El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

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

Thursday, August 17, 2017 – 5:00 pm

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

Sharon Anolik Shakked will be participating via teleconference from 214 Hidden Lake Loop Dr. Olympic Valley, CA 96145.

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. Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee Meeting (May 18, 2017) ***Information*** b. Progress Against FY18 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.	**POLICY FOR APPROVAL** **ATTACHMENT 6**	Diane Wigglesworth, Sr. Director, Corporate Compliance	*public comment*	**possible motion** **5:15 – 5:20**
7.	**REVIEW IT SECUIRTY AWARENESS TRAINING PLAN** **ATTACHMENT 7**	Deb Muro, Interim CIO; Diane Wigglesworth, Sr. Director, Corporate Compliance		**information** **5:20 – 5:25**
8.	**REVIEW RECORD RETENTION PERIODS** **ATTACHMENT 8**	Diane Wigglesworth, Sr. Director, Corporate Compliance; Mary Rotunno, General Counsel		**information** **5:25 – 5:35**
9.	**KPIs, SCORECARD AND TRENDS** **ATTACHMENT 9**	Diane Wigglesworth, Sr. Director, Corporate Compliance		**information** **5:35 – 5:40**
10.	**ADJOURN TO CLOSED SESSION**	John Zoglin, Chair		**motion required** **5:40 – 5:41**

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	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	John Zoglin, Chair		**5:41 – 5:42**
12.	**CONSENT CALENDAR** *Any Committee Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2* a. Minutes of the Closed Session of the Corporate Compliance/Privacy and Internal Audit Committee Meeting (May 18, 2017) ***Information*** *Gov't Code Section 54956.9(d)(2)* – Conference with legal counsel – pending or threatened litigation. b. Compliance Log (May-June 2017) c. Privacy Log (May-June 2017) d. Internal Audit Work Plan e. Committee Pacing Plan	John Zoglin, Chair		**motion required** **5:42– 5:45**
13.	Report involving *Gov't Code Section 54956.9(d)(2)* – Conference with legal counsel – pending or threatened litigation: - FY17 Patient Safety/Claims Report	Sheetal Shah, Director, Risk Management and Patient Safety		**motion required** **5:45 – 5:55**
14.	Report involving *Gov't Code Section 54956.9(d)(2)* – Conference with legal counsel – pending or threatened litigation: - FY 17 Annual Compliance and Privacy Report	Diane Wigglesworth, Sr. Director, Corporate Compliance		**motion required** **5:55 – 6:05**
15.	Report involving *Gov't Code Section 54956.9(d)(2)* – Conference with legal counsel – pending or threatened litigation: - Report on Internal Audit Activity	Diane Wigglesworth, Sr. Director, Corporate Compliance		**information** **6:05 – 6:10**
16.	*Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets: - ERM Activity and Framework	Mick Zdeblick, COO; Diane Wigglesworth, Sr. Director, Corporate Compliance		**discussion** **6:10 – 6:40**
17.	Discussion involving *Gov't Code Section 54956.9(d)(2)* – Conference with legal counsel – pending or threatened litigation: - IT Security Discussion	Deb Muro, Interim CIO		**information** **6:40 – 6:50**
18.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters: - Executive Session	John Zoglin, Chair		**discussion** **6:50 – 6:55**
19.	**ADJOURN TO OPEN SESSION**	John Zoglin, Chair		**motion required** **6:55 – 6:56**
20.	**RECONVENE OPEN SESSION / REPORT OUT**	John Zoglin, Chair		**6:56 – 6:59**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
21.	**ADJOURNMENT**	John Zoglin, Chair		**motion required** **6:59 – 7:00pm**

Upcoming Meetings

- September 13, 2017 (*Joint Session with Hospital Board, to provide ERM Program Update)*
- September 28, 2017
- November 16, 2017
- January 18, 2018
- March 15, 2018
- May 17, 2018

Board & Committee Educational Gatherings

- October 25, 2017
- April 25, 2018

Minutes of the Open Session of the
Corporate Compliance/Privacy and Internal Audit Committee
Thursday, May 18, 2017
El Camino Hospital | Conference Room F
2500 Grant Road, Mountain View, CA 94040

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

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 Committee of El Camino Hospital (the "Committee") was called to order at 5:01pm by Chair Zoglin. A verbal roll call was taken. Committee Members Chiu and Hartman participated via teleconference. Ms. Lica Hartman joined the meeting at 5:05pm during Agenda Item 6: Policies for Approval. All other Committee members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Zoglin asked if any Committee members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. PUBLIC COMMUNICATION	None.	
4. CONSENT CALENDAR	Chair Zoglin asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Meeting Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee (March 16, 2017). **Movant:** Anolik Shakked **Second:** Sublett **Ayes:** Anolik Shakked, Chiu, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** Hartman **Recused:** None	***Consent Calendar approved***
5. REPORT ON BOARD ACTIONS	Chair Zoglin noted that the strategic plan is still in progress with multiple workgroups working on specific initiatives. He requested that staff have the CEO candidates sign NDAs so that the Board may share some of the strategic work with them during the interview process.	
6. POLICIES FOR APPROVAL	Diane Wigglesworth, Sr. Director, Corporate Compliance, explained that five new IT Security policies were brought to the Committee for review as part of IT's policy restructuring (separating policies from procedures). She noted that 40 additional policies will be brought in August for a total of 45 new IT Security policies to meet required regulatory and security requirements. Mary Rotunno, General Counsel, explained that the modifications for the Physician Financial Arrangement Policy are driven by new	***Policies recommended for approval: Formatting to be edited, IT example language to be refined, and physician***

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<table>
<tr><td></td><td>physician employment through SV Primary Medical Group, P.C., which has a Professional Services Agreement with ECH. The revisions would allow for a higher threshold for Board approval. She noted that cost of salary and benefits for employed physicians will always be higher than $250,000 (which is the current cap for arrangements like medical directorships, etc.). Ms. Wigglesworth clarified that, for employed physicians only, a renewal or amended PSA with SVPMG can be executed without Board approval if it is below the 75th percentile of FMV data and under $1 million annually.

Chair Zoglin requested the physician arrangement policy be separated out rather than included on the consent calendar when it goes to the Board.

Staff described the physician recruitment efforts and the policy changes to expedite providing timely employment offers, but not eliminate the approval process.

Mr. Chiu requested that the numbering and formatting on pages 14, 17, and 25 of the packet be cleaned up before it is brought to the Board.

The Committee and staff discussed whether or not to include specific examples in policies or more general language regarding adhering to good practices in line with changes in the industry.

Motion: To recommend that the Board approve the policies included in the packet with the proposed changes.

Movant: Sublett
Second: Anolik Shakked
Ayes: Anolik Shakked, Chiu, Hartman, Sublett, Zoglin
Noes: None
Abstentions: None
Absent: None
Recused: None</td><td>arrangements to be brought to the Board as a non-consent item</td></tr>
<tr><td>7. PROPOSED FY18 COMMITTEE GOALS</td><td>Ms. Wigglesworth noted that for the goal related to enterprise risk management (ERM), the proposed framework will be brought in Q1and proposed implementation in Q2.

The Committee and staff discussed the goal related to HIPAA Readiness; staff noted that there will be regular communication to Committee on HIPAA Readiness, with updates to be presented in Q2 and Q4, the target completion for HIPAA Readiness is in 2019, and the plan will address security and privacy gaps identified by the Protiviti and Coalfire audits.

The Committee requested that there be a Q2 update ahead of the approval in Q4.

Proposed goal: To review reports on the completion of HIPAA Readiness plan milestones for FY18. (Q2: Review update and provide feedback; Q4: review the report).

Motion: To recommend that the Governance Committee review and approve the FY18 Compliance Committee Goals as amended.

Movant: Sublett
Second: Anolik Shakked
Ayes: Anolik Shakked, Chiu, Hartman, Sublett, Zoglin
Noes: None
Abstentions: None
Absent: None</td><td>Proposed FY18 Committee Goals recommended to the Governance Committee for review and approval</td></tr>
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	Recused: None	
8. PROPOSED FY17 FINANCIAL AUDIT PLAN	Brian Conner from Moss Adams provided an overview of the audit team, consistent with prior years. He outlined the required communications (making sure Committee and team are on the same page before proceeding with the plan), the responsibilities under US generally accepted auditing standards, and the audit process. Mr. Conner explained that areas with higher risks of potential material misstatement will be emphasized in the audit, including capital asset activity, net patient accounts receivable and revenue, pension, and long-term debt. In response to the Committee's questions, Mr. Conner explained the evaluation of judgment involved audit areas and the review of IT infrastructure. He highlighted the upcoming standards, noting that retiree health benefit plan information will be on the balance sheet for next year and will affect this coming year's accounting activity. In response to Mr. Chiu's question, Mr. Conner explained that GASB-77 will not have a significant impact on District tax revenues. Mr. Conner left the meeting.	
9. HIMSS CONFERENCE: COMPLIANCE RISKS AND IT SECURITY HIGHLIGHTS	Ms. Wigglesworth provided a summary of highlights from the HIMSS and HCCA Conferences that she attended recently highlighting that: - In the eyes of the government, cybersecurity is a significantly increasing area of risk. - Health care information is more financially lucrative than almost any other (including credit card data), which increases in value over time unlike most data. The Committee members emphasized that organizations could have prevented the recent global ransomware attack with patches that were already available. Timely software updates are crucial and an important consideration in vendor selection. Ms. Wigglesworth outlined guidance and corrective actions to mitigate top cybersecurity compliance risks including (but not limited to) complete/accurate risk assessment, business associate agreements, and reducing insider threats. In response to Ms. Sublett's questions, Deb Muro, Interim CIO explained the risk assessment process for medical devices. Ms. Wigglesworth outlined next steps to incorporate the lessons learned from these conferences and noted that it is meaningful to educate the Committee and the Board on these emerging cybersecurity risks to health care.	
10. KPIs SCORECARD, AND TRENDS	Ms. Wigglesworth reported that due to an increase in Compliance/Privacy Activity, a new manager position in the Compliance Department is part of the FY18 budget, and will be starting in January 2018 to assist with investigations and follow ups. She reviewed the KPI trends and noted there was an uptick in Anti-Kickback and Stark issues related to contracts and FMV analysis; She commented that this increase is largely due to increased executive leadership awareness about the laws and physicians reaching out to Compliance. She reported that there were more high severity audit findings this year	

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	(11) compared to the previous year (6). Ms. Anolik Shakked commended staff for the maintenance in average number of days to investigate concerns despite the significant increase in the number investigations.	
11. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 5:59 pm pursuant to *Gov't Code Section 54957.2* for approval of Meeting Minutes of the Closed Session of the Corporate Compliance/Privacy and Internal Audit Committee (May 18, 2017); pursuant to *Gov't Code Section 54956(d)(2)* – conference with legal counsel – pending or threatened litigation: Compliance Activity Log, Privacy Activity Log, Internal Audit Follow Up, Internal Audit Work Plan, FY17 Pacing Plan; pursuant to *Gov't Code Section 54956(d)(2)* – conference with legal counsel – pending or threatened litigation: FY18 Internal Audit Assessment and Work Plan; pursuant to *Gov't Code Section 54956(d)(2)* – conference with legal counsel – pending or threatened litigation: Report on Internal Audit Activity; pursuant to *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets: Discussion on ERM Reporting; pursuant to *Gov't Code Section 54956(d)(2)* – conference with legal counsel – pending or threatened litigation: Discussion on IT Security Plan; pursuant to *Gov't Code Section 54957* for discussion and report on personnel matters: Executive Session. **Movant:** Anolik Shakked **Second:** Sublett **Ayes:** Anolik Shakked, Chiu, Hartman, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 5:59pm.***
12. AGENDA ITEM 20: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:14 pm. Agenda Items 12-19 were covered in closed session. During the closed session, the Committee approved the Closed Session Minutes of the Corporate Compliance/Privacy and Internal Audit Committee Meeting of March 16, 2017, the FY18 Internal Audit Work Plan, and the IT Security Plan by a vote of all members present (Anolik Shakked, Chiu, Hartman, Sublett, Zoglin).	
13. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 7:17 pm. **Movant:** Sublett **Second:** Anolik Shakked **Ayes:** Anolik Shakked, Chiu, Hartman, Sublett, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:17pm.***

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, Corporate Compliance/
Privacy and Internal Audit Committee

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FY18 COMMITTEE GOALS

Corporate Compliance/Privacy and Internal Audit Committee

PURPOSE

The purpose of the Corporate Compliance/Privacy and Audit Committee ("Compliance Committee") is to advise and assist the El Camino Hospital (ECH) 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 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**, Sr. Director, Corporate Compliance

The Sr. Director, Corporate Compliance shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team or outside consultants may participate in the meetings upon the recommendation of the Sr. Director, Corporate Compliance 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
1. Review and evaluate Hospital's plan for IT Security awareness training for organization	• Q1 FY18	• Committee reviews training plan
2. Review and evaluate Hospital's policy and education plan regarding responding to government investigations	• Q1 FY18	• Committee reviews policy and education plan
3. Review reports on the completion of HIPAA Readiness plan milestones for FY18	• Q2 and Q4 FY18	• Committee reviews HIPAA Readiness Plan milestones for FY18
4. Review and evaluate Management's recommended ERM framework regarding how the Board will establish its risk appetite and tolerance levels	• Q1 FY18: Preliminary Framework Report • Q2 FY18: Final Recommendations	• Committee reviews recommendations

SUBMITTED BY:

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

Diane Wigglesworth **Executive Sponsor**, Corporate Compliance/Privacy and Internal Audit Committee

Approved by the ECH Board of Directors on June 14, 2017

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Corporate Compliance/Privacy and Internal Audit Committee August 17, 2017
	Responsible party:	Cindy Murphy, Director of Governance Services
	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: 1. Report on ECH and ECHD June and August 2017 Board Actions	

June and August 2017 ECH Board Actions*

1. June 14, 2017
    a. Approved the FY17 Period 10 Financials
    b. Approved the FY18 Operating and Capital Budget
    c. Approved the FY18 Community Benefit Plan awarding approximately $3.2 million in grants and sponsorships.
    d. Approved the FY18 CEO and Executive Salary Ranges
    e. Approved recommended revisions to the Executive Benefits Design Plan increasing Long-Term Disability Benefits
    f. Approved Funding for the Xi Da Vinci Robot, 828 Winchester Tenant Improvements, Los Gatos MRI Replacement, and Initial Development Steps for Patient Family Residence
    g. Approved FY18 Board Committee Appointments and Re-Appointments
    h. Approved FY18 Advisory Committee Goals
    i. Approved Recommended Revisions to the Physician Financial Arrangements Review and Approval Policy authorizing the CEO to execute certain agreements not to exceed $1 million.
    j. Approved the FY18 Organizational Goals
    k. Approved the Management of Serious Events and Red Alert Patient safety Policy
    l. Approved Employment of Dan Woods as El Camino Hospital's CEO.

2. June 28, 2017
    a. Approved the El Camino Hospital Strategic Framework.
    b. Adopted a Resolution acknowledging Neal Cohen's 5 years of service on the Hospital Board.

3. August 9, 2017
    a. Appointed Ms. Ina Bauman as patient advocate member of the Quality, Patient Care and Patient Experience Committee
    b. Approved the FY18 Board Education Plan, including attendance at the Estes Park Institute Conference in San Francisco October 29 – November 1, 2017. All Board and Committee members are invited and encouraged to attend.
    c. Approved the proposed FY18 Competency Matrix for use in evaluating gaps on the ECH Board. The Competency Matrix will be referred to the District Board for consideration.
    d. FY18 Executive Individual Incentive Goals approved.
    e. FY18 Executive Base Salaries approved as revised.
    f. Director Peter Fung, MD, was appointed to serve on the Silicon Valley Medical Development, LLC Board of Managers.
    g. Approved the FY17 Period 12 Financials

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

June 2017 ECHD Board Actions*

1. June 14, 2017
    a. Approved the Selection of Dan Woods as El Camino Hospital's CEO.

2. June 20, 2017
    a. Approved the FY18 El Camino Hospital Capital and Operating Budget
    b. Approved the FY18 Community Benefit program awarding approximately $7 million in grants and sponsorships
    c. Elected Board Officers:
        i. Chair – Peter C. Fung, MD
        ii. Vice Chair – Julia Miller
        iii. Secretary/Treasurer – John Zoglin
    d. Voted to fill the vacancy on the ECHD Board created by Dennis Chiu's resignation by appointment at a meeting scheduled for August 16, 2017.
    e. Elected John Zoglin and Dave Reeder to serve on an Ad hoc Committee that will make recommendations to the District Board regarding selection of ECH Board Members. Christina Lai, a member of the Hospital's Governance Committee, will serve as Advisor to the Committee.

3. June 28, 2017
    a. Approved the El Camino Hospital Strategic Framework.
    b. Adopted a Resolution acknowledging Dennis Chiu's nearly 5 years of service on the District and Hospital Boards.
    c. Approved a revision to the El Camino Hospital Bylaws expanding the Board to 10 seats, but removing the CEO as a voting member of the Board.

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

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Approval of Policies Corporate Compliance/Privacy and Internal Audit Committee August 17, 2017
	Responsible party:	Diane Wigglesworth, Sr. Director, Corporate Compliance
	Action requested:	For Possible Motion
	Background: As required by Title 22 and The Joint Commission, the Hospital's governing body must review and approve all organizational policies, plans, and scope of services 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 place on the Hospital Board consent calendar for approval. All policies have been internally reviewed and have received appropriate approvals before being presented to a Board Committee.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None	
	Summary and session objectives: Modified policy to remove requirement of both Hospital Board and District Board approval for physician recruitment loans. There is no legal requirement for the District Board to approve such loans.	
	Suggested discussion questions: None.	
	Proposed Committee motion, if any: To recommend that the Hospital Board approve the policy.	
	LIST OF ATTACHMENTS: 1. Physician Recruitment Program Policy (redline)	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Finance: Physician Recruitment Program Policy

CATEGORY: Administrative
LAST APPROVAL DATE: 02/2016

SUB-CATEGORY: Finance
ORIGINAL DATE: 02/07

COVERAGE:

All El Camino Hospital staff

PURPOSE:

This policy is intended to set forth the procedures by which the Hospital authorizes and undertakes independent physician recruitment activities using recruitment incentives. All activities undertaken to recruit independent physicians and the recruitment of certain primary care allied health professionals by independent physicians shall be taken in full compliance with all applicable local, state and federal laws. This policy does not apply to Hospital's recruitment of any person to be employed or salaried as a W-2 employee by the Hospital or a Hospital Affiliate.

STATEMENT:

As part of the planning and budget process of the Hospital, the Hospital shall determine whether, during the budget year, it is in the best interest of the public health of the community served by the Hospital to recruit licensed physicians and certain primary care allied health professionals to practice in the community served by the Hospital and whether the Hospital should participate in the recruitment of physicians and certain primary care allied health professionals A plan and budget for such activities shall also be developed consistent with community need and in support of the Hospital's strategic plan and be subject to approval as provided in Section E.

PROCEDURE:

1. **Approval.**

As part of the approval process, the need for recruitment, the recruitment plan and the recruitment budget shall be presented to the Board for its review and approval. ~~and, if and as approved, shall then be presented to the District Board of Directors for its review and approval.~~ Once

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approved, the Chief Executive Officer of the Hospital shall have the authority to develop particular recruitment proposals and implement them in accordance with the budget. Any recruitment that is proposed that would exceed the amount budgeted or that in any one case exceeds the amount of $500,000 shall be brought to the Board of the Hospital. ~~and the Board of the District for approval.~~

2. **Permissible Physician Recruitment Incentives.**

Subject to compliance with all applicable laws, permissible physician recruitment incentives shall be no greater than those described in Health and Safety Code Section 32121.3 . Permissible incentives for purpose of this Policy include:

(1) Guaranteeing to a physician a minimum income and expense reimbursement for a period of no more than two years from the opening of the physician's practice.

(2) Guaranteeing leases of necessary equipment by the physician for at least over the life of the equipment

(3) Provision of reduced rental rates of office space in any building owned or leased by the District or any of its affiliated entities, or subsidize rental payments for office space in any other buildings, for a term of no more than three years.

(4) Provision of other recruitment incentives to a physician in exchange for consideration and upon terms and conditions deemed reasonable and appropriate.

Income guarantees must be commercially reasonable and based upon local, regional and national compensation data. Repayments of any income guarantee maybe forgiven if the recruited physician or primary care allied health professional remains in and continues to practice in the service area of the hospital for a specified period of time (for example, five years beyond the guarantee period). Refer to Appendix A regarding the Income/ Salary Guarantee Loan Program.

The Board of the Hospital has determined that the Hospital is in an extraordinarily costly real estate market and that the high cost of real estate is a significant barrier to physicians relocating to the Hospital's primary service area and serving patients and practicing in the communities served by the Hospital. Accordingly, a recruitment incentive may include a second mortgage or the guarantee of a second mortgage not

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to exceed the lesser of $200,000 or 10% of the purchase price (without Hospital Board approval) fully secured by a second mortgage (or third mortgage in the case of a guarantee) on the primary residence of such physician. Interest on such mortgage may be forgiven each year as long as the physician practices in the service area. Refer to Appendix B regarding the Corporate Second Home Mortgage Program.

It has been determined that recruitment expenses (primarily relocation expenses to move the physician into the Hospital's service area) may be reimbursed. As with the Home Second Mortgage Program and Income/ Salary Guarantee Loan Program, it must be demonstrated that there is a community need for the physician's specialty. To assist the physician to relocate into the Hospital's service area, the physician's cost of moving into the area may be reimbursed. All receipts for moving expenses, which may include travel, temporary living, and relocation moving expenses, must be documented and the Request for Reimbursement of Physician Recruiting Expenses (see Appendix C) completed. Reimbursements are only made directly to the physician and not the physician's medical group. These payments become IRS Form 1099 reportable immediately in the year the reimbursement payment is made.

3. **Permissible Recruitment Incentives provided for recruitment of certain primary care allied health professionals by physicians.**

Subject to compliance with all applicable laws, permissible recruitment incentives paid to a physician for compensation of a primary care allied health professional shall be no greater than those described in 42 CFR 411.357(x), which include:

1. Guaranteeing up to fifty percent of the allied health care professional's actual compensation and benefits paid by the physician for a period of no more than two years.

4. **Compliance.**

While recruitment packages may be offered to new physicians who will practice independently, recruitment of physicians and primary allied health professionals to existing practices (including existing solo practices) is preferred. All recruitment incentives support must be paid to the recruited physician or primary care allied health professional and not to any other individual or group. Home Second Mortgage support may be provided to recruit and retain physicians who are also first time home buyers in the service area.

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4.1. Prohibited Provisions.

In addition to full compliance with all applicable provisions of the federal anti-kickback statute, the Stark II legislation, Section 650 of the Business and Professions Code, and all applicable state and federal laws, there may be no contract or understanding with respect to such recruitment that is prohibited by Health and Safety Code Section 32121.3 and any such provision and any contract or any express or implied understanding shall be void. The prohibited provisions are any contract term or understanding that

(1) imposes as a condition any requirement that the patients of the physician, or a quota of the patients of the physician, only be admitted to a specified hospital.

(2) restricts the physician from establishing staff privileges at, referring patients to, or generating business for another entity.

(3) provides payment or other consideration to the physician for the physician referral of patients to the hospital or an affiliated nonprofit corporation.

4.2. Required Provisions.

Any contract with a physician for recruitment or with a physician for the recruitment of a primary care allied health professional which requires inducements to be repaid shall be repaid with interest and every recruitment contract must contain a provision that states that "no payment or other consideration shall be made for the referral of patients to the Hospital or an affiliated nonprofit corporation."

4.3. Other Requirements

All recruitment incentives must comply in all respects with the requirements of the federal and state anti-kickback or rebate and referral laws. Moreover, any such arrangement shall comply with the requirements imposed by Stark II and any regulation promulgated thereunder. Stark II provides with respect to recruitment:

In the case of remuneration which is provided by a hospital to a physician or primary care allied health professional to induce the

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physician or primary care allied health professional to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if -

(a) the physician or primary care allied health professional is not required to refer patients to the hospital;

(b) the amount of the remuneration under the arrangement is not determined in any manner that takes into account (directly or indirectly) the volume or value of any referrals of the referring physician or primary care allied health professional; and

(c) the arrangement meets such other requirements as the Secretary of Department of Human and Health Services may impose by as needed to protect against program or patient abuse.

5. **Reporting**.

The CEO shall regularly report to the Board on implemented recruitment activities, whether recruited physicians and primary care allied health professionals have been retained in the community and whether the terms and conditions of such recruitment requiring payment or forgiveness have been followed.

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THE HOSPITAL OF SILICON VALLEY

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
______Medical Committee (if applicable):	
ePolicy Committee:	01/2016
Pharmacy and Therapeutics (if applicable):	
Finance Committee:	01/2016
Board of Directors:	02/2016

Historical Approvals:

02/01/07, 06/09, 10/12

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IT Security Awareness Training Compliance Committee

August 17, 2017
Deb Muro
Interim CIO

Executive Summary

- The following slides outline the IT Security Awareness Plan which is currently in the implementation/execution phase.

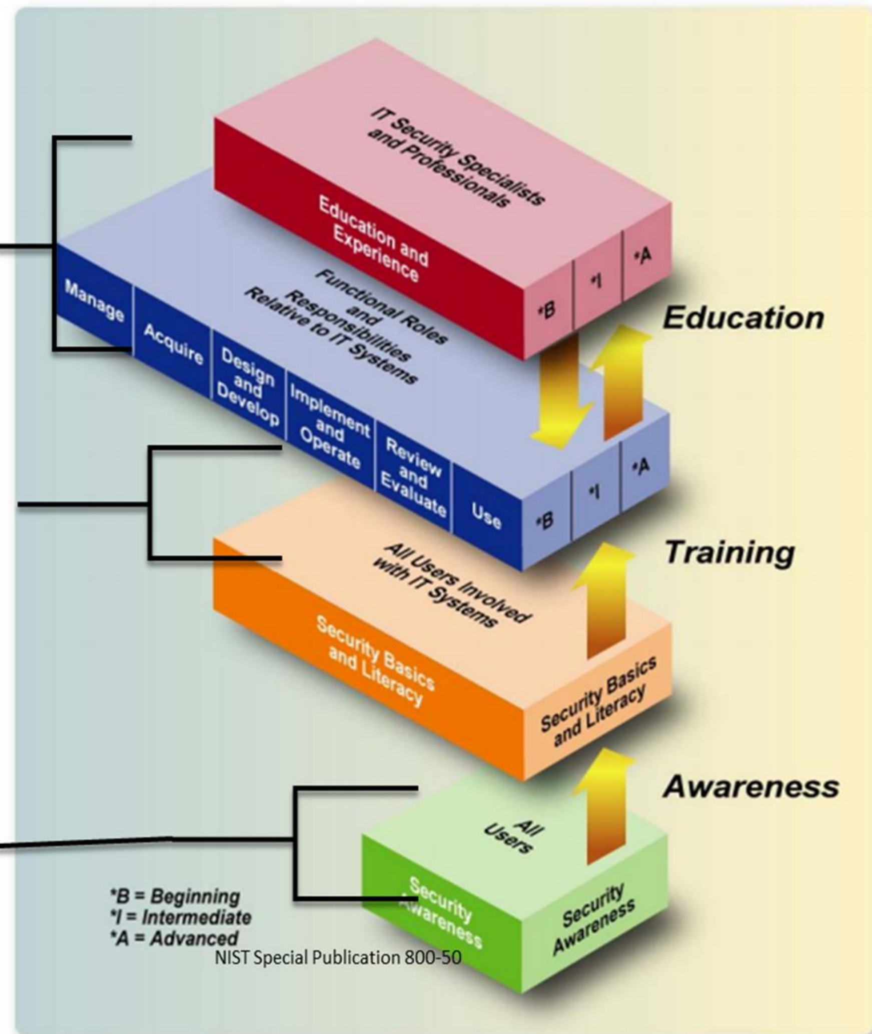
- The plan began in March of 2017 with the first IT Security Awareness topic distributed through the hospital communication tool known as "Intercom."

IT Security Awareness Methodology

Education integrates all of the security skills and competencies of the various functional specialties into a common body of knowledge . . . and strives to produce IT security specialists and professionals capable of vision and proactive response.

Training strives to produce relevant and needed security skills and competencies.

Awareness is not training. The purpose of awareness presentations is simply to focus attention on security. Awareness. Presentations are intended to allow individuals to recognize IT security concerns and respond accordingly.



IT Security Awareness Plan

Scheduled IT Security Awareness Topics for CY17/18*

Date	Topic
March 2017	Social Engineering
April 2017	Password Usage and Management
May 2017	Definition of PHI and Why We Need To Safeguard it.
June 2017	Web Usage
July 2017	Sending Email Securely
August 2017	IT Security Policies
September 2017	IT Security Incident Response
October 2017	Laptop Security
August through October 2017	Policy and Procedure Training for All ECH Staff
November 2017	Access Control
December 2017	Email
January 2018	Physical Access Control
February 2018	Desktop Security
March 2018	Data Backup and Storage

IT Security Team Training in FY18

Date	Coarse Name	Role Attending
July 2017	SANS - Incident Handling	IT Security Engineer
August 2017	HITRUST CSF	IT Security Engineer
August 2017	SANS - Network Penetration Testing and Ethical Hacking	IT Security Engineer
September 2017	SANS – Network Security 2017	IT Security Engineer

Questions?

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Record Retention Periods Corporate Compliance/Privacy and Internal Audit Committee August 17, 2017
	Responsible party:	Diane Wigglesworth, Sr. Director Corporate Compliance
	Action requested:	For Information
	Background: At the March 16, 2017 Compliance Committee meeting, the Committee requested review of the Hospital's general record retention documentation policy (including emails) to evaluate the potential to shorten document retention periods to mitigate risk.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives: The Compliance department reviewed the current ECH Retention and Destruction of Organization Records Policy and Procedure against both California and Federal laws and regulations as well as against California Hospital Associations (CHA) Guidance. Based on the analysis, ECH's policy meets legal requirements and generally ECH's record retention periods are shorter than recommend by CHA. With respect to email retention, there is no statutory requirement and CHA does not provide any guidance specific to email retention. CHA recommends a retention period for general records and correspondence for 6 years, which meets ECH's current retention period for correspondence that should apply to emails. **Conclusion**: ECH's retention policy is adequate and could be modified to specify email retention period of 6 years, however a process to operationalize destruction of emails would need to be implemented by IT and will be labor intensive.	
	Suggested discussion questions: None.	
	Proposed Committee motion, if any: None. This is an informational item.	
	LIST OF ATTACHMENTS: 1. ECH Retention and Destruction of Organizational Records Policy and Procedure	

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

CATEGORY: Patient Care Services
LAST APPROVAL DATE: 2/2017

☐Policy ☑Procedure ☐Protocol ☐ Standardized Procedure ☐Scope of Service
☐ Practice Guideline

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 (HIPAA)*
- *It is the procedure of El Camino Hospital regarding health insurance portability and accountability act (HIPAA) 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;

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- When signatures are required, an imaging system is employed that can copy signed documents;
- Once put in electronic form, the information is unalterable;

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- 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.
- Secure Texting currently used for secure communication of sensitive information, including PHI will not be included in the El Camino Hospital record retention practice. This medium is treated as verbal communication (e.g. phone calls and face-to-face) and will not be archived beyond the 5-day retention interval as set within the application.

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.

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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
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

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Statistics on admissions and services	Permanent
Survey reports ((TJC) JOINT COMMISSION, etc.)	6 years

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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	

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• 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 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

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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
	Life of contract plus 6 years

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Contract files	
Exterminator records	6 years

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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

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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

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	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 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

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	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

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	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.

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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 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

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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

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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)	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

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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

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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 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

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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.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

<u>POLICY/PROCEDURE TITLE:</u>HIMS -Retention and Destruction of Organization Records

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APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
______Medical Committee (if applicable):	
ePolicy Committee:	1/17
Pharmacy and Therapeutics (if applicable):	
Compliance Committee:	1/17
Board of Directors:	2/17

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

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ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Key Performance Indicators Corporate Compliance/Privacy and Internal Audit Committee August 17, 2017
	Responsible party:	Diane Wigglesworth, Sr. Director, Corporate Compliance
	Action requested:	For Information
	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.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives: To review the trending of key indicators. Compliance investigated various reported concerns regarding chart documentation discrepancies and potential charging errors. All concerns were investigated and corrective actions implemented. The total number of privacy breaches self-reported by the Hospital to CDPH continues to trend down compared to previous years. Cybersecurity concerns with certain vendors were identified and remediation plans developed.	
	Suggested discussion questions: 1. Are there any trends of concern?	
	Proposed Committee motion, if any: None. This is an informational item.	
	LIST OF ATTACHMENTS: 1. Corporate Compliance Scorecard 2. KPI 2-year Trend Graph	

Corporate Compliance Scorecard FY17

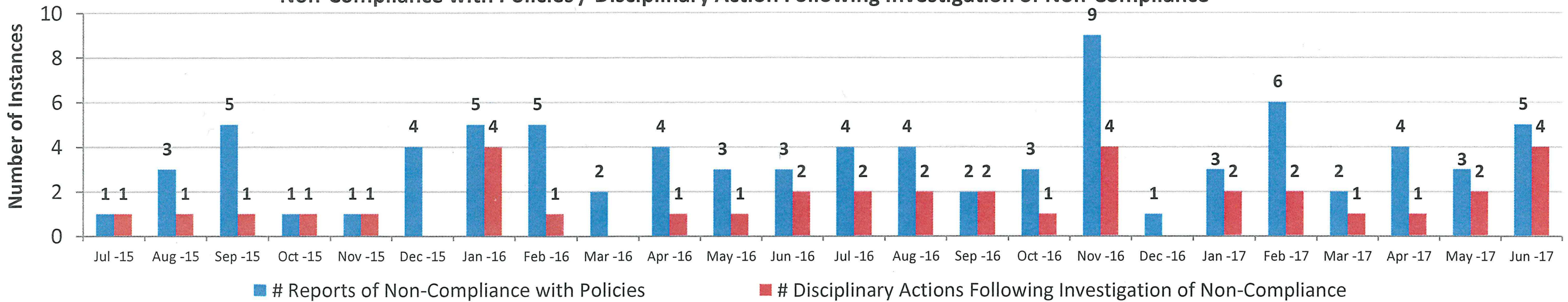
El Camino Hospital

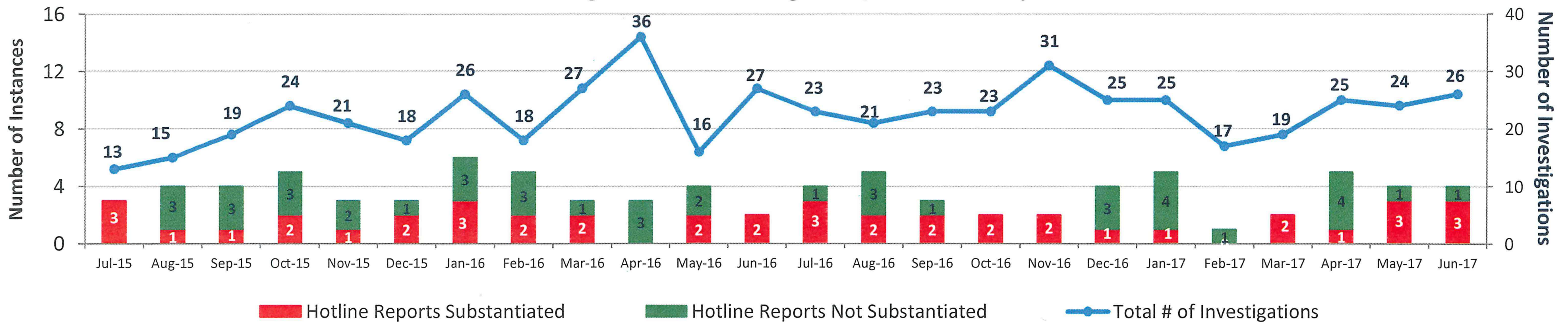
Key Performance Indicator	FY17 Current Month	Current YTD Actual	Prior YTD Actual
Total Number of Hospital Discharges (excluding normal newborn)	***1,643***	***19,205***	***13,980***
Core Elements			
Policies and Procedures	**Jun. 2017**	***Jul - Jun FY17***	***Jul - Jun FY16***
Number of reported instance when policies not followed	5	46	37
Number of disciplinary actions due to Investigations	4	23	14
Education and Training	**Jun. 2017**	***Jul - Jun FY17***	***Jul - Jun FY16***
Percentage of new employees trained within 30 days of start date	100%	100%	100%
Investigations	**Jun. 2017**	***Jul - Jun FY17***	***Jul - Jun FY16***
Total number of investigations	26	282	260
Investigations open	2	2	0
Investigations closed	24	280	260
Hotline concerns substantiated	3	22	21
Hotline concerns not substantiated	1	19	24
Average number of days to investigate concerns	7	7	6
Reporting Trends	**Jun. 2017**	***Jul - Jun FY17***	***Jul - Jun FY16***
Anti-Kickback/Stark	1	56	45
EMTALA	1	3	4
HIPAA Reports	15	159	185
HIPAA Security Incidents	3	10	4
Billing or Claims	7	85	104
Conflict of Interest	0	9	5
Reported Events to CMS	**Jun. 2017**	***Jul - Jun FY17***	***FY16 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	**Jun. 2017**	***Jul - Jun FY17***	***FY16 Actual***
Number of total regulator events self reported by ECH	2	7	11
Number of self reported events followed up by CDPH	0	7	5
Number of total privacy breaches self reported by ECH	0	13	18
CDPH initiated visits (separate from ECH self reported events)	1	10	7
Number of statement of deficiencies issued to ECH	0	1	3
Number of Actual/Realized Sanctions, fines or penalties	0	0	0
Monitoring and Audit Findings	**Jun. 2017**	***Jul - Jun FY17***	***FY16 Actual***
Total number of Audit Findings	0	37	47
Number of findings identified has high severity	0	11	6
Monitoring and Audit Findings	**Jun. 2017**	***Jul - Jun FY17***	***FY16 Actual***
Number of Open Liability Claims	8	*8*	*10*
Number of Open Liability Lawsuits	7	*7*	*7*

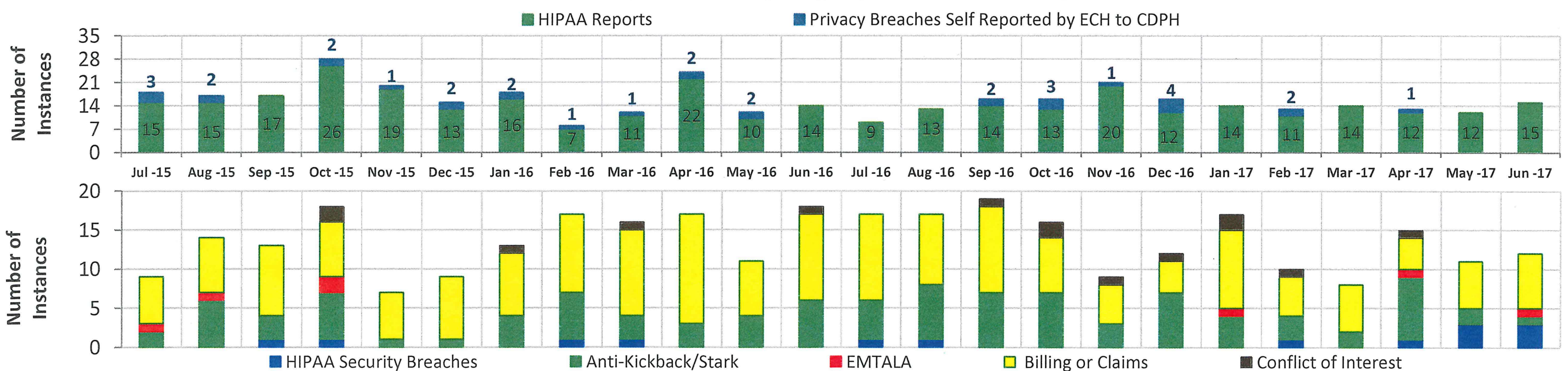
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Corporate Compliance

Policies & Procedures







7/26/2017