TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE AUDIT, COMPLIANCE AND ETHICS COMMITTEE
March 16, 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/ Recommendatio	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.	Ratification of Minutes- February16, 2017	3 min.	Action	Chair
5.	Old Business - None	--	--	--
6.	New Business – **Discussion and Possible Action**			
	A) **Administrative/Compliance Policies** 1. 8610-278 – Contract Review 2. 8610-279 – File Maintenance for Contract and Leases (DELETE) 3. 8610-292 – Internal Charge Audit 4. 8610-530 Emergency Response Employees, Notification of 5. 8610-562 - Responding to Compliance Issues; Remedial Action 6. 8610-574 – Tracking, Remuneration & Use of Items & Services to and from Referral Source and Tracking Use of TCHD Resources by Referral Sources	20 min.	Action	K. Topp
	B) Review of FY2017 Year to Date Financial Statement Results	15 min.	Information only	R. Rivas
7.	Motion to go into Closed Session			
8.	Closed Session			
	a. Approval of Audit, Compliance & Ethics Closed Session Minutes of February 16, 2017 (Authority: Government Code Section 54957.2)	5 min.	Action	Chair
	b. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (1 Matter)	10 min.	Action	CCO

	Agenda Item	Time Allotted	Action/ Recommendation	Requestor/ Presenter
9.	Motion to go into open session			
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: April 20, 2017	1 min.		Chair
14.	Adjournment			Chair
15.	Total Time Budgeted for Meeting	1 hour		

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
February 16, 2017
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino, DPT, PT; Director Leigh Anne Grass; 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
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 Schallock.		
2. Approval of Agenda	**It was moved by Mr. Cumming and seconded by Director Dagostino 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 – January 19, 2017	**It was moved by Mr. Leslie Schwartz and seconded by Ms. Kathryn Fitzwilliam to approve the minutes as presented. The motion passed unanimously.**	Minutes ratified.	Ms. Donnellan
5. Old Business a. A) Fiscal Year 2017 – Financial Statement Audit Proposal	Pursuant to the recommendation by the committee last month, Mr. Rivas reported a proposal was requested from Moss Adams to perform the FY2017 Financial Statement Audit.		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	Mr. Rivas distributed the proposed Engagement Letter and Professional Services Agreement from Moss Adams which outlined the Scope of Services, Timing, Fees and Reporting. Mr. Rivas stated Mr. Blakey would once again be the Engagement Reviewer and Mary Nguyen, Engagement Senior Manager. He explained Moss Adams has requested a 2% increase in fees for this year from prior year to adjust for inflation which amounts to approximately $3,000. Mr. Rivas stated there was no increase in fees for FY2015 or FY2016 and he believes this is a modest increase. Discussion was held regarding additional fees that may be incurred. Mr. Dietlin explained there could be additional fees based on audit findings however we are prohibited from limiting the scope of the audit. Mr. Rivas stated historically Moss Adams has been conservative in their fees and he recommends the committee recommend the proposal to the Board. **It was moved by Mr. Cumming to recommend the Board engage Moss Adams to perform the FY2017 Financial Statement Audit with the terms and fees presented. Mr. Schwartz seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to engage Moss Adams to perform the FY2017 Financial Statement Audit with the terms and fees described; item to be placed on Board Agenda and included in agenda packet.**	Ms. Donnellan
6. New Business			
A) Interviews of community candidates for open community seat on the Audit, Compliance & Ethics Committee 1) Faith Devine	Chairman Schallock reported four (4) individuals have applied for the open seat on the committee, Ms. Faith Divine, Mr. Bryan Gonzales, John Harper and Robert Knezek. Chairman Schallock explained the interview process to the candidates in which they would be interviewed one at a time in alphabetical order.		

	Discussion	Action Recommendations/ Conclusions	ırson(s) Responsible
	The first candidate interviewed was Faith Devine. Ms. Devine provided a brief summary of her background and experience. Ms. Devine stated she was a federal prosecutor with the U.S. Department of Justice specializing in financial fraud, waste and abuse. Committee members asked questions of Ms. Devine related to her educational background and any potential conflicts that might prevent her from serving on the committee. In closing, Ms. Devine stated she is an average private citizen interested in utilizing her knowledge and background and believes she could provide insight on many issues.		
2) Bryan Gonzales, JD, MBA	The second candidate, Mr. Bryan Gonzales presented a brief summary of his background and experience. Mr. Gonzales stated he is the Chief Executive Officer and Corporate Counsel for Pacific Medical Care, Inc. & Pacific Recovery, Inc. Committee members asked questions of Mr. Gonzales related to his educational background and any potential conflicts that might present him from serving on the committee. In closing, Mr. Gonzales stated he has been a member of the Tri-City community for approximately 18 months and feels that he can bring a real life hands on experience to the committee.		
3) John Harper, R.T.	Mr. John Harper provided a brief summary of his background and experience. He stated he worked at Tri-City previously as a MRI Technologist and has been a member of the Tri-City community since 1983. Committee members asked questions of Mr. Harper related to educational background. Mr. Harper also described his experience in neogitating with union personnel.		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
4) Robert Knezek	In closing, Mr. Harper stated he is familiar with compliance regulations related to government acquisition processes and understands healthcare and the processes involved in healthcare. He is recently retired and has the time to devote to the committee. Mr. Robert Knezek provided a brief summary of his background and experience. He stated he has served previously on the Audit, Compliance & Ethics Committee as well as the Finance, Operations & Planning Committee. Committee members asked questions of Mr. Knezek related to his educational background. In closing, Mr. Knezek stated he is very familiar with the hospital and committee structure and would bring an analytical mind to the committee. At the conclusion of the interviews, committee members had discussion and reviewed the qualifications of each candidate. Committee members concurred it was an impressive group of candidates and all individuals presented outstanding credentials. **It was moved by Mr. Cumming to recommend Ms. Faith Devine be appointed to the Audit, Compliance & Ethics Committee. Director Dagostino seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to appoint Ms. Faith Devine to the Audit, Compliance & Ethics Committee; item to be placed on Board agenda and included in agenda packet.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
B) Administrative Policies & Procedures: 1) 8610-530 – Notification to Pre-Hospital Personnel; Exposure to Infectious Disease	Ms. Kathy Topp, Director of Education and Clinical Informatics joined the meeting at 9:40 a.m. Ms. Kathy Topp explained Policy #8610-530 – Notification to Pre-Hospital Personnel; Exposure to Infectious Disease was designed to protect our personnel from infectious communicable diseases on preadmission. She stated by law we are required to report exposures of pre-hospital emergency medical personnel to certain infectious diseases. Director Grass noted this policy applies to police officers, firefighters, volunteers and others who might provide emergency care or rescue services as well. Dr. Mells expressed concern with the process and questioned if there is a mechanism in place to "close the loop" by providing notification back to staff if it is discovered a patient presented with an infectious disease. Mr. Schwartz questioned what the "Act" refers to in E. 3. and 4. Director Dagostino questioned if the policy applies to other TCHD entities such as the Wellness Center. Due to the number of unanswered questions and ambiguity of the policy, It was recommended the policy be pulled for further review and clarification.	**Policy 8610-530 – Notification to Pre-Hospital Personnel; Exposure to Infectious Disease will be sent back to the appropriate committees for further review and clarification.**	Ms. Topp
2) 8750-537 – Hiring and Employment : Definitions (Deleted)	Ms. Topp explained the deleted policies on today's agenda were incorporated into existing policies to avoid redundancy.	**Policy deleted as recommended.**	
3) 8750-539 – Screening Covered Contractors	Policy #8750-539 – Screening Covered Contractors was reviewed by the Committee. Minor formatting and typographical changes were suggested.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
4) 8750-540 – Pending Debarment, Criminal Charges or Adverse Action against Current Covered Contractors	The committee reviewed Policy #8750-540 – Pending Debarment, Criminal Charges or Adverse Action against Current Covered Contractors. It was suggested Definitions 1. and 2. be reversed for consistency with Policy #8750-539. There was extensive discussion regarding sections C. 2. a. and b. It was suggested Ms. Topp and Ms. Bernard-Shaw work with General Counsel on acceptable language and move forward to the Board for approval.		
5) 8750-541- Conviction/Exclusion/License Revocation of Current Covered Contractors (Deleted)	Policy 8750-541 - Conviction/Exclusion/License Revocation of Current Covered Contractors has been deleted.	**Policy deleted as recommended.**	
6) 8750-542 – Covered Contractor Requirements to Report Changes in Certification (Deleted)	Policy 8750-542 – Covered Contractor Requirements to Report Changes in Certification has been deleted.	**Policy deleted as recommended.**	
7) 8750-546 – Education and Training; Distribution/Certification of Code of Conduct and/or Policies	The committee reviewed Policy 8750-546 – Education and Training; Distribution/Certification of Code of Conduct and/or Policies. Ms. Topp recommended the Addendums be amended to reflect that the employee has read the Code of Conduct and will adhere to the Tri-City Healthcare Districts Policies. It was also suggested that the abbreviation for Tri-City Healthcare District be used in lieu of the full name when it appears more than once in the document. Discussion was held regarding the location that the contracts are housed. After extensive discussion it was suggested the language "in each employee's personnel file" be struck from D. 2.		
	It was moved by Ms. Kathryn Fitzwilliam to recommend approval of Policies 8750-539 – Screening Covered Contractors, 8750-540 – Pending Debarment, Criminal Charges or Adverse Action against Current Covered Contractors, deletion of Policies 8750-537 – Hiring and	**Recommendation to be sent to the Board of Directors to approve the Policies described and delete policies as**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	erson(s) Responsible
	Employment: Definitions, 8750-541 – Conviction/Exclusion/License Revocation of Current Covered Contractors and 8750-542 - Covered Contractor Requirements to Report Changes in Certification with amendments as described. Director Grass seconded the motion. The motion passed unanimously.	**recommended; items to appear on the Board agenda and included in agenda packet.**	
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Schallock made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes and one matter of Potential Litigation.		
8. Motion to go Into closed session	**It was moved by Director Dagostino and seconded by Mr. Cumming to go into closed session at 10:30 a.m.**		
9. Open Session	The committee returned to open session at 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 Schallock reported no action was taken in closed session.		
11. Comments from Committee Members	None.		
12. Date of Next Meeting	Chairperson Schallock stated the Committee's next meeting will be held on March 16, 2017.	**The committee's next meeting is scheduled for March 16, 2017.**	
13. Adjournment	Chairperson Schallock adjourned the meeting at 10:44 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
March 16th, 2017

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Contract Review 278	**278**	3 year review, practice change	
2. File Maintenance for Contract and Leases 279	**279**	DELETE	
3. Internal Charge Audit	**292**	3 year review, practice change	
4. Emergency Response Employees, Notification of 530	**530**	3 year review, practice change	
5. Responding to Compliance Issues; Remedial Action 562	**562**	3 year review, practice change	
6. Tracking Remuneration & Use of Items & Services to & from Referral Source and Tracking Use of TCHD Resources by Referral Sources 574	**574**	3 year review, practice change	

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 11/02 **SUBJECT:** Contract Review

REVISION DATE: 05/03; 04/06; 01/11; 07/11; 04/12 09/15 **POLICY NUMBER:** 8610-278

Department Approval Date(s):	~~11/15~~ 2/17
Administrative Policies & Procedures Committee Approval:	~~12/15~~0217
Organizational Compliance Committee Approval:	02/17
Audit, Compliance and Ethics Committee	01/16
Board of Directors Approval:	01/16

A. **PURPOSE:**

1. To ensure all agreements executed by or on behalf of Tri-City Healthcare District or its operating units ("TCHD") have received appropriate administrative review and approval, are legally sufficient, minimize risk to TCHD and comply with legal, accreditation and TCHD requirements.

B. **DEFINITION(S):**

1. Clinical – to meet the intent of the contract that will require a direct patient interface (for example Physician Contracts, Infusion Pumps and Operating Room Equipment).
2. Non-Clinical – the intent of the contract is for supportive services to the organization not requiring a patient interaction (for example Coder Contract, maintenance contracts, or legal agreements)
3. Other - the intent of the information is any miscellaneous documents that do not include clinical or non-clinical information (for example Regulatory agreements, Real Estate Leases, Certificates, Non-Disclosure Agreements). Includes Confidentiality Agreements signed by physicians for trade secrets.
4. Protected Health Information (PHI) – individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND
   a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
5. Business Associate Agreement (BAA) – is considered a contract with PHI.

C. **POLICY:**

1. Contracts shall be categorized into:
   a. Clinical with or without PHI
   b. Non-clinical with or without PHI
   c. Other with or without PHI
   d. BAA with PHI
2. The Governing Body is responsible for **oversight of** all services covered under contracts at Tri-City Healthcare District (TCHD).
   a. All contracts shall be assessed through the following committees to identify quality and performance problems, implement appropriate corrective or improvement activities and ensure monitoring and sustainability of those corrective actions or improvement activities.
      i. The Organizational Compliance Committee will review all contracts initially and upon renewal.
      ii. The Medical Executive Committee will review all Clinical contracts.

iii. The Audit, Compliance and Ethics Committee will review the Non-clinical, Other and BAA contracts.

3. All personnel associated with contracted services will adhere to Hospital Orientation for Non-Employees of Tri-City Healthcare District (Administrative Policy – Human Resources #8610-451 – Non-TTCHD Worker's Orientation and Identification Badge Process, Non-Employees).
4. General Policy. Agreements between TCHD and other parties must be in writing, submitted by the contract requestor for appropriate administrative and/or legal review and approval and signed by the CEO or his/her authorized designee as set forth in Administrative Policy #8610-232, Signature Authority.
5. Competitive Bidding and Other Procurement Procedures. TCHD has adopted policies and procedures, including competitive bidding regulations, governing the purchase of materials, supplies, equipment, services including professional services and public works, as set forth in Board Policy #13-013. Contract requestors must comply with TCHD procurement policies and procedures, including competitive bidding requirements when applicable, as set forth in Board Policy #13-013.
6. Fair Market Value. Compensation under an agreement, and any changes in compensation, shall compensate the contractor for the services under the agreement for the reasonable fair market value of such services.
7. TCHD Standard Form Agreements. A contractor must utilize TCHD standard form agreements when possible. The list of TCHD standard form agreements is attached as Exhibit A, and such lists may be amended periodically by the Contract Manager. The TCHD standard agreements may not be altered, modified, changes or amended, unless the proposed changes are approved by the Contract Manager or the Contract Manager's designee (i.e. Board counsel, or other outside legal counsel retained by TCHD.)
8. Legal Review. Review and approval by TCHD's legal counsel ("Legal Counsel") is required for some agreements, based on agreement type and dollar amount as set forth below.
9. Agreements with Physicians. All agreements between TCHD and a referring physician (and/or physician's immediate family members) require review and approval by Legal Counsel to ensure compliance with the federal Stark and Anti-kickback statutes and similar California laws unless conforming fully to an approved form agreement. Agreements with physicians also must be approved or ratified as provided in Administrative Policy #8610-232, Signature Authority.
10. Independent Contractor and Consulting Services Agreements - All consulting services agreements must be approved by the CEO and comply with IRS guidelines with respect to the status of independent contractors. All Consulting Services Agreements shall be reviewed in accordance with B.9, B.10 and B.11 of this policy, whichever is applicable depending on the dollar amount of the expenditure.
11. Materials, Supply and Equipment. All requests to purchase or lease materials, items, equipment and supplies must be submitted by the contract requestor to Supply Chain Management. Supply Chain Management may use form agreements, or the vendor's terms and conditions, if they terms comply with the Contract Term. Supply Chain Management will submit all equipment lease requests to Finance to ensure appropriate accounting treatment of capital and/or operating leases. All materials, supplies and equipment agreements shall be reviewed in accordance with B.9, B.10 and B.11 of this policy, whichever is applicable depending on the dollar amount of the expenditure.
12. Real Property Agreements. All requests to enter Real Property Agreements, whether via lease, acquisition, broker, or otherwise, must be submitted to the Contract Manager. The Contract Manager shall then forward the request to Legal Counsel for review and approval. All Real Property Agreements, regardless of the amount of the expenditure, shall be reviewed and approved by Legal Counsel. The contract requestor also must submit the proposal to Finance to ensure appropriate accounting treatment of capital and/or operating leases.
13. Agreements involving expenditures less than $25,001. Unless otherwise expressly provided in this policy, the responsible C-Level Executive, as set forth in Administrative Policy #8610-232 Signature Authority, may approve the language in non-standard agreements without review by Legal Counsel, so long as the material terms comply with the Contract Check-List, as may be

amended from time-to-time by Legal Counsel.

14. Agreements involving expenditures between $25,001 and $100,000. Unless otherwise expressly provided in this policy, the Contracts Manager may approve the language in non-standard agreements and/or modifications to TCHD standard form agreements that comply with the Contract Check-List or other contracting guidelines developed by Legal Counsel.
15. Agreements involving an expenditure in excess of $100,000. Unless otherwise expressly provided in this policy, all agreements involving an expenditure in excess of $100,000 shall be reviewed and approved by Legal Counsel.

D. **PROCEDURE:**

1. Contract Review and Approval. The contract review and approval process shall comply with this policy, Board Policy #013. .
2. Procedure for Legal Review. If legal review will be required, the contract requestor shall submit a request for legal review to TCHD's Contract Manager. The Contract Manager will then forward the request to Legal Counsel.
3. Contract Execution. The contract requestor is responsible for obtaining all appropriate signatures for approved contracts in accordance with Administrative Policy #8610-232 Signature Authority.
4. Electronic Signatures. Contracts may be accepted in electronic form (e.g., by scanned copy of a signed document, or with an electronic or digital signature) provided that:
    a. A copy of the signature is on file with the Contract Manager so that it can be determined the person to which electronic signature is attributable and
    b. The contract includes a provision pursuant to which the parties agree that
        i. An electronic signature by either party shall be deemed binding on that party.
        ii. The parties will not contest the validity or enforceability of the contract, including under any applicable stature of frauds, because it was accepted or signed in electronic form, and
        iii. The parties will not contest the validity or enforceability of a signed facsimile copy of the contact on the basis that it lacks original handwritten signature.
5. Contract Management System Compliance. All duly approved and fully executed contracts must be scanned into TCHD's contract management system, as soon as reasonably practicable following the execution of the contract, as failure to do so may result in delays in the payment process. The contract requestor shall be responsible to confirm with the Contract Manager that the executed contract has been scanned into TCHD's contract management system.
6. Approval of Invoices. The contract requestor and/or a TCHD-authorized approver will also be responsible for approving any invoices as valid and consistent with the approved contract before Accounts Payable can pay the invoice.
7. Monitoring Contract Renewal and Termination. The contract requestor for each contract as noted in TCHD's contract management system shall monitor timelines for the renewals and/or terminations of their contracts, and shall notify the Contract Manager when any change in contract terms are required.

E. **PROHIBITED CONFLICTS OF INTEREST:**

1. Any practices which might result in unlawful activity including, but not limited to, rebates, kickbacks, or other unlawful consideration are prohibited. No employee may participate in the contract process, including but not limited to the bid or other procurement process, contractor selection, negotiation, review or approval of a contract, when the employee has a relationship with a person or business entity seeking the contract that requires disqualification of the employee under the Political Reform Act or other provisions of law.

COMPLIANCE WITH POLICY:

1. It is the responsibility of the TCHD manager, director or other executive or employee requesting a contract to ensure compliance with Board Policy #13-013, the contract approval process as stated in this policy and the TCHD Handbook for Contracting, and to ensure that a fully executed agreement is obtained prior to initiating any contracted service or payment for such service.

G. **RELATED DOCUMENTS:**

1. **Administrative Policy #8610-232, Signature Authority**
2. **Administrative Policy – Human Resources #8610-451 – Non-TCHD Worker's Orientation and Identification Badge Process, Non-Employees**
3. **Board of Directors Policy 13-013 – Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts**
4. Contract Categories
5. Contract Request Form (CRF) – for contracts greater than $25,000
6. Contract Legal Terms Checklist – for contracts less than $25,000

H. **REFERENCES:**

1. CMS Hospital Conditions of Participation and Interpretive Guidelines, Contracted Services 482.12 (e)(1), 482.12 (e) (2)

EXHIBIT A

Standard Form Agreements

The following is a list of types of Standard Form Agreements available: ~~from Clinical Trial Agreements (device and drug)~~

~~a.~~ Co-Management Agreement
- ~~b.~~**a.** Confidentiality Agreement
- ~~c.~~**b.** Education Affiliation Agreements
- ~~d.~~**c.** Group Purchasing Organization ("GPO") Agreements are deemed to comply with TCHD requirements when reviewed and completed by the Director of Supply Chain Management in compliance with Contract Check-list
- ~~e.~~**d.** Independent Contractor/Consulting Services Agreement [Non-Physician]
- ~~f.~~**e.** Joint Marketing Agreements
- ~~g.~~**f.** HIPAA Business Associate and Addendum
- ~~h.~~**g.** Hospice Services Agreement
- ~~i.~~**h.** Medical Office Lease and Sublease
- ~~j.~~**i.** Patient Transfer Agreement
- ~~k.~~**j.** Physician Agreements
  - i. Medical Director Agreement
  - ii. Medical Staff Leadership Agreement
  - iii. On-Call Coverage Agreement and Guidelines
  - iv. Physician Consulting Services Agreement
  - v. Physician Recruitment Agreement and associated forms.
- ~~l.~~**k.** Professional Services Agreement [Non-Physician]
- ~~m.~~**l.** Purchase Order Terms and Conditions
- ~~n.~~**m.** Registry Agreement
- ~~o.~~**n.** Request for Bids and associated forms for public works projects
- ~~p.~~**o.** Secured Promissory Note
- ~~q.~~**p.** Security Agreement
- **q.** Travel Agency Agreement
- r. **Clinical Trial Agreements**

Tri-City Health Care District
Oceanside, California

DELETE – incorporated into Administrative Policy: Contract Review 278

Administrative Policy Manual

ISSUE DATE: 11/02

SUBJECT: File Maintenance for Contracts and Leases

REVISION DATE: 05/03; 04/06; 05/09

POLICY NUMBER: 8610-279

Department Approval:	02/17
Administrative Policies & Procedures Committee Approval:	~~05/09~~ 2/17
~~**Operations Team Committee Approval:**~~	~~05/09~~
Organization Compliance Committee Approval:	02/17
Audit, Compliance and Ethics Committee Approval:	
~~**Professional Affairs Committee Approval:**~~	~~06/09~~
Board of Directors Approval:	06/09

~~A.~~**~~PURPOSE:~~**

~~To ensure that files of all contracts and leases are maintained by the responsible administrative office.~~

~~B.~~**~~POLICY:~~**

~~1. A file of all contracts and leases for hospital services, physician services, professional services, transfer agreements, educational affiliations, real estate agreements, and consignments will be maintained in an up-to-date and easily accessible manner in the administrative offices.~~

~~2. It is the responsibility of the Vice Presidents, Directors and Risk Management to ensure compliance with the file maintenance process.~~

~~C.~~**~~PROCESS:~~**

~~1. The purchasing office maintains originals of all purchase orders.~~

~~2. As soon as signatures have been obtained, all original contracts, leases, and agreements will be sent to Risk Management to be filed, except those assigned a purchase order number. Those will be maintained in the purchasing department.~~

~~3. Upon receipt of the properly executed contract, lease, or agreement, Risk Management will follow this process:~~

~~a. All contracts, leases, and agreements will be filed in a locked filing cabinet located in Administration.~~

~~b. An alphabetically sequenced master list and a categorically sequenced master list will be maintained for cross reference purposes. Those lists will include name of the party the hospital is entering into the contract with, effective date, expiration date, term, and category.~~

~~c. Risk Management must approve all requests for copies of a contract, lease, or agreement.~~

~~d. Directors will be notified of contract expiration at least 90 days prior to actual expiration.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 12/10 **SUBJECT: INTERNAL CHARGE AUDIT**

REVISION DATE: **POLICY NUMBER: 8610-292**

Department Approval:	**01/16**
Administrative Policies & Procedures Committee Approval:	**~~01/11~~08/16**
~~**Executive Council Approval:**~~	~~**01/11**~~
~~**Finance & Operations Committee Approval:**~~	~~**01/11**~~
Organizational Compliance Committee Approval:	**10/16**
Audit, Compliance and Ethics Committee Approval:	
Board of Directors Approval:	**01/11**

A. **PURPOSE:**

1. Provide the structure by which the hospital may realize organizational benefits through improvements in internal processes.
2. Improve the provider service relationship by prompt response to patients' billing questions.
3. Identify deficiencies in charge pathways and processes, and strengthen the controls necessary for high-quality fiscal and clinical data.

B. **POLICY:**

1. To ensure all medical billing audits are performed efficiently and effectively, thereby, promoting the accuracy and integrity of hospital charges.

C. **PROCEDURE:**

1. The scope of a medical billing audit is limited to verifying that charges on the detailed hospital bill are accurate, represent services rendered to the patient, and are ordered by a physician. However, services or items may be provided based upon standard hospital practices and/or ~~Nursing~~ **Medical** protocols and procedures.
2. The audit does not assess the "reasonableness" of the charges, or medical necessity related to patient bills. A review of medical necessity for the services provided may be performed, but the billing audit process does not encompass these tasks.
3. Documentation—In concert with the position taken by the American Hospital Association's (AHA) publication, Billing Audit Guidelines (1992), the hospital does not attempt to make the patient's Medical Record a duplicate bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by ~~Nursing~~ **Medical** protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that may be used to substantiate charges. In a business relationship, the hospital will act in good faith during the course of all transactions involving a patient's account, and the same is expected of all outside parties acting on behalf of the patient.
4. ~~HOSPITAL AUDITOR RESPONSIBILITIES~~**Hospital Auditor Responsibilities**:
   a. The hospital will designate an individual to be responsible for coordinating all medical billing audit activities (i.e., Patient Account Auditor; hereafter referred to as Chart Auditor). Medical billing audit activities are prompted via both internal and external processes, and include concurrent, focus, miscellaneous, patient request, and insurance defense audit types. In addition to coordinating all internal audit activities, (i.e., concurrent, focus, and miscellaneous audits), the Chart Auditor will serve as the primary liaison between the hospital and all outside parties requesting patient account audits. All medical billing audit activities are to be documented and logs maintained within the hospital. All audit-related

account adjustments are to be processed only after appropriate facility-level sign off approval has been obtained. All audit related account adjustments are to be signed and dated by the requestor. Principles related to segregation of duties dictate that audit-related account adjustments shall not be processed by the requestor. All audit-related account adjustment documents are to be maintained in accordance with applicable hospital record retention policies.

D. **CONCURRENT ACCOUNT AUDITS INTERNALLY PROMPTED MEDICAL BILLING AUDIT ACTIVITIES**

1. The Chart Auditor will perform concurrent account audits on a monthly basis to identify charge issues that may indicate deficiencies in charge pathways and processes. A concurrent audit is defined as a complete audit of an account completed within 30 days of patient discharge. The audit samples for concurrent review will be determined by the ~~Compliance Committee~~**Senior Director Revenue Cycle Integrity, Finance**.

~~2. Acute care, psychiatric, and rehabilitation are required to perform additional concurrent account audits. A monthly sample will be determined by the **Senior Director Revenue Integrity, Finance**Compliance Committee.~~

~~3. The Chart Auditor shall be a core member of the Hospital Medical Audit Committee, which is a subcommittee of the Compliance Committee. He/she shall communicate all concurrent audit statistics and identified problems to administrative management within five working days of completion. Concurrent audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee.~~

~~4.~~2. ~~After review and signature by the Hospital Chief Financial Officer, all concurrent audit statistics, Medical Audit Committee Meeting Minutes, and Departmental Corrective Action Plans are to be sent to the Finance Department by the fifth of each month.~~

~~5.~~3. ~~**FOCUS AUDITS**~~**Focus Audits**

a. The Chart Auditor will perform audits on claims chosen to target a specific departmental issue or concern. Focus audits take an in-depth look at very small segments of the hospital's charging structure to make a determination, decision, or conclusion about specific billing or charging practices.

b. Focus audits, which are performed on a select group of claims, may be self-prompted by the Chart Auditor or may come from a committee, group, or entity within the hospital or Tri-City Medical Center. Focus audits are designed to address a variety of issues, including, but not limited to:

   i. Validate or quantify a trend or pattern of billing errors noticed during routine/concurrent audits.
   ii. Complete a quality check on a new service line or new charge capture mechanism.
   iii. Check on the effectiveness of a previously implemented corrective action plan.
   iv. Retrospectively correct accounts in which a specific billing error has been identified.

c. Prior to starting a focus audit, the Chart Auditor must define and document the impetus, approach, timeframe, and extent of the review. This documentation is to be included in the medical billing audit activity logs.

~~d. The Chart Auditor shall communicate all focus audit statistics and identified problems to administrative management within five working days of completion. Focus audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee.~~

~~6.~~4. ~~MISCELLANEOUS AUDITS~~**Miscellaneous Audits**

a. Internal requests for single account audits from various individuals or departments within the hospital are processed at the discretion of hospital administration. These single account audit requests originate from, but are not limited to, Clinical departments, Business Office, Medical Records, and Finance. ~~A clearly defined internal process for these requests is the responsibility of the Chart Auditor at the direction of hospital~~

~~administration.~~ Documentation of miscellaneous audit activity is recorded and maintained in the medical billing audit activity logs.

b. ~~The Chart Auditor shall communicate all miscellaneous audit statistics and identified problems to administrative management within five working days of completion. Miscellaneous audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee.~~

E. EXTERNALLY PROMPTED MEDICAL BILLING AUDIT ACTIVITIES

1. ~~PATIENT REQUEST AUDITS~~**Patient Request Audits**
   a. The hospital will establish and maintain an internal policy for processing patients' questions regarding the validity of itemized charges.
   b. The hospital's Patient Request Audit Policy must address the following issues:
      i. Procedure for referring requests to the Chart Auditor.
      ii. Procedure for communicating audit information to Business Office and Accounts Receivable departments.
      iii. Procedure for communicating audit results to the patient.
      iv. Audit fees (if any).
   c. In the event that a patient's questions can be answered without auditing the bill, notes to that effect must be entered into appropriate hospital files. (i.e., a patient may want to know when or why a particular item or service was provided and has no further billing questions.) If the patient requests a complete bill audit, the following points should be noted:
      i. The entire bill will be audited, not just one department or one section.
      ii. Inform the patient that the bill will be audited for both overcharges and undercharges, and that the claim will be corrected to reflect all billing errors as a result.
      iii. Debits and credits will impact the total charges, but depending on reimbursement methodology, the patient's out-of-pocket expenses may or may not be impacted.
   d. The Chart Auditor shall **provide summary reports for all audits (concurrent, focus, miscellaneous, patient request and third party defense) completed during the month to the Director Revenue Cycle.** ~~**Corrective action plans will be provided by Department Director/Manager with a 5% or greater error rate**communicate all patient request audit statistics and identified problems to administrative management within five working days of completion. Patient request audit summary statistics are to be presented at the monthly meetings of the Hospital Medical Audit Committee~~.

~~F. MEDICAL AUDIT COMMITTEE~~

~~1. Tri-City Medical Center will have a Medical Audit Committee, which is a subcommittee of the Compliance Committee. The purpose of the Medical Audit Committee is to provide a forum for communicating audit results, discussing problematic charge practices, and identifying, initiating, and monitoring corrective actions. The Medical Audit Committee will meet at least nine times annually.~~

~~2. The Medical Audit Committee will include at a minimum: CFO, Director of Patient Business Services, Chart Auditor, HIM director or representative, Nursing director(s), and department directors/managers from Central Supply, Pharmacy, Radiology, Laboratory, and Surgery, as determined necessary by facility. The Medical Audit Committee must be comprised of appropriate representation at a level which ensures problem resolution and decision making.~~

~~3. Department directors/managers are required to attend based on identified error rates:~~
   ~~a. 0 % - 4.99 % error rate: department director/manager is not required to attend Medical Audit Committee meeting~~
   ~~b. 5% or greater error rate: department director/manager attends Medical Audit Committee meeting until all action items are resolved. Director/Manager provides an explanation of the source of errors, how errors may be corrected and presents a detailed corrective action plan addressing root causes; corrective action plans shall include education to prevent recurrence.~~

4. ***THE MEDICAL AUDIT COMMITTEE SHALL:***

a. Analyze the summarized concurrent audit findings presented by the Medical Billing Auditor. The analysis should:

i. Identify departments demonstrating an error rate of greater than 5% in overcharges and undercharges.

ii. Discuss possible reasons why overcharges and undercharges are occurring; i.e., failure to properly document services, failure to process credits, failure to accurately capture charges, incomplete documentation on Medication Administration Record, inaccurate charge sheets, lack of departmental charge reconciliation, etc.

iii. Discuss corrective action plans. Action plans are designed to assist the departments in moving progressively toward a 0% error rate. Department directors/managers are responsible for establishing control mechanisms to ensure timely, accurate charging and documentation of services rendered.

iv. Ensure corrective action plans are implemented no later than 30 days from the date the error rate was identified.

v. Monitor and evaluate the effectiveness of all open action plans. Corrective action plans are considered closed when the error rate is below 5% for two consecutive months.

b. Analyze the Monthly Late Charge Summary Report. The analysis should:

i. Identify departments showing a trend of late charges. Evaluate departments exhibiting late charges greater than 1% of monthly department gross charges.

ii. Discuss possible reasons why charges are not processed on a timely basis; i.e., charges not submitted on weekends, failure to batch charges regularly, failure to cross train personnel on charging practices, incomplete charge information sent to Data Processing, charges generated by the NIC/NMC, lack of departmental reconciliation, etc.

iii. Discuss ideas for corrective action by departments exhibiting late charges.

iv. Ensure corrective actions are implemented no later than 30 days from the date the late charge rate was reported.

v. Monitor and evaluate the effectiveness of all open action items. Corrective actions are considered closed when the applicable department late charge rate is less than 1% for two consecutive months.

c. Analyze summarized focus, patient request, miscellaneous, and insurance defense audit findings.

5. ***MEDICAL AUDIT COMMITTEE DOCUMENTATION***

a. The CFO must review and sign all documented Medical Audit Committee activity, which shall include the following:

i. Medical Audit Committee meeting agenda and minutes;

ii. Signed roster of Medical Audit Committee meeting attendees;

iii. Corrective action plans;

iv. Summary reports for all audits (concurrent, focus, miscellaneous, patient request and third party defense) completed during the month.

6. ***REPORTING TO COMPLIANCE COMMITTEE***

a. The Medical Audit Committee shall provide monthly reports to the facility's Compliance Committee, including Medical Audit Committee meeting minutes, overall facility error rate trended over 12 months, department error rates trended over 12 months and corrective action plans for any department with an error rate of 10 % or greater. The Compliance Officer or the Compliance Committee shall determine if further audits are required for evaluation and will coordinate this through appropriate channels.

7. ***ENFORCEMENT***

i. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy.

~~Failure to comply with this policy will be subject to appropriate disciplinary action pursuant to all applicable policies and procedures, up to and including termination.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 5/04

SUBJECT: ~~Emergency Response Employees~~, **Notification ~~of~~to Pre-Hospital Personnel; Exposure to Infectious Disease**

REVISION DATE: 7/04; 12/05; 05/09

POLICY NUMBER: 8610-530

Department Approval:	**10/16**
Administrative Policies & Procedures Committee Approval:	**~~05/09~~10/16**
~~**Operations Team Committee Approval:**~~	~~**05/09**~~
Organization Compliance Committee Approval:	**11/16**
Medical Executive Committee Approval:	**01/17**
Audit, Compliance and Ethics Committee Approval:	
~~**Professional Affairs Committee Approval:**~~	~~**06/09**~~
Board of Directors Approval:	**06/09**

A. **PURPOSE:**

1. Both federal and California law establish requirements for reporting exposures of pre-hospital emergency medical personnel to certain infectious diseases.

B. **DEFINITIONS:**

1. Pre-hospital emergency medical care personnel may include: Paramedic, Registered Nurse (RN), Emergency Medical Technician (EMT), lifeguard, fire fighters, peace officers, **federal offices,** volunteers, and physicians who provide pre-hospital emergency medical care or rescue services.
2. Reportable disease or condition means those diseases listed in Section I and prescribed by Title 17, CCR Sections 2500-2640 **and Title 8, CCR Section 5199 Appendix A.**~~.~~

C. **CALIFORNIA REPORTING LAW:**

1. Under specified circumstances, pre-hospital emergency medical care personnel exposed to a person afflicted with a disease or condition listed as reportable and transmitted through oral contact or secretions of the body must be notified that they have been exposed to a disease as defined in Section I [Health and Safety Code Section 1797.188
2. Notification of exposure: The pre-hospital emergency medical care person who provided services must give their name and phone number to the TCMC Base Hospital Coordinator or the **MICN** ~~"Radio Nurse"~~ at the time patient is transferred from their care to the admitting health facility. Pre-hospital emergency medical care persons may also give their name and phone number to the transporting party to relay to the hospital.
3. The **Tri-City Medical Center** (TCMC) Base Hospital Coordinator**, MICN, or Emergency Department Charge nurse facilitates the completion of the County of San Diego Communicable Disease Exposure Report. The report is then forwarded to the Infection Control department. The Base Hospital Nurse Coordinator will follow up with the EMS Coordinator/Infection Control Officer of the appropriate EMS agency.** ~~or the "Radio Nurse" shall complete the "Confidential Morbidity Report (CMR Form)" and submit to the California Department of Public Health (CDPH).~~
4. Exposed personnel arriving at TCMC are directed to Occupational Health/Emergency Department for evaluation and treatment.
5. If the exposed personnel do not arrive at TCMC, the TCMC Base Hospital Coordinator or MICN must report the name(s) and telephone number(s) to the county health officer, as soon as the patient is diagnosed with a reportable disease or condition. The phone number to call is 619-

515-6620 (San Diego County Community Epidemiology Branch).

6. The County Health Officer is then responsible for informing the involved pre-hospital emergency medical care personnel of the exposure. The statute does not provide for any release of information from hospitals to pre-hospital emergency medical care personnel.
7. Furnish other pertinent information related to the occurrence as may be requested by the local health officer or CDPH.

D. **FEDERAL LAW:**

1. The Ryan White Comprehensive AIDS Resources Emergency Care Act, requires medical facilities to give a report to the "designated officer" (DO) of the pre-hospital emergency response service when personnel are exposed to specified infectious diseases (see Section I for list of diseases) during the transport of a patient to the hospital. The TCMC Base Hospital Coordinator or designee maintains a current list of facilities and designated officers.
2. The hospital is responsible for initiating reports only regarding infectious pulmonary tuberculosis. Reports regarding questions about all other infectious conditions (i.e. Hepatitis B, HIV infection (including AIDS), Diphtheria, Meningococcal disease, Plague, Hemorrhagic fevers (ex. Lassa, Marburg, Ebola, Crimean-Congo), Rabies, and others yet to be identified) will be initiated by the DO of the pre-hospital emergency response service.

E. **SCOPE OF RESPONSIBILITY:**

1. The duties of Tri-City Healthcare District terminate upon discharge of the patient for conditions arising from the emergency or at the end of the 60-day period (beginning on the date the victim is transported by the emergency response employee to the hospital), whichever period is shorter. A response must be made as soon as possible but not later than 48 hours after the request is made.
2. This time period can be extended to a maximum of 90 days if the request for information is received within 30 days of the applicable 60-day period.
3. ~~The~~ **The Ryan White Comprehensive AIDS Resources Emergency Care Act** ~~Act~~ does not authorize or require a facility to test any patient for any infectious disease.
4. ~~The~~ **The Ryan White Comprehensive AIDS Resources Emergency Care Act** ~~Act~~ does not authorize or require any facility, designated officer or emergency response employee to disclose identifying information with respect to a patient or an emergency response employee.
5. The designated officer and any emergency response employee to whom disclosure is made must maintain the confidentiality of HIV test results and may be personally liable for unauthorized release of any identifying information about the HIV results.

F. **EVALUATION:**

1. TCMC receives by mail, fax, phone, or in person a request from the DO for information about possible exposure to one of the above infectious diseases.
2. These are all referred to and evaluated by the TCMC Base Coordinator.
3. After hours and on weekends, the ED "Radio Nurse" will review the request.
4. If the request is made without a Confidential Morbidity Form, one is completed by the TCMC Base Coordinator or "Radio Nurse" to gather appropriate information.
5. Infection Control can be contacted for assistance.
6. One of the following determinations is made:
   a. The pre-hospital emergency medical personnel were exposed.
   b. The pre-hospital emergency medical personnel were not exposed.
   c. Facts about the case are insufficient to determine an exposure.

~~6.~~ 7. **Infection Control will notify TCMC Base Coordinator of potential exposure if a patient was transferred via ambulance/EMS.**

. **RESPONSE:**

1. All requests must be answered and shall be made in writing ASAP but no later than 48 hours after receiving the request. The response will be sent by fax whenever possible. The information provided to the DO will include the name of the infectious disease, the date the patient was transported and the run number of the EMS call.
2. If a response is sent by mail, the DO will be notified by telephone that the response has been

sent. The DO, within 10 days, must inform the facility whether the notification has been received.

3. The local public health officer will be contacted when:
   a. The hospital reviewer is unable to make an independent determination that the pre-hospital emergency medical personnel were exposed to a reportable disease or condition.
   b. The public health officer will resubmit the request to TCMC after evaluation. TCMC staff will make the follow-up report to the DO.
4. If the patient dies and a different facility is responsible for determining the cause of death, a copy of the request will be sent to that facility for the follow-up.

H. **CONFIRMED AIRBORNE DISEASES:**

1. If a patient is transported by pre-hospital emergency medical personnel to TCMC and is determined to have infectious pulmonary tuberculosis, the Infection Control Practitioner or designee will send a notice to the DO of the Emergency Medical Service that transported the patient.
2. This notice shall be made as soon as is practicable, but no later than 48 hours after a positive Mycobacterium tuberculosis culture is obtained or notification of a positive culture is received from San Diego Health and Human Services TB Control Program.
3. Notice will include the date, run number, and infectious disease involved.

I. **REPORTABLE DISEASE LIST, TITLE 17, CALIFORNIA CODE OF REGULATIONS, SECTION 2500:**

1. The following communicable diseases can be transmitted through oral contact (for example mouth to mouth respirations) or by mucus membrane or non-intact skin contact with secretions (including blood) from the patient.
   a. Acquired Immune Deficiency Syndrome (AIDS)
   b. Diphtheria
   c. Human Immunodeficiency Virus infection (HIV)
   d. Hepatitis, Viral
   e. Invasive Group A Streptococcal Infection
   f. Leprosy (Hansen Disease)
   g. Measles (Rubella)
   h. Meningococcal Infections *(Neisseria meningitidis)*
   i. Mumps
   j. Pertussis (Whooping cough)
   k. Plague, Pneumonic
   l. Poliomyelitis, Paralytic
   m. Rabies
   n. Rubella (German Measles)
   o. Tuberculosis
   p. Viral Hemorrhagic Fevers (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses)
   q. Anthrax
   r. Botulism (infant, food-borne, wound, other)
   s. Cholera
   t. Food-borne Disease
   u. Smallpox

J. **REFERENCES:**

1. California Healthcare Association Current Consent Manual
2. Title 22, California Code of Regulations, Section 70737 (General Acute Care Hospital) and 71535 (Acute Psychiatric Hospital).
3. **https://www.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf**
4. **https://www.dir.ca.gov/title8/5199a.html**

~~2.~~**5. http://www.dir.ca.gov/title8/5199.HTML**

~~3.~~**6. Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Ryan White Care Act, Ryan White, Pub.L. 101-381, 104 Stat. 576, enacted August 18, 1990)**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: **Responding to Compliance Issues; Remedial Action**

REVISION DATE: 12/12

POLICY NUMBER: 8750-562

Department Approval Date(s):	**~~01/16~~ 01/17**
Administrative Policies and Procedures Approval Date(s):	**~~01/16~~ 01/17**
Organizational Compliance Committee Date(s):	**01/17**
Medical Executive Committee Approval Date(s):	**~~02/16~~02/17**
Audit, ~~and~~ Compliance and Ethics Committee Approval Date(s):	
Board of Directors Approval Date(s):	**12/12**

A. **PURPOSE:**

1. This policy sets forth Tri-City Healthcare District's (TCHD) policy governing remedial actions taken in response to identified misconduct, and procedures to ensure that TCHD's practices are consistent with the stated policy.

B. **PROGRAMMATIC CORRECTIVE ACTIONS:**

1. TCHD shall take appropriate remedial actions to correct internal operational or programmatic deficiencies identified by the **Chief** Compliance Officer, ~~Internal~~ **Organizational** Compliance Committee, Audit, ~~&~~ Compliance **and Ethics** Committee, or Board of Directors in connection with a report prepared per Policy 8750-561.
   a. If the violation involves an ongoing activity or practice,
      i. **T**~~t~~he activity or practice shall be stopped, and
      ii. **T**~~t~~he ~~Legal~~ **Compliance** Department shall be notified of the violation.
      ~~ii.~~**iii.** **The Compliance Department shall notify outside legal counsel when appropriate.**
   b. If the violation involves federal or state health care programs, the **Chief** Compliance Officer, in conjunction with regulatory counsel, shall evaluate the violation and determine an appropriate course of action.
   c. If the same or a similar violation could or might be prevented in the future by making changes to TCHD's Compliance Program, such changes shall be considered, developed, instituted, and promptly communicated to all affected employees.

C. **CORRECTIVE AND/OR DISCIPLINARY ACTION:**

1. An employee who has violated any laws, regulations, policies, or the Code of Conduct shall be subject to a corrective plan of action and/or disciplined, as appropriate.
2. TCHD also may take corrective and/or disciplinary action against supervisors who fail to detect or report misconduct on the part of employees under their supervision.
3. Any employee who intentionally files a false report of misconduct also shall be subject to corrective and/or disciplinary action.
4. Corrective and/or disciplinary action shall take one or more of the following forms:
   a. Imposition of a corrective action plan, which may include training, education and/or other remedial measures
   b. Verbal warning
   c. Written warning

~~c.~~**d. Final written warning**
~~d.~~**e. Probation Administrative leave with pay**
~~e.~~**f.** Suspension with**out** pay
~~f.~~**g. Suspension without pay Intent to terminate**
~~g.~~**h.** Termination

5. When corrective and/or disciplinary action is appropriate, the severity of the disciplinary action will depend on a variety of factors, including:
   a. the nature and severity of the violation
   b. whether the violation was committed intentionally, recklessly, negligently, or accidentally
   c. whether the employee had previously violated any laws, regulations, or policies or the Code of Conduct
   d. whether the employee self-reported his or her misconduct
   e. whether (and the extent to which) the employee cooperated with TCHD in connection with its investigation of the misconduct
6. The determination as to the appropriate disciplinary action will be made by members of senior management (in consultation with the **Chief** Compliance Officer and the employee's supervisor, as appropriate).

D. **DISCLOSURE; RESTITUTION:**

1. If the **Chief** Compliance Officer believes that there has been a material violation of any laws or regulations, **outside** Legal **counsel** shall be consulted to determine whether District should
   a. make a report to appropriate government authorities and/or
   b. make a repayment of any kind to the government or other entity or person (if a program overpayment has been determined), and/or
   c. perform another type of remedial action.

E. **CONTINUAL MONITORING AND FOLLOW-UP AUDITS:**

1. Any issue for which corrective action is taken (whether or not in the form of a formal corrective action plan), will be targeted for monitoring and review in future audits of that department or area. Investigative findings will be incorporated into department education and training.

F. **DOCUMENTATION:**

1. TCHD shall document any remedial actions taken pursuant to this policy and maintain such documentation in the Compliance Program files consistent with TCHD's document retention policies. This is in addition to any documentation maintained by the Human Resources Department.

G. **RELATED DOCUMENTS:**

1. **Administrative Policy 8750-561; Responding to Compliance Issues; Reports of Suspected Misconduct; Confidentiality**
~~1.~~**2. Administrative Policy 8610-424; Coaching and Counseling for Work Performance**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE:

SUBJECT: **Tracking Physician Remuneration and Non-Monetary Compensation ~~Use of Items and Services to and from Referral Source and Tracking Use of Tri-City Healthcare District (TCHD) Resources by Referral Sources~~**

REVISION DATE(S):

POLICY NUMBER: 8750-574

Department Approval Date(s):	**~~06/16~~ 01/17**
Administrative Policies and Procedures Approval Date(s):	**01/17**
Organizational Compliance Committee Approval Date(s):	**01/17**
Medical Executive Committee Approval Date(s):	**02/17**
Audit, Compliance and Ethics Committee Approval Date(s):	**03/13**
Board of Directors Approval Date(s):	**03/13**

A. **PURPOSE:**

1. ~~The purpose of this policy is t~~To ensure compliance with the federal Anti-Kickback statute and Stark law and the regulations, directives, and guidance related to those statutes.

B. **GENERAL POLICIES:**

1. Each **Tri-City Healthcare District** (TCHD) department shall track remuneration, items, and services provided to or received from Referral Sources. Every Department is responsible for ensuring that, prior to execution; all Referral Source Arrangements are reviewed and approved through TCHD's Contract Approval system (See Administrative Policy 278). TCHD's ~~Legal~~ **Compliance** Department has adopted a number of policies specific to particular types of Referral Source Arrangements, and each department is responsible for complying with the applicable policies.

C. **DEFINITIONS:**

1. Referral Source - means any individual or entity in a position to make or influence referrals to, or otherwise generate business for TCHD. Examples include physicians, medical device companies, pharmaceutical companies, ambulance companies, emergency services providers, etc.
2. Federal health care program - means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to: Medicare, Medicaid/MediCal, managed Medicare/Medicaid/MediCal, Tricare/VA/ CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corps Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.
3. Referral Source Arrangement - means any documented arrangement or transaction that involves, directly or indirectly, the offer or payment of anything of value and is between TCHD and any actual source of referrals from Federally funded health care programs; or an arrangement that is between TCHD and a physician (or physician's immediate family member) who makes a referral to TCHD for designated health services as defined under the Stark law.
4. Remuneration - means anything of value, including, but not limited to, cash, items or services.

D. **SCOPE OF POLICY:**

1. This policy applies to (1) TCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tri-City Healthcare District or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").

E. **PROCEDURE:**

1. Department
   a. Step 1 – Tracking Remuneration:
      i. Each TCHD Department shall designate an individual or individuals responsible for tracking all remuneration to and from Referral Sources. Such tracking should occur on a regular periodic basis and should be conducted at least once per calendar year for each Referral Source. This tracking shall ensure that all payments to Referral Sources are made in accordance with an approved written agreement.
   b. Step 2 – Tracking Use of Tri-City Health Care District Resources:
      i. Each department shall develop and maintain a reasonable system of monitoring procedures and other internal controls designed to ensure that any services, leased space, medical supplies, medical devices, equipment, or other items provided to Referral Sources are provided pursuant to a written agreement reviewed and approved in advance in accordance with the applicable policy.
   c. **The Department staff person responsible for logging remuneration to a physician, or physician group or other entity involving physicians should record the description of the remuneration, the dollar value and the name of the physician in the Shared Folder. They should also note the department reporting the remuneration and the name and position of the person logging the information. The date the remuneration was provided and the date of the entry in the Shared Folder should also be listed.**
   d. **No later than The second Friday in December, all departments reporting remuneration should log all remuneration provided to physicians, physician groups or other physician entities during the calendar year in the Shared Folder.**
   e. **No later than the third Friday in December, the Compliance Department paralegal shall reconcile all remuneration provided to physicians and confirm and reconcile this information with the reporting departments. For any physician exceeding the Remuneration Limit (which could change each year), repayment by the physician, physician group or physician entity shall be made.**
   ~~c.~~**f. Documentation of the Repayment must be noted** ~~on~~ **in the designated** ~~Shared~~ **folder on the Shared Drive.**
2. ~~Enforcement~~ All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject employee to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

F. **REFERENCE LIST:**

1. Legal Department Contracting Policies
2. Stark Law, 42 U.S.C. §1395nn, and implementing regulations
3. Anti-Kickback Law, 42 U.S.C. §1320a-7b(b), and implementing regulations
4. 42 C.F.R. § 411.357

G. **RELATED DOCUMENT:**

1. **Administrative Policy 8610-278; Contract Review**

~~4.~~2. Administrative Policy 8750-569; Referral Source Policies ; Contractual Arrangement with Physicians and Other Referral Sources