El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Thursday, January 19, 2017 – 5:00 pm

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

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER / ROLL CALL**	John Zoglin, Chair		**5:00 – 5:01 pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	John Zoglin, Chair		**5:01 – 5:02**
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** **5:02 – 5:05**
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 (11/9/16) b. Meeting Minutes of the Joint Open Session of the Hospital Board of Directors and the Corporate Compliance/Privacy and Internal Audit Committee (11/9/16) ***Information*** c. Status of FY17 Committee Goals	John Zoglin, Chair	*public comment*	**motion required** **5:05 – 5:10**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	John Zoglin, Chair		**information** **5:10 – 5:15**
6.	**POLICIES FOR APPROVAL AND BOARD POLICY OVERSIGHT** i. Cover Sheet – Approval of Policies *Policies with Major Revisions* a. Board of Directors Approval of Hospital Policies	Diane Wigglesworth, Compliance/ Privacy Officer	*public comment*	**motion for recommendation required** **5:15 – 5:25**

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
	Policies with Minor Revisions b. Administrative – Policy on Policies			
7.	**KEY PERFORMANCE INDICATORS, SCORECARD AND TRENDS** Memo, Scorecard, and Trend Graphs **ATTACHMENT 7**	Diane Wigglesworth, Compliance/Privacy Officer		**information** **5:25 – 5:30**
8.	**ADJOURN TO CLOSED SESSION**	John Zoglin, Chair		**motion required** **5:30 – 5:31**
9.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	John Zoglin, Chair		**5:31 – 5:32**
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 (11/9/16) b. Meeting Minutes of the Closed Session of the Hospital Board of Directors and the Corporate Compliance/Privacy and Internal Audit Committee (11/9/16) ***Information*** *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation. c. Compliance Activity Log d. Privacy Activity Log e. Internal Audit Follow Up f. Internal Audit Work Plan g. Pacing Plan	John Zoglin, Chair		**motion required** **5:32 – 5:45**
11.	Report involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation: - Report on Internal Audit Activity	Diane Wigglesworth, Compliance/Privacy Officer		**information** **5:45 – 6:10**
12.	Discussion involving *Gov't Code Section 54956(d)(2)* – Conference with legal counsel – pending or threatened litigation: - Discussion on IT Security Plan	Deb Muro, Interim CIO		**motion for recommendation required** **6:10 – 6:45**
13.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters: - Executive Session	John Zoglin, Chair		**discussion** **6:45 – 6:50**
14.	**ADJOURN TO OPEN SESSION**	John Zoglin, Chair		**motion required**

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
			6:50 – 6:51
15. RECONVENE OPEN SESSION / REPORT OUT	John Zoglin, Chair		**6:51 – 6:55**
To report any required disclosures regarding permissible actions taken during Closed Session.			
16. ADJOURNMENT	John Zoglin, Chair		**motion required 6:55 – 7:00 pm**

Upcoming Corporate Compliance Committee Meetings:

- 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 (11/9/16)

Minutes of the Open Session of the
Corporate Compliance/Privacy and Internal Audit Committee
Wednesday, November 9, 2016
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040
Conference Rooms A&B (ground floor)

Members Present
John Zoglin, Chair
Sharon Anolik Shakked, Vice Chair
Christine Sublett

Members Absent
Dennis Chiu

A quorum was present at the El Camino Hospital Corporate Compliance/ Privacy and Internal Audit Committee on the 9th day of November, 2016 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Corporate Compliance/ Privacy and Internal Audit Committee of El Camino Hospital (the "Committee") was called to order at 3:30 pm by Chair Zoglin. All Committee members were present.	***None***
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Zoglin asked if any Committee member believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.	***None***
3. PUBLIC COMMUNICATION	None.	***None***
4. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 3:45pm. **Movant:** Anolik Shakked **Second:** Sublett **Ayes:** Anolik Shakked, Sublett, and Zoglin. **Noes:** None **Abstentions:** None **Absent:** Chiu **Recused:** None	***A motion to adjourn to closed session at 3:45p.m. was approved.***
5. AGENDA ITEM 10: RECONVENE TO OPEN SESSION/ REPORT OUT	*Agenda Items 5 – 9 were reported in closed session.* Chair Zoglin reported that Closed minutes of the October 5, 2016 Corporate Compliance Committee Meeting were approved.	***None***
6. AGENDA ITEM 11: CONSENT CALENDAR	**Motion:** To approve closed consent calendar of the November 9, 2016 meeting of the Corporate Compliance Committee. **Movant**: Zoglin **Second:** Anolik Shakked **Ayes:** Anolik Shakked, Sublett, and Zoglin. **Noes:** None **Abstentions:** None **Absent:** Chiu **Recused:** None	***The Open Consent Calendar of the November 9, 2016 Corporate Committee meeting was approved.***
7. AGENDA ITEM 12: REPORT ON BOARD ACTIONS	Chair Zoglin briefly reviewed the Board Report as further detailed in the packet and asked the Committee if there were any questions or concerns and discussion ensued.	***None***

8. AGENDA ITEM 13: KEY PERFORMANCE INIDCATORS, SCORE CARD AND TRENDS	Ms. Wigglesworth reported that there were no increased risks or patterns on the KPI's. She further noted EPIC billing issues that were addressed. She explained that root causes were identified and additional training was provided.	***None***
9. AGENDA ITEM 14: COMMITTEE RECRUITMENT	**Motion:** For recommendation to the Board that Lica Hartman be appointed as a Corporate Compliance Committee Member. **Movant:** Zoglin **Second:** Shakked **Ayes:** Sublett, Anolik Shakked, Zoglin **Noes:** None **Abstentions:** None **Absent:** Chiu **Recused:** None	***A Motion for Recommendation to the Board that Ms. Hartman be appointed as a Corporate Compliance Committee Member was approved.***
10. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn the Corporate Compliance Committee Meeting at 5:28pm. **Movant:** Anolik Shakked **Second:** Sublett **Ayes:** Sublett, Anolik Shakked, Zoglin **Noes:** None **Abstentions:** None **Absent:** Chiu **Recused:** None	***Meeting adjourned at 5:28 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, Compliance Committee

b. Meeting Minutes of the Joint Open Session of the Hospital Board of Directors and the Corporate Compliance/Privacy and Internal Audit Committee (11/9/16)

Minutes of the Joint Open Session of the El Camino Hospital Board of Directors and the Corporate Compliance/Privacy and Internal Audit Committee

Wednesday, November 9, 2016
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040
Conference Rooms E, F & G (ground floor)

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen	**Jeffrey Davis, MD**	None
Dennis Chiu, Vice Chair		
Neal Cohen, MD, Chair	**Committee Members Present**	**Committee Members Absent**
Peter Fung, MD	**Sharon Anolik Shakked**	None
Julia Miller	**Christine Sublett**	
David Reeder		
John Zoglin		

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The joint open session meeting of the Board of Directors of El Camino Hospital (the "Board") and the Corporate Compliance/Privacy and Internal Audit Committee (the "Committee") was called to order at 5:33pm by Chair Cohen. A silent roll call was taken. Director Chen joined the meeting during Agenda Item 4: Office of Inspector General Work Plan. Director Davis was absent. All other Board and Committee members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Director Cohen asked if any Board or Committee members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. PUBLIC COMMUNICATION	There were no comments from the public.	
4. OFFICE OF INSPECTOR GENERAL WORK PLAN	Director Chen joined the meeting at 5:34pm. Diane Wigglesworth, Sr. Director, Corporate Compliance, presented a summary of the OIG Audit Work Plan and how it informs ECH's internal audit work plan. She noted that the purpose of the OIG is to protect the integrity of Health and Human Services programs. The Audit Work Plan summarizes new and ongoing OIG reviews as well as areas of focused attention for the coming year; these plans are dynamic and are updated every year based on OIG audit findings. Ms. Wigglesworth reported that in 2016, the OIG expects to recover of $3 billion in audit and investigative receivables. Ms. Wigglesworth explained that part of the Corporate Compliance Committee's responsibility is to review management's responses to the OIG work plan and assure internal audits incorporate OIG recommendations. She also described the OIG's enforcement tools (False Claims Act, Anti-Kickback Statutes, etc.) and the 2016 OIG Work Plan focus areas, including hospitals, amublatory surgical centers, prescription drug programs, and encounter data: CMS oversight of data integrity. Ms. Wigglesworth highlighted the hospital-related focus areas from the OIG Work Plan that she has prioritized on ECH's internal audit work	

	plan. She reported that she focuses on areas with significant financial impact and risk areas for non-compliance with regulations. Director Cohen commented that areas identified by the OIG are not necessarily areas of high risk or concern, but instead highlight significant changes in CMS payments for services; he noted the audits are conducted to ensure that care is appropriate and consistent with patient needs. In response to Director Reeder's question, Ms. Wigglesworth clarified that ECH has hospital-based clinics, but currently does not have free-standing clinics. She noted that if the organization acquires any free-standing clinics, there are different billing regulations and standards to be met. The Committee members had no additional comments.	
5. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:44 pm pursuant to *Gov't Code Section 54956.9(d)(2)* for conference with legal counsel – pending or threatened litigation: IT Security Update. **Movant:** Chen **Second:** Chiu **Ayes:** Anolik Shakked, Chen, Chiu, Cohen, Fung, Miller, Reeder, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	***Adjourned to closed session at 6:44 pm.***
6. AGENDA ITEM 9: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 6:26pm. There were no actions taken during the closed session.	
7. AGENDA ITEM 10: ADJOURNMENT	**Motion**: To adjourn at 6:26 pm. **Movant:** Chen **Second:** Miller **Ayes:** Anolik Shakked, Chen, Chiu, Cohen, Fung, Miller, Reeder, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	***Meeting adjourned at 6:26 pm.***

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

_____
Neal Cohen, MD
Chair, ECH Board

_____
Peter C. Fung, MD
ECH Board Secretary

_____
John Zoglin
Chair, Corporate Compliance/Privacy and Internal Audit Committee

Prepared by: Cindy Murphy, Board Liaison
Sarah Rosenberg, Board Services Coordinator

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.- Final plan presented at 1/19/17 meeting.
▪ 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. – Results of assessment and corrective actions presented at 1/19/17 meeting.
▪ 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 Corporate Compliance, Privacy and Internal Audit Committee Meeting Date: January 19, 2017
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	For Information
	Background: IN FY16 we added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. This written report is intended to supplement the Chair's verbal 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 November 2016 and January 2017 Board Actions	

November 2016 – January 2017 Board Actions*

1. November 9, 2016 – Hospital Board
    a. Approved Collective Bargaining Agreements with PRN and Local 39
    b. Approved FY17 Executive Salary Ranges and Base Salaries
    c. Approved FY16 Executive Incentive Goal Scores and Incentive Payments
    d. Approved Appointment of Lanhee Chen, Dave Reeder, john Zoglin, Lane Melchor, Ramtin Agah, MD; Karen Pike, MD; Teri Eyre and Gary Kalbach to the CEO Search Committee
2. December 6, 2016 – District Board
    a. Elected Dennis Chiu, Julia Miller and John Zoglin to new terms on the Hospital Board
    b. Directed an Ad Hoc Committee of the District Board to begin work on recruitment of a Hospital Board member to replace Dr. Neal Cohen who is not seeking reappointment when his current term ends on June 30, 2017.
3. January 4, 2017 – Hospital Board
    a. Held a closed session study session on strategic priorities
4. January 11, 2017 – Hospital Board
    a. Approved FY17 Period 3 and 4 Financials
    b. Reviewed and discussed CEO Position Specification
    c. Approved Annual Board Self-Assessment SurveyTool
    d. Appointed Nahid Aliniazee to the El Camino Hospital Foundation Board of Directors
    e. Appointed Lica Hartman to the Corporate Compliance, Privacy and Internal Audit Committee
    f. Approved Funding for MV Lab Upgrades, LG Medical Office Building Upgrades and an updated Stryker Laparascopic Platform

*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.

Cover Sheet – Approval of Policies

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES				
Policy Number	**Policy Name**	**Department**	**Revised Date**	**Summary of Policy Changes**
	Board of Director Approval of Hospital Policies	Administrative	NEW	New policy to document when a policy requires Board approval.
POLICIES WITH MAJOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Administrative: Policy & Procedure Formulation, Approval & Distribution (Policy on Policies)	Administrative	12/16	Added content to explain process for review and clarified which committees must review which document
POLICIES WITH MINOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	

POLICIES TO ARCHIVE				
Policy Number	**Policy Name**	**Department**	**DATE ARCHIVE**	

a. Board of Directors Approval of Hospital Policies

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Board of Director Approval of Hospital Policies
CATEGORY:	Administrative
LAST APPROVAL:	

TYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Board***
OFFICE OF ORIGIN:	
ORIGINAL DATE:	

I. COVERAGE:

All El Camino Hospital Employees, Medical Staff and Volunteers

II. PURPOSE:

To define which hospital policies require approval by the Board of Directors of El Camino Hospital ("the Board").

III. POLICY STATEMENT:

This Board policy describes the criteria for determining when documents as defined below require approval by the Board, approval. All policies, plans and scopes of services of El Camino Hospital will be approved by the Board a minimum of every 3 years or as required by regulation.

IV. DEFINITIONS :

1. **Policy**: A policy is defined as a brief written statement of intent or principle that determines actions or decisions. Generally, a policy is based on law, regulations, accreditation standards, or leadership decisions.
2. **Plan:** A single document that provides detailed description of provision of particular program or scope of service, often required by regulation. Ex. Disaster Plan, Pandemic Plan, Plan for Provision of Care**.**
3. **Procedure**: A step-by-step written outline detailing how something is to be accomplished. Procedures answer the "what" and "How do I do it" questions. Ex: Chemotherapy, Administration of.
4. **Protocol***:* Defines care and management of a broad patient care issue. A prescriptive, detailed definition of what is to be implemented using precise, sequential steps, preferably evidenced based. Examples include Alcohol Withdrawal, Management of.

5. **Guideline**. Guidelines describe the recommended care approach for a given diagnosis or condition. Guidelines must be evidenced based and are often listed in evidence based data bases.
6. **Standardized Procedure**. The legal mechanism for nurses and nurse practitioners to perform specific functions which would otherwise be considered the practice of medicine. Physician Leadership at El Camino Hospital (ECH) has agreed to allow specific functions to be performed by specific nurses in specific circumstances
7. **Scope of Service**: A document that describes the provision of service of a particular program or department of the hospital.

V. PROCEDURE:

1. All policies, plans and scopes of services requiring Board approval will be reviewed and approved by the appropriate hospital committee prior to coming to the Board. Dates for hospital committee approvals shall be reflected in documents. For clinical policies/plans/scopes of service, the Medical Executive Committee and the E Policy Committee shall approve prior to Board approval. For non-clinical policies, the E Policy Committee shall approve policies prior to Board approval.

2. Policies/Plans/Scopes of Service shall be sent to the designated advisory committee of the Board (eg Quality/Finance/Compliance) for review and recommendation prior to final Hospital Board approval.

3. Procedures, protocols, standardized procedures and guidelines as defined above are reviewed by designated hospital committees identified in the Policy & Procedure Formulation, Approval and Distribution policy, and do not require Board approval.

APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	
Medical Committee (if applicable):	
ePolicy Committee:	12/2016
Medical Executive Committee:	
Board of Directors:	

Administrative – Policy on Policies

POLICY/PROCEDURE TITLE: Policy & Procedure Formulation, Approval & Distribution (Policy on Policies)

CATEGORY: Administration
LAST APPROVAL DATE: 10/2015

SUB-CATEGORY: Administration
ORIGINAL DATE: 06/98

I. COVERAGE:

All El Camino Hospital Employees, Medical Staff ~~, Volunteers~~

II. PURPOSE:

It is the policy of El Camino Hospital to monitor and control the development, review, revision, modification, approval, and distribution ~~of all~~of ~~-~~policies, ~~and~~ procedure, plans, protocols, and standardized procedures. ~~The policies and procedures will be reviewed and approved by the El Camino Hospital Board of Directors a minimum of every three years or as required by Title 22.~~

III. STATEMENT:

A. It is the policy of El Camino Hospital to provide a process for the development and implementation of policies and other related documents.

B. All policies and other documents as defined below must be developed with the review and input of all affected policy owners, approved by leadership of the organization and routinely reviewed. This review must be

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minimally every three years unless required more frequently as defined by Title 22 or other regulatory bodies, when there is accreditation or regulatory changes, or when operations or patient care practices changes.

C. The Board of Directors shall approve policies, plans and scopes of services as outlined in the Administrative policy-Board of Director Approval of Hospital Policies.

D. ECH reserves the right to change or eliminate policies and other documents as defined below as needed to comply with regulatory changes or changes in practice. ECH will be responsible for communicating any such actions to the policy owner.

~~It is the policy of El Camino Hospital to comply the requirements for the development, approval, and ongoing review of policies and procedures, protocols, and standardized procedures as outlined below.~~

IV. DEFINITIONS

1. **Policy**: A policy is defined as a brief written statement of intent or principle that determines actions or decisions. Generally, a policy is based on law, regulations, accreditation standards, or leadership decisions.
2. **Plan:** A single document that provides detailed description of provision of particular program or scope of service, often required by regulation. Ex. Disaster Plan, Pandemic Plan, Plan for Provision of Care Procedure.
3. **Procedure**: A step-by-step written outline detailing how something is to be accomplished. Procedures answer the "what" and "How do I do it" questions. Ex: Chemotherapy, Administration of.
4. **Protocol***:* Defines care and management of a broad patient care issue. A prescriptive, detailed definition of what is to be implemented using precise, sequential steps, preferably evidenced based. Examples include Alcohol Withdrawal, Management of.

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5. **Guideline**. Guidelines describe the recommended care approach for a given diagnosis or condition. Guidelines must be evidenced based and are often listed in evidence based data bases.
6. **Standardized Procedure**. The legal mechanism for nurses and nurse practitioners to perform specific functions which would otherwise be considered the practice of medicine. Physician Leadership at El Camino Hospital (ECH) has agreed to allow specific functions to be performed by specific nurses in specific circumstances.
7. **Scope of Service**: A document that describes the provision of service of a particular program or department of the hospital.

V. PROCEDURE:

A. Document Development and Format

1. Documents should be written by the individuals most closely related to the issues with input by persons who have special expertise on the subject matter.
2. Documents should reflect what is considered to be the professional standard of care and match practice. There must be a realistic expectation that compliance with the document can be met.
3. Documents as defined above should be concise, and words and phrases not universally understood should be defined.

~~a.~~4. All ~~policies, procedures, or protocols~~documents will be developed and revised in the template available on the toolbox ~~i~~on the Policy Tech site, and contain the following elements:.

~~b.~~ Purpose section: ~~n:~~

a. ~~A~~ a clear and concise purpose to educate readers on what the policy/procedure entails.
b. Statement section~~:~~
c. Definitions

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d. Procedure: This section contains a clear and concise step-by-step methodology to be followed for compliance with the purpose and statement.
e. Approval Box: The approvals section will list any committees that are required to approve the policy and the date(s) when they approved it. This section will also list the Board of Directors and the date when it approved the policy. The minutes of these various groups will reflect approval of the policy. Only the most recent date will be reflected in the box. The previous dates will be listed under Historical.

5. ECH nursing uses the reference tool Lippincott for standard nursing procedures and is updated periodically by Lippincott and is available on the Toolbox.

~~The 2 examples can be used to determine the statement. One statement example can be used, or both. One can also be created if the examples are not used.~~

~~**6. Procedure:**~~

~~This section contains a clear and concise step-by-step methodology to be followed for compliance with the policy purpose and statement.~~

~~**7. Approval Box:**~~

~~**The approvals section will list any committees that are required to approve the policy and the date(s) when they approved it. This section will also list the Board of Directors and the date when it approved the policy. The minutes of these various groups will reflect approval of the policy. Only the most recent date will be reflected in the box. The previous dates will be listed under Historical.**~~

B. Approval Matrix for ECH Manuals

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1. Documents which involve accreditation, state and federal statutory requirements shall be reviewed by Director of Accreditation and/or Risk Management.

~~1.~~2. Documents which involve compliance with HIPAA and privacy concerns shall consult with the Privacy Officer.

~~a.~~3. In addition to approval matrix below, nursing related documents require approval as follows:

a.. All applicable unit based practice councils and Patient Care Leadership committees
b. For broad based changes enterprise changes to nursing practice, Central Partnership Council approval is required.
c. For approval of standardized procedures, Interdisciplinary Practice Committee is required.

~~1.~~4. Medical Staff collaboration and approval through the appropriate medical staff committee is required when the content of the policies, procedures, or protocols involves care of the patient.

5. Any policies, procedures, or protocols that will apply to a Mountain View and Los Gatos location must have approval from department managers and medical staff committees from each campus before the policy is sent through the final approval processes.

6. Department documents shall be approved by the department manager or designee, and apply to only one department. Approval shall be by department leadership along with matrix below.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Policy & Procedure Formulation, Approval & Distribution (Policy on Policies)

CATEGORY: Administration
LAST APPROVAL DATE: 10/2015

	Administrative	Clinical/Patient Care Services	Emergency/Disaster Management	Human Resources	Infection Prevention	Support Services (Non Clinical Departments)	Safety/Environment of Care
Department/VP Approval	X	X	X	X	X	X	X
Central Safety Committee			X				X
Infection Control Committee ** Any document relating to cleaning, prevention of infection across the organization		** Any document relating to cleaning, prevention of infection across the organization			X	** Any document relating to cleaning, prevention of infection across the organization	
Pharmacy and Therapeutics ** Any document concerning administration of medication		** Any document concerning administration of medication			** Any document concerning administration of medication		
E Policy Committee	X	X	X	X	X	X	X

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POLICY/PROCEDURE TITLE: Policy & Procedure Formulation, Approval & Distribution (Policy on Policies)

CATEGORY: Administration
LAST APPROVAL DATE: 10/2015

Medical Executive Committee **Review required for any document relating to care of patient		X			X		
Board of Directors (only policies/scope of services/plans)							

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~~2. Administrative:~~

~~a. Administrative Policies and Procedures are developed by Administrative Staff in collaboration with Management and as appropriate the Medical Staff.~~

~~b. These type of policies and procedures are reviewed and approved by:~~

~~i. Executive Leadership~~

~~ii. E-policy committee~~

~~iii. El Camino Hospital Board of Directors~~

~~iv. This is completed at a minimum of every three years.~~

~~3. Human Resources:~~

~~a. Human Resources Policies and Procedures are developed by Human Resources in collaboration with Administrative Staff, and Management Staff;~~
~~a. These type of policies and procedures are reviewed and approved by:~~
~~i. Human Resources leadership~~
~~ii. E-policy committee~~
~~iii. El Camino Hospital Board of Directors~~
~~iv. This is completed at a minimum of every three years.~~

~~3. Environment of Care and Emergency Management:~~
~~a. Environment of Care Policies and Procedures are developed by Safety Committee Work Groups in collaboration with Safety Committee Work Group members, Management Staff, and Administrative Staff~~
~~b. These type of policies and procedures are reviewed and approved by:~~
~~i. Central Safety Committee~~
~~ii. E-policy committee~~
~~iii. El Camino Hospital Board of Directors~~
~~4. This is completed at a minimum of every three yearsInfection Control:~~
~~Infection Control Policies and Procedures are developed by the Epidemiology Manager in collaboration with Infection Control Committee, Safety Committee, and Administrative Staff;~~
~~These type of policies and procedures are reviewed and approved by:~~
~~Infection Control Committee~~
~~Pharmacy and Therapeutics (as applicable)~~
~~E-policy committee~~
~~Medical Executive Committee (MEC)~~
~~El Camino Hospital Board of Directors~~
~~This is completed at a minimum of every three years.~~

~~5. Patient Care Services:~~

~~a. Unit or department-specific Patient Care Policies and Procedures are developed by clinical staff and reviewed and approved by Partnership Councils.~~
~~a. Division-wide policies and procedures are developed by clinical management staff.~~
~~b. These type of policies and procedures are reviewed and approved by:~~

~~i. Patient Care Leadership~~
~~ii. Pharmacy and Therapeutics (as applicable)~~
~~iii. E-policy committee~~
~~iv. Medical Executive Committee (MEC)~~
~~v. El Camino Hospital Board of Directors~~
~~vi. This is completed at a minimum of every three years.~~

~~8. Medical Staff:~~
~~a. Medical Staff Policies and Procedures are developed and approved by the Medical Staff~~
~~b. These type of policies and procedures are reviewed and approved by~~
~~i. Pharmacy and Therapeutics Committee when the content of the policy includes medications or biologics~~
~~ii. Medical Executive Committee (MEC)~~
~~iii. El Camino Hospital Board of Directors~~
~~iv. This is completed at a minimum of every three years.~~
~~9. Departmental:~~
~~a. Departmental policies, procedures, or protocols have specific application only to one department.~~
~~b. Departmental policies, procedures, or protocols are developed by the departmental manager or designee.~~
~~c. Medical Staff collaboration is required when the content of the policies, procedures, or protocols involves care of the patient.~~

d. Any policies, procedures, or protocols that will apply to a Mountain View and Los Gatos location must have approval from department managers and medical staff committees from each campus before the policy is sent through the final approval processes.

e. These type of policies, procedures, or protocols when the content involves care of the patient are reviewed and approved by:
   i. Service Line Administrative Staff
   ii. Laboratory when the content of the policy includes specimen collection, transfusion procedure, laboratory/pathology procedure, or Point of Care testing
   iii. Pharmacy and Therapeutics Committee when the content of the policy includes medications or biologics.
   iv. E-policy committee
   v. Medical Executive Committee (MEC)
   vi. El Camino Hospital Board of Directors
   vii. This is completed at a minimum of every three years

f. These type of policies or procedures that do not have a direct impact on patient care are reviewed and approved by
   i. Service Line Administrative Staff
   ii. E-policy committee
   iii. El Camino Hospital Board of Directors

10. For all policies/procedures identified above, for 90 days after go live with iCare (November 7, 2015), the Board of Directors designates the E Policy Committee of the hospital to review required changes to policies and procedures resulting from that implementation. These policy changes can be implemented as soon as approved by the E Policy committee and will be sent to MEC and Board of Directors as soon as possible per regular scheduling.

11. Electronic copies of Administrative, Human Resources, and Environment of Care, Emergency Management, Infection Control, and Patient Care, Medical Staff, and Departmental policies are available on the hospital network in the Hospital Toolbox under the Policy and Procedure site.

12. **Policy and Procedure Format:**

a.l. All policies, procedures, or protocols will be developed and revised in the format found directly on the toolbox on the Policy Tech site.

b.l. Purpose section:
A clear and concise purpose to educate readers on what the policy/procedure entails.
Statement section:

The 2 examples can be used to determine the statement. One statement example can be used, or both. One can also be created if the examples are not used.

13.7. **Procedure:**

This section contains a clear and concise step-by-step methodology to be followed for compliance with the policy purpose and statement.

14.8. **Approval Box:**

The approvals section will list any committees that are required to approve the policy and the date(s) when they approved it. This section will also list the Board of Directors and the date when it approved the policy. The minutes of these various groups will reflect approval of the policy. Only the most recent date will be reflected in the box. The previous dates will be listed under Historical.

C. **Distribution:**

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a. Documents defined in this policy are available on the hospital network to all staff, physicians and volunteers.

b. A copy of the organizations policies will be stored on a USB device that will be maintained in the hospital supervisor office at each campus.

~~13.~~ **D. Policy, Procedure, Protocol Maintenance:**

a. The original electronic copy of current hospital-wide policies and procedures will be centralized on the hospital network file directory.

~~b. All policies and procedures will be reviewed a minimum of every three years, or more often as legislation or practice requires.~~

~~c.~~b. To meet legal requirements, all ~~policies and procedures~~documents in PolicyTech that have been deleted or revised will be archived for a minimum of seven years.

~~d.~~c. Maternal Child Health ~~Policies and Procedures~~documents in PolicyTech will be retained for 25 years.

~~14.~~ **E. Process for ~~Policy, Procedure, Protocol~~Document Updates in Policy Tech**

a. All El Camino Hospital staff covered by policies, procedures, or protocols will have "Read Only" access to currently approved ~~policies, procedures, or protocols~~documents through the hospital network via Policy Tech. Any new policy or updates made to ~~the departmental policy, procedures, or protocols~~documents in Policy Tech are to be made through the following process:

i. ~~The process starts when a document owner writes the original draft of a policy, procedure, or protocol or revises a current policy, procedure, or protocol document~~ For new documents, the document owner shall use the identified template available in Policy Tech. For revisions to existing documents, the document owner shall begin revisions within Policy Tech in the document itself.

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a) If desired, the document owner can collaborate with other writers to complete the first draft.
b) The document owner then submits the document to review, where each reviewer can accept, revise, or decline the document.
c) If all reviewers accept it, the document is automatically moved to the approval status.
d) If revised or declined by one or more reviewers, the document is placed back in draft status, and a task email is sent to the document owner to review the revised or declined document, make the necessary changes, and then resubmit the document for review.
e) The document goes back to draft status only after all reviewers have accepted, revised, or declined it.
f) This part of the process can be repeated as many times as necessary to create an acceptable document.

ii. Once all reviewers approve a subsequent draft, the document is moved automatically to approval status.
a) Approvers have the same options as reviewers for dealing with the document (accept, revise, and decline).
~~b) If all approvers accept it, the document is automatically published.~~
~~c)~~b) If one or more approvers revise or decline the document, it again goes back to draft status where the document owner can again make needed changes and resubmit the document for review or directly to ~~approval~~approval.

~~iii. The only time a document is not immediately published upon approval is if the document owner designates a publication date sometime in the future. In that case, the document is moved to pending status until that date arrives, and then the document is published.~~

~~iv. As soon as a document is published, task notifications to read the document can be sent to all assigned readers.~~

~~v.~~iii. If an approved document is a new version of an existing document, the previous version is automatically archived when the new version is published

~~vi.~~iv. After these steps are completed via Policy Tech for the departmental approval and any other committees that need to approve the policy, ~~the necessary steps for further approval is as follows~~please see matrix above for approval process. ~~:~~

~~vii. Policy is approved at e-policy committee.~~

~~viii. If policy is Administrative, it will then need to be approved by Executive Leadership and go to MEC (Medical Executive Committee) and from there approval from the Board.~~

~~ix. If policy is not Administrative, but involves patient care, it will go to MEC and from there approval from the Board.~~

~~x. If the policy is not administrative and does not involve patient care, it will go straight to the Board for approval.~~

~~xi. For 90 days after go live with iCare (November 7, 2015), the Board of Directors designates the E Policy Committee of the hospital to review required changes to policies and procedures resulting from that implementation. These policy changes can be implemented as soon as approved by the E Policy committee and will be sent to MEC and Board of Directors as soon as possible per regular scheduling.~~

~~xii.~~v. Once approved by the Board and/or MEC, the Policy and Procedure Specialist will be notified and will make the final approval via Policy Tech and publish the document.

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POLICY/PROCEDURE TITLE: **(**Inserted PolicyTech field)

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	02/2015
_____Medical Committee (if applicable):	N/A
ePolicy Committee:	03/2015
Pharmacy and Therapeutics (if applicable):	N/A
Corporate Compliance:	08/2015
Board of Directors:	10/2015

Historical Approvals:

06/98, 08/99, 05/03, 01/04, 03/02/05, 11/06, 09/07, 05/08, 05/09, 08/12, 4/2015

ATTACHMENT 7

COMPLIANCE COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Key Performance Indicators
	Responsibility party:	Diane Wigglesworth, Sr. Director Corporate Compliance
	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 investigated a number of concerns brought forth by staff and management. Some of the errors identified were a result of staff not following policy or the need to provide additional clarification to a hospital policy. Compliance also responded to written complaints from CMS, Noridian and OCR. No additional actions were required after responding to the complaints. There were reportable privacy violations to CDPH in the last two months. The privacy violations were the result of staff not carefully reviewing documents before providing or disclosing PHI.	
	Suggested discussion questions: 1. Are there any trends of concern?	
	Proposed board motion, if any: None	
	LIST OF ATTACHMENTS: Corporate Compliance Scorecard and KPI 2 year trend graph	

Corporate Compliance Scorecard FY17

El Camino Hospital

Key Performance Indicator	FY:17 Current Month	Current YTD Actual	Prior YTD Actual
Total Number of Hospital Discharges (excluding normal newborn)	***1,659***	***9,301***	***9,244***
Core Elements			
Policies and Procedures	**Dec. 2017**	***Jul - Dec FY:2017***	***Jul - Dec FY:2016***
Number of reported instance when policies not followed	1	23	15
Number of disciplinary actions due to Investigations	0	11	5
Education and Training	**Dec. 2017**	***Jul - Dec FY:2017***	***Jul - Dec FY:2016***
Percentage of new employees trained within 30 days of start date	100%	100%	100%
Investigations	**Dec. 2017**	***Jul - Dec FY:2017***	***Jul - Dec FY:2016***
Total number of investigations	25	146	110
Investigations open	2	2	0
Investigations closed	23	144	110
Hotline concerns substantiated	1	12	10
Hotline concerns not substantiated	3	8	12
Average number of days to investigate concerns	7	7	6
Reporting Trends	**Dec. 2017**	***Jul - Dec FY:2017***	***Jul - Dec FY:2016***
Anti-Kickback/Stark	7	36	19
EMTALA	0	0	4
HIPAA Reports	13	83	105
HIPAA Security Breaches	0	2	2
Billing or Claims	4	47	43
Conflict of Interest	1	5	2
Reported Events to CMS	**Dec. 2017**	***Jul - Dec FY:2017***	***FY:2016 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	**Dec. 2017**	***Jul - Dec FY:2017***	***FY:2016 Actual***
Number of total regulator events self reported by ECH	0	2	11
Number of self reported events followed up by CDPH	0	2	5
Number of total privacy breaches self reported by ECH	4	10	18
CDPH initiated visits (separate from ECH self reported events)	1	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	**Dec. 2017**	***Jul - Dec FY:2017***	***FY:2016 Actual***
Total number of Audit Findings	3	27	47
Number of findings identified has high severity	2	7	6
Monitoring and Audit Findings	**Dec. 2017**	***Jul - Dec FY:2017***	***FY:2016 Actual***
Number of Open Liability Claims	15	*15*	*10*
Number of Open Liability Lawsuits	5	*5*	*7*

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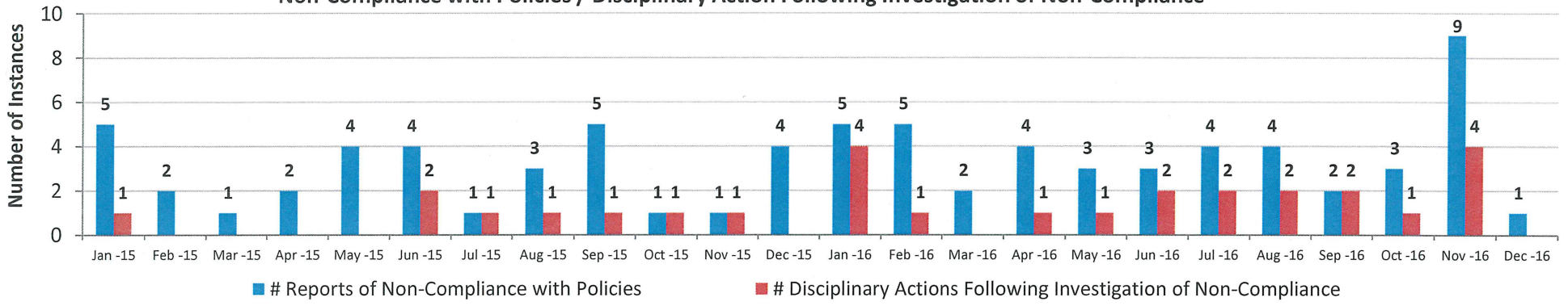
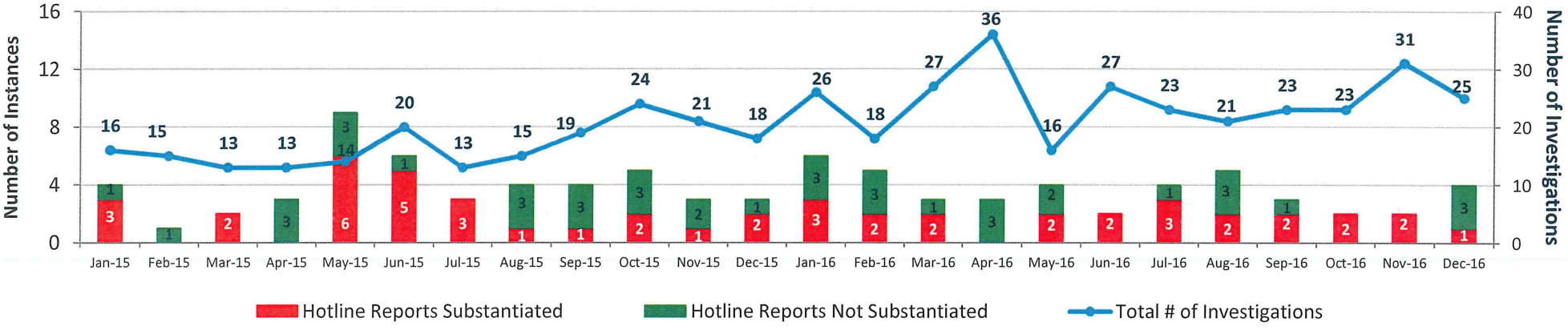
Corporate Compliance

Policies & Procedures

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



Investigations: Total Investigations / Hotline Activity



Privacy Breaches Requiring Report to Outside Entity