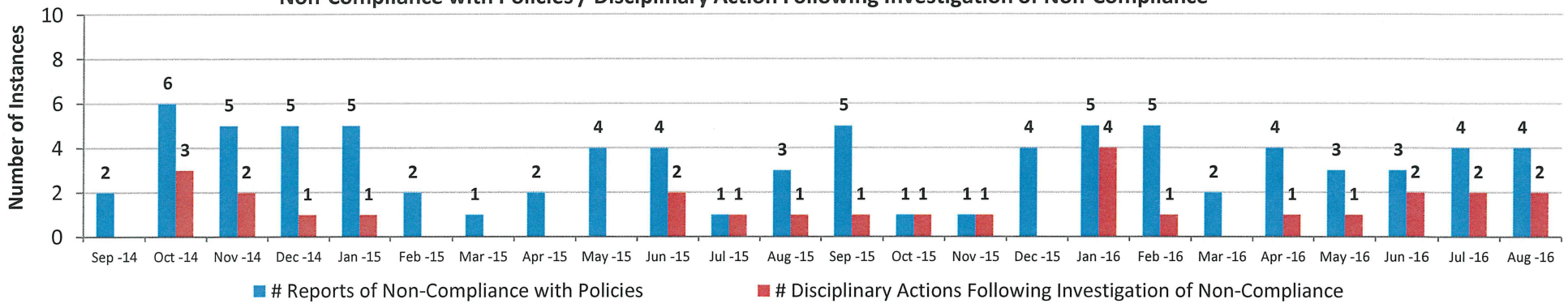
Att. 07c KPI Trend Graph

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

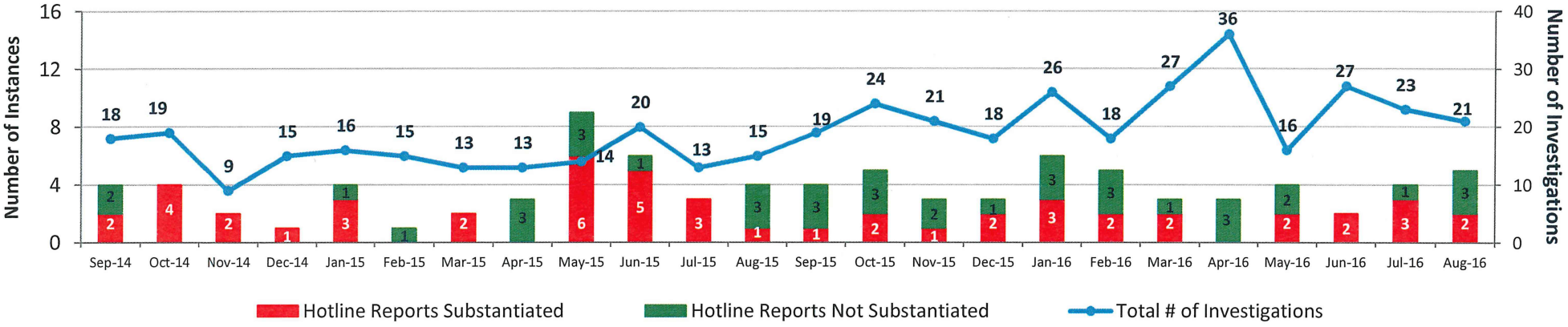
Corporate Compliance

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