TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE AUDIT, COMPLIANCE AND ETHICS COMMITTEE
January 19, 2017
8:30 a.m. – 10:30 a.m.
Assembly Rm. 1
Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Action/ Recommendation	Requestor/ Presenter
1.	Call to order	5 min.		Chair
2.	Approval of Agenda	2 min.		Chair
3.	Public Comments – Announcement Comments may be made at this time by members of the public and Committee members on any item on the Agenda before the Committee's consideration of the item or on any matter within the jurisdiction of the Committee. NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.	1 min.		Standard
4.	Introductions	5 min.		Chair
5	Compliance Overview Update	10 min.	Information Only	C. Bernard-Shaw, CCO
6	Audit/Finance Overview Update	10 min.	Information Only	R. Rivas, CFO
4.	Ratification of Minutes- November 17, 2016	3 min.	Action	Chair
5.	Old Business a. Community Member Opening – Interviews at February Meeting	2 min.	Information Only	Chair
5.	New Business – **Discussion and Possible Action**			
	A) **Compliance Policies** 1. #8650-561 – Responding to Compliance Issues – Reports of Suspected Misconduct Investigation	10 min.	Action	K. Topp
	B) FY2017 Financial Statement Audit	10 min.	Action	Chair/CFO
7.	Motion to go into Closed Session			
8.	Closed Session			
	a. Approval of Audit, Compliance & Ethics Closed Session Minutes of November 17, 2016 (Authority: Government Code Section 54957.2)	5 min.	Approve	Chair
	b. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (2 Matters)	30 min.	Approve	CCO
9.	Motion to go into open session			

	Agenda Item	Time Allotted	Action/ Recommendation	Requestor/ Presenter
10.	Open Session			
11.	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1).	1 min.		
12.	Committee Communications	5 min.		All
13.	Date of Next Meeting February 16, 2017	1 min.		Chair
14.	Adjournment			Chair
	At community member's request a brief tour of facility will be available for those interested in seeing some of the new equipment and areas of the hospital			
15.	Total Time Budgeted for Meeting	2 hours		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations

Tri-City Medical Center
Audit, Compliance & Ethics Committee
November 17, 2016
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member; Dr. Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, Acting CFO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; Colleen Thompson, Director Medical Records
Absent:	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairperson Finnila.		
2. Approval of Agenda	**It was moved by Mr. Jack Cumming and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – October 20, 2016	**It was moved by Director Schallock and seconded by Mr. Jack Cumming to approve the minutes as presented. The motion passed unanimously.**	**Minutes ratified.**	Ms. Donnellan
5. New Business			

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
A) Administrative Policies & Procedures: 1) 8610-292 – Internal Charge Audit	The committee had extensive discussion and questions on Policy 8610-292 – Internal Charge Audit. It was moved by Director Mitchell and seconded by Mr. Cumming to table Policy 8610-202 – Internal Charge Audit pending further review and clarification.	**Policy 8610-292 – Internal Charge Audit will be brought back to the committee pending further review.**	Ms. Donnellan
B) Compliance Policies: 1) 8610-(NEW) Minimum Necessary Requirements for Use and Disclosure of PHI	The committee reviewed the Minimum Necessary Requirements for Use and Disclosure of PHI. There were no recommended changes to the policy. **It was moved by Mr. Schwartz to recommend approval of Compliance Policy 8610(NEW) Minimum Necessary Requirements for Use and Disclosure of PHI as presented. Director Mitchell seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8610 (NEW) Minimum Necessary Requirements for Use and Disclosure of PHI; item to appear on next Board agenda and included in Board Agenda packet.**	Ms. Donnellan
2) 8610-586 – Breach Response	The committee reviewed Policy 8610-586 – Breach Response. The following revisions were recommended: ➢ Amend title to read "PHI Breach Response. ➢ Strike the word "volume" and replace with the word "number" throughout. ➢ Strike the word "fewer" and replace with "less". ➢ Strike the word "more" and replace with "greater". Ms. Racicot clarified that the number "500" referred to in the policy is based on HIPAA language. **It was moved by Director Schallock to recommend approval of Compliance Policy 8610-586 – Breach Response as presented and amended. Mr. Cumming seconded the motion. The motion passed unanimously.** *Ms. Colleen Thompson left the meeting at 8:35 a.m.*	**Recommendation to be sent to the Board of Directors to approve Policy 8610-586 – Breach Response as amended; item to appear on next Board agenda and included in Board Agenda packet.**	Ms. Donnellan
C) Review of FY2017 1st Quarter Financials	Mr. Rivas gave a brief report on the 1st Quarter Fiscal 2017 YTD financial results as follows (Dollars in Thousands):	**Information only.**	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	• Net Operating Revenue – $83,603 • Operating Expense – $83,622 • EROE - $1,246 • EBITDA - $5,094 Other Key Indicators for the current year included the following: • Average Daily Census - 184 • Adjusted Patient Days – 29,071 • Surgery Cases – 1,577 • Deliveries – 736 • ED Visits – 16,486 Mr. Rivas also reviewed Current Month (September) Financial Results as follows: • Net Operating Revenue – $27,704 • Operating Expense – $27,383 • EROE - $746 • EBITDA - $2,015 Other Key Indicators for the current month are as follows: • Net Patient Accounts Receivable – $43.1 • Days in Net Account Receivable – 50.2 Average Daily Census - 184 • Adjusted Patient Days – 29,071 • Surgery Cases – 1,577 • Deliveries – 736 • ED Visits – 16,486 Mr. Rivas also presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, Emergency Department Visits, EROE and EBITDA. Mr. Rivas commented that despite myths in the public		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	sector, Tri-City is solvent and very strong financially. Mr. Schwartz questioned why expenses were lower than projected in September. Mr. Rivas stated the largest expense is labor and when census is down staff are flexed accordingly. Mr. Cumming questioned what we might anticipate with bundled payments. Mr. Rivas stated one advantage we have is our costs are lower than our competitors. Mr. Dietlin commented that there are a couple of pilot programs in place however they have not shown the results expected. At Chairperson Finnila's request, Mr. Dietlin commented on the Leap Frog Patient Safety Rating and other publicly reported data. He explained the various reporting agencies and things that may impact the scores. Mr. Dietlin stated the reality is that our clinical outcomes are excellent at Tri-City. We have made good strides in HCAHP scores however it takes time to move the "star" rating.		
6. Old Business - None			
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Finnila made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes. Prior to Director Dagostino's departure he requested the opportunity to provide a public comment. Director Dagostino expressed his appreciation to Director Finnila for her leadership on the committee which was done admirably. Director Dagostino also commented on Director Finnila's contributions to the Board as a whole. *Director Dagostino left the meeting at 9:00 a.m.*		
8. Motion to go Into closed session	**It was moved by Director Mitchell and seconded by Ms. Fitzwilliam to go into closed session at 9:03 a.m. The motion passed unanimously.**		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
9. Open Session	The committee returned to open session at 9:05 a.m. with attendance as previously noted.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Finnila reported no action was taken in closed session.		
11. Comments from Committee Members	Chairperson Finnila stated it has been a pleasure to work with such knowledgeable and competent committee members. She expressed her appreciation for their commitment to the Committee and setting such a high standard. Committee members also expressed their appreciation for Chairperson Finnila's leadership. Director Schallock stated during HUD's recent visit he commented on the importance and value of having knowledgeable community members on Board committees. Director Mitchell expressed her appreciation to Director Finnila for her leadership on the committee and the opportunity to be a member of the committee.	Information only.	
12. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting will be held on January 19, 2017.	**The committee's next meeting is scheduled for January 19, 2017.**	
13. Adjournment	Chairperson Finnila adjourned the meeting at 9:05 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
January 19th, 2017

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Responding to Compliance Issues - Reports of Suspected Misconduct Investigation	561	3 year review, practice change	

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

Proposed Version

ISSUE DATE: 05/12

SUBJECT: Responding to Reports of Suspected or Non-Compliance and Misconduct

REVISION DATE(S):

POLICY NUMBER: 8750-561

Department Approval Date(s):	01/16
Administrative Policies and Procedures Approval Date(s):	08/16
Organizational Compliance Committee Approval Date(s):	08/16
Medical Executive Committee Approval Date(s):	09/16
Audit and Compliance Committee Approval Date(s):	
Board of Directors Approval Date(s):	05/12

A. **PURPOSE:**

1. To identify Tri-City Healthcare District (TCHD)'s policy regarding its response to reports of suspected non-compliance and misconduct including the investigation of such reports.

B. **POLICIES**:

1. The Chief Compliance Officer (CCO) and/or his or her designee is responsible for conducting and overseeing investigations of reports of potential or actual non-compliance with ethical standards, applicable laws and regulations and TCHD's Code of Conduct and policies and procedures.
2. The CCO is responsible for reporting the outcome of investigations to Executive Management, Directors and appropriate staff in a timely manner.
3. Reports involving allegations of non-compliance or misconduct by individuals or entities who are hired by the Board (CEO, CCO, General Counsel, Board consultants) shall be reported immediately to the Board.

C. **PROCEDURES**:

1. Upon receipt of a report of suspected or actual non-compliance or misconduct, a Confidential Reporting Line (Values Line) report, audit findings or other information suggesting a possible compliance issue, the Chief Compliance Officer will record the information (as detailed below) and develop a preliminary written plan of action, usually within 72 hours of receiving the report unless the reported matter requires urgent attention.
2. If the CCO makes an initial assessment that the matter **does not** involve a bona fide instance of non-compliance or misconduct and that it warrants no further action, the CCO will close the report documenting this determination.
3. If the CCO determines after initial assessment that the matter **does not** involve a bona fide instance of non-compliance or misconduct but raises an area for improvement or concern for future violations, the matter will be referred to the appropriate staff or committee for further action.
4. If the CCO determines after initial assessment that the matter **does** raise a bona fide concern of suspected non-compliance or misconduct, the CCO shall promptly and thoroughly investigate and oversee the investigation of such matter. The CCO may also, on his/her own initiative, investigate instances of suspected non-compliance or misconduct that have not been reported but are identified through other sources such as audit findings.
5. The scope of the investigation/review will be determined by the Chief Compliance Officer or his or her designee; however, investigations/reviews will be conducted in a thorough manner. For example, the veracity of individual statements provided in an interview may be verified by documentary evidence or corroborating evidence.

6. Depending on the nature and severity of the suspected non-compliance or misconduct the Chief Compliance Officer may consult with appropriate TCHD Departments for additional information;
7. The CCO may also consult with and utilize outside legal counsel to assist in conducting certain internal investigations or in providing legal guidance and support for CCO investigations.
8. In conducting an internal investigation, the CCO, his or her designee and other investigators engaged by the CCO shall as necessary and appropriate:
   a. Take steps to secure, and prevent the destruction of, documents and other evidence relevant to the investigation.
   b. Review relevant documents and data.
   c. Interview persons with relevant information.
   d. Take all reasonable and necessary steps to ensure that identified actual misconduct or non-compliance is stopped and does not recur.
   e. Where the investigation reveals actual coding, billing and/or documentation issues, take all reasonable and necessary steps to ensure that TCHD does not submit non-compliant claims during the pendency of the investigation.
9. Internal investigations may encompass the following components: identification of non-compliant conduct, analysis of the root cause of identified non-compliant conduct, detection of gaps and weaknesses (e.g. function, systems, supervision, education and training, etc.) and recommendations for, and oversight of, corrective and remediation actions.
10. Internal reviews and investigations will be conducted in a fair and objective manner. Individuals involved in the underlying conduct which is the subject of the investigation or review will not direct the investigation.
11. Investigations will be conducted uniformly to the extent possible.
12. The investigation will be conducted and concluded within time periods that are reasonable based on the allegations under investigation and in order to comply with Federal and State fraud and abuse reporting and/or overpayment laws where such matters are at issue.
13. If applicable, the CCO will review whether any implemented "litigation hold" needs to be released before closing the investigation.

D. **DOCUMENTATION:**

1. Upon conclusion of the investigation a short, written report will be prepared by the Chief Compliance Officer or his or her designee or other party approved to conduct the investigation which will generally include:
   a. A description of the allegation(s)
   b. A description of the nature of the suspected matter investigated (if different than the allegation(s))
   c. The investigation procedures
   d. Identification of the persons involved and their role in the conduct (consistent with policy 8750-559; Reports of Suspected Misconduct: Confidentiality),;
   e. Conclusions related to whether the suspected allegations are unfounded or founded;
   f. Description of corrective actions/remediation; and
   g. Where applicable, an estimate of the nature and extent of liability or overpayment due.
2. TCHD shall maintain in a confidential and secure fashion, copies of any work papers, interview notes and any other documents generated as part of the internal investigation.
3. TCHD shall maintain in the Compliance Program files copies of any key documents that relate to the practice or matter under investigation.
4. TCHD shall document the scope, findings and recommendations of the internal investigation and shall maintain such documentation in the Compliance Program files.
5. In connection with any internal investigation, TCHD shall maintain in a confidential and secure fashion any documents, whether electronic or hard copy, that are attorney-client communications or attorney work-product. Such documents should be appropriately labeled or stamped as attorney-client privileged or attorney work product and maintained consistent with District's document retention policies. However, failure to label such documents in this manner will not mean the documents are not protected under the attorney-client privilege or attorney work product doctrine.

E. **REPORTING**:

1. The CCO will report the outcome of investigations to Executive Management, the Board of Directors and other staff (if and as appropriate) in a timely manner. Reporting mechanisms will vary and will be determined by the CCO.
2. The CCO will review whether the investigation results must be reported to any regulator and the mechanism for doing so. The CCO will confer with Executive Staff and the Board as appropriate before submitting such reports.
3. The CCO will notify the CEO, Board of Directors and General Counsel immediately if any report or subsequent investigation suggests that the conduct at issue raises criminal ramifications.

F. **CONFIDENTIALITY**:

1. The existence and substance of the investigation or review will be kept confidential to the extent possible and as appropriate under the circumstances and applicable laws and regulations.

G. **REFERENCES:**

1. Administrative Policy 8750-559; Reports of Suspected Misconduct: Confidentiality
2. Administrative Policy 8610 -424; Coaching and Counseling for Work Performance

Prior Version

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: **Responding to Compliance Issues; Reports of Suspected Misconduct; Investigation**

REVISION DATE(S):

POLICY NUMBER: 8750-561

Department Approval Date(s):	**01/16**
Administrative Policies and Procedures Approval Date(s):	**08/16**
Organizational Compliance Committee Approval Date(s):	**08/16**
Medical Executive Committee Approval Date(s):	**~~02/16~~09/16**
Audit and Compliance Committee Approval Date(s):	
Board of Directors Approval Date(s):	**05/12**

A. **PURPOSE:**

1. ~~Policy 8750-561 provides (1)~~**To provide** a statement of Tri-City Healthcare District **(TCHD)**'s policy with respect to its investigation of reports of suspected misconduct and (2) to ensure that the ~~District's~~ **TCHD's** practices are consistent with the stated policy.

B. **TIMELINESS:**

1. Upon receipt of a report concerning a compliance-related review, a Confidential Reporting Line (Values Line) report, or other information suggesting a possible compliance issue, the Chief Compliance Officer will record the information (as detailed in Section E below) and develop a preliminary written plan of action, usually within ~~24~~ **72 hours** ~~hours~~ of receiving the report.

C. **INVESTIGATORS:**

1. ~~District~~ **TCHD** (through its Chief Compliance Officer) shall promptly and thoroughly investigate all bona fide reported instances of suspected misconduct or potential compliance irregularities. The Chief Compliance Officer may also, on his/her own initiative, investigate instances of suspected misconduct or concern that have not been reported.
2. The internal investigation of suspected misconduct or potential irregularity shall be initiated and overseen by the Chief Compliance Officer.
~~2.~~**3.** Depending on the nature and severity of the suspected misconduct or potential irregularity, the Chief Compliance Officer should consult with the **appropriate** ~~Legal~~ Department;
~~3.~~**4.** **Consulting with** ~~and~~ ~~and consider~~ utilizing outside legal counsel to assist in conducting certain internal investigations.

D. **INVESTIGATION:**

1. In conducting an internal investigation, investigators shall as necessary:
   a. Take steps to secure, and prevent the destruction of, documents and other evidence relevant to the investigation.
   b. Review relevant documents.
   c. Interview persons with relevant information.
   d. Take all reasonable and necessary steps to ensure that the conduct of concerns is stopped and does not recur.
   ~~d.~~**e.** **Internal investigations may encompass identification on non-compliant conduct, analysis or why identified non-compliance conduct occurred in the first instance, detection of gaps and weaknesses (e.g. function, systems, supervision, education**

and training, etc.) and recommendations for, and oversight of, corrective and remediation actions.

E. **DOCUMENTATION:**

1. Upon conclusion of the investigation a short, written report will be prepared by the **person conducting the investigation or the** Chief Compliance Officer which includes:
   a. The nature of the problem
   b. The investigation procedures
   c. Consistent with policy 8750-559 ("reports of suspected misconduct: confidentiality"), the identity of the persons involved and the degree of culpability of said individuals; and
   d. Where appropriate, an estimate of the nature and extent of liability or overpayment due.
2. ~~District~~ **TCHD** shall maintain in a confidential and secure fashion, copies of any work papers, interview notes and any other documents generated as part of the internal investigation.
3. ~~District~~ **TCHD** shall maintain in the Compliance Program files copies of any key documents that relate to the practice **or matter** under investigation~~, consistent with District's TCHD's document retention policies~~.
4. ~~District~~ **TCHD** shall document the scope, findings and recommendations of the internal investigation and shall maintain such documentation in the Compliance Program files~~, consistent with District's TCHD's document retention policies.~~
5. In connection with any internal investigation, ~~District~~ **TCHD** shall maintain in a confidential and secure fashion any documents, whether electronic or hard copy, that are attorney-client communications or covered by the attorney work-product privilege. As appropriate, any such documents should be appropriately labeled or stamped as attorney-client privileged or attorney work product and maintained consistent with District's document retention policies. However, failure to label such documents in this manner will not mean the documents are not protected under the attorney-client privilege or attorney work product doctrine.

F. **OBJECTIVITY:**

1. **Internal reviews and investigations will be conducted in a fair and objective manner. Individuals involved in the underlying conduct which is the subject of the investigation or review will not direct the investigation.**

G. **UNIFORMITY:**

1. **Investigations will be conducted uniformly to the extent possible.**

H. **CONFIDENTIALITY:**

~~B.~~1. **The existence and substance of the investigation or review will be kept confidential to the extent possible and appropriate under the circumstances.**

I. **SCOPE OF INVESTIGATION:**

1. **The scope of the investigation/review will be determined by the Chief Compliance Officer or his or her designee; however, investigations/reviews will be conducted in a thorough manner. For example, the veracity of individual statements provided in an interview may be verified by documentary evidence or corroborating evidence.**

~~C.~~J. **REFERENCES:**

~~6.~~1. **Administrative Policy 8750-559; Reports of Suspected Misconduct: Confidentiality**
~~7.~~2. **Administrative Policy 8610 -424; Coaching and Counseling for Work Performance**