

AGENDA

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

Thursday, May 17, 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 (March 15, 2018) Information b. Status of FY18 Committee Goals c. Compliance Education (provided to Hospital Board on March 14, 2018)	Sharon Anolik Shakked, Chair	<i>public comment</i>	motion required 5:05 – 5:10
5. REPORT ON BOARD ACTIONS ATTACHMENT 5	Board Members		information 5:10 – 5:15
6. COMMITTEE CHARTER REVIEW ATTACHMENT 6	Diane Wigglesworth, Sr. Director, Corporate Compliance	<i>public comment</i>	possible motion 5:15 – 5:20
7. FY19 PROPOSED COMMITTEE GOALS AND MEETING DATES ATTACHMENT 7	Diane Wigglesworth, Sr. Director, Corporate Compliance	<i>public comment</i>	possible motion 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 – 5:30
10. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Sharon Anolik Shakked, Chair		5:30 – 5:31

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 (March 15, 2018) Information <i>Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</i> b. Compliance Log (March-April 2018) c. Privacy Log (March-April 2018) d. Internal Audit Work Plan e. Committee Pacing Plan	Sharon Anolik Shakked, Chair		motion required 5:31 – 5:35
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		information 5:35 – 6:05
13. <i>Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</i> - Report on Internal Audit Assessment and Work Plan	Alex Robison, Protiviti		information 6:05 – 6:25
14. <i>Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</i> - IT Security Discussion	Deb Muro, CIO		information 6:25 – 6:50
15. <i>Gov't Code Sections 54957 for report and discussion on personnel matters – Senior Management:</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 (*pending Committee and Board approval*)

- August 2018 (final date TBD)
- September 27, 2018
- November 15, 2018
- January 17, 2019
- March 2019 (final date TBD)
- May 15, 2019



**Minutes of the Open Session of the
Corporate Compliance/Privacy and Internal Audit Committee
Thursday, March 15, 2018
El Camino Hospital | Conference Room E
2500 Grant Road, Mountain View, CA 94040**

Members Present

Sharon Anolik Shakked, Chair
Neysa Fligor, Vice Chair
Lica Hartman
Christine Sublett
Bob Rebitzer (via teleconference)
John Zoglin

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 5:00pm by Chair Anolik Shakked. A verbal roll call was taken. Mr. Rebitzer joined the meeting via teleconference at 5:05pm and Mr. Zoglin joined the meeting in person at 5:11pm during Agenda Item 6: Review Proposed FY18 Financial Audit Plan. All other Committee members were present at roll call. Ms. Anolik Shakked noted that Ms. Cindy Fineran from Via Healthcare Consulting was present in an observational capacity to review Board Committee processes.	
2. POTENTIAL CONFLICT OF INTEREST	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	Chair Anolik Shakked asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. Motion: To approve the consent calendar: Meeting Minutes of the Open Session of the Corporate Compliance/Privacy and Internal Audit Committee (January 18, 2018); and for information: Status of FY18 Committee Goals. Movant: Sublett Second: Fligor Ayes: Anolik Shakked, Fligor, Hartman, Sublett Noes: None Abstentions: None Absent: Rebitzer, Zoglin Recused: None	Consent Calendar approved
5. REPORT ON BOARD ACTIONS	Chair Anolik Shakked referred the Committee to the recent Board actions as further detailed in the packet. Ms. Fligor reported that Bruce Harrison, President of SVMd, attended the Hospital Board’s March 14, 2018 meeting and is a welcome addition to the executive team. There were no additional questions from the Committee.	
6. REVIEW PROPOSED FY18 FINANCIAL AUDIT PLAN	Brian Conner and Joelle Pulver of Moss Adams outlined the Proposed FY18 Financial Audit Plan: - Responsibilities of Moss Adams include 1) issuing an opinion whether or not the financial statements are fairly stated in all material respects, not opining on operational effectiveness, and 2) reporting deficiencies in internal control structures that rise to a certain level;	

	<ul style="list-style-type: none"> - Mr. Conner reviewed the concept of materiality and how it is calculated; - Significant risk areas that will be monitored closely include: new projects, areas affected by accounting standards changes (like post-retirement benefits), internal control findings from the prior year, areas that involve large management estimates like Net Patient Service Accounts Receivable and Revenue (projecting future collections based on historical collections, predictive revenue analytics based on volumes) and pension liability calculations; and - Ms. Pulver described the process and consideration of fraud, including interviews with all levels of management and staff outside of finance and adding a level of unpredictability. <p>Ms. Pulver described the timeline for next steps: initial walkthroughs in April, control testing in June, completing the audit onsite in August, and drafting and presenting statements in September/October.</p> <p>In response to Ms. Wigglesworth's question, Ms. Pulver noted that Silicon Valley Medical Development, LLC (SVMD) will be reviewed by the auditors when it has grown to a size exceeding materiality, but can also be reviewed upon request.</p> <p>In response to Ms. Fligor's question, Ms. Pulver described historical audits of District expenses and the challenges related to the evaluation of Community Benefit grants. She noted that the evaluation of grants for organizations located outside the District but providing services within District boundaries or to District residents is outside of Moss Adams' scope of review.</p> <p>In response to Ms. Hartman's question, Ms. Pulver described the fees for this year's audit, noting the changes in the scope of work, as Moss Adams will not be issuing standalone statements for the Foundation (at the request of its Board) and CONCERN. Ms. Pulver reported that the total fees will be \$333,000. Ms. Hartman requested that Moss Adams provide a record of year-over-year fees in subsequent presentations.</p> <p>In response to Mr. Zoglin's questions, Ms. Pulver explained that the fees include nonattest services (assistance with statement drafting and new disclosures), which are approximately 40-80 hours of work.</p>	
<p>7. KPIs, SCORECARD, AND TRENDS</p>	<p>Ms. Wigglesworth reported that trends are consistent with the prior year and that February issues that have been reviewed and remediated included incidents related to SVMD clinics and the employed physician group, El Camino Medical Associates, P.C. She noted that the organization has had 12 privacy breaches to date through February, compared to 13 in the prior year.</p> <p>In response to Mr. Rebitzer's question, Ms. Wigglesworth explained that the items tracked on the scorecard are areas that the government considers to be high risk and should be tracked by any Compliance program. The Committee discussed their areas of focus in reviewing the trends, including the ratio of open to closed investigations, overall appropriate operations of the Compliance program, and highlights on the cover pages of any areas of concern.</p> <p>In response to Chair Anolik Shakked's question, Ms. Wigglesworth described the types of events reported to CDPH so far this year, but noted that they have been varied, CDPH has not issued findings, and the reportable events are not indicative of any sort of trend.</p>	

<p>8. ADJOURN TO CLOSED SESSION</p>	<p>Motion: To adjourn to closed session at 5:42pm pursuant to <i>Gov't Code Section 54957.2</i> for approval of Minutes of the Closed Session of the Corporate Compliance/Privacy and Internal Audit Committee Meeting (January 18, 2018); pursuant to <i>Gov't Code Section 54956.9(d)(2)</i> – conference with legal counsel – pending or threatened litigation: for information (Compliance Log, Privacy 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>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 – Senior Management.</p> <p>Movant: Sublett Second: Zoglin Ayes: Anolik Shakked, Fligor, Hartman, Rebitzer, Sublett, Zoglin Noes: None Abstentions: None Absent: None Recused: None</p>	<p><i>Adjourned to closed session at 5:42pm.</i></p>
<p>9. AGENDA ITEM 15: RECONVENE OPEN SESSION/ REPORT OUT</p>	<p>Open session was reconvened at 6:36pm. Agenda Items 9-14 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 (January 18, 2018) by a unanimous vote of all members present (Anolik Shakked, Fligor, Hartman, Rebitzer (via teleconference) Sublett, Zoglin).</p>	
<p>10. AGENDA ITEM 16: COMMITTEE SELF-ASSESSMENT RESULTS</p>	<p>In response to Director Zoglin's question, Cindy Murphy, Director of Governance Services, (participating via teleconference) reported that the survey was conducted in December 2017.</p> <p>The Committee discussed the opportunities for improvement related to communication between the Committee and the Board. The Committee discussed different formats that may be useful: written reports on the consent calendar, joint meetings with the Committee, and report outs from the Board members on the Committee. Chair Anolik Shakked suggested that the Board be queried about what information the Board would like to see from the Committee. Mr. Rebitzer suggested that Committee communication to the Board be on an issue basis.</p> <p>The Committee suggested that the item related to "working with the external auditor to resolve any issues brought forth" either be clarified or removed in subsequent surveys, as it did not seem appropriate as written.</p> <p>The Committee discussed how the Committee's work ties to the overall organizational strategy: 1) Some of the Committee's work is a "must have," for general organizational operations regardless of strategy; 2) strategy can be linked to risk (mitigating risk to achieve strategic goals, Enterprise Risk Management).</p> <p>Ms. Fligor suggested that staff share a copy of the strategic plan with the Committee members.</p>	
<p>11. AGENDA ITEM 17: COMMITTEE CHARTER</p>	<p>Ms. Wigglesworth noted that the Committee reviews its charter every two years.</p> <p>In response to Ms. Hartman's question, Ms. Wigglesworth described the use</p>	<p><i>Proposed revisions to be discussed</i></p>

<p>REVIEW</p>	<p>of internal versus external resources to conduct internal audits.</p> <p>Chair Anolik Shakked suggested the following revisions:</p> <ul style="list-style-type: none"> - In Section C (External Audit Functions), replace “Ensure that the external auditors have the opportunity to meet with the Board to present the annual audit report and financial statements” with “Review the external auditor reports and financial statements before presentation to the Board. Make recommendations to the Board.” - All references to the Committee should reflect all areas of the Committee’s scope of work: Compliance, Privacy, Audit, Enterprise Risk Management, and Information Security. - Replicate “Recommend policies and processes for approval by the Board” relating to compliance, audit, privacy, and IT security. <p>The Committee noted that the Committee’s abbreviated name should be “Compliance and Audit Committee.”</p> <p>Ms. Fligor requested additional information about the independent director appendix. Ms. Sublett requested that there be specific duties related to IT Security in the charter.</p> <p>The Committee requested that staff bring back proposed revisions to the charter to the Committee’s May meeting for review.</p> <p>Mr. Rebitzer discontinued participation in the meeting at 7:06pm.</p>	<p><i>at the Committee’s May meeting</i></p>
<p>12. AGENDA ITEM 18: FY19 PROPOSED COMMITTEE GOALS AND MEETING DATES</p>	<p>The Committee discussed the proposed goal related to the Self-Assessment and improving the operations of the Committee. Chair Anolik Shakked commented that Committee goals should move an organization forward from a programmatic maturity or a compliance standpoint. Ms. Fligor suggested that there should be goals focused on both the Committee and on the organization.</p> <p>The Committee requested that staff solicit Committee member feedback and compile a list of proposed goals for consideration.</p> <p>The Committee discussed availability for the proposed dates. Ms. Sublett noted that she is unable to attend two of the proposed meeting dates (August and March). The Committee requested that staff provide alternatives at the Committee’s next meeting.</p>	<p><i>Further discussion on goals and dates to be paced for the Committee’s May meeting</i></p>
<p>13. AGENDA ITEM 19: ADJOURNMENT</p>	<p>Motion: To adjourn at 7:14pm.</p> <p>Movant: Sublett</p> <p>Second: Fligor</p> <p>Ayes: Anolik Shakked, Fligor, Hartman, Rebitzer, Sublett, Zoglin</p> <p>Noes: None</p> <p>Abstentions: None</p> <p>Absent: None</p> <p>Recused: None</p>	<p><i>Meeting adjourned at 7:14pm.</i></p>

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

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 Report Q2 FY18: Final Recommendations 	<ul style="list-style-type: none"> Committee reviews recommendations Initial recommendations reviewed at 11/16/17 & 1/18/18 meeting, Joint meeting with Hospital Board on 5/9/18 to review ERM scoring and discuss tolerance

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



El Camino Hospital[®]

THE HOSPITAL OF SILICON VALLEY

Board of Directors Compliance Training

Mary Rotunno, General Counsel
Diane Wigglesworth,
Sr. Director, Corporate Compliance

March 14, 2018

Education Objectives

- Understand the fiduciary responsibilities of corporate directors as they relate to corporate compliance.
- Identify the most relevant legal parameters and compliance risks to the Company's business.
- Highlight what directors can do to hold management accountable for an effective compliance program that minimizes organizational risk.

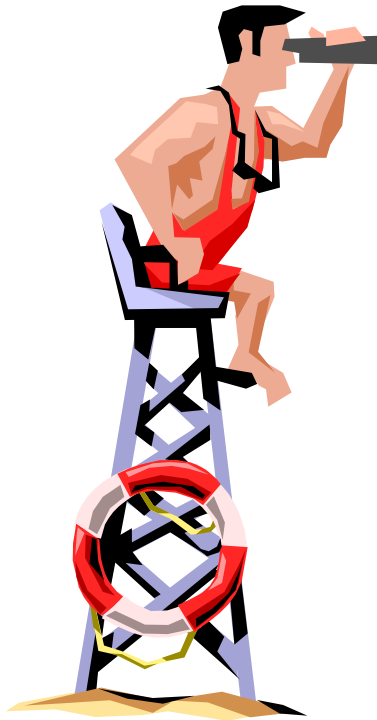
Appendix

- Fiduciary Responsibilities as a Corporate Director
- Corporate Governance Guidelines and Committee Roles
- Board Oversight of the Company Compliance Program: Key Questions to Ask of Leadership and Compliance Teams
- The Importance of Director Vigilance in Mitigating Personal and Organizational Compliance Risks
- Practical Guidance for Health Care Governing Boards on Compliance Oversight (OIG publication)

Fiduciary Responsibilities As A Corporate Director

Understand, Lead and Monitor

Corporate Leadership Responsibility



- Corporate directors have an obligation to act as fiduciaries for the organization.
- This duty includes an obligation to ***actively monitor organizational performance, processes and systems.***
- Failure to monitor organizational performance may result in liability for the corporation and corporate officers and directors.

Your Obligations

- As a Board member, you have ultimate oversight responsibility for the Company's Compliance Program.
- Fiduciary duties cannot be avoided by lack of knowledge.
- Increased funding, better use of technology, and enhanced cooperation and coordination among Government agencies have resulted in more effective and efficient enforcement.

Fiduciary Duties of Directors

- Directors have fiduciary duties to the company
- Directors' fiduciary duties are:
 - Duty of Care
 - Duty of Loyalty

Duty of Care

- Act in good faith with the care an ordinarily prudent person would exercise in similar circumstances.
- Directors must act on an informed basis after due consideration and appropriate deliberation.
- The Board may rely – so long as doing so is reasonable – on:
 - The records of the corporation; and
 - Other information presented by any person if the board reasonably believes:
 - Topics are within the competence of such persons, and
 - Such persons were selected with reasonable care.
- Board may NOT delegate basic duty of care to management or outside advisors.

Duty of Loyalty

- Directors must put the interests of the Company above any personal interests that they may have.
- Directors must disclose the existence and nature of any conflict of interest and any other facts that are material to transactions or other matters before the Board.
 - Where the Board's compliance responsibilities are concerned, this includes disclosure of information regarding potential compliance violations, even if such information might implicate an individual with whom they have a close personal or business relationship.

Overview of Director Responsibilities Under Common Law

- Act in good faith (*e.g.*, disclose any conflict of interest).
- Investigate transactions and other matters within their purview through management and advisors.
- Be satisfied on all key points.
- Ask questions if any point is not clear.
- Exercise independent judgment.

Business Judgment Rule

- State law presumes that, in making a decision, directors acted:
 - On an informed basis;
 - In good faith; and
 - With the honest belief that the action is in best interests of company.
- Courts will defer to directors unless plaintiff overcomes this presumption.
- Courts generally review the process, not the ultimate outcome.
- Where the Board's compliance oversight duties are concerned, it is essential that the Board, through its Committees receive sufficient information about the Compliance function to act on an informed basis.

Corporate Governance Guidelines and Committee Roles

Corporate Governance Guidelines

- The Board's core responsibilities include, but are not limited to, the following:
 - Select, monitor, evaluate and compensate senior management
 - Review the Company's financial controls, reporting systems and enterprise risk management program.
 - Review and monitor:
 - The Company's ethical standards and compliance with applicable healthcare laws, regulations, policies, professional standards and industry guidelines, and
 - The Company's programs, policies and procedures that support and enhance the quality of care provided by the Company
- The Board is authorized to delegate these core responsibilities to one or more Board committees.

Corporate Compliance / Privacy & Internal Audit Committee Role and Responsibilities

- It is the Committee's responsibility to assist the Board in monitoring the Company's compliance with legal and regulatory requirements, including:
 - Review the adequacy and effectiveness of the Company's internal regulatory, corporate compliance and risk management controls, and elicit recommendations for improvement.
 - Review management's response to any such recommendations.
 - Obtain and review reports regarding legal or compliance matters that may have a material effect on the Company's business, financial statements or compliance policies.
 - Review issues reported through the compliance hotline or other channels and the results of any internal investigations regarding any regulatory issues that may have a material effect on the Company's business, financial statements or compliance policies.

- It is the Committee's responsibility to assist the Board in evaluating and monitoring the Company's compliance with applicable healthcare laws, regulations, policies, professional standards and industry guidelines and the Company's Code of Conduct. Specific duties include:
 - Evaluate management's appointment, termination or replacement of the Compliance Officer.
 - Review policies and procedures designed to comply with all applicable health care laws, regulations, professional standards and industry guidelines, as well as the Company's policies and Code of Conduct.
 - Review internal systems and controls to carry out the Company's policies and procedures relating to clinical compliance matters and ethics.
 - Review the steps the Company is taking to educate its employees regarding its Code of Conduct and compliance issues.
 - Review procedures for (i) the receipt, retention and treatment of complaints received by the Company regarding compliance related matters; and (ii) the confidential, anonymous submission by employees of the Company of concerns regarding compliance and ethical issues.
 - Review issues reported through the compliance hotline or other channels and the results of any internal investigations pertaining to clinical outcomes or quality of care-related compliance issues.
 - Apprise the Board on the Company's clinical compliance and performance improvement efforts with appropriate internal and external sources.

Board Oversight of the Company Compliance Program: Key Questions to Ask of Leadership and Compliance Teams

Board Oversight Function: Duty of Inquiry

- Board oversight of the compliance function as it relates to hospital operations is mandatory. The Board, through the Compliance Committee, must ask the right questions to hold Management accountable for an effective compliance program.
- Does the Company leadership team foster a culture that values and even rewards the prevention, detection and resolution of compliance issues?
- Do compensation structures place undue pressure to pursue profit over compliance?
- Does the Company have clear policies and internal controls addressing major risk areas?

Bottom Line: Board should hold the management team accountable for setting the proper "tone at the top" and the Compliance Officer accountable for appropriate policies and internal controls to address risk areas.

Board Oversight Function: Compliance Infrastructure

- Does the Compliance Officer report directly to the Board and CEO on the “state of compliance” at the Company?
- Does the Compliance Officer ensure effective compliance, education, auditing/monitoring of risk areas, investigations and corrective actions?
- Does the Compliance Officer have sufficient authority and resources to perform his/her responsibilities effectively?
- Is there an appropriately configured compliance committee that meets on a regular basis?

Bottom Line: The Board should ensure that Compliance has adequate resources and infrastructure to effectuate an effective compliance program.

Oversight Function: Compliance Education

- Do all the Company employees complete annual compliance training?
- Is compliance training scenario-based and geared to risk areas?
- Are compliance training programs evaluated and updated to maximize effectiveness and reflect regulatory developments?
- Does the Company track attendance and have procedures for follow up with employees who have not satisfied requirements as deadlines approach?

Bottom Line: The Board should be advised of the compliance education curriculum, completion rates and evaluation results.

Board Oversight Function: Effective Lines of Communication

- Does the Company maintain multiple, well-publicized channels for reporting compliance concerns?
- Does the Company maintain and enforce a well-publicized, non-retaliation policy to encourage candid reporting?
- Are there clearly defined channels for employees to seek guidance on the legal/compliance ramifications of potential actions **before** they are taken?
- Are significant legal and regulatory developments monitored and communicated to the business and the Board?
- Is the Board actively engaged in discussions regarding appropriate remedies to systemic or material compliance problems?

Bottom Line: The Board should receive statistics regarding reports of suspected non-compliance through various channels and specific information about material risks confronting the Company.

Board Oversight Function: Auditing and Monitoring

- Is there a robust audit plan to test/monitor major risk areas?
- Does the Company adhere to this plan in practice?
- Are audit trends tracked, reported and appropriately addressed?
- When audits reveal issues, are appropriate corrective action plans developed and implemented?
- When audits identify overpayments, are timely reports and refunds made in accordance with regulatory/payor requirements?
- Does the Company conduct periodic compliance program effectiveness reviews?

Bottom Line: The Board should be apprised of the audit plan, audit statistics, audit trends, overpayment refunds and material/systemic risks.

Board Oversight Function: Prompt Response to Suspected Non-Compliance

- Does the Company have an appropriate investigations policy/SOP in place?
- Are reports of suspected non-compliance in fact promptly investigated?
- Does the Company have an appropriate system to log reports of suspected non-compliance, investigation steps, findings and follow up?
- When violations are identified, is a root cause analysis performed and corrective action implemented to appropriately redress issues and prevent recurrence?
- Are investigators appropriately trained and subject to competency testing?
- Are investigation results tracked and trended to identify systemic issues that may pose a material risk to the Company?

Bottom Line: The Board should receive reports with aggregated information regarding investigations and results, as well as more granular information regarding investigation outcomes that pose a material risk to the Company.

Board Oversight Function: Effective Enforcement

- Does the Company establish and disseminate disciplinary policies identifying the consequences of compliance violations?
 - Does the Company have progressive disciplinary procedures while imposing serious sanctions for serious violations and intentional or reckless noncompliance?
- Are disciplinary standards consistently applied and enforced?
- Is the executive/management team held accountable for their own compliance failures, as well as for the foreseeable failures of their subordinates?
- Are there concrete compliance performance review criteria and bonus prerequisites to drive compliance?

Bottom Line: The Board should hold the management team, HR and Compliance accountable for appropriate, consistently enforced disciplinary standards.

The Importance of Director Vigilance in Mitigating Personal and Organizational Compliance Risks

Corporate Leadership Responsibility

- An effective compliance program minimizes organizational and personal risks in three important ways:
 - Reduces risk that violations will occur
 - When violations do occur, ensures that appropriate corrective actions are implemented to appropriately remediate in accordance with law and prevent recurrence
 - Results in more lenient sanctions under a variety of Governmental guidance detailed later in this presentation:
 - Reduced penalties
 - Reduced risk of corporate integrity agreement (“CIA”)


OIG Guidance: Importance of Culture and Leadership

- The U.S. Department of Health and Human Services (“HHS”) Office of Inspector General (“OIG”) website notes that “because of their oversight responsibilities, boards of directors have a unique opportunity to promote quality of care and embrace compliance with law.”
- The OIG Guidance emphasize the importance of leadership and culture:
 - “Leadership should foster an organizational culture that values, and even rewards, the prevention, detection, and resolution of quality of care and compliance problems.”
 - “The organization should endeavor to develop a culture that values compliance from the top down and fosters compliance from the bottom up. Such an organizational culture is the foundation of an effective compliance program.”



Practical Guidance for Health Care Governing Boards on Compliance Oversight

Office of Inspector General,
U.S. Department of Health and Human Services
Association of Healthcare Internal Auditors
American Health Lawyers Association
Health Care Compliance Association



About the Organizations

This educational resource was developed in collaboration between the Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

AHIA is an international organization dedicated to the advancement of the health care internal auditing profession. The AHLA is the Nation's largest nonpartisan, educational organization devoted to legal issues in the health care field. HCCA is a member-based, nonprofit organization serving compliance professionals throughout the health care field. OIG's mission is to protect the integrity of more than 100 HHS programs, including Medicare and Medicaid, as well as the health and welfare of program beneficiaries.

The following individuals, representing these organizations, served on the drafting task force for this document:

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This document is intended to assist governing boards of health care organizations (Boards) to responsibly carry out their compliance plan oversight obligations under applicable laws. This document is intended as guidance and should not be interpreted as setting any particular standards of conduct. The authors recognize that each health care entity can, and should, take the necessary steps to ensure compliance with applicable Federal, State, and local law. At the same time, the authors also recognize that there is no uniform approach to compliance. No part of this document should be taken as the opinion of, or as legal or professional advice from, any of the authors or their respective agencies or organizations.

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Introduction

Previous guidance¹ has consistently emphasized the need for Boards to be fully engaged in their oversight responsibility. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management. Given heightened industry and professional interest in governance and transparency issues, this document seeks to provide practical tips for Boards as they work to effectuate their oversight role of their organizations' compliance with State and Federal laws that regulate the health care industry. Specifically, this document addresses issues relating to a Board's oversight and review of compliance program functions, including the: (1) roles of, and relationships between, the organization's audit, compliance, and legal departments; (2) mechanism and process for issue-reporting within an organization; (3) approach to identifying regulatory risk; and (4) methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

A critical element of effective oversight is the process of asking the right questions....

1 OIG and AHHA, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003); OIG and AHHA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors* (2004); and OIG and AHHA, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* (2007).

Expectations for Board Oversight of Compliance Program Functions

A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.² The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations. The Federal Sentencing Guidelines (Guidelines),³ OIG's voluntary compliance program guidance documents,⁴ and OIG Corporate Integrity Agreements (CIAs) can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program. The Guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program."⁵ The compliance program guidance documents were developed by OIG to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. CIAs impose specific structural and reporting requirements to

2 *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996).

3 U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf.

4 OIG, *Compliance Guidance*, <https://oig.hhs.gov/compliance/compliance-guidance/>

5 USSG Ch. 8, Intro. Comment.

promote compliance with Federal health care program standards at entities that have resolved fraud allegations.

Basic CIA elements mirror those in the Guidelines, but a CIA also includes obligations tailored to the organization and its compliance risks. Existing CIAs may be helpful resources for Boards seeking to evaluate their organizations' compliance programs. OIG has required some settling entities, such as health systems and hospitals, to agree to Board-level requirements, including annual resolutions. These resolutions are signed by each member of the Board, or the designated Board committee, and detail the activities that have been undertaken to review and oversee the organization's compliance with Federal health care program and CIA requirements. OIG has not required this level of Board involvement in every case, but these provisions demonstrate the importance placed on Board oversight in cases OIG believes reflect serious compliance failures.

Although compliance program design is not a “one size fits all” issue, Boards are expected to put forth a meaningful effort....

Although compliance program design is not a “one size fits all” issue, Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. Ensuring that management is aware of the Guidelines, compliance program guidance, and relevant CIAs is a good first step.

One area of inquiry for Board members of health care organizations should be the scope and adequacy of the compliance program in light of the size and complexity of their organizations. The Guidelines allow for variation according to “the size of the organization.”⁶ In accordance with the Guidelines,

6 USSG § 8B2.1, comment. (n. 2).

OIG recognizes that the design of a compliance program will depend on the size and resources of the organization.⁷ Additionally, the complexity of the organization will likely dictate the nature and magnitude of regulatory impact and thereby the nature and skill set of resources needed to manage and monitor compliance.

While smaller or less complex organizations must demonstrate the same degree of commitment to ethical conduct and compliance as larger organizations, the Government recognizes that they may meet the Guidelines requirements with less formality and fewer resources than would be expected of larger and more complex organizations.⁸ Smaller organizations may meet their compliance responsibility by “using available personnel, rather than employing separate staff, to carry out the compliance and ethics program.” Board members of such organizations may wish to evaluate whether the organization is “modeling its own compliance and ethics programs on existing, well-regarded compliance and ethics programs and best practices of other similar organizations.”⁹ The Guidelines also foresee that Boards of smaller organizations may need to become more involved in the organizations’ compliance and ethics efforts than their larger counterparts.¹⁰

Boards should develop a formal plan to stay abreast of the ever-changing regulatory landscape and operating environment. The plan may involve periodic updates from informed staff or review of regulatory resources made available to them by staff. With an understanding of the dynamic regulatory environment, Boards will be in a position to ask more pertinent questions of management

7 Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59436 (Oct. 5, 2000) (“The extent of implementation [of the seven components of a voluntary compliance program] will depend on the size and resources of the practice. Smaller physician practices may incorporate each of the components in a manner that best suits the practice. By contrast, larger physician practices often have the means to incorporate the components in a more systematic manner.”); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289 (Mar. 16, 2000) (recognizing that smaller providers may not be able to outsource their screening process or afford to maintain a telephone hotline).

8 USSG § 8B2.1, comment. (n. 2).

9 *Id.*

10 *Id.*

and make informed strategic decisions regarding the organizations' compliance programs, including matters that relate to funding and resource allocation. For instance, new standards and reporting requirements, as required by law, may, but do not necessarily, result in increased compliance costs for an organization. Board members may also wish to take advantage of outside educational programs that provide them with opportunities to develop a better understanding of industry risks, regulatory requirements, and how effective compliance and ethics programs operate. In addition, Boards may want management to create a formal education calendar that ensures that Board members are periodically educated on the organizations' highest risks.

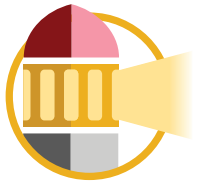
Finally, a Board can raise its level of substantive expertise with respect to regulatory and compliance matters by adding to the Board, or periodically consulting with, an experienced regulatory, compliance, or legal professional. The presence of a professional with health care compliance expertise on the Board sends a strong message about the organization's commitment to compliance, provides a valuable resource to other Board members, and helps the Board better fulfill its oversight obligations. Board members are generally entitled to rely on the advice of experts in fulfilling their duties.¹¹ OIG sometimes requires entities under a CIA to retain an expert in compliance or governance issues to assist the Board in fulfilling its responsibilities under the CIA.¹² Experts can assist Boards and management in a variety of ways, including the identification of risk areas, provision of insight into best practices in governance, or consultation on other substantive or investigative matters.

11 See Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

12 See Corporate Integrity Agreements between OIG and Halifax Hospital Medical Center and Halifax Staffing, Inc. (2014, compliance and governance); Johnson & Johnson (2013); Dallas County Hospital District d/b/a Parkland Health and Hospital System (2013, compliance and governance); Forest Laboratories, Inc. (2010); Novartis Pharmaceuticals Corporation (2010); Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2010); Synthes, Inc. (2010, compliance expert retained by Audit Committee); The University of Medicine and Dentistry of New Jersey (2009, compliance expert retained by Audit Committee); Quest Diagnostics Incorporated (2009); Amerigroup Corporation (2008); Bayer HealthCare LLC (2008); and Tenet Healthcare Corporation (2006; retained by the Quality, Compliance, and Ethics Committee of the Board).

Roles and Relationships

Organizations should define the interrelationship of the audit, compliance, and legal functions in charters or other organizational documents. The structure, reporting relationships, and interaction of these and other functions (e.g., quality, risk management, and human resources) should be included as departmental roles and responsibilities are defined. One approach is for the charters to draw functional boundaries while also setting an expectation of cooperation and collaboration among those functions. One illustration is the following, recognizing that not all entities may possess sufficient resources to support this structure:



The compliance function promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program.

The legal function advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted.

The internal audit function provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Internal audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional

Board oversight may be required. Internal audit helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Internal audit can fulfill the auditing requirements of the Guidelines.

The human resources function manages the recruiting, screening, and hiring of employees; coordinates employee benefits; and provides employee training and development opportunities.

The quality improvement function promotes consistent, safe, and high quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize risk of patient harm.

Boards should be aware of, and evaluate, the adequacy, independence,¹³ and performance of different functions within an organization on a periodic basis. OIG believes an organization's Compliance Officer should neither be counsel for the provider, nor be subordinate in function or position to counsel or the legal department, in any manner.¹⁴ While independent, an organization's counsel and compliance officer should collaborate to further the interests of the organization. OIG's position on separate compliance and legal functions reflects the independent roles and professional obligations of each function;¹⁵

13 Evaluation of independence typically includes assessing whether the function has uninhibited access to the relevant Board committees, is free from organizational bias through an appropriate administrative reporting relationship, and receives fair compensation adjustments based on input from any relevant Board committee.

14 See OIG and AHHA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors*, 3 (2004) (citing Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998)).

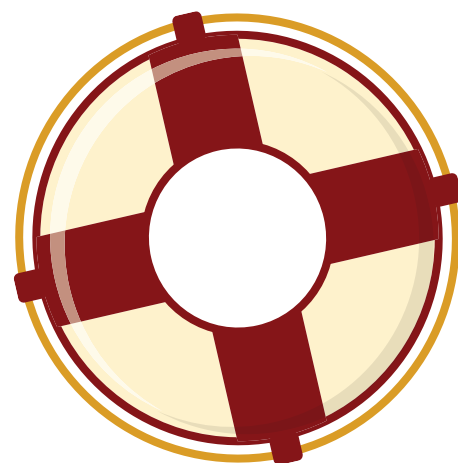
15 See, generally, *id.*

the same is true for internal audit.¹⁶ To operate effectively, the compliance, legal, and internal audit functions should have access to appropriate and relevant corporate information and resources. As part of this effort, organizations will need to balance any existing attorney-client privilege with the goal of providing such access to key individuals who are charged with the responsibility for ensuring compliance, as well as properly reporting and remediating any violations of civil, criminal, or administrative law.

The Board should have a process to ensure appropriate access to information; this process may be set forth in a formal charter document approved by the Audit Committee of the Board or in other appropriate documents. Organizations that do not separate these functions (and some organizations may not have the resources to make this complete separation) should recognize the potential risks of such an arrangement. To partially mitigate these potential risks, organizations should provide individuals serving in multiple roles the capability to execute each function in an independent manner when necessary, including through reporting opportunities with the Board and executive management.

Boards should also evaluate and discuss how management works together to address risk, including the role of each in:

- 1.** identifying compliance risks,
- 2.** investigating compliance risks and avoiding duplication of effort,
- 3.** identifying and implementing appropriate corrective actions and decision-making, and
- 4.** communicating between the various functions throughout the process.



¹⁶ Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998) (auditing and monitoring function should “[b]e independent of physicians and line management”); Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,424 (Aug. 7, 1998) (auditing and monitoring function should “[b]e objective and independent of line management to the extent reasonably possible”); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,302 (Mar. 16, 2000).

Boards should understand how management approaches conflicts or disagreements with respect to the resolution of compliance issues and how it decides on the appropriate course of action. The audit, compliance, and legal functions should speak a common language, at least to the Board and management, with respect to governance concepts, such as accountability, risk, compliance, auditing, and monitoring. Agreeing on the adoption of certain frameworks and definitions can help to develop such a common language.

Reporting to the Board

The Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology. By engaging the leadership team and others deeper in the organization, the Board can identify who can provide relevant information about operations and operational risks. It may be helpful and productive for the Board to establish clear expectations for members of the management team and to hold them accountable for performing and informing the Board in accordance with those expectations. The Board may request the development of objective scorecards that measure how well management is executing the compliance program, mitigating risks, and implementing corrective action plans. Expectations could also include reporting information on internal and external investigations, serious issues raised in internal and external audits, hotline call activity, all allegations of material fraud or senior management misconduct, and all management exceptions to the organization's

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code of conduct and/or expense reimbursement policy. In addition, the Board should expect that management will address significant regulatory changes and enforcement events relevant to the organization's business.

Boards of health care organizations should receive compliance and risk-related information in a format sufficient to satisfy the interests or concerns of their members and to fit their capacity to review that information. Some Boards use tools such as dashboards—containing key financial, operational and compliance indicators to assess risk, performance against budgets, strategic plans, policies and procedures, or other goals and objectives—in order to strike a balance between too much and too little information. For instance, Board quality committees can work with management to create the content of the dashboards with a goal of identifying and responding to risks and improving quality of care. Boards should also consider establishing a risk-based reporting system, in which those responsible for the compliance function provide reports to the Board when certain risk-based criteria are met. The Board should be assured that there are mechanisms in place to ensure timely reporting of suspected violations and to evaluate and implement remedial measures. These tools may also be used to track and identify trends in organizational performance against corrective action plans developed in response to compliance concerns. Regular internal reviews that provide a Board with a snapshot of where the organization is, and where it may be going, in terms of compliance and quality improvement, should produce better compliance results and higher quality services.

As part of its oversight responsibilities, the Board may want to consider conducting regular “executive sessions” (i.e., excluding senior management) with leadership from the compliance, legal, internal audit, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called.

Identifying and Auditing Potential Risk Areas

Some regulatory risk areas are common to all health care providers. Compliance in health care requires monitoring of activities that are highly vulnerable to fraud or other violations. Areas of particular interest include referral relationships and arrangements, billing problems (e.g., upcoding, submitting claims for services not rendered and/or medically unnecessary services), privacy breaches, and quality-related events.

The Board should ensure that management and the Board have strong processes for identifying risk areas. Risk areas may be identified from internal or external information sources. For instance, Boards and management may identify regulatory risks from internal sources, such as employee reports to an internal compliance hotline or internal audits. External sources that may be used to identify regulatory risks might include professional organization publications, OIG-issued guidance, consultants, competitors, or news media. When failures or problems in similar organizations are publicized, Board members should ask their own management teams whether there are controls and processes in place to reduce the risk of, and to identify, similar misconduct or issues within their organizations.



The Board should ensure that management consistently reviews and audits risk areas, as well as develops, implements, and monitors corrective action plans. One of the reasonable steps an organization is expected to take

under the Guidelines is “monitoring and auditing to detect criminal conduct.”¹⁷ Audits can pinpoint potential risk factors, identify regulatory or compliance problems, or confirm the effectiveness of compliance controls. Audit results that reflect compliance issues or control deficiencies should be accompanied by corrective action plans.¹⁸

Recent industry trends should also be considered when designing risk assessment plans. Compliance functions tasked with monitoring new areas of risk should take into account the increasing emphasis on quality, industry consolidation, and changes in insurance coverage and reimbursement. New forms of reimbursement (e.g., value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations) lead to new incentives and compliance risks. Payment policies that align payment with quality care have placed increasing pressure to conform to recommended quality guidelines and improve quality outcomes. New payment models have also incentivized consolidation among health care providers and more employment and contractual relationships (e.g., between hospitals and physicians). In light of the fact that statutes applicable to provider-physician relationships are very broad, Boards of entities that have financial relationships with referral sources or recipients should ask how their organizations are reviewing these arrangements for compliance with the physician self-referral (Stark) and anti-kickback laws. There should also be a clear understanding between the Board and management as to how the entity will approach and implement those relationships and what level of risk is acceptable in such arrangements.

Emerging trends in the health care industry to increase transparency can present health care organizations with opportunities and risks. For example, the Government is collecting and publishing data on health outcomes and quality measures (e.g., Centers for Medicare & Medicaid Services (CMS) Quality Compare Measures), Medicare payment data are now publicly available (e.g.,

¹⁷ See USSG § 8B2.1(b)(5).

¹⁸ See USSG § 8B2.1(c).

CMS physician payment data), and the Sunshine Rule¹⁹ offers public access to data on payments from the pharmaceutical and device industries to physicians. Boards should consider all beneficial use of this newly available information. For example, Boards may choose to compare accessible data against organizational peers and incorporate national benchmarks when assessing organizational risk and compliance. Also, Boards of organizations that employ physicians should be cognizant of the relationships that exist between their employees and other health care entities and whether those relationships could have an impact on such matters as clinical and research decision-making. Because so much more information is becoming public, Boards may be asked significant compliance-oriented questions by various stakeholders, including patients, employees, government officials, donors, the media, and whistleblowers.

Encouraging Accountability and Compliance

Compliance is an enterprise-wide responsibility. While audit, compliance, and legal functions serve as advisors, evaluators, identifiers, and monitors of risk and compliance, it is the responsibility of the entire organization to execute the compliance program.

In an effort to support the concept that compliance is “a way of life,” a Board may assess employee performance in promoting and adhering to compliance.²⁰ An organization may assess individual, department, or facility-level performance or consistency in executing the compliance program. These assessments can then be used to either withhold incentives or to provide bonuses

Compliance is an enterprise-wide responsibility.

19 See Sunshine Rule, 42 C.F.R. § 403.904, and CMS *Open Payments*, <https://www.cms.gov/newsroom/press-releases/affordable-care-act-sunshine-rule-increases-transparency-health-care>

20 Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,298-14,299 (Mar. 16, 2000).

based on compliance and quality outcomes. Some companies have made participation in annual incentive programs contingent on satisfactorily meeting annual compliance goals. Others have instituted employee and executive compensation claw-back/recoupment provisions if compliance metrics are not met. Such approaches mirror Government trends. For example, OIG is increasingly requiring certifications of compliance from managers outside the compliance department. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards have multiple incentives to build compliance programs that encourage self-identification of compliance failures and to voluntarily disclose such failures to the Government. For instance, providers enrolled in Medicare or Medicaid are required by statute to report and refund any overpayments under what is called the 60 Day Rule.²¹ The 60-Day Rule requires all Medicare and Medicaid participating providers and suppliers to report and refund known overpayments within 60 days from the date the overpayment is “identified” or within 60 days of the date when any corresponding cost report is due. Failure to follow the 60-Day Rule can result in False Claims Act or civil monetary penalty liability. The final regulations, when released, should provide additional guidance and clarity as to what it means to “identify” an overpayment.²² However, as an example, a Board would be well served by asking management about its efforts to develop policies for identifying and returning overpayments. Such an inquiry would inform the Board about how proactive the organization’s compliance program may be in correcting and remediating compliance issues.

21 42 U.S.C. § 1320a-7k.

22 Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012) (Under the proposed regulations interpreting this statutory requirement, an overpayment is “identified” when a person “has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.”) disregard or deliberate ignorance of the overpayment.”); Medicare Program; Reporting and Returning of Overpayments; Extensions of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).

Organizations that discover a violation of law often engage in an internal analysis of the benefits and costs of disclosing—and risks of failing to disclose—such violation to OIG and/or another governmental agency. Organizations that are proactive in self-disclosing issues under OIG’s Self-Disclosure Protocol realize certain benefits, such as (1) faster resolution of the case—the average OIG self-disclosure is resolved in less than one year; (2) lower payment—OIG settles most self-disclosure cases for 1.5 times damages rather than for double or treble damages and penalties available under the False Claims Act; and (3) exclusion release as part of settlement with no CIA or other compliance obligations.²³ OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations.²⁴ Boards should ask management how it handles the identification of probable violations of law, including voluntary self-disclosure of such issues to the Government.

As an extension of their oversight of reporting mechanisms and structures, Boards would also be well served by evaluating whether compliance systems and processes encourage effective communication across the organizations and whether employees feel confident that raising compliance concerns, questions, or complaints will result in meaningful inquiry without retaliation or retribution. Further, the Board should request and receive sufficient information to evaluate the appropriateness of management’s responses to identified violations of the organization’s policies or Federal or State laws.

Conclusion

A health care governing Board should make efforts to increase its knowledge of relevant and emerging regulatory risks, the role and functioning of the organization’s compliance program in the face of those risks, and the flow and elevation of reporting of potential issues and problems to

23 See OIG, *Self-Disclosure Information*, <https://oig.hhs.gov/compliance/self-disclosure-info/>

24 See *id.*, at 2 (“we believe that using the [Self-Disclosure Protocol] may mitigate potential exposure under section 1128J(d) of the Act, 42 U.S.C. 1320a-7k(d).”)

senior management. A Board should also encourage a level of compliance accountability across the organization. A Board may find that not every measure addressed in this document is appropriate for its organization, but every Board is responsible for ensuring that its organization complies with relevant Federal, State, and local laws. The recommendations presented in this document are intended to assist Boards with the performance of those activities that are key to their compliance program oversight responsibilities. Ultimately, compliance efforts are necessary to protect patients and public funds, but the form and manner of such efforts will always be dependent on the organization's individual situation.

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ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Report on Board Actions Corporate Compliance Privacy, and Internal Audit Committee May 17, 2018
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 or Board members on each Committee. This written report is intended to supplement the 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 Board Actions	

March 2018 ECH Board Actions*

1. March 14, 2018
 - a. Approved Resolution 2018-03 recognizing Emergency Department physicians and staff for their work during this winter's severe flu season
 - b. Received annual Compliance education
 - c. Approved the Community Benefit Mid-Year Metrics
 - d. Approved Resolution 2018-04: required by Premier, Inc. listing the CEO and CFO as authorized individuals to sell stock.
2. April 18, 2018
 - a. Approved the FY 18 Period 7 and 8 Financials
 - b. Approved a Resolution Delegating Authority to the Executive Compensation Committee to Approve Annual Salary Ranges, Annual Base Pay Adjustments, Individual Incentive Goals, and Incentive Payments for Executives other than the CEO.
 - c. Approved a Resolution Approving the Winding Up and Dissolution of Pathways Continuous Care (Private Duty Services).
 - d. Approved Revised ECH Bylaws Sections 5.1 and 5.2.

March 2018 ECHD Board Actions

1. March 20, 2018
 - a. Approved Resolution 2018-05 acknowledging the District's partnership with the AHA on the "Check.Change.*Control*" Hypertension Initiative.
 - b. Approved the FY18 YTD Financial Report
 - c. Completed a Periodic Review of the District's Bylaws and Approved Revisions
 - d. Approved Resolution 2018-03 Calling a District General Election and Resolution 2018-04 Requesting and Consenting to Consolidation of District Election with the November 2018 Statewide Election.

*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:	Committee Charter Review Corporate Compliance/Privacy and Internal Audit Committee May 17, 2016
Responsible party:	Diane Wigglesworth, Sr. Director, Corporate Compliance
Action requested:	Possible Motion
<p>Background: The Governance Committee's charter provides that it will ensure that each Board Advisory Committee reviews its Charter every other year. The Governance Committee will review any proposed revisions and make a recommendation to the Board.</p> <p>Staff does not have any specific recommendations to revise the Charter at this time. At its March 15, 2018 meeting, the Committee requested certain changes that are incorporated in the attached draft for review. These changes include 1) reflecting all areas of the Committee's oversight (corporate compliance, internal and external audit, enterprise risk management, and IT security); 2) updating the name of the Committee to the "Compliance and Audit Committee;" and 3) incorporating more detail regarding IT Security oversight.</p>	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
Summary and session objectives: For the Committee to review the proposed changes to the Charter.	
<p>Suggested discussion questions:</p> <ol style="list-style-type: none"> 1. Are there any Compliance Committee activities provided in the Charter that the Committee is not performing? 2. Are there any activities the Compliance Committee should be engaging in that are not provided in the Charter? 	
<p>Proposed Committee motion, if any:</p> <p>To recommended that the Governance Committee and the Board approve the proposed revised Compliance Committee Charter.</p>	
<p>LIST OF ATTACHMENTS:</p> <ol style="list-style-type: none"> 1. Proposed Revised Compliance Committee Charter 	

~~Corporate Compliance/Privacy and Internal Audit~~
Committee Charter
Draft Revised 4/2/18 For Committee Review

Purpose

The purpose of the ~~Corporate Compliance/Privacy~~ and Audit Committee (~~“Compliance and Audit Committee”~~)(~~“The Committee”~~) is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors (“Board”) in its exercise of oversight of Corporate Compliance, Privacy, Internal and External Audit, Enterprise Risk Management and IT Security. The Committee will accomplish this by monitoring the compliance policies, controls and processes of the organization and the engagement, independence and performance of the internal auditor and external auditor. The ~~Compliance and Audit~~ Committee assists the Board in oversight of any regulatory audit and in assuring the organizational integrity of ECH in a manner consistent with its mission and purpose.

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee’s authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on compliance, privacy, IT security, enterprise risk management, or audit related issues. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

Membership

- The ~~Compliance and Audit~~ Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.

- The Committee may also include 2-4 external (non-Hospital Board member) members with expertise in compliance, privacy, enterprise risk, IT security, audit and/or financial management expertise.
- All Committee members shall be appointed by the Board Chair, subject to approval by the Board, for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice-Chair of the Committee shall be a Hospital Board Director.

Conflict of Interest

Members of the Committee shall be independent as to conflicts of interest with El Camino Hospital pursuant to the Conflict of Interest Policy. Should there be a potential conflict, the determination regarding independence shall follow the criteria approved by the Board (see appendix).

Any member of a Board or Board committee who has a conflict of interest with respect to a proposed contract, transaction, relationship, arrangement or activity shall refrain from the deliberations and vote on any matter related to the contract, transaction or arrangement. Such member, however, may be present to answer questions and provide information needed by the Board or Board Committee for its deliberations. The Board Chair may appoint one or more qualified individuals to take the place of any affected member of a Board or Board Committee with regard to the matter or interest being considered. Any such reconstituted Committee shall be considered to have all rights, authority and obligations of the ~~Corporate Compliance/Privacy and Audit~~ Committee.

Staff Support and Participation

The Sr. Director of Corporate Compliance/Privacy Officer (“Corporate Compliance Officer”) shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair’s consideration. Additional members of the executive team may participate in the Committee meetings upon the recommendation of the Corporate Compliance Officer and subsequent approval from both the CEO and Committee Chair.

General Responsibilities

The Committee’s primary role is to provide oversight and to advise the management team and the Board on matters pertaining to this Committee. With input from the Committee, the management team shall develop dashboard metrics that will be used to measure and track corporate compliance, privacy, audit, IT Security and enterprise risk management for the Committee’s review and subsequent approval by the Board. It is the management team’s responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee

members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for monitoring that performance metrics are being met to the Board's expectations and requiring explanation of any deficiencies and reporting to the Board such deficiencies.

Specific Duties

The specific duties of the ~~Corporate Compliance/Privacy and Audit~~ Committee include the following:

A. Corporate Compliance/Privacy, IT Security and Enterprise Risk Management

- Oversee the activities of the Corporate Compliance program and all subcommittees providing support relative to corporate compliance ~~and~~, HIPAA/Patient Privacy, ~~and IT Security~~.
- Oversee the information security risk assessment process and review the mitigation plan to reduce vulnerabilities. Review at least annually the overall status of the information security program
- Oversee efforts to develop, implement and maintain an effective information security program and advise the Board on risk tolerance levels
- Advise the organization on Enterprise Risk Management structure and provide oversight of Enterprise Risk reporting metrics and measurements to help monitor organizational risks.
- Advise the organization on corporate compliance implementation strategies. Review strategies for improving the corporate compliance program(s) and recommend for approval by the Board.
- Review with management the assessment of physician relationship risk as it relates to Stark laws, anti-kickback statutes, and other compliance rules and regulations.
- Encourage continuous improvement of policies and procedures for corporate accountability, integrity, and privacy. Review the organization's policy oversight guidelines and oversee the process being systematic and robust.

B. Internal Audit Functions

- Provide direction related to findings and recommendations of internal audits performed.

- Provide direction for issues relating to internal audit responses by management.
- Review the annual internal audit priorities for the organization.
- Serve as the ad-hoc governance team regarding non routine investigations or action taken by external agencies and authorities against ECH.
- Recommend policies and processes for approval by the Board relating to systems of internal controls for finance.
- Oversee the work of independent compliance, audit and privacy staff.
- Provide escalation vehicle from any source to identify and address relevant issues.

C. External Audit Functions

- Make recommendations to the Board regarding the external financial audit firm selection, retention and when necessary, replacement.
- Review the expected fee for the audit and assure that the fee is fair to the organization and is compatible with a full, complete and professional audit. Make recommendations to the Board.
- Review the scope and approach of the annual audit, including the identification of business and financial risks and exposures, with the external auditor.
- Meet with the auditor and management, as needed, to resolve issues regarding financial reporting, and make recommendations to the Board for discussion and action.
- Any services provided by the external auditors, outside the scope of the annual audit of financial statements must be presented to the Committee for pre-approval.
- Review the external auditor reports and financial statements before presentation to the Board. Make recommendations to the Board~~Ensure that the external auditors have the opportunity to meet with the Board to present the annual audit report and financial statements.~~
- At the completion of the annual audit examination, review with management and the external auditors the following:
 - a. The organization's annual financial statements and related footnotes.

- b. The external auditor's audit of the financial statements and the auditor's report thereon.
 - c. Judgments about the quality, not just the acceptability of accounting principles and the clarity of the financial disclosure practices used or proposed to be used, and particularly the degree of aggressiveness or conservatism of accounting principles and underlying estimates.
 - d. Any significant changes in scope required in the external auditor's plan.
 - e. Any serious difficulties or disputes with management encountered during the course of the audit.
- Conduct an executive session if necessary to allow the Committee to meet privately with the auditor.
 - Review all significant financial communications to external parties (e.g., public, press, lenders, creditors and regulators), ensuring they are prepared in accordance with generally accepted accounting principles and fairly represent the financial condition of ECH.
 - Review and recommend for approval by the Board the audit firm's annual engagement proposal and review the independent auditor's performance.

Independence of the External Auditor

It is the Committee's responsibility to confirm the independence of the external auditor on an annual basis through a written statement. The statement shall confirm their independence and address services or relationships that may impact independence. The lead and concurring partner on the audit engagement team may not serve for more than five years unless special circumstances exist and with the approval of the Board. Members of the external audit team are prohibited from employment at ECH in a financial role within one year of leaving the external audit firm.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and workplan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the

agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for review and approval.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

Approved as Revised: November 12, 2014

Appendix

Definition of Independent Director – Compensation and Internal Audit Committee

1. An independent director is a more limited and narrow classification of director than otherwise required by law and is not meant to expand or limit the definition of interested director for purposes of the El Camino Hospital Conflict of Interest Policy or to expand or reduce the scope of any legal duty or otherwise applicable legal obligation of a director. The Board of Directors, by separate resolution, may determine to limit membership on particular committees to independent directors to avoid even the appearance of a conflict of interest.
2. A member of the Board of Directors of El Camino Hospital shall be deemed to be an independent director so long as such director (and any spouse, sibling, parent, son or daughter, son- or daughter-in-law or grandparent or descendant of the director):
 - i. has not, within the preceding twelve (12) months, received payments from El Camino Hospital, a subsidiary or affiliate of El Camino Hospital in excess of Ten Thousand Dollars (\$10,000), excluding reimbursement of expenses or other permitted payments to a director related to service as a director;
 - ii. does not own an interest in an entity, or serve as a Board member or executive of an entity, that is a direct competitor of El Camino Hospital (or an entity controlling, controlled by or under common control with El Camino Hospital) for patients or services, located within ten (10) miles of El Camino Hospital (or an entity controlling, controlled by or under common control with El Camino Hospital). An entity is not a direct competitor if it provides competing services in the above area that do not exceed ten percent (10%) of such entity's revenues.
3. If a director is an owner of an entity, then the amount received from El Camino Hospital during any period shall be determined by multiplying the percentage ownership interest of the director in such entity by the total amount paid by El Camino Hospital to such entity during such period.
4. Each director appointed to the Compensation Committee and the Compliance and Internal Audit Committee shall be, at the time of appointment and while a member of such Committee, an independent director as defined above.
5. Note: Other laws may prohibit certain contracts or interests in their entirety and this definition is not intended to narrow or otherwise limit the application of any such law.

Approved as Revised – November 12, 2014

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Proposed FY19 Committee Goals and Meeting Dates Corporate Compliance/Privacy and Internal Audit Committee May 17, 2018
Responsible party:	Diane Wigglesworth, Sr. Director, Corporate Compliance
Action requested:	Possible Motion
Background: <p>Every year, each of the Advisory Committees develops goals for the upcoming fiscal year. The Governance Committee reviews draft goals for all Committees and makes recommendations for approval to the Hospital Board.</p> <p>Also attached are the proposed meeting dates for FY19, including alternatives for the August 2018 and March 2019 Committee meetings. The entire Committee meeting calendar for all Board Advisory Committees will be reviewed by the Governance Committee and recommended to the Board for approval in June.</p>	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
Summary and session objectives: <p>To review the proposed FY19 Committee goals and advise if changes are recommended.</p> <p>To review the proposed Committee meeting dates.</p>	
Suggested discussion questions: <ol style="list-style-type: none"> 1. Are the proposed Committee goals appropriate? Measurable? 2. Are there any conflicts for any of the proposed FY19 dates? 	
Proposed Committee motion, if any: <ol style="list-style-type: none"> 1. To recommend that the Governance Committee recommend and the Board approve the Proposed FY19 Compliance Committee goals. 2. To recommend that the Governance Committee recommend and the Board approve the Proposed FY19 Compliance Committee dates. 	
LIST OF ATTACHMENTS: <ol style="list-style-type: none"> 1. Proposed FY19 Corporate Compliance/Privacy and Internal Audit Committee Goals 2. Proposed FY19 Committee Meeting Dates 	

DRAFT POTENTIAL
FY19 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. Based on the FY18 Committee Self-Assessment, review options to reduce the number of agenda items covered in the meetings.	<ul style="list-style-type: none"> Q1 FY19 	<ul style="list-style-type: none"> Committee evaluates options and provides recommendations
2. Review the Hospital’s Compliance Program internal assessment compared to DOJ 2017 Compliance Program guidance on evaluation of Compliance Programs	<ul style="list-style-type: none"> Q2 FY19 	<ul style="list-style-type: none"> Committee recommends changes in Compliance Program to Compliance Officer
3. Ensure strategic alignment and proper oversight of the Enterprise Risk Management Program	<ul style="list-style-type: none"> Q3 FY19 	<ul style="list-style-type: none"> Committee reviews and provides guidance on the ERM Program to the Board
4. Review results of IT metrics tracked during the fiscal year to ensure metrics support appropriate oversight.	<ul style="list-style-type: none"> Q4 FY19 	<ul style="list-style-type: none"> Committee reviews and provides recommendations to the Board
5. Review the Hospital’s cybersecurity policies to ensure they are robust to detect and protect against cyber-attacks, including medical devices.	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> Committee reviews and provides recommended policy updates for Board approval

SUBMITTED BY:

Sharon Anolik Shakked
 Diane Wigglesworth

Chair, Corporate Compliance/Privacy and Internal Audit Committee
Executive Sponsor, Corporate Compliance/Privacy and Internal Audit Committee

Compliance Committee Meetings

Proposed FY19 Dates

RECOMMENDED CC DATE THURSDAYS	CORRESPONDING HOSPITAL BOARD DATE
Thursday, August 23, 2018 OR Wednesday, August 22, 2018	Wednesday, September 12, 2018
Thursday, September 27, 2018	Wednesday, October 10, 2018
Thursday, November 15, 2018	Wednesday, January 9, 2019
Thursday, January 17, 2019	Wednesday, February 13, 2019
Thursday, March 21, 2019 OR Wednesday, March 20, 2019	Wednesday, April 10, 2019
Thursday, May 16, 2019	Wednesday, June 12, 2019

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Key Performance Indicators Corporate Compliance/Privacy and Internal Audit Committee May 17, 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 investigated during the current fiscal year is consistent the same time period from the previous fiscal year. All incidents have been reviewed for corrective action to mitigate further risk. There was an increase in the number of IT Security issues reported and resolved, and most involved non-compliance with hospital policies. The number of hotline calls remains consistent and the majority of calls have been from patients or employees.	
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 FY18

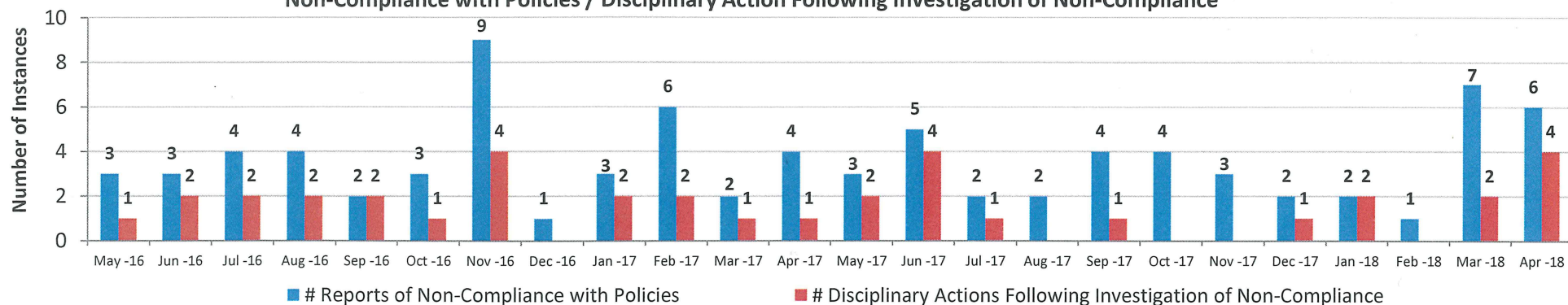
El Camino Hospital

Key Performance Indicator	FY18 Current Month	Current YTD Actual	Prior YTD Actual
Total Number of Hospital Discharges (excluding normal newborn)	1,537	16,562	15,931
Core Elements			
Policies and Procedures	Apr. 2018	Jul - Apr. FY18	Jul -Apr. FY17
Number of reported instance when policies not followed	6	33	38
Number of disciplinary actions due to Investigations	4	11	17
Education and Training	Apr. 2018	Jul - Apr. FY18	Jul -Apr. FY17
Percentage of new employees trained within 30 days of start date	100%	100%	100%
Investigations	Apr. 2018	Jul - Apr. FY18	Jul -Apr. FY17
Total number of investigations	25	229	232
Investigations open	0	3	0
Investigations closed	25	226	232
Hotline concerns substantiated	0	14	16
Hotline concerns not substantiated	3	15	17
Average number of days to investigate concerns	7	7	7
Reporting Trends	Apr. 2018	Jul - Apr. FY18	Jul -Apr. FY17
Anti-Kickback/Stark	4	33	53
EMTALA	0	0	2
HIPAA Reports	13	120	132
HIPAA Security Incidents	4	11	4
Billing or Claims	4	62	72
Conflict of Interest	1	4	9
Reported Events to CMS	Apr. 2018	Jul - Apr. FY18	FY 2017 Total
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	Apr. 2018	Jul - Apr. FY18	FY 2017 Total
Number of total regulator events self reported by ECH	3	22	7
Number of self reported events followed up by CDPH	7	10	7
Number of total privacy breaches self reported by ECH	1	16	13
CDPH initiated visits (separate from ECH self reported events)	1	2	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	Apr. 2018	Jul - Apr. FY18	FY 2017 Total
Total number of Audit Findings	3	34	37
Number of findings identified has high severity	1	4	11
Monitoring and Audit Findings	Apr. 2018	Jul - Apr. FY18	FY 2017 Total
Number of Open Liability Claims	11	11	8
Number of Open Liability Lawsuits	5	5	7

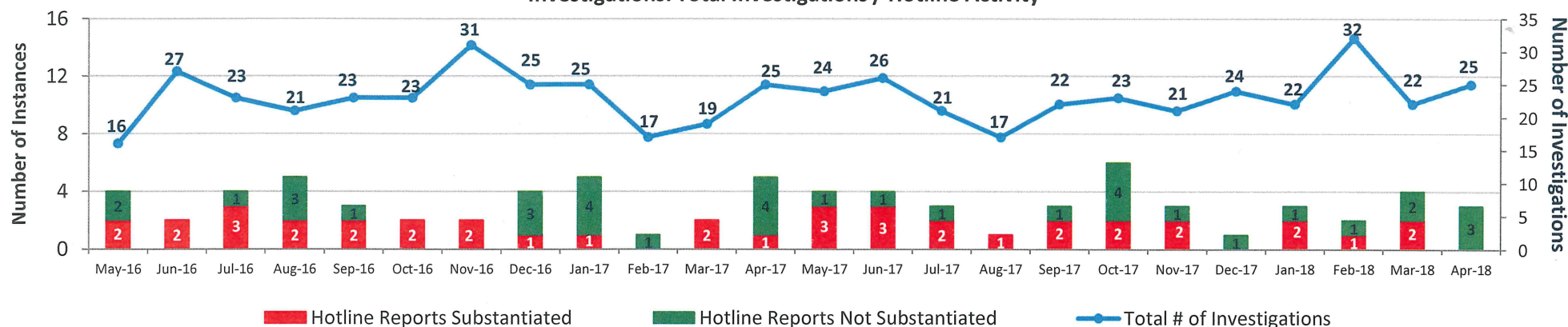
Corporate Compliance

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

