

AGENDA

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

Thursday, January 18, 2018 – 5:00 pm

El Camino Hospital, Conference Room E (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	Sharon Anolik Shakked, Chair		5:00 – 5:01pm
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Sharon Anolik Shakked, Chair		5:01 – 5:02
3. PUBLIC COMMUNICATION a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.</i> b. Written Correspondence	Sharon Anolik Shakked, Chair		information 5:02 – 5:05
4. CONSENT CALENDAR <i>Any Committee Member or member of the public may remove an item for discussion before a motion is made.</i> Approval a. Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee Meeting (November 16, 2017) Information b. Status of FY18 Committee Goals	Sharon Anolik Shakked, Chair	<i>public comment</i>	motion required 5:05 – 5:07
5. REPORT ON BOARD ACTIONS ATTACHMENT 5	Board Members		information 5:07 – 5:10
6. POLICIES FOR APPROVAL ATTACHMENT 6	Diane Wigglesworth, Sr. Director, Corporate Compliance	<i>public comment</i>	possible motion 5:10 – 5:20
7. REVIEW EMPLOYEE IT SECURITY/ HIPAA AWARENESS TRAINING CONTENT ATTACHMENT 7	Diane Wigglesworth, Sr. Director, Corporate Compliance		information 5:20 – 5:25
8. KPIs, SCORECARD, AND TRENDS ATTACHMENT 8	Diane Wigglesworth, Sr. Director, Corporate Compliance		information 5:25 – 5:30
9. ADJOURN TO CLOSED SESSION	Sharon Anolik Shakked, Chair		motion required 5:30 – 5:31
10. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Sharon Anolik Shakked, Chair		5:31 – 5:32

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11. CONSENT CALENDAR <i>Any Committee Member or member of the public may remove an item for discussion before a motion is made.</i> Approval <i>Gov't Code Section 54957.2:</i> a. Minutes of the Closed Session of the Corporate Compliance/Privacy and Internal Audit Committee Meeting (November 16, 2017) Information <i>Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</i> b. Compliance Log (Nov-Dec 2017) c. Privacy Log (Nov-Dec 2017) d. Internal Audit Work Plan e. Committee Pacing Plan	Sharon Anolik Shakked, Chair		motion required 5:31 – 5:40
12. <i>Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</i> - Report on Internal Audit Activity	Diane Wigglesworth, Sr. Director, Corporate Compliance; Alex Robison, Protiviti		information 5:40 – 6:05
13. <i>Health and Safety Code Section 32106(b) for a report and discussion involving health care facility trade secrets:</i> - ERM Activity and Framework	David Clark, Interim COO; Diane Wigglesworth, Sr. Director, Corporate Compliance		discussion 6:05 – 6:30
14. <i>Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</i> - IT Security Discussion	Michael Mellor, Interim CISO		information 6:30 – 6:50
15. <i>Gov't Code Sections 54957 for report and discussion on personnel matters:</i> - Executive Session	Sharon Anolik Shakked, Chair		discussion 6:50 – 6:55
16. ADJOURN TO OPEN SESSION	Sharon Anolik Shakked, Chair		motion required 6:55 – 6:56
17. RECONVENE OPEN SESSION/ REPORT OUT	Sharon Anolik Shakked, Chair		6:56 – 6:59
To report any required disclosures regarding permissible actions taken during Closed Session.			
18. ADJOURNMENT	Sharon Anolik Shakked, Chair		motion required 6:59 – 7:00pm

Upcoming Meetings

- March 15, 2018
- May 17, 2018

Board/Committee Educational Gatherings

- April 25, 2018



**Minutes of the Open Session of the
Corporate Compliance/Privacy and Internal Audit Committee
Thursday, November 16, 2017
El Camino Hospital | Conference Room F
2500 Grant Road, Mountain View, CA 94040**

Members Present

Sharon Anolik Shakked, Chair
Neysa Fligor
Robert Rebitzer
Christine Sublett (via teleconference)
John Zoglin

Members Absent

Lica Hartman

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 5:10pm by Chair Anolik Shakked. A verbal roll call was taken. Ms. Hartman was absent. Ms. Sublett participated via teleconference. Ms. Fligor joined the meeting at 5:17pm during Agenda Item 7: KPIs, Scorecard, and Trends. All other Committee members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Anolik Shakked 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	<p>This agenda item was taken out of order to enable a quorum to be present. Chair Anolik Shakked asked if any member of the Committee or the public wished to remove an item from the consent calendar. Ms. Fligor requested that Agenda Item 4b “Progress Against Committee Goals” be discussed.</p> <p>Ms. Fligor requested that the status be revised to reflect that any upcoming item is “to be reviewed,” to avoid any confusion as to whether or not a task was already completed.</p> <p>Ms. Fligor asked whether the Committee should add additional goals, as it appeared everything except one item was already completed for FY18. The Committee and staff discussed the status of the outstanding goals and the aggressive timelines set for FY18 goals at the Committee’s request. Staff noted that goal revisions need to be approved by the Governance Committee and the Hospital Board and Committee goals for FY19 will be reviewed and approved by the Committee in March.</p> <p>Motion: To approve the consent calendar: Meeting Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee (September 28, 2017).</p> <p>Movant: Zoglin Second: Rebitzer Ayes: Anolik Shakked, Fligor, Rebitzer, Sublett, Zoglin Noes: None Abstentions: None Absent: Hartman Recused: None</p>	<i>Consent Calendar approved</i>

5. APPOINTMENT OF VICE CHAIR	Chair Anolik Shakked reported that she has appointed Ms. Neysa Fligor as Vice Chair of the Committee.	
6. REPORT ON BOARD ACTIONS	Committee Member Zoglin referred to the recent Board actions as further detailed in the packet, highlighting the District Board's recruitment efforts to fill the two new seats on the Hospital Board and the value add of the Estes Park Conference that Board and Committee members attended recently.	
7. KPIs, SCORECARD, AND TRENDS	<p>Ms. Wigglesworth reported that trends are consistent with the prior year. She explained that there has been an increase in the number of privacy breaches self-reported by the Hospital to CDPH (13 YTD for FY18; 7 for FY17) and agreed to provide more detail at the next meeting. The Committee requested specific identification of meaningful variance and highlights of repeat offenders in the trends. Ms. Wigglesworth agreed to provide more context, but cautioned that some of the detail requested may be more appropriate for closed session.</p> <p>Ms. Sublett recommended using a third party tool for incident tracking and analytics. Ms. Wigglesworth noted that the QRR system currently and primarily used for tracking patient safety trends could provide some of this functionality for compliance matters.</p>	<i>Additional context for reports to CDPH to be reported at the next meeting</i>
8. ADJOURN TO CLOSED SESSION	<p>Motion: To adjourn to closed session at 5:32pm pursuant to <i>Gov't Code Section 54957.2</i> for approval of Meeting Minutes of the Closed Session of the Corporate Compliance/Privacy and Internal Audit Committee (September 28, 2017); pursuant to <i>Gov't Code Section 54956.9(d)(2)</i> – conference with legal counsel – pending or threatened litigation: for information (Compliance Activity Log, Privacy Activity Log, Internal Audit Follow Up, Internal Audit Work Plan, Committee Pacing Plan); pursuant to <i>Gov't Code Section 54956.9(d)(2)</i> – conference with legal counsel – pending or threatened litigation: Report on Internal Audit Activity; pursuant to <i>Health and Safety Code Section 32106(b)</i> for a report involving health care facility trade secrets: ERM Reporting Discussion; pursuant to <i>Gov't Code Section 54956.9(d)(2)</i> – conference with legal counsel – pending or threatened litigation: IT Security Discussion; pursuant to <i>Gov't Code Section 54957</i> for discussion and report on personnel matters: Executive Session.</p> <p>Movant: Zoglin Second: Fligor Ayes: Anolik Shakked, Fligor, Rebitzer, Sublett, Zoglin Noes: None Abstentions: None Absent: Hartman Recused: None</p>	<i>Adjourned to closed session at 5:32pm.</i>
9. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT	<p>Open session was reconvened at 7:04pm. Agenda Items 9-15 were covered in closed session.</p> <p>During the closed session, the Committee approved the Closed Session Minutes of the Corporate Compliance/Privacy and Internal Audit Committee Meeting of September 28, 2017 by a unanimous vote of all members present (Anolik Shakked, Fligor, Rebitzer, Sublett, Zoglin). Ms. Hartman was absent.</p>	
10. AGENDA ITEM 17: ADJOURNMENT	<p>Motion: To adjourn at 7:04 pm.</p> <p>Movant: Zoglin Second: Fligor Ayes: Anolik Shakked, Fligor, Rebitzer, Sublett, Zoglin</p>	<i>Meeting adjourned at 7:04pm.</i>

	Noes: None Abstentions: None Absent: Hartman Recused: None	
--	---	--

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

Sharon Anolik Shakked
Chair, Corporate Compliance/
Privacy and Internal Audit Committee

DRAFT



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	<ul style="list-style-type: none">Q1 FY18	<ul style="list-style-type: none">Committee reviews training plan – reviewed at 8/17/17 meeting
2. Review and evaluate Hospital’s policy and education plan regarding responding to government investigations	<ul style="list-style-type: none">Q1 FY18	<ul style="list-style-type: none">Committee reviews policy and education plan – reviewed at 9/28/17 meeting
3. Review reports on the completion of HIPAA Readiness plan milestones for FY18	<ul style="list-style-type: none">Q2 and Q4 FY18	<ul style="list-style-type: none">Committee reviews HIPAA Readiness Plan milestones for FY18 initial Q2 review at 11/16/17 meeting. Additional Q4 milestones to be reviewed on 5/17/18
4. Review and evaluate Management’s recommended ERM framework regarding how the Board will establish its risk appetite and tolerance levels	<ul style="list-style-type: none">Q1 FY18: Preliminary Framework ReportQ2 FY18: Final Recommendations	<ul style="list-style-type: none">Committee reviews recommendations Initial recommendations reviewed at 11/16/17 meeting, to be reviewed again

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 January 18, 2018
Responsible party:	Cindy Murphy, Director of Governance Services
Action requested:	For Information
Background: <p>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.</p>	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: <p>None.</p>	
Summary and session objectives : <p>To inform the Committee about recent Board actions.</p>	
Suggested discussion questions: None.	
Proposed Committee motion, if any: <p>None. This is an informational item.</p>	
LIST OF ATTACHMENTS: <p>1. Report on ECH January 2018 Board Actions</p>	

January 10, 2018 ECH Board Actions*

1. January 10, 2018
 - a. Recognized the Los Gatos Operations team for increasing personalized service to physicians and patients.
 - b. Approved the FY18 Period 3 and Period 4 Financials.
 - c. Approved the Letters of Rebuttable Presumption of Reasonableness (related to Executive Compensation)
 - d. Approved the FY18 Salary Range for the new President, SVMD position and its inclusion in the Executive Compensation and Benefits Plans
 - e. Approved physician contracts for Ophthalmology Call Coverage, Gastroenterology ED Call, and OB Hospitalist Coverage
 - f. Approved the Amended & Restated Limited Liability Company Operating Agreement of Silicon Valley Medical Development, LLC (SVMD)

*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 January 18, 2018
Responsible party:	Diane Wigglesworth, Sr. Director, Corporate Compliance
Action requested:	For Possible Motion
Background: <p>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 placed 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.</p>	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
Summary and session objectives: <ul style="list-style-type: none"> • The Government Investigations Policy is coming back with some additional edits the Hospital incorporated after receiving feedback from outside counsel. • The Physician Financial Arrangements – Review and Approval Policy has been modified as requested by the Board Finance Committee, to present the summary of all physician financial arrangements annually instead of semi-annually (see page 10). The policy has also been updated to reflect current practices. 	
Suggested discussion questions: None.	
Proposed Committee motion, if any: <p>To recommend that the Hospital Board approve the policies.</p>	
LIST OF ATTACHMENTS: <p><i>Policies</i></p> <ol style="list-style-type: none"> 1. Government Investigation 2. Physician Financial Arrangements – Review and Approval 	

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations**CATEGORY: Administrative****LAST APPROVAL DATE:**

SUB-CATEGORY: Administrative Policies and Procedures**ORIGINAL DATE: 9/99****COVERAGE:**

All El Camino Hospital staff, Governing Board, Medical Staff and Contract Personnel

PURPOSE:

This policy establishes the guidelines for the proper response to a contact by a Government or Law Enforcement Official. The purpose of this policy is to enable El Camino Hospital to promptly and cooperatively respond to lawful requests for information or access by Government and Law Enforcement Officials while protecting its interests.

STATEMENT:

El Camino Hospital will cooperate with any request for information or access pursuant to a valid search warrant, subpoena, or other lawful demand; however, El Camino Hospital will assert all protections afforded it by law with respect to any such request. Nothing herein prohibits El Camino staff, Governing Board, Medical Staff or Contract Personnel from reporting possible violations of state or federal law or regulation in good faith to an appropriate governmental agency or entity.

DEFINITIONS:

Employee in Charge - The El Camino Hospital Chief Executive Officer, Corporate Compliance Officer, General Counsel, or Administrator-On-Call.

Government or Law Enforcement Official - An official representative of a federal, state, or local government agency with jurisdiction over El Camino Hospital. Examples of such agencies include, but are not limited to:

1. Mountain View Police Department;
2. Centers for Medicare and Medicaid Services;
3. U.S. Department of Health and Human Services;
4. U.S. Department of Justice; and
5. State of California Department of Justice.

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

Government Contact - A Government Contact occurs when, for example:

1. A Government or Law Enforcement Official appears in person at El Camino Hospital to execute a valid search warrant, subpoena, or civil investigative demand;
2. A Government or Law Enforcement Official appears in person at El Camino Hospital and asks to speak with a particular person with whom the official does not have a pre-existing appointment;
3. A subpoena or civil investigative demand is received at El Camino Hospital via mail, fax, or e-mail; or
4. A Government or Law Enforcement Official appears in person at the home of an El Camino Hospital staff member, Governing Board member, or Medical Staff member regarding activity related to the hospital.

Interviewee - The El Camino Hospital staff member, Governing Board member, Medical Staff member, or Contract personnel that a Government or Law Enforcement Official seeks to interview.

Receiving Employee - The El Camino Hospital staff member, Governing Board member, Medical Staff member, or Contract personnel who makes the initial contact with a Government or Law Enforcement Official or takes custody of a subpoena or civil investigative demand.

PROCEDURE:

In the event of a Government Contact, all El Camino Hospital staff, Governing Board members, Medical Staff members, and Contract personnel, whether or not a Receiving Employee or Employee in Charge shall abide by the following procedures.

General

1. All El Camino Hospital staff, Governing Board members, Medical Staff members, and Contract personnel must be courteous, cooperative, and professional in their interactions with Government and Law Enforcement Officials.
2. All Government Contacts must be reported to an Employee in Charge.
3. All El Camino Hospital staff, Governing Board members, Medical Staff members, and Contract personnel should remember that the nature of the Government Contact, including the very fact that such a contact has been made, is sensitive information and should not be shared with anyone other than an Employee in Charge without prior consultation with the General Counsel.

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

4. El Camino Hospital staff, Governing Board members, Medical Staff members, and Contract personnel are free to speak or not to speak with Government or Law Enforcement Officials in the event that they are individually questioned about matters concerning their own, non-employment related activities. If an El Camino Hospital staff member, Governing Board member, Medical Staff member, or Contractor decides to speak with Government or Law Enforcement Officials regarding their own, non-employment related activities, they must respond to questions truthfully.
5. If Government or Law Enforcement Officials appear because of an emergency jeopardizing personal safety (for example, a fire, accident, or natural disaster), follow their instructions.

In-Person Request for Interview at El Camino Hospital

1. When a Government or Law Enforcement Official appears at El Camino Hospital and requests to speak with an El Camino Hospital staff member, Governing Board member, Medical Staff member, or Contractor without an appointment, the person receiving the request shall be deemed the Receiving Employee.
2. The Receiving Employee shall promptly notify an Employee in Charge.
3. The Receiving Employee may not disclose any information or documentation to the Government or Law Enforcement Official without the approval of an Employee in Charge.
4. The Receiving Employee should always be polite and should obtain and record the following information from the investigator or officer:
 - a. The name, agency affiliation, business telephone number and address of all investigators;
 - b. The investigator's business card; and
 - c. The reason for the visit.
5. The Receiving Employee should ask if there is a warrant, subpoena, or investigative demand to be served and request a copy of that document.
6. When a Government or Law Enforcement Official requests an interview without a warrant, subpoena, or civil investigative demand, the Interviewee has no obligation to consent to an interview, but may volunteer to do so. The interviewee may request that legal counsel be present for the interview.
7. The Interviewee may stop the interview at any time, with a request that the investigator return when counsel can be present. Its corporate counsel will

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

represent El Camino Hospital. Employees have the right to their own individual legal counsel at their own expense or to request the hospital's legal counsel. Legal counsel should be present for all interviews.

8. If the Interviewee chooses not to respond to the questions of a Government or Law Enforcement Official or does not consent to an interview, the Government or Law Enforcement Official may have the authority to subpoena the Interviewee to appear before a grand jury or for a deposition. El Camino Hospital will assist the employee in preparing their response by providing legal counsel. Legal counsel will be provided if a potential conflict of interest may exist between hospital departments or between the Interviewee and the hospital.
9. Following any interview, the Interviewee should provide an Employee in Charge with as much information and documentation about the interview as possible.

In-Person Request for Interview not at El Camino Hospital

1. If a Government or Law Enforcement Official requests to interview an El Camino Hospital staff member, Governing Board member, Medical Staff member, or Contractor outside of El Camino Hospital, the Interviewee shall report that request to the Corporate Compliance Officer at (650) 988-7733032.
2. When a Government or Law Enforcement Official requests an interview without a warrant, subpoena, or civil investigative demand, the Interviewee has no obligation to consent to an interview, but may volunteer to do so. The interviewee may request that legal counsel be present for the interview.
3. The Interviewee may require that the interview take place during normal business hours either at El Camino Hospital or at another location.
4. The Interviewee may stop the interview at any time, with a request that the investigator return when counsel can be present. Its corporate counsel will represent El Camino Hospital. Employees have the right to their own individual legal counsel at their own expense or to request the hospital's legal counsel. Legal counsel should be present for all interviews.
5. If the Interviewee chooses not to respond to the questions of a Government or Law Enforcement Official or does not consent to an interview, the Government or Law Enforcement Official may have the authority to subpoena the Interviewee to appear before a grand jury or for a deposition. El Camino Hospital will assist the employee in preparing their response by providing legal counsel. Legal counsel will be provided if a potential conflict of interest may exist between hospital departments or between the Interviewee and the hospital.

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

6. Following any interview, the Interviewee should provide an Employee in Charge with as much information and documentation about the interview as possible.

Request for Documents or Access

1. When a Government or Law Enforcement Official appears at El Camino Hospital with a valid search warrant, subpoena, or investigative demand for documents or information, the person receiving the request shall be deemed the Receiving Employee.
2. The Receiving Employee shall promptly notify an Employee in Charge and request that the Government or Law Enforcement Official on El Camino Hospital premises wait until the Employee in Charge arrives before starting the search.
3. If not the General Counsel, the Employee in Charge shall provide legal counsel with a copy of the search warrant, subpoena, or investigative demand immediately. Please call Administration at 7300/7301 to obtain home and phone numbers of legal counsel. If counsel can be reached by telephone, counsel shall be connected directly to the lead Government or Law Enforcement Officer.
4. ~~If the hospital counsel is not available, the Employee in Charge should contact the U.S. Attorney, Northern District of California at (415) 436-7200 immediately and request that the search be stopped. One can negotiate alternatives to the search and seizure, including provisions to ensure that all existing evidence will be preserved undisturbed. If the U.S. Attorney refuses to stop the search, request agreement to delay the search to enable our hospital to obtain a hearing on the warrant or to consult with hospital counsel regarding the subpoena or investigative demand.~~
5. El Camino Hospital staff members, Governing Board members, Medical Staff members, and Contract personnel must not alter, remove, or destroy permanent documents or records of the hospital. All records are subject to Federal and State of California recognized retention guidelines which are stated in the El Camino Hospital Health Information Management Services Policies and Procedures, ~~1.14~~ Record Retention Rules and Regulations, ~~paragraph D.1. The policy states that Medicare/Medi-Cal patient accounts and charge slips are retained for 5 years, while the Non-Medicare/Medi-Cal accounts are retained for 4 years. The records may be disposed of only in accordance with these guidelines.~~ Once there has been notice of an investigation, the destruction portion of any policy on record retention is suspended. Legal Counsel will send out a litigation hold notification to all persons who may be in possession, custody or control of relevant documents and the continued obligation to preserve potentially relevant documents.
6. When the Government or Law Enforcement Official presents a valid search warrant, subpoena, or investigative demand, the investigators have the authority to enter private premises, search for evidence of unlawful or criminal activity, and

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

- take those documents listed in the warrant, subpoena, or investigative demand. No staff member has to speak to the investigators, but must provide the documents requested in the warrant, subpoena, or investigative demand.
7. The Employee in Charge shall request a copy of the subpoena, investigative demand, or search warrant and the affidavit providing reason for the issuance of the warrant. The Employee in Charge shall also inspect the subpoena, investigative demand, or search warrant to verify the following:
- a. that the date the Government Contact falls within the dates on the document;
 - b. that the address on the document matches the physical location of El Camino Hospital; and
 - c. the specific business areas or departments identified in the document.
 - d. that the document is signed by a judge
8. For valid search warrants, ~~The~~ Employee in Charge and all other El Camino Hospital staff members, Governing Board members, Medical Staff members, or Contract personnel involved in the search must cooperate with the Government or Law Enforcement Officials, but state that you do not consent to the search.
- a. The Employee in Charge should instruct the lead Government or Law Enforcement Official that:
 - i. El Camino Hospital objects to the search;
 - ii. ~~The search is unjustified because El Camino Hospital is willing to voluntarily cooperate with the government.~~
 - b. Under no circumstances should staff obstruct or interfere with the search. Although they should cooperate, any El Camino Hospital staff member, Governing Board member, Medical Staff member, or Contract personnel involved in the search should clearly state that cooperation does not constitute “consent to the search.”
 - c. Whenever possible, keep track of all documents and all information the documents contain that are given to the investigators.
9. The Employee in Charge should attempt to negotiate an acceptable methodology with the Government or Law Enforcement Officials to minimize disruption and allow El Camino Hospital employees to keep track of the process and continue operations necessary to ensure patient safety. Considerations include the sequence of the search; whether Government or Law Enforcement Officials are willing to accept copies in place of originals; and if so, who will make the copies

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

and the arrangements of access to records seized.

10. The Employee in Charge should point out limitations on the premises to be searched and on the property to be seized.
 - a. Only provide what is specified in the search warrant, subpoena or investigative demand.
 - b. Never consent to an expansion of the search.
 - c. Disputes regarding the scope should be referred to legal counsel for potential discussion with the U.S. Attorney, Northern District of California, or court intervention. El Camino Hospital staff members, Governing Board members, Medical Staff members, and Contract personnel should not prevent the investigators from searching areas they claim to have the right to search.
 - d. Government or Law Enforcement Officials generally have the right to seize evidence of crimes that is in their plain view during a search, regardless of whether such evidence is described in the warrant.
11. The Employee in Charge should take appropriate steps to protect other El Camino Hospital staff members, Governing Board members, Medical Staff members, and Contract personnel.
 - a. The Employee in Charge should send all, except essential department personnel, home or temporarily reassign them to other areas when a warrant, subpoena, or investigative demand is served.
 - b. Selected employees should remain along with the Employee in Charge and/or El Camino Hospital legal counsel to monitor the search.
 - c. Government or Law Enforcement Officials should never be left alone on El Camino Hospital's premises. There should be at least two El Camino Hospital staff members with the investigators at all times.
12. The Employee in Charge should object to any search of privileged or protected documents.
 - a. If there is any possibility that the search will compromise privileged or protected information, the Employee in Charge should object on that basis, and instruct legal counsel to raise the issue with the court, if necessary.
 - b. Privileged and protected information is defined as any and all knowledge of value to the institution, which cannot be divulged, except by court order.
13. The Employee in Charge should keep a record regarding the search and should:

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

-
- a. ask each Government or Law Enforcement Official for proper identification, including their business cards;
 - b. list the names and positions of all the Government or Law Enforcement Officials with the date and time and verify the list with the lead Government or Law Enforcement Official and request he or she sign it;
 - c. monitor and record the manner in which the search is conducted, noting, in detail, the precise areas and files searched, the time periods when each of them was searched, the manner in which the search was conducted, the Government or Law Enforcement Officials who participated, and which specific files or other materials were taken; and
 - e. if the monitor is ordered to leave, contact the lead Government or Law Enforcement Official: the monitor should only be ordered to move if they are in the way of the search, not to avoid observing the search. Never provoke a confrontation with an agent.
14. ~~If possible, do not release a document to the investigators, unless hospital legal counsel has reviewed it. However, this may not be possible.~~
 15. If possible, the Employee in Charge should keep all privileged, protected, and confidential documents separated and labeled accordingly.
 16. If possible, the Employee in Charge should make a record and a copy of all records taken.
 - a. If this is not possible, before the Government or Law Enforcement Officials leave El Camino Hospital premises, the Employee in Charge should request an inventory of the documents taken.
 - b. The Employee in Charge should request that the lead Government or Law Enforcement Official note the date and time the search was completed, as well as signs the inventory of documents taken with the Government or Law Enforcement Official's full title, address, and telephone number.
 - c. If the Employee in Charge is unable to make copies of the documents taken at the time of the search, the Employee in Charge should request copies of the documents taken, especially medical records, as these records are required for patient care and this is the most efficient way to inventory the documents taken.
 - d. The Employee in Charge should create a duplicate inventory of the documents seized.
 - e. If the Government or Law Enforcement Officials take any computer hard drives or other electronic media, the Employee in Charge should request to download copies of files from that media, especially if the material is essential to the ongoing operations of El Camino Hospital.

POLICY/PROCEDURE TITLE: Corporate Compliance: Government Investigations

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
Legal Review (if applicable):	10/2015
ePolicy Committee:	10/2015
Pharmacy and Therapeutics (if applicable):	
Corporate Compliance Committee:	11/2015
Board of Directors:	01/2016

Historical Approvals:

09/99, 05/01, 03/05, 07/06, 06/09, 10/12



POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Last Approval Date: 06/2017

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 6/08

COVERAGE:

All El Camino Hospital staff, Contract Personnel, Physicians, Healthcare Providers, and the Governing Board.

PURPOSE:

The purpose of this policy is to comply with the Stark law, Anti-Kickback, HIPAA and all other Federal and State Laws.

STATEMENT:

This policy implements the overall compliance goals of the Hospital with respect to Physician financial arrangements.

This policy establishes administrative principles and guidelines, Board delegation of authority and oversight, and review processes and approvals that must be followed before the Hospital enters into a direct or indirect financial arrangement with an individual physician, a physician group, other organizations representing a physician, or a member of immediate family of a physician ("Physician"). Physician financial arrangements that involve any transfer of value, including monetary compensation, are subject to this and the following policies: 1) Signature Authority policy 17.00, 2) Reimbursement of Business Expenses policy 5.00, and 3) Physician Recruitment policy 42.00.

All financial arrangements of any kind involving Physician, including but not limited to, medical director, consulting, on-call arrangements, professional service agreements, education and training, conference reimbursement or real estate leases, will comply with the Stark law, Anti-Kickback, HIPAA and all other Federal and State Laws.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.



POLICY/PROCEDURE TITLE: Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval

Last Approval Date: 06/2017

All Physician financial arrangements are prohibited except those Physician financial arrangements that are approved and documented as provided in this Policy.

Physician financial arrangements may be entered into only where they are needed and serve the strategic goals (including quality and value) of the Hospital. Each Physician financial arrangement must meet or exceed the complex and stringent legal requirements that regulate Physician financial relationships with the Hospital. All Physician financial arrangements between a physician and the Hospital must be in writing and meet fair market value, commercial reasonableness and the following requirements as applicable.

PROCEDURE:

A. Administrative Standards:

When creating or renewing a Physician financial arrangement, the following principles must be followed. This Policy applies to any Physician financial arrangement including, but not limit to: Medical Directorships, ED Call Panels, Professional Services, Panel Professional Services, Consulting, Lease, Education and Training, Conference Payment, and Physician Recruitment.

1. All Physician Financial Arrangements:

- a) Each Physician financial arrangement (except Physician Lease Contracts) must provide a service that is needed for at least one of the following reasons: 1) it is required by applicable law, 2) required administrative or clinical oversight can only be provided by a qualified physician, 3) the administrative services to be provided support an articulated strategic goal of the Hospital, such as patient safety, and 4) the arrangement must solve, prevent or mitigate an identified operational problem for the Hospital.
- b) The terms of the Physician financial arrangement must be fair market value and commercially reasonable and must not take into account the volume or value of any referrals or other business generated between the

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

POLICY/PROCEDURE TITLE: Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval

Last Approval Date: 06/2017

parties. All of the terms of the Physician financial arrangement must be in a written contract that details the work or activities to be performed and all compensation of any kind or the lease terms ("Physician Contracts"). The services contracted for may not exceed those that are reasonable and necessary for the legitimate business purposes of the Physician financial arrangement. If there is more than one Physician Contract with a Physician, the Physician Contracts must cross-reference one another (or be identified on a list of Physician Contracts) and be reviewed for potential overlapping commitments prior to negotiating additional agreements.

The process for determining Physician compensation for each Physician financial arrangement must be set forth in the Physician Contract file and identified in sufficient detail so that it can be objectively verified as meeting fair market value standards. Any compensation paid to or remuneration received by a Physician shall not vary based on the volume or value of services referred or business otherwise generated by the Physician and must reflect fair market value. Compensation cannot exceed the seventy-fifth percentile of fair market value without prior Board approval. All Physician contracts should use local or regional market data, when available, to determine the seventy-fifth percentile of FMV.

In order to support reasonableness of compensation or remuneration, written fair market data must accompany the Physician Contract and show compensation paid by similar situated organizations and/or independent compensation surveys by nationally recognized independent firms.

- c) Compensation cannot be revised or modified during the first twelve (12) months of any Physician financial arrangement. If the compensation is revised thereafter, it must be evidenced by a written amendment to the Physician Contract, signed by both parties before the increase in compensation takes effect. For example, if the increase in compensation is to take effect on April 1, the amendment must be signed by both parties on or before April 1 and the original Physician Contract must



POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Last Approval Date: 06/2017

have been effective on or before March 31 of the prior year. The compensation cannot be changed for twelve (12) months after the effective date of such amendment.

- d) All Physician Contract renewals must be signed before the expiration of the term of the existing Physician Contract.
- e) Physician Contracts must be in writing and executed by the parties before commencement. Only the CEO of the Hospital or designee by CEO in his or her absence may execute a Physician Contract, except Physicians Contracts that are real estate or equipment leases with Physicians may be signed by the Chief Administrative Services Officer (“CASO”). Physicians cannot be compensated for work performed, nor may a lease commence, prior to execution by both parties.
- f) The Physician financial arrangement must not violate the Stark law, the anti-kickback statute (section 1128B(b) of the Act) or any Federal or State law or regulations.
- g) The Physician Contract will permit the Hospital to suspend performance under the Physician Contract if there is a compliance concern. Concerns about compliance should be directed to Compliance, Legal, or the office of the Chief Medical Officer (“CMO”). Performance under Physician Contracts deemed to not meet the administrative guidelines shall be suspended until the Physician Contract can be remedied.
- h) Physician Contracts must contain termination without cause provisions (except for real estate and equipment leases). Physician Contracts which grant an exclusive right to Hospital-based physicians to perform services may not exceed five years. If a Physician Contract is terminated, then the Hospital may not enter into a new financial arrangement with the same Physician covering the same arrangement on different terms within twelve (12) months of the effective date of the terminated Physician Contract.
- i) Physicians with potential conflicts of interest must complete a conflict of interest form (see Policy 4.00) that must be reviewed by the



POLICY/PROCEDURE TITLE: ~~Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval~~
~~Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval~~
~~Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval~~
Last Approval Date: 06/2017

Compliance Officer prior to entering into a Physician Contract. The conflict must be addressed and referenced in the Physician Contract. A conflict may prevent entry into a Physician Contract.

- j) All Physician Contracts must be prepared using the appropriate Hospital contract template prepared by Legal Services. All Physician Contracts must be drafted by personnel designated by Legal Services.
 - k) Attached to the final version of a Physician Contract prior to execution by Hospital must be a completed “Contract Cover Sheet and Summary of Terms” and a signed “Certification of Necessity and Fair Market Value” (Appendix A); ~~a~~ a Physician Lease Contract must also include a signed “Contract Certification” (Appendix B) and “Lease Contract Review Checklist” (Appendix C) to be reviewed and approved by Legal Services and Compliance.
 - l) All executed Physician Contracts must be scanned into the Meditract system.
 - m) Payments may not be made to a Physician unless there is adherence with all of the requirements of this Policy.
 - n) Each Physician Contract shall comply with all applicable laws.
2. **Medical Director Contracts:** In addition to the criteria set forth above (D.1) for *All Physician Financial Arrangements*, the following must be met *prior* to creating, renewing or amending a Medical Directorship:
- a) A Medical Directorship may not be intended or used as a means to recruit a Physician to practice at the Hospital.
 - b) A Medical Directorship must fit within a rational management framework that optimizes coordination of the Medical Director’s knowledge and work efforts with Hospital needs and resources. To meet this requirement, the Medical Director must work with, and be accountable to, a supporting Hospital manager-partner who is a Hospital supervisor, manager or executive director who verifies the

Formatted: Not Highlight

Formatted: Not Highlight

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Last Approval Date: 06/2017

- Medical Director's work and efforts. ~~The Hospital manager partner~~ Designated Manager shall participate in the negotiation of the Medical Director Contract, including setting duties and goals, and will be familiar with the details of the Medical Director ~~Contract~~. The CMO will evaluate and approve all Medical Director contracts.
- c) The number of hours assigned to the Medical Directorship must be appropriate considering the work required. Medical Director contracts are typically a two-year term and upon renewal, a ~~An annual~~ evaluation shall be conducted by the CMO and the ~~Hospital manager partner~~ Designated Manager to evaluate whether all such services are needed in any new or renewal term, whether new services are needed and if the hours are still reasonable and necessary for the legitimate business purpose of the Medical Directorship arrangement. The proposed services may not duplicate work that is provided to the Hospital by other Physicians unless the total work under all arrangements are needed.
 - d) Medical Director Contracts must require Physician completion and submission of a ~~P~~physician ~~t~~ Sstudy ~~R~~reports ~~(see Exhibit C)~~ each month, and each such report must be approved by the ~~Hospital manager partner~~ Designated Manager and the Compliance Department before any compensation is paid. There must be one or more internal review processes to verify that the Medical Director is performing the expected duties and tasks, of which the required time report is one example.
 - e) All Medical Director Contracts providing for total compensation of \$30,000 or more shall include two (2) annual quality incentive goals that support the Hospital's strategic initiatives, one of which shall be related to an outcome quality metric and the other shall be related to a process metric or milestone for service to patients, unless an exception is approved by the CMO for two (2) process goals. For Medical Director Contracts greater than \$100,000 in compensation per year, 20% of the total compensation will be held at risk based on the completion of the quality incentive goals. For Medical Director Contracts between \$50,000 to \$99,999 per year, 10% of the total

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

POLICY/PROCEDURE TITLE: Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval

Last Approval Date: 06/2017

compensation will be held at risk based on the completion of the goals. For Medical Director Contracts between \$30,000 to \$49,999 per year, 5% of the total compensation will be held at risk based on the completion of the goals.

~~f) If a Medical Director would oversee a function in a service line, then a development and selection committee (that includes at least one physician leader in the service line) will evaluate the candidates and recommend a final candidate with whom the Hospital should negotiate. An effective alignment of the Physician and the service line should be created.~~

~~g) If the Medical Directorship is intended to oversee a function outside of a defined service line, the CMO will evaluate and approve the Medical Director candidates for the proposed function.~~

~~h) Each year, the Medical Executive Committee will review a summary report of all Medical Directorship arrangements and goals.~~

~~i) Medical Director Contracts must include a Hospital-approved HIPAA Business Associate Agreement.~~

3. Physician Consulting Contracts:

In addition to the criteria set forth in the *All Physician Financial Arrangements* section (D.1) above, the following criteria must be met *before* creating or renewing a Physician Consulting Contract:

- a) Physician Consulting Contracts must require concise deliverables and due dates and require completion of a ~~P~~physician ~~T~~ime ~~S~~tudy ~~R~~eport ~~(see Exhibit C)~~. The deliverables and due dates must be set for the duration of the Physician Consulting Contract before the services begin and the Physician Consulting Contract is signed.
- b) The number of hours assigned to the Physician Consulting Contract must be appropriate in light of the work required.
- c) Physician Consulting Contracts must include a Hospital-approved HIPAA Business Associate Agreement.

POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
~~Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval~~
~~Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval~~
Last Approval Date: 06/2017

4. Physician Lease Contracts:

In addition to the criteria set forth in the *All Physician Financial Arrangements* section above (D.1), the following criteria must be met *before* creating, amending, or renewing a Physician Lease Contract:

- a) Attached to the final version of a Physician Lease Contract, and prior to execution, must be a completed "Lease Contract Review Checklist" (Appendix C) and an executed "Contract Certification" (Appendix B).
- ~~b)~~ The Physician Lease Contract shall confirm total measurement of the space to be utilized by Physician under the lease.
- ~~c)~~ The Physician Lease Contract ~~must~~ be supported by fair market value documentation from a property appraiser or brokers opinion of value.
- ~~b)d)~~ Tenant Improvements must be incorporated into the Physician Lease Contract as a Tenant expense.
- ~~e)e)~~ Physician must not use the space and the Hospital must not make the space available for use prior to the execution of the Physician Lease Contract by both parties.
- ~~f)f)~~ The Physician Lease Contract shall require that all property taxes are to be paid by the Tenant for Triple Net leases.
- ~~e)g)~~ Physician Lease Contracts are executed by the CEO or the CASO.

5. Physician Education, Training and Conference Payment Contracts:

In addition to the criteria set forth in the *All Physician Financial Arrangements* section above (D.1) , the following criteria must be met *before* creating a new Education, Training and Conference Reimbursement Contracts and prior to attendance:

- a) Physician Education, Training and Conference Payment Contracts must be created and reimbursed in accordance with Hospital Policy Reimbursement of Business, Education and Travel Expenses (see Hospital Policy 5.00).
- b) The Hospital's need for this training to be provided to the Physician shall be documented as part of the approval process.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.



POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
~~Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval~~
~~Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval~~
Last Approval Date: 06/2017

6. Physician Recruitment Contracts:

In addition to the criteria set forth in the *All Physician Financial Arrangements* section above (D.1), the following criteria must be met *before* creating a new Physician Recruitment Contract:

- a) Physician Recruitment Contracts must be created in accordance with the Physician Recruitment Policy Program, (see Hospital Policy 42.00) and must be presented to the Board for review before the recruitment proposal is developed.

B. Approval of Physician Contracts:

1. Attached to the final version of a Physician Contract *before* CEO execution must be a completed “Contract Cover Sheet and Summary of Terms” and “Certification of Necessity and Fair Market Value” (Appendix A).
2. Attached to the final version of a Physician Lease Contract, *prior* to execution by the CEO or the CASO, must be a completed “Lease Contract Review Checklist” (Appendix C) ~~and signed~~ and signed “Contract Certification” (Appendix B).
3. Corporate Compliance and the General Counsel will verify the checklist, certification, and documentation accompanying all Physician Contracts (including FMV) prior to execution by the CEO or the CASO. Incomplete or missing checklist and certifications will be returned to the originator for completion.
4. All proposed Physician Contracts lacking the appropriate documentation will be returned to the originator for completion. No services may be performed under the Physician Contract or leases implemented until the Physician Contract is fully executed.
5. CEO Approval: The CEO will have authority to execute new, renewal and amended Physician Contracts (up to \$250,000.00 in total possible compensation annually), except as set forth in Section 6(~~bc~~) below.

If a new arrangement is over \$250,000.00; or a renewal or amended ~~agreement~~ related to compensation -is over \$250,000; or the annual

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Last Approval Date: 06/2017

increase is greater than ten percent (10%), the Board must approve prior to CEO execution, except as set forth in Section 6(~~bc~~) below. All recruitment proposals must be approved prior to the CEO executing.

6. Board Approval:

or amended agreement is over \$250,000; or the annual increase is greater than ten percent (10%), the Board must approve prior to CEO execution of the Physician Contract.

- ~~a-6.~~ If a new arrangement is over \$250,000.00; or a renewal or amended agreement is over \$250,000; or the annual increase is greater than ten percent (10%), the Board must approve prior to CEO execution of the Physician Contract.

→ a) All ~~new~~ Physician financial arrangements that exceed \$250,000 annually should be presented to the appropriate Board Committees for review and recommendation to the Board of Directors prior to being placed on the Board of Directors' agenda and prior to execution.

→ b) A memo prepared by ~~Hospital Manager Partner~~ Designated Manager that justifies the Hospital's needs shall be provided to the appropriate Board Committees and Board of Directors as part of the approval documents.

B. c). Notwithstanding Section 6(a), the CEO may execute without Board approval a ~~new~~ renewal or amended Professional Services Agreement with ~~SV Primary Medical Group, P.C.~~ El Camino Medical Associates ("~~SVPMG~~ECMA") so long as the total cash compensation to each individual physician employed by ~~SVPMG-ECMA~~ does not exceed 75% percentile of fair market value or \$1,000,000 annually.

C. Board Oversight and Internal Review Process:

During the ~~second and fourth~~ third quarter of each Hospital fiscal year, management and staff will prepare a summary report for all Physician financial arrangements describing: 1) the names of all such arrangements and associated physicians, 2) the organizational need that justifies each arrangement, 3) the total

Formatted: Indent: Left: 0.75", Hanging: 0.38", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Tab after: 1.5" + Indent at: 1.5", Keep with next, Tab stops: 1.25", List tab + Not at 1.5"

Formatted: Indent: Left: 1.44", No bullets or numbering

Formatted: Indent: Left: 1.5", No bullets or numbering

Formatted: Indent: Left: 1.5", Tab stops: 1.44", Left



POLICY/PROCEDURE TITLE: Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval
Last Approval Date: 06/2017

amounts paid to each physician and/or group for each Physician Contract annually (and in total for duration on of contract term), 4) current and prior year annual financial comparison, ~~5) Education, Training or Conference Contracts that reimburse for travel expenses out of the state of California,~~ and ~~6) any~~ recommendations for changes to the Policy or any procedure.

For Medical Directorships, the summary report will also include: 1) the goals set forth for each Medical Directorship, 2) the contracted rate and hours, and 3) assessment of the performance goals of Medical Directors over the past year.

The CFO, COO & CMO will review the information and prepare recommendations if any regarding specific actions or changes that will be implemented.

The report will then be reviewed by the CEO and presented to the Compliance and Finance committees of the Board of Directors for review and submission to the Board of Directors no later than the end of the following quarter.

D. Exceptions:

There are no exceptions to this Policy unless approved by the Board of Directors in advance.

E. Review and/or Validate:

The CEO and the Corporate Compliance Officer shall be responsible for reviewing the policy and guidelines as conditions warrant but at a minimum at least annually to assure consistency with Board expectations. The Compliance department will annually monitor organizations adherence to the policy and report to the Board.



POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval
Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval

Last Approval Date: 06/2017

F. Policy Enforcement

El Camino Hospital's Compliance Officer is responsible for monitoring enforcement of this policy. Any workforce member found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

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

Historical Approvals:

New 6/08, 06/09; 8/12, 10/12, 11/13, 1/14, 5/14

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.



POLICY/PROCEDURE TITLE: Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval

APPENDIX A
ECH Contract Cover Sheet and Summary of Terms

Physician/Physician Group Name Party to Agreement:

Type of Agreement: ☐ Medical Director ☐ Consulting Services ☐ Professional Services
 ☐ ED Call ☐ Hospital-Based Physician Services
 ☐ Other:

Agreement is: ☐ New ☐ Amendment ☐ Extension ☐ Renewal

Department/Program:

Campus:

Designated ECH Manager:

Effective Date:

Expiration Date:

Need for Agreement:

Reason Physician or Physician group was chosen for the position:

Number of Hours to be Worked:

Hourly/PerDiem Rate to Physician/Physician Group:

Does Agreement include two Quality Goals for Medical Directorships, if Total Annual Compensation is greater than \$30,000.00 annually:

Total Annual Amount:

Finance Committee Review and Board approval required under Policy 51.00:

☐ No ☐ Yes (if yes, attach approval documentation)

Approvals

Compliance: _____ Date: _____

Legal: _____ Date: _____

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.



POLICY/PROCEDURE TITLE: Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval

CERTIFICATION OF NECESSITY AND FAIR MARKET VALUE:

I certify that: (1) the services to be provided by Physician/Medical Group are reasonable and necessary because

____; and (2) the compensation proposed for this arrangement is fair market value because (check one):

____ MD Ranger Data attached hereto, is at or below the 75th percentile, or

____ I have a FMV opinion, attached hereto, which demonstrates fair market value.

Signature: _____

Designated ECH Manager

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.



POLICY/PROCEDURE TITLE:Corporate Compliance:51.00 Physician Financial Arrangements - Review and Approval

APPENDIX B

Contract Certification

I, _____ of El Camino Hospital hereby certify that to the best of my knowledge,
(responsible party negotiating)

the following matters are true for the attached contract by and between El Camino Hospital and _____
(Physician) dated _____ (the "Arrangement").

- 1) There are no other arrangements, written or oral with the physician except set forth in the Arrangement;
- 2) No payment has been or will be made to the physician referenced herein outside of the terms and condition of the arrangement unless such outside payment is also consistent with El Camino Hospital's policies;
- 3) The contract is in compliance with Administrative Policy 51.00 guidelines.
- 4) All of the statements above and in the Compliance Checklist are complete and correct.

Date: _____ Signature: _____
(Hospital responsible party negotiating)

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.



POLICY/PROCEDURE TITLE: Corporate Compliance: 51.00 Physician Financial Arrangements - Review and Approval

CATEGORY: Administrative

LAST APPROVAL DATE:

APPENDIX C

Lease Contract Review Checklist

- Yes ___ No ___ 1. Is the term of the Physician Lease Contract for at least one year?
- Yes ___ No ___ 2. Does the Physician Lease Contract describe what is being leased and all services that will be included?
- Yes ___ No ___ 3. Are the costs of Tenant Improvements incorporated into the Physician Lease Contract?
- Yes ___ No ___ 4. Have fair-market value (FMV) rates been determined based at time of signing? [The Physician Lease Contract]
- Yes ___ No ___ 5. Does the lease rate include an inflator value for future FMV?
- Yes ___ No ___ 6. Is Physician using the space now?
- Yes ___ No ___ 7. Will all applicable property taxes be paid by the Physician under the Physician Lease Contract?
- Yes ___ No ___ 8. Were any loans or loan guarantees made to the Physician?
- Yes ___ No ___ 9. Was the Hospital template used to create this Physician Lease Contract?
- Yes ___ No ___ 10. Were any of the terms modified? If yes, attach a copy marked to show changes.
- Yes ___ No ___ 11. Within 5 days after final execution, the Physician Lease Contract must be forwarded for scanning into Meditract.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

[illegible]

Formatted: Font: 36 pt

REPORT

17

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Review IT Security Awareness Training Content Corporate Compliance/Privacy and Internal Audit Committee January 18, 2018
Responsible party:	Diane Wigglesworth, Sr. Director, Corporate Compliance
Action requested:	For Information
Background: <p>At the August 17, 2017 meeting the committee reviewed the IT Security Awareness Training plan. The plan presented included educational on-line training, security awareness highlighted through monthly emails along with periodic huddles with departments and executives, and testing effectiveness of the training with phishing campaigns, employee interviews, and HelpDesk tickets. The Committee requested that staff bring back the content of the on-line training modules.</p>	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: None	
Summary and session objectives : <p>To provide additional detail to the Committee about the on-line HealthSteam training modules that staff complete annually.</p>	
Suggested discussion questions: None.	
Proposed Committee motion, if any: <p>None. This is an informational item.</p>	
LIST OF ATTACHMENTS: <ol style="list-style-type: none"> 1. Summary of the annual HIPAA and Security Training modules for employees 2. Policy attestation all employees acknowledge annually after completing training 	

HIPAA COMPLIANCE FOR PROVIDERS LIBRARY
TABLE OF CONTENTS

INTRODUCTION COURSE	2
HIPAA AWARENESS	2
PRIVACY RULE INTRODUCTION	2
PROTECTED HEALTH INFORMATION	3
PATIENT RIGHTS	3
WORKING WITH BUSINESS ASSOCIATES	3
LAW ENFORCEMENT USES AND DISCLOSURES	3
SECURITY AWARENESS	3
SECURITY RULE INTRODUCTION	4
ADMINISTRATIVE SAFEGUARDS	4
PHYSICAL SAFEGUARDS	4
TECHNICAL SAFEGUARDS	4
ELECTRONIC TRANSACTIONS	5
POLICY ATTESTATION.....	5

HCCS HIPAA COMPLIANCE FOR PROVIDERS LIBRARY

Introduction Course

Introduction

- Video depicting challenges of maintaining privacy and security faced by healthcare organizations
- Introduction to HIPAA.

Conclusion

HIPAA Awareness

Introduction

- Video depicting a breach of patient privacy

Introduction of Protected Health Information

Notice of Privacy Practices

Explanation of Covered Entity

Basic premise for disclosures

Reporting options

Non-retaliation

Interactive exercises

Conclusion

Quiz

Privacy Rule Introduction

Introduction

- Video depicting the need to protect patient privacy

Minimum Necessary

Notice of Privacy Practices – requirements

Interactive exercise

Conclusion

Quiz

Protected Health Information

Introduction

Explanation of Protected Health Information

Disclosure

- Treatment, Payment and Healthcare Operations
- Authorization
- De-Identification
- Marketing
- Incidental Disclosures

Interactive exercises

Conclusion

Quiz

Patient Rights

Introduction

- Video depicting a patient's request for records

Patient rights regarding Protected Health Information

- Access
- Minors
- Amendments to the record
- Accounting of disclosures
- Confidential communications
- Restriction requests

Interactive exercise

Conclusion

Quiz

Working with Business Associates

Introduction

- Video discussing contract language

Definition of Business Associate

HIPAA requirements for Business Associates

Business Associate agreements

Interactive exercise

Conclusion

Quiz

Law Enforcement Uses and Disclosures

Introduction

- Video depicting Emergency Department scene with request from law enforcement

Uses and disclosures for law enforcement purposes

Uses and disclosures for health and safety

Legal requests for protected health information

Interactive exercise

Conclusion

Quiz

Security Awareness in the Healthcare Setting

Introduction

Understanding Threats

Physical Security

Safe Computing

Safe Remote and Mobile Computing

Protecting and Handling Data

Conclusion

Quiz

Security Rule Introduction

Introduction

Covered forms of protected health information

Requirements for covered entities

Keeping electronic protected health information secure

Designation of a Security Officer

Portable devices

Implementation specifications requirements

Interactive exercises

Conclusion

Quiz

Administrative Safeguards

Introduction

- Video depicting appropriate access

Administrative safeguards standards

Creating a secure password

Cybersecurity

Interactive exercises

Conclusion

Quiz

Physical Safeguards

Introduction

Physical safeguard standards

Definition of data integrity

Definition of encryption

Keeping medical devices secure

Disposal

Interactive exercises

Conclusion

Quiz

Technical Safeguards

Introduction

Technical safeguard standards

- Access control
 - User identification
 - Emergency access
 - Automatic log off
 - Encryption and decryption
- Audit controls
- Integrity

- o Integrity controls
- o Encryption ‘
- Person or entity authentication
- Transmission security

Interactive exercise

Conclusion

Quiz

Electronic Transactions

Introduction

Electronic transactions standards

- Claims and encounter information
- Payment and remittance advice
- Claims status
- Referral certification
- Coordination of benefits
- Health plan premiums
- Enrollment/disenrollment
- Eligibility

Operating rules required by the Affordable Care Act

Code sets

Unique identifiers in transactions

Conclusion

Quiz

Policy Attestation

TITLE: 07.c1 Acceptable Use Workforce Communication

CATEGORY: 7.01 Responsibility for Assets

LAST APPROVAL:

TYPE:

☐ Policy ☐ Protocol ☐ Practice Guideline ☐ Standardized
☒ Procedure ☐ Plan ☐ Scope of Service Procedure

SUB-CATEGORY: *(This is the sub-category, i.e. pharmacy, environmental Services , facilities...etc.)*

OFFICE OF ORIGIN: *(please list department or unit)*

ORIGINAL DATE:

I. COVERAGE:

This procedure applies to all workforce members that access or uses El Camino Hospital information systems, IT assets, medical devices or restricted physical areas.

II. PURPOSE:

To communicate to the workforce members the rules for the acceptable use of information, information systems, IT assets, medical devices and access to restricted areas within the hospital or on the premises.

III. POLICY REFERENCE:

The policy that is implemented by this procedure is titled “7.01 Responsibility for Assets”.

IV. DEFINITIONS (if applicable):

1. ISO - Information Security Office
2. MSO – Medical Staff Office

V. PROCEDURE:

ECH Asset Ownership Rights

The ISO in collaboration with Human Resources and other departments or organizations (MSO) with authorization to on-board and off-board workforce members must inform each workforce member that ECH retains ownership rights to all information, information systems, IT assets, medical devices, and physical protected areas.

This includes but is not limited to PHI, PII, sensitive data, financial data or business related documentation.

The Acceptable Use Workforce Communication and the Confidentiality Statement (2.01) are the tools ECH uses for communicating asset ownership rights and recording workforce attestation.

TITLE: 07.c1 Acceptable Use Workforce Communication

CATEGORY: 7.01 Responsibility for Assets

LAST APPROVAL:

Workforce Member Privacy

Workforce members with access to information systems, IT assets, medical devices and physical protected areas are advised that their use of these resources and certain communications are subject to monitoring and filtering.

ECH reserves the right to monitor the use of Internet and ECH information systems, IT assets, and medical devices connections and traffic.

Any activity conducted on the ECH network or resources (including but not limited to computers, networks, medical devices, mobile devices, e-mail, storage devices, etc.) may be monitored, logged, recorded, filtered, archived, or captured for other purposes applicable to ECH policies and procedures or federal and state laws or regulations.

ECH reserves the right to perform these actions with or without specific notice to the workforce member.

Workforce Member Role and Responsibility

ECH leaders authorizes access to ECH resources and ensures workforce members use their access rights to data, information systems, IT assets, medical devices and physical protected areas on behalf of ECH in a manner that does not violate ECH policies and procedures or federal and state laws or regulations.

Workforce members must complete the annual “**Security Awareness in the Healthcare Setting**” that is offered through the HealthStream system. Workforce members acquire security insight and training on the following subjects:

- **Understanding Threats**
 - Reporting an Incident
- **Physical Security**
 - Securing Work Areas and Resources
 - Access Controls
- **Safe Computing**
 - Electronic Threats
 - Social Engineering Threats
 - Phishing Threats
 - Ransomware
 - Password Guidelines
 - Electronic Communications
 - Acceptable Use

TITLE: 07.c1 Acceptable Use Workforce Communication

CATEGORY: 7.01 Responsibility for Assets

LAST APPROVAL:

- Social Media Risks and Benefits at a Glance
- **Safe Remote and Mobile Computing**
 - Protecting Data on Mobile Devices
 - Safe Computing Away from the Office
 - Connecting Securely to Networks
- **Protecting and Handling Data**
 - Data Classifications
 - Data Storage, Retention, and Destruction
 - Data Transmission

Workforce members must complete and pass an assessment to receive credit in the HealthStream system. A record is maintained as evidence that each workforce member's security and awareness training is current for the year.

Cybersecurity bulletins and department huddles are other avenues where workforce members are provided security awareness training.

Acceptable Use Rules

Workforce members are expected to use data, information systems, IT assets, medical devices and physical protected areas responsibly and professionally by obeying and agreeing:

- To protect the confidentiality, integrity and availability of ECH data by behaving in a manner consistent with ECH policies that explicitly states ECH workforce members will comply with all applicable federal and state laws or regulations.
- To follow and obey the procedures, standards and guidelines for the data, information systems, IT assets, medical devices and physical protected areas to which the workforce member has been granted access.
- To report any potential or identified privacy or security incident to the ECH leader, Help Desk, Compliance Office or ISO.
- To ensuring incidental personal use of ECH information systems, IT assets, medical devices and physical protected areas is used in a reasonable manner as long as:
 - Such use does not adversely impact productivity or duty performance
 - Such use does not incur unauthorized charges or legal action against ECH
 - Such use does not cause intentional damage to ECH information systems, IT assets, medical devices and physical protected areas

TITLE: 07.c1 Acceptable Use Workforce Communication

CATEGORY: 7.01 Responsibility for Assets

LAST APPROVAL:

- To respect the security and integrity of ECH resources.
- To be considerate of the needs of other workforce members by making every reasonable effort not to impede the ability of others to utilize resources and show restraint in the consumption of shared resources.
- To respect the rights and property of others, including but not limited to; privacy, confidentiality and intellectual property (e.g. copyright, trademarks, etc.).
- To follow and obey contractual and license agreements when using third party resources.
- To cooperate appropriately during incident response and investigation of potential unauthorized or illegal use of resources.

Permissible Uses

- Workforce members may download audio or video stream for a work-related webinar or audio conference with prior authorization from the ISO.

Prohibited Uses

Workforce members may not do any of the following:

- Attempt to disguise their identity, the identity of their account or the resource that they are using.
- Attempt to impersonate another person (i.e. use another person's account) or misrepresent the department's name, resource names, or network address spaces.
- Attempt to intercept, monitor (i.e. read), forge, alter (i.e. change) or destroy (i.e. delete) another workforce member's communications without prior written permission from the ISO.
- Use resources in a way that disrupts or adversely impacts (degrades performance) their legitimate uses or creates interference to other users. Such conduct includes, but is not limited to: hacking; illegal peer-to-peer file sharing; unauthorized alteration of resources that are likely to result in the loss of work, resource downtime; or excessive consumption resulting in congestion that interferes with the work of others.

TITLE: 07.c1 Acceptable Use Workforce Communication

CATEGORY: 7.01 Responsibility for Assets

LAST APPROVAL:

- Use resources in an unlawful or illegal manner, including but not limited to; cyberstalking; threats of violence; obscenity; adult pornography; child pornography; or any form that would constitute a criminal offense, a civil liability, or violation of any applicable federal and state laws or regulations. In addition, users may not intentionally access, create, store or transmit material which may be deemed to be offensive, indecent or obscene. This applies to any digital communication associated with an ECH information systems, IT assets, or medical device.
- Use resources for private business, commercial or political activities, fundraising, non-departmental advertising, or activity that is prohibited by ECH.
- Download, install or run security software or utilities that reveals weaknesses in resources (e.g. vulnerability scanning, port mapping, network-mapping, etc.); monitors or intercept communications (e.g. packet sniffers, keystroke loggers, etc.); or allows for the attempting to bypass security controls (e.g. password crackers, etc.) without written permission from the ISO.
- Download, install or distribute software without prior coordination and written permission from the ISO.
- Knowingly take any action which has the likelihood of introducing any virus, Trojan, malware (spyware, bot, ransomware, etc.) or other harmful software onto information systems, IT assets, or medical devices; nor should action be taken to deliberately circumvent controls designed to prevent such threats.
- Attempt to access restricted resources or communications without authorization by the appropriate owner or administrator.
- Engage in the unauthorized copying, distributing, altering or translating of copyrighted materials, software, music or other media without the express permission of the copyright holder or as otherwise allowed by law and coordinated through the ISO.
- Use resources in a manner that allows for the unauthorized gathering, dissemination or disclosure of confidential data (social security numbers, Personally Identifiable Information (PII), credit card numbers, medical records, Federal Tax Information (FTI), etc.)

TITLE: 07.c1 Acceptable Use Workforce Communication

CATEGORY: 7.01 Responsibility for Assets

LAST APPROVAL:

- Extend, modify or retransmit network resources beyond what has been configured accordingly by Technical Services through the installation of software or hardware (e.g. switches, routers, wireless access points, etc.) without prior written permission from Technical Services or ISO is forbidden.
- Connecting personal devices to the ECH network without prior written permission from the ISO is forbidden (this requirement does not apply to “guest” Wi-Fi networks).
- Connect personally-owned “smart” devices (thermostats, wearable tech, gaming devices, or appliances) to the ECH network is forbidden.
- Sharing personal account(s), passwords, Personal Identification Numbers (PIN), Security Tokens (i.e. Smartcard), or other similar information or devices used for identification and authorization purposes on ECH information systems, IT assets, or medical device is forbidden.
- Downloading ECH sensitive data (PHI, PII or Financial) to personally owned devices without prior written permission from the ISO.
- Attempt to obtain extra resources beyond those allocated, or circumvent information security measures is forbidden.
- Discarding or abandoning information systems, IT assets, or medical devices that contains sensitive data (PHI, PII or Financial) is forbidden and may result in disciplinary actions.
- Releasing information systems, IT assets, or medical devices that contains sensitive data (PHI, PII or Financial) to an external source that does not have an appropriate contract to authorize their use of the data is forbidden and may result in disciplinary actions. The ISO must be consulted to determine if data sanitization or media destruction is applicable.

VI. APPROVAL:

APPROVERS	NAME	APPROVAL DATES
Technical Services — Leader		
InfoSec — CISO		
Information Services Division — CIO		
Historical Approvals:		

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

TITLE: 07.c1 Acceptable Use Workforce Communication

CATEGORY: 7.01 Responsibility for Assets

LAST APPROVAL:

VII. ATTACHMENTS (if applicable):

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Key Performance Indicators Corporate Compliance/Privacy and Internal Audit Committee January 18, 2018
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. The overall number of issues brought to Compliance and investigations completed in the last 6 months is trending down slightly from the same time period in the previous fiscal year. There has been a slight increase in the total number of privacy breaches self-reported by the hospital to CDPH. All incidents have been reviewed for corrective action to mitigate further errors. The number of hotline calls remains consistent and the majority of concerns or risks have been brought forth by management or employees directly to the Compliance Department.	
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

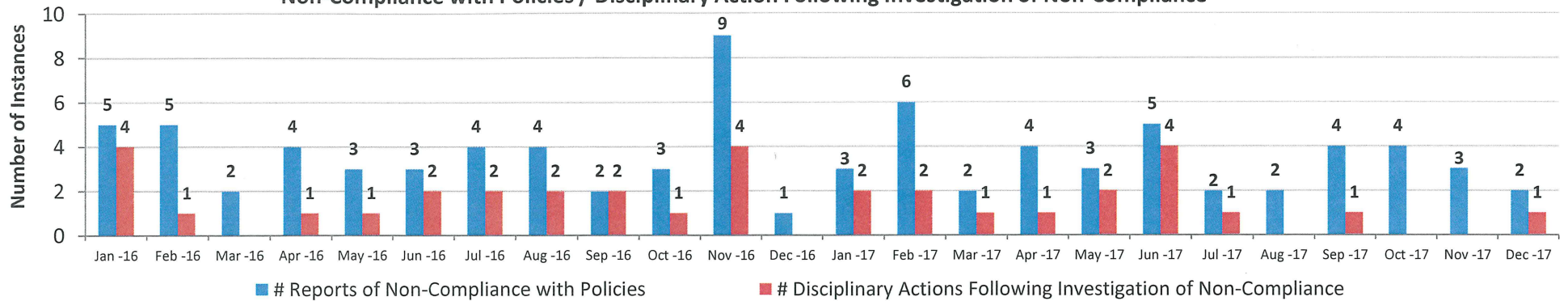
El Camino Hospital

Key Performance Indicator	FY18 Current Month	Current YTD Actual	Prior YTD Actual
Total Number of Hospital Discharges (excluding normal newborn)	1,780	10,016	9,352
Core Elements			
Policies and Procedures	Dec. 2017	Jul - Dec. FY 2018	Jul -Dec. FY 2017
Number of reported instance when policies not followed	2	17	23
Number of disciplinary actions due to Investigations	1	3	11
Education and Training	Dec. 2017	Jul - Dec. FY 2018	Jul -Dec. FY 2017
Percentage of new employees trained within 30 days of start date	100%	100%	100%
Investigations	Dec. 2017	Jul - Dec. FY 2018	Jul -Dec. FY 2017
Total number of investigations	24	128	146
Investigations open	1	2	0
Investigations closed	23	126	146
Hotline concerns substantiated	0	9	12
Hotline concerns not substantiated	1	8	8
Average number of days to investigate concerns	7	7	7
Reporting Trends	Dec. 2017	Jul - Dec. FY 2018	Jul -Dec. FY 2017
Anti-Kickback/Stark	4	14	36
EMTALA	0	0	0
HIPAA Reports	11	69	81
HIPAA Security Incidents	0	3	2
Billing or Claims	5	33	47
Conflict of Interest	0	2	5
Reported Events to CMS	Dec. 2017	Jul - Dec. FY 2018	Jul -Dec. FY 2017
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 2018	Jul -Dec. FY 2017
Number of total regulator events self reported by ECH	1	15	7
Number of self reported events followed up by CDPH	2	8	7
Number of total privacy breaches self reported by ECH	2	10	13
CDPH initiated visits (separate from ECH self reported events)	0	4	10
Number of statement of deficiencies issued to ECH	0	1	2
Number of Actual/Realized Sanctions, fines or penalties	0	0	0
Monitoring and Audit Findings	Dec. 2017	Jul - Dec. FY 2018	Jul -Dec. FY 2017
Total number of Audit Findings	2	13	37
Number of findings identified has high severity	0	3	11
Monitoring and Audit Findings	Dec. 2017	Jul - Dec. FY 2018	Jul -Dec. FY 2017
Number of Open Liability Claims	7	7	8
Number of Open Liability Lawsuits	9	9	7

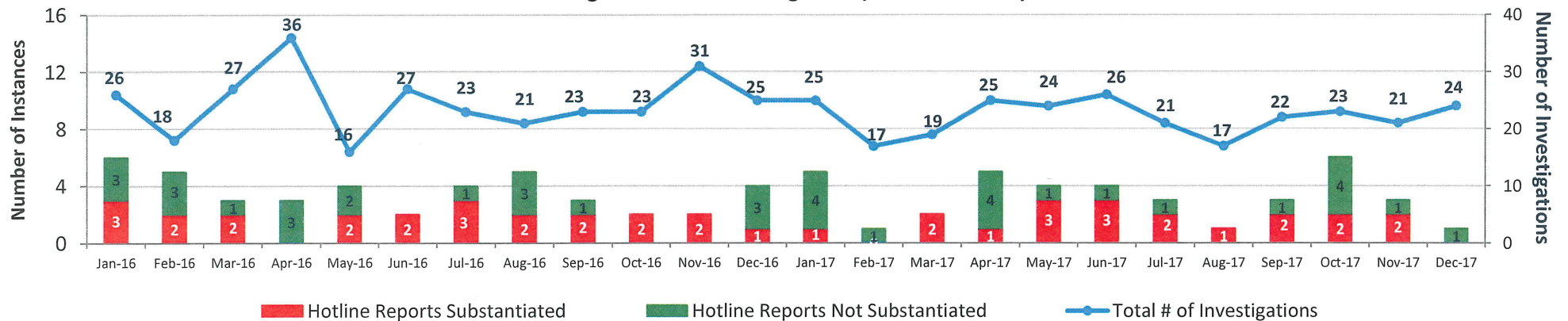
Corporate Compliance

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

