TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE AUDIT, COMPLIANCE AND ETHICS COMMITTEE
January 18, 2018
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/Introduction of Director Julie Nygaard	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- October 19, 2017	3 min.	Action	Chair
	Old Business – Discussion regarding FY2018 Financial Statement Audit	5 min.	Discussion/ Possible Action	CFO
6.	New Business – **Discussion and Possible Action**			
	a) **Administrative Policies & Procedures:**			
	1. Medical Procedures & Interrogations Requested by Law Enforcement	10 min.	Discussion/ Possible Action	CCO/K. Topp
	b) FY2018-2019 Compliance Program Work Plan	15 min.	Information Only	CCO
	c) Approval of Committee Charter	5 min.	Discussion/ Possible Action	Chair
7.	Motion to go into Closed Session			
8.	Closed Session			
	a) Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (2 Matters)	20 min.	Action	Chair
9.	b) Motion to go into Open Session	2 min.	Action	Chair
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.	Committee Openings – None	3 min.		Chair

	Agenda Item	Time Allotted	Action/ Recommendatio	Requestor/ Presenter
14.	Date of Next Meeting: April 19, 2018	1 min.		Chair
15.	Adjournment			Chair
16.	Total Time Budgeted for Meeting	1.5 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
October 19, 2017
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino; Director Leigh Anne Grass; Faith Devine, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, CFO; Carlos Cruz, CCO, Susan Bond, Director, Legal Services
Others Present:,	Jody Root, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp, Director of Education & Clinical Informatics
Absent:	Kapua Conley, COO; Scott Livingstone, Vice President/Transformation; Cary Mells, M.D., Physician Member

	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 Chairman Schallock.		
2. Approval of Agenda	**It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	
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 – September 21, 2017	**It was moved by Director Dagostino and seconded by Ms. Kathryn Fitzwilliam to approve the minutes as presented. The motion passed unanimously.**	**Minutes ratified.**	
5. Old Business	None		
6. New Business a) Administrative Policies & Procedures:			

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
1. Conflicts of Interest (DELETE)	Ms. Kathy Topp stated the Conflicts of Interest Policy is a duplication of Policy 8610-483. In addition, Conflicts of Interest Attestation is not required by law and is inconsistent with reporting obligations set forth by TCHD's Conflict of Interest Code.		
2. Compliance Education & Training	Ms. Topp stated the Compliance Education & Training Policy is brought forward for a routine three-year review. She noted revisions were made for clarity. Ms. Topp reviewed the orientation/training timeline for new employees and noted Net Learning modules are all required within 30 days of start date. Ms. Topp explained the training process for Covered Contractors. She stated Covered Contractors complete consolidated training modules followed by an abbreviated test. **It was moved by Director Grass and seconded by Director Dagostino to recommend deletion of the Conflicts of Interest Policy and approval of the Compliance Education & Training policy. The motion passed unanimously.** *Ms. Kathy Topp left the meeting at 8:37 a.m.*	**Recommendation to be sent to the Board of Directors to delete the Conflict of Interest Policy and approve the Compliance Education & Training policy; items to be placed on Board agenda and included in agenda packet.**	Ms. Donnellan
b) Consideration to appoint Leslie Schwartz to an additional two-year term on the Committee	**It was moved by Director Grass and seconded by Director Dagostino to recommend Mr. Leslie Schwartz be appointed to the committee for an additional two-year term. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to appoint Mr. Leslie Schwartz to an additional two-year term; item to be placed on Board agenda.**	Ms. Donnellan
c) Discussion regarding 2018 Financial Statement Audit	Chairman Schallock questioned if the committee is satisfied with Moss Adams or if they would prefer to do an RFP and look at other firms. Chairman Schallock stated he did have		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	some frustration with the change in auditors mid-cycle. Discussion was held regarding best practice. Ms. Fitzwilliam stated large facilities are obliged to bid periodically however many keep the same auditors for decades. She did comment that there should be a partner rotation every five years. Discussion was held regarding the advantages of continuing with the same firm including cost containment, continuity and local presence. Mr. Dietlin stated costs tend to be higher when a new firm is engaged as they have to start from scratch. We have been able to keep costs down as the audits have been less complicated and clean. Mr. Dietlin stated when a facility makes the decision to change auditors there can be a perception that there was a major difference in opinion. Ms. Fitzwilliam questioned if the partner change mid-cycle caused any difficulties for the district. Mr. Rivas stated Ms. Stelzeride had extensive experience in how the district operates and also had familiarity with HUD and the need for a single audit. **It was moved by Ms. Fitzwilliam to direct Administration to seek an audit proposal with Moss Adams to conduct the FY2018 Financial Statement audit with no increase in fees. Director Dagostino seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to seek an audit proposal with Moss Adams to conduct the FY2018 Financial Statement audit with no increase in fees; item to be placed on board agenda.**	Ms. Donnellan
d) Chief Compliance Officer Update	Mr. Carlos Cruz, Chief Compliance Officer provided a summary of his background and experience. Mr. Cruz presented a Chief Compliance Officer Report reviewing the following: 1) Effective Compliance Program Elements established by	**Information Only**	

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	the U.S. Federal Sentencing Commission and includes the following: a) Policies and Procedures b) Standards of Conduct c) Training and Education d) Open Lines of Communication e) Enforcement f) Internal Auditing and Monitoring g) Prompt Response 2) Program Effectiveness: Strategic Plan which includes the following Strategic Objectives: a) Refresh awareness of the organization's commitment to compliance b) Increase understanding of role of compliance program c) Review and develop tools that ensure effective program 3) Refresh Awareness: Marketing of Program that might include "meet and greets", program advertising and a Compliance Program "Road Show". 4) The Role of Compliance at TCMC that includes education of all levels of staff on compliance and the 5 "W"s of Compliance – What? When? Who? Why? Where? 5) Effectiveness Tools which might include the development of a formal enterprise-wide risk assessment to proactively identify organizational gaps/opportunities, review of each element of the program and update as needed and development of formal reporting. Mr. Cruz stated the Board is ultimately responsible for the compliance program and it is important to develop a dashboard that identifies what issues we are focusing on and what issues we are working on. Mr. Cruz presented a sample dashboard that mimics the seven areas of an		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	effective compliance program. Director Dagostino questioned what the OIG exclusion is. Mr. Cruz explained that the OIG has a list of vendors who are not allowed to do business with the federal government and the district cannot employ an individual or company that is on the exclusion list. Discussion was held on internal auditing that can often be time consuming. Mr. Cruz stated he is evaluating what expertise we have in place. Mr. Cruz stated he is confident we have the seven elements of an effective compliance program in place and we are ready to take it to the next level. Mr. Cruz stated in his short time here he has not identified any major issues of concern. Lastly, Mr. Cruz commented on the Timeline that was included in today's meeting packet. Mr. Cruz stated this is a very fluid document and he is looking at things we can do in the next couple of months. He stated he wants to get education done as soon as possible. Mr. Cruz stated the OIG Work Plan comes out in November and we will develop our Work Plan based on the OIGs. There was brief discussion on the various Compliance Committees including the Operational Committee for the manager level and Executive Compliance Committee where issued get reported up. Mr. Dietlin emphasized that the tone at the top matters.		
e) Review and discussion of Committee Structure, Membership and Meeting Frequency	Chairman Schallock stated a Board Workshop was held in September and the Board was charged with finding ways to be more efficient and cognizant of the utilization of staff on those committees. Chairman Schallock referred the committee to the Charter which was included in the agenda packet which indicates the committee should review and oversee the non-clinical		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	contracts at least twice annually. Discussion was held regarding the committee structure which includes three Board members, one physician and up to four community members, along with management as prescribed by the CEO. Discussion was held regarding the fact that it might not be wise for community members to outnumber Board members on the committee. It was suggested the Charter be amended to provide for up to three community members and a subject matter expert who would not be a voting member. Mr. Cruz suggested language be added to the membership section that provides that members also have an understanding of compliance. Mr. Cruz stated he would be happy to conduct 1:1 training with our community members. Mr. Schwartz questioned whether the word procedures should be included in section I. a. f. Mr. Dietlin explained that many of the policies currently include specific procedures. It was recommended the I. a. f stand as written.	**Recommendation to be sent to the Board of Directors to allow up to three community members and a subject matter expert; item to be placed on Board agenda.**	Ms. Donnellan
	With regard to the meeting schedule for 2018, Chairman Schallock suggested the committee meet in January, April, July and October for the compliance component and May and September for the audit component. Members concurred with this approach. With regard to education of community members, Director Dagostino suggested committee members attend the December 14th Regular Board Meeting in which a webinar will be presented by CHA related to healthcare reimbursement.	**Recommendation to be sent to the Board of Directors to modify meeting schedule to provide for six meetings as described; item to be placed on agenda.**	Ms. Donnellan
	It was recommended that the Charter be amended to reflect today's discussion and be placed on the January agenda for consideration.	**Charter to be amended to accurately reflect discussion and placed on January agenda for**	Ms. Donnellan/Mr. Cruz

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
		consideration.	
10. Motion to go into Closed Session	It was moved by Ms. Devine and seconded by Ms. Fitzwilliam to go into closed session at 9:52 a.m.		
11. Open Session	The committee returned to open session at 9:59 a.m. with attendance as previously noted.		
12. Report from Chairperson on an any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Schallock reported no action was taken in closed session.		
13. Comments from Committee Members	There were no comments from members of the committee.		
14. Committee Openings	There are no committee openings.	**None**	
15. Date of Next Meeting	Chairman Schallock stated the next meeting will be held on January 18, 2018.	**The Committee's next meeting is scheduled for January 18, 2018.**	
16. Adjournment	Chairman Schallock adjourned the meeting at 9:59 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
January 18, 2018

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Medical Procedures and Interrogations Requested by Law Enforcement	595	NEW	

Tri-City Medical Center
Oceanside, California

Administrative Policy ~~Manual~~
Compliance

ISSUE DATE: **NEW**

SUBJECT: **Medical Procedures and Interrogations Requested by Law Enforcement**

REVISION DATE(S):

POLICY NUMBER: 8750-595

Department Approval:	**06/17**
Administrative Policies and Procedures Approval:	**07/17**
Organizational Compliance Committee Approval:	**08/17**
Medical Executive Committee Approval:	**10/17**
Audit, Compliance and Ethics Committee Approval:	
Board of Directors Approval:	

A. **DEFINITION(S):**

1. HIPAA – Health Insurance Portability and Accountability Act (HIPAA) of 1996, privacy regulations published under the Congress of the United States.
2. Law enforcement/-officer – includes Oceanside or Carlsbad Police Officers, Sheriff's Department officers, Detectives, **Federal Bureau Investigation**, Homeland Security, **United~~.~~ States~~.~~ Marshal or other applicable state or federal agents.**
3. Vehicle Code Section 23612 – a code of California Legislature which allows tests to detect the presence of alcohol or drugs. ~~CA law states that a person who drives a motor vehicle is deemed to have given consent to testing of his or her blood or breath to determine his or her blood alcohol content.~~ **According to the California DMV, anyone who has a license and operates a motor vehicle in California has "impliedly" given consent to submit to a blood or breath test. A person who refuses to submit will still be arrested, the refusal can be used against them in court, and they face possible additional mandatory custody and a DMV administrative license suspension.**
   - ~~3.~~**a. CA implied consent laws require all drivers lawfully arrested for a DUI to submit to chemical testing to determine blood alcohol concentration. If found not to have reasonable suspicion or probable cause during any of those stages, the patient can later move to suppress any illegally obtained evidence through motion to suppress. CA Vehicle Code Section 23612(a) CA implied consent law also includes- if arrested for DUI, even if unconscious or dead, blood and urine can be obtained.**

B. **POLICY:**

1. A law enforcement officer may bring a person to a hospital and request an evaluation of that person's medical condition and/or requests that the hospital perform medical procedures on the person. The person may be a suspect, victim, witness or bystander.
2. In general, physicians and hospital personnel are not required by law to perform medical evaluations or procedures at the request of law enforcement officers except in the narrow area of tests to detect the presence of alcohol or drugs, authorized by Vehicle Code Section 23612.
3. If a state or federal law requires a health care provider to report to law enforcement, then patient-identifiable information may be disclosed to the extent necessary to comply with the reporting law. Thus hospital, physician and others may, without violating health information confidentiality laws, report child abuse, elder abuse, rape, suspicious injuries, etc., to law enforcement officers or agencies.

~~4.~~a. Only the minimum information necessary to fulfill the requirement of the reporting law may be disclosed. There are instances where California law applies and limits the disclosures that would otherwise be permissible under HIPAA.

~~5.~~4. Physicians and other hospital personnel should not perform medical evaluations or procedures request by law enforcement officers except in the following circumstances:
   a. The patient or legal representative consents,
   b. A medical emergency exists and the patient does not object to the procedure,
   c. The officer requests a blood test pursuant to Vehicle Code Section 23612 and the patient does not forcibley resist,
   d. The officer requests a noninvasive medical evaluation to determine if it is medically safe to incarcerate the person,
   e. The officer requests the medical evaluation or procedure to be performed pursuant to his or her authority to conduct constitutionally permissible searches,
   f. The officer requests the medical evaluation or procedure to be performed pursuant to a valid court order **with judge's signature**.

~~6.~~5. If the patient (or legally authorized representative) consents, a physician and/or hospital personnel may perform the medical evaluations or procedures requested by law enforcement. When indicated the hospital should verify that the person has given informed consent.

~~7.~~6. The California Legislature has stated that adults housed in state prison have the fundamental right to control decisions relating to their own health care. This includes the right to give informed consent.

~~8.~~7. A law enforcement officer may bring an arrested person to the hospital for a limited physical examination to determine if it is medically safe to incarcerate the arrestee. If the patient is brought to an ED for pre-jail clearance, the hospital performs a medical screening examination. There is no legal requirement for the hospital to communicate any information to law enforcement about the patient. The conclusion as to whether or not it is medically contraindicated to incarcerate the arrestee may be disclosed to law enforcement officers.

~~9.~~8. Law enforcement officers may conduct constitutionally permissible searches pursuant to a valid search warrant. The procedures may be performed only if the warrant:
   a. States a finding of probable cause and
   b. Specifically describes the person and the procedures to be performed.

~~10.~~9. Law enforcement may request to interrogate a patient in a hospital. If the officer has a court order, (a **signed** search warrant), the hospital should generally permit the officer access to the patient. In addition, if the officer is responding to a crime or an emergency on the facility premises, the hospital also should generally permit the officer access to the patient/s. If the hospital has concerns or questions, contact risk management.

~~11.~~10. If a competent adult consents to cooperate with law enforcement officers, that person's desire should be respected. A patient who indicates a desire to cooperate with law enforcement should be fully informed of any possible adverse medical consequences, and the patient's consent, in light of his or her receipt of such information, should be documented in the medical record.

~~12.~~11. Hospitals are generally under no duty to inform law enforcement upon the discharge of a patient, with the exceptions noted which follow. Information about discharge is protected health information by both state confidentiality laws and HIPAA and thus must meet legal requirements for release. Situations which disclosure of discharge information to law enforcement would appear to be permissible are as follows:
   a. When a patient communicates a serious threat of physical violence to a licensed psychotherapist, and it is appropriate that law enforcement be contacted in order to protect the threatened person/s after consulting with risk management
   b. Upon discharge or release of a patient who was detained or apprehended for examination of his or her mental condition and who had a weapons confiscated by law enforcement.
   c. Upon the escape/**elopement**, disappearance, release, or transfer of specified mental health patients,

d. When a patient is detained for 72-hour evaluation and treatment or 14-day intensive treatment, and the peace officer who detained the patient did the following: requested notification of discharge when he/she brought the patient in and certified in writing that the patient was referred to the facility under circumstances that support the filing of criminal charges. Only the patients' name, address, date of admission for 72 hour evaluation, date of certification for intensive treatment, and date of release may be disclosed.

~~13.~~**12.** For other circumstances, please consult with Risk Management before providing any patient requested information or before performing medical procedures or allowing interrogations by law enforcement officers.

~~14.~~**13.** Requests for any hospital video surveillance by law enforcement should be referred to Risk Management.

C. **RELATED DOCUMENT(S):**

1. Administrative **Policy**: **308** Reporting Suspected Child Abuse and Neglect~~-308~~
2. Administrative **Policy**: **309** Reporting Suspected Dependent Adult Elder Abuse Neglect~~-309~~
3. Administrative **Policy**: **310** Assault Victims Domestic Violence Report Requirement~~-310~~
4. Administrative **Policy**: **372** Consent to Photograph and Videotape~~-372~~
5. Drawing Blood For Vehicle Code ~~§Section~~ **23612**

D. **REFERENCE(S)~~ LIST~~:**

1. CHA Consent Manual 2017

~~1.~~**2. CA Vehicle Code Section 23612(a)**

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Tri-City Healthcare District
Compliance Program
Work Plan
January 18, 2018-DRAFT

Table of Contents

I. Executive Summary

Background

Tri-City Healthcare District ("TCHD") established the TCHD Compliance Program ("Program") to demonstrate the commitment to the culture of ethics and doing the right thing. In an organization that demonstrates the culture of ethics employees understand the importance of observing the relevant laws and regulations affecting their work. The Program contains the fundamental elements of an effective compliance program, as established by guidance developed by the Office of Inspector General [1]("OIG").

The TCHD Compliance Office ("Office") is responsible for administering the Program and provides strategic direction, guidance and resources to ensure that TCHD fulfills its commitment to providing an environment that is compliant with all applicable laws, rules, regulations and organizational policies. On an annual basis, the Office develops a work plan with the goal of mitigating issues that may pose a high-risk to the District. In addition, the work plan identifies key operational projects/initiatives that have potential compliance implications. The work plan ensures that the District's mission, vision and values are supported by effective compliance controls which are evaluated on an ongoing basis.

The TCHD Compliance Work Plan ("Plan") for FY2018/2019 ("FY18/19") identifies key compliance-related focus areas that are priorities for Office in FY18 and FY19. The Plan is subject to change depending on internal and external factors.

Key Compliance Focus Areas

Nine Program focus areas were identified during the Plan development process. These focus areas encompass both compliance/privacy risk areas and operational projects that may have compliance implications for the District.

The following key compliance focus areas (and associated sub-areas) were identified as priorities for TCHD in FY18/FY19:

1. **Compliance Office Structure**

   Goal: To ensure that the TCHD Compliance Office has the appropriate infrastructure and staffing in place to support an effective compliance program

   A. Department Staffing Review/Re-organization
   B. Investigation Process Development
   C. Investigation Report Development

[1] Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.

2. **Compliance Program Marketing**
   Goal: To ensure that there is awareness of the Compliance Program by TCHD staff members
   A. Compliance Program Marketing Materials Development/Distribution
   B. Compliance Intranet Page Rollout
   C. Compliance Newsletter Rollout
   D. Staff Rounding by Compliance Office Staff

3. **Compliance Program Oversight**
   Goal: To ensure that TCHD Leadership and the Board of Directors are informed on compliance risks facing the District and ongoing mitigation efforts
   A. Compliance Program Dashboard Development
   B. Internal Compliance Committee Re-Initiation
   C. TCHD Board of Directors Compliance Program Training

4. **Compliance Policies and Procedures**
   Goal: To ensure that the appropriate compliance policies and procedures are implemented
   A. Policy and Procedure Gap Analysis
   B. Code of Conduct Review/Update

5. **Compliance Training and Education**
   Goal: To ensure compliance training and education is up-to-date and meets CMS[2] requirements
   A. New Employee Orientation Review/Update
   B. Annual Employee Training Review/Update
   C. Targeted Training Development
   D. Targeted Training Tracking Initiation

6. **Auditing and Monitoring**
   Goal: To ensure that TCHD has adequate controls in place to identify and mitigate compliance risks to the District
   A. Monthly Employee Exclusions Screening Process Initiated

[2] Centers for Medicare and Medicaid Services

B. OIG Work Plan Review Process
C. Coding and Documentation Audit Program Development/Implementation
D. Physician Agreement Audit Program Development/Implementation

7. **Open Lines of Communication**

Goal: To ensure that the TCHD Values Line is being utilized appropriately by staff members

A. Values Line Usage Assessment
B. Values Line Staff Education
C. Values Line Work Flow Review/Update

8. **HIPAA Privacy and Security**

Goal: To ensure that TCHD has adequate controls in place to protect patients' protected health information ("PHI")

A. Privacy Program Reporting Structure and Process Review/Update
B. Policies and Procedures Gap Analysis
C. Access Monitoring Reviews Initiation

9. **Operational Support**

Goal: To provide support to operational units and address critical risk areas as specified by leadership

A. 1206(b) Clinics Support (as needed)
B. TCHD Strategic Plan Support (as needed)

II. TCHD Compliance Program Work Plan Development

1. **Elements of an Effective Compliance Program**

The elements of an effective compliance program are based on the foundation established by the United States Sentencing Commission's seven elements of an effective compliance program. The OIG expanded upon the seven elements in the compliance program guidance documents. Both the Sentencing Commission and the OIG Guidelines recommend that an effective compliance program contain the following elements:

I. Implementing written policies and procedures
II. Designating a compliance officer and compliance committee
III. Conducting effective training and education
IV. Developing effective lines of communication
V. Conducting internal monitoring and auditing
VI. Enforcing standards through well-publicized disciplinary guidelines
VII. Responding promptly to detected problems and undertaking corrective action

The implementation of the elements of an effective compliance program advances the prevention of fraud, waste and abuse and furthers the mission of TCHD by ensuring that patients receive quality care in an ethical environment.

2. **Work Plan Flexibility: Adapting to Change**

The healthcare regulatory environment is complex and ever-changing. The pressures facing healthcare organizations and their compliance programs require that compliance plans be transparent and systematic while being flexible and responsive to organizational changes. As a result, effective compliance programs and work plans should be dynamic and able to change focus as risks evolve and new ones are identified.

A key strength of the TCHD Compliance Program is its ability to adapt to emerging issues, trends and regulatory changes. Office staff will conduct routine assessments of the Plan in collaboration with senior leadership at TCHD. This ongoing review will allow the Office to change the Plan in a timely manner to address unanticipated and/or emerging risks that have the potential for impacting the District. Current and emerging risks were considered in the development of the FY17/FY18 Plan.

3. **Development Process**

The development of a compliance work plan is a multi-step process. The following steps were taken by the Office in developing the TCHD Compliance Program Work Plan:

a) Interviews of leadership of the different operational units were conducted to identify current and potential organizational risk areas;
b) Compliance program gap analysis conducted by the Chief Compliance Officer. The analysis included review of the current Program and comparing it with compliance programs at similar organizations; and
c) Review of applicable state and federal rules and regulations and consulted guidance documents published by state and federal regulatory agencies.

The development of the FY18/FY19 also included a review of the FY 2018/FY 2019 Work Plan. The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections.

III. Key TCHD Compliance Program Focus Areas-Compliance Program Elements

1. Compliance Office Structure

A. **Overview:** An effective compliance program requires that an organization have appropriate and sufficient resources, including staff. The TCHD Compliance Office will develop formal internal processes and tools. In addition, an evaluation of current staff will ensure that staff is in the best possible position to support the goals of the Compliance Program

B. **Goal:** To ensure that the TCHD Compliance Office has the appropriate infrastructure and staffing in place to support an effective compliance program.

C. **Action Plan:**

1) Develop a Compliance Program investigations/consults tracking database. This will allow the Chief Compliance Officer to track Program data and identify risk areas.
2) Assess current Office staffing needs and transition Contracts Specialist into Compliance Manager role.
3) Develop and implement a formal investigation process to ensure consistency in how investigations of compliance-related concerns are conducted.
4) Develop and implement formal investigation report format to ensure consistency in how investigations are documented and closed.

2. Compliance Program Marketing

A. **Overview:** The establishment of an organizational culture that values and understands the importance of compliance and integrity is essential to having an effective compliance program. A key to establishing such a culture is to ensure that staff members understand their role in creating it and know who to contact when questions arise. The TCHD Compliance Office will market the TCHD Compliance Program to all staff members to improve their understanding of the role of the Program in promoting a culture of compliance and integrity.

B. **Goal:** To ensure that there is awareness of the TCHD Compliance Program by staff members.

C. **Action Plan:**

1) Market TCHD Compliance Program by distributing posters, business cards and celebrating National Compliance and Ethics Week.

2) Develop and rollout Compliance Program intranet site. The site will create a compliance and ethics resource for all TCHD staff members. The site will provide staff with access to training materials, policies & procedures and Office contact information.
3) Schedule and initiate TCHD staff rounding at all District locations to increase Compliance Program awareness and initiate relationship building between staff and the Compliance Office.

3. **Compliance Program Oversight**
   A. **Overview:** An effective compliance program requires active oversight by compliance program staff and the organization's Board of Directors. In addition, operational leadership should play a part in identifying and addressing compliance risks facing the organization. The TCHD Compliance Office will strive to ensure that senior leadership and the Board of Directors are sufficiently informed on the compliance risks facing TCHD.
   B. **Goal:** To ensure that TCHD Leadership and the Board of Directors are informed on compliance risks facing the District and the ongoing mitigation efforts implemented by the Compliance Program.
   C. **Action Plan**
      1) Develop a compliance dashboard for the TCHD leadership and the Board of Directors. The dashboard will highlight Compliance Program activities.
      2) Re-initiate meeting of TCHD Organizational Compliance Committee ("Committee"). The Committee membership will include leadership of the various operational units at TCHD.
      3) Conduct annual compliance training for the TCHD Board of Directors. The training will focus on Boards' responsibility for oversight of an organization's compliance program.

4. **Compliance Program Policies & Procedures**
   A. **Overview:** Relevant and accessible policies and procedures ("P&Ps") are the critical foundation of an effective compliance program. Because of the importance of P&Ps, compliance programs must review and revise policies on a routine basis. The TCHD Compliance Office will provide transparent and easily accessible compliance P&Ps that clearly outline TCHD staff members' responsibilities.

B. **Goal:** To ensure that the appropriate compliance P&Ps are implemented
C. **Action Plan:**
    1) Conduct a gap analysis of current compliance P&Ps and revise, as needed. In addition, draft and implement P&Ps identified as needed but missing in the analysis.
    2) Review and revise TCHD Code of Conduct to ensure updated compliance and HIPAA Privacy concepts are included.

5. **Compliance Training and Education**
    A. **Overview:** An organization's ability to provide effective compliance and HIPAA Privacy-related training, both routine and targeted, is essential to the establishment and maintenance of an effective compliance program. The TCHD Compliance Office will review/revise and develop general compliance and HIPAA Privacy training and education. All training and education will be relevant for all current and new TCHD staff members.
    B. **Goal:** To ensure that compliance training and education is up-to-date and meets CMS requirements.
    C. **Action Plan**
        1) Review and revise new employee orientation. Revised training and education will include expanded general compliance and HIPAA-related concepts and additional "real world" examples to enforce concepts.
        2) Review and revise current annual staff training to include expanded general compliance and HIPAA-related concepts.
        3) Develop and provide targeted training to address specific risk areas as they are identified.
        4) Develop and implement tracking of targeted training provided to document Compliance Office efforts.

6. **Auditing and Monitoring**
    A. **Overview:** Ongoing auditing and monitoring leads to the identification and mitigation of potential compliance risks faced by an organization. In addition, an effective auditing and monitoring program can lead to improved operational workflows leading to increased efficiencies.
    B. **Goal:** To ensure that TCHD has adequate controls in place to identify and mitigate compliance risks to the District.

C. **Action Plan:**
   1) Identify vendor to conduct monthly OIG exclusions screening and implement process.
   2) Review areas of focus in the OIG Work Plan for FY 2018/2019 and identify risks relevant to TCHD.
   3) Evaluate current coding and documentation audits being performed by or on behalf of TCHD. Once the current audits are identified, assess high risk areas not currently being audited. Once high risk areas are identified, implement revised coding and documentation audit plan.
   4) Develop and implement audit of current physician agreements, including professional services agreements and leases.

7. **Open Lines of Communication**
   A. **Overview:** The maintenance of open lines of communication between staff members and the compliance office is considered important to the successful implementation of an effective compliance program. The TCHD Compliance Office will review current utilization of the organizational compliance hotline ("Values Line") and provide education to staff members on its purpose.
   B. **Goal:** To ensure that the TCHD Values Line is being utilized appropriately by TCHD staff members.
   C. **Action Plan**
      1) Assess current utilization of Values Line by TCHD staff members and create a dashboard report.
      2) Re-educate staff members on the purpose of the Values Line. In addition, the TCHD Compliance Office will educate staff members on "speaking up" and non-retaliation.
      3) Evaluate current Values Line work flow and revise process, as necessary. The evaluation will be conduct in collaboration with the TCHD Human Resources Department.

8. **HIPAA Privacy Program**
   A. **Overview:** The protection of privacy and security of patient information continues to be an area of risk for all healthcare organizations. Notification and mitigation requirements have the potential of increasing operational costs and

creating reputational harm to an organization. TCHD is committed to protecting the privacy and security of our patients' PHI

B. **Goal:** To ensure that TCHD has adequate controls in place to protect patients' PHI

C. **Action Plan:**

1) Move Privacy program responsibility from the Health Information Management Department to the Compliance Office.
2) Conduct a gap analysis of current HIPAA P&Ps and revise, as needed. In addition, draft and implement P&Ps identified as needed but missing in the analysis.
3) Determine feasibility of conducting proactive/ongoing electronic medical record ("EMR") access by TCHD staff. If feasible, implement proactive EMR access monitoring program.
4) Identify all current business associate agreements ("BAAs") in place at TCHD and ensure that information required by the Office of Civil Rights is included in the MediTract[3] contracts database.

9. **Operational Support**

A. **Overview:** An effective compliance program can lead to increased efficiency of operational processes as well as risk identification and mitigation. The TCHD Compliance Program is committed to providing compliance support to leadership in the various operational units at TCHD, when requested.

B. **Goal:** To provide support to operational units and address critical risk areas as specified by leadership.

C. **Action Plan:**

1) Provide compliance support to 1206(b) clinic leadership, as needed.
2) Provide compliance support on relevant items in current and future TCHD strategic plan.

[3] Contracts database purchased by TCHD

IV. Summary

Compliance programs are designed to create and maintain an organizational culture of compliance and ethics. The development of a formal annual compliance work plan shows the organization's commitment to that culture. Although it requires a significant commitment, compliance work plans are essential to ensuring that an organization's compliance program is focusing its resources on addressing the appropriate areas of risk. The TCHD Compliance Work Plan for FY2018/FY2019 highlights the key compliance areas that the Compliance Program will focus on in the upcoming months. As with all compliance work plans, as the regulatory environment changes, the Work Plan is subject to change.

TCHD COMPLIANCE PROGRAM PLAN
FY 2018-2019

	Focus Area	Project Name	Key Tasks	Responsible Individual(s)	Initiation Date	Status	Comments
1	***Department Structure***	***Goal: To ensure appropriate infrastructure and staffing in place***					
A		Compliance Issue/Consult Tracking	1) Develop compliance issue/consult tracking database/spreadsheet	CCO	10/2/17	Completed	
B		Reorganize Department Staffing	1) Transition Contracts Specialist into Compliance Manager role	CCO	1/8/18	In progress	Contracts responsibility transitioning from Compliance to Legal Department.
C		Investigation Process	1) Develop and implement formal investigation process	CCO	12/4/17	In progress	
D		Investigation Reports	1) Develop and implement formal investigations report format	CCO	1/29/18		
2	***Program Marketing***	***Goal: To ensure that there is awareness of the Compliance Program by TCHD staff members***					
A		Compliance Program Materials	1) Create and distribute Values Line posters/business cards	CCO/Marketing	1/10/18		
			2) Distribute posters to all hospital and 1206(b) clinics	CCO	2/26/18		
B		Compliance Webpage	1) Create Compliance Program webpage on TCHD intranet site	CCO/Marketing	1/10/18		
C		Compliance Newsletter	1) Develop and implement monthly compliance newsletter called "The Compliance Corner".	CCO	2/8/18		
D		Staff Rounding	1) Initiate routine monitoring of staff at hospital and 1206(b) clinics	CCO	2/5/18		
3	***Program Oversight***	***Goal: To ensure that TCHD Leadership and the Board of Directors are informed on compliance risks facing the District and ongoing mitigation efforts***					
A		Compliance Program Dashboard	1) Develop compliance dashboard for Board and Senior Leadership	CCO	10/19/17	In progress	
B		Internal Compliance Committee	1) Re-initiate meeting of Organizational Compliance Committee	CCO	2/12/18		
			2) Draft Organizational Compliance Committee Charter	CCO	1/8/18	In progress	
C		TCHD Board of Directors Training	1) Conduct Board of Directors Training on Compliance Program oversight role	CCO	1/8/18	In progress	
4	***Compliance Policies and Procedures***	***Goal: To ensure that the appropriate compliance policies and procedures are implemented***					
A		Policy Gap Analysis	1) Conduct compliance policy gap analysis and identify additional policies needed (if applicable)	CCO	11/1/17	Completed	

TCHD COMPLIANCE PROGRAM PLAN FY 2018-2019							
	Focus Area	**Project Name**	**Key Tasks**	**Responsible Individual(s)**	**Initiation Date**	**Status**	**Comments**
			2) Draft and implement needed policies (if applicable)	CCO	1/8/18	In progress	
B		Code of Conduct	1) Review current Code of Conduct and revise (if necessary)	CCO	5/7/18		
5	***Compliance Training and Education***	***Goal: To ensure compliance training and education is up-to-date and meets CMS requirements***					
A		New Employee Training	1) Review and update new employee training module	CCO	10/2/17	Completed	
B		Annual Training	1) Develop and implement CMS-approved Fraud, Waste and Abuse Training module	CCO[1]/HR[2]	10/16/17	Completed	
C		Targeted Training	1) Develop new targeted training to address specific risk areas	CCO	ongoing	ongoing	
			2) Track ad hoc training provided to employees	CCO	11/6/17	ongoing	
6	***Auditing and Monitoring***	***Goal: To ensure that TCHD has adequate controls in place to identify and mitigate compliance risks to the District***					
A		Monthly Exclusions Screening	1) Identify vendor to conduct monthly exclusions screening and implement process	CCO/HR	1/22/18		
B		OIG Work Plan	1) Review areas noted on the OIG[3] Work Plan for fiscal year 2018/2019 and identify risks relevant to TCHD	CCO	1/2/18	In progress	
C		Coding and Documentation	1) Evaluate current coding and documentation audits	CCO/AMD[4]/HIM[5]	1/16/18		
			2) Assess coding and documentation high risk areas and develop audit schedule	CCO/AMD/HIM	3/12/18		
			3) Implement coding and documentation audit plan	CCO/AMD /HIM	4/16/18		
D		Physician Agreements	1) Develop and implement audit of	CCO/AMD	4/2/18		

[1] Chief Compliance Officer
[2] Human Resources
[3] Office of Inspector General
[4] Director of Audit & Monitoring
[5] Health Information Management

TCHD COMPLIANCE PROGRAM PLAN FY 2018-2019							
	Focus Area	**Project Name**	**Key Tasks**	**Responsible Individual(s)**	**Initiation Date**	**Status**	**Comments**
			current physician agreements				
7	***Open Lines of Communication***	***Goal: To ensure that the TCHD Values Line is being utilized appropriately by staff members***					
A		Reporting	1) Assess current utilization of Values Line by TCHD staff	CCO/HR	10/30/17	Completed	
B		Education	1) Re-educate staff on purpose of Values Line	CCO	12/4/17	In progress	
			2) Educate staff on "speaking up" and non-retaliation (Development of a "speak up culture")	CCO/HR	4/30/18		
C		Values Line Management	3) Evaluate current Values Line work flow and make changes, as needed	CCO/HIM	1/8/18	In progress	
8	***HIPAA Privacy Program***	***Goal: To ensure that TCHD has adequate controls in place to protect patients' protected health information ("PHI")***					
A		Program Reporting	1) Move Privacy Program from HIM to Compliance Department	CCO	1/8/18	In progress	
			2) Evaluate investigation and state/Federal reporting process and implement any required changes	CCO	1/22/18		
B		Policies and Procedures	1) Conduct HIPAA policy gap analysis and identify additional policies need (if applicable)	CCO	2/4/18		
			2) Draft and implement needed policies (if applicable)	CCO	3/5/18		
C		Electronic Medical Record ("EMR") Access	1) Determine feasibility of conducting proactive/ongoing EMR access monitoring	CCO/VP of Information Technology[6]	4/2/18		
			2) Initiate proactive monitoring of EMR access by TCHD staff	CCO/VP of IS	7/1/18		
D		Business Associate Agreement Tracking	1) Identify all current business associate agreements in place and ensure that all information required by the Office of Civil Rights is included in the MediTract	CCO/AMD	6/2/18		

[6] Information Technology

TCHD COMPLIANCE PROGRAM PLAN FY 2018-2019							
	Focus Area	**Project Name**	**Key Tasks**	**Responsible Individual(s)**	**Initiation Date**	**Status**	**Comments**
			contracts database.				
9	***Operational Support***	***Goal: Provide support to operational units and address critical risk areas as specified by leadership***					
A		1206(b) Clinics	1) Provide compliance support to 1206(b) clinic leadership, as needed	CCO	Ongoing	Ongoing	
B		TCHD Strategic Plan	1) Provide compliance support on relevant items in current and future strategic plan	CCO	Ongoing	Ongoing	

TRI-CITY HEALTHCARE DISTRICT

AUDIT, COMPLIANCE & ETHICS COMMITTEE CHARTER

Tri-City Healthcare District's (the "District") Audit, Compliance & Ethics Committee (the "Committee") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to provide assistance, and make recommendations, to the District's Board of Directors ("Board") by overseeing the Internal Audit Program, the external audit, the District's financial reporting obligations and the Ethics & Compliance Program. The Committee is responsible for making recommendations to the Board regarding the appointment, compensation, retention and oversight of the District's independent auditors; Report to the Board regarding any issue involving the integrity and trustworthiness of the District's annual financial statements;

1. **Internal Audit Program and Ethics & Compliance Program Oversight**. The Committee will oversee the District's Internal Audit Program and Ethics & Compliance Program, including the following:

   a. Review and oversee the non-clinical contracts at least twice annually;

   b. Review the District's compliance with applicable federal, state and local legal and regulatory requirements relating to providers and suppliers of healthcare services;

   c. Monitor the development and implementation of the District's Internal Audit and Ethics & Compliance programs via periodic reports from the internal auditor, District's Chief Compliance Officer, the Internal Compliance Committee, and legal counsel;

   d. Review risk assessments and work plans (including audit schedules) and the Ethics & Compliance Program, at least annually, as presented by the internal auditor, the Chief Compliance Officer, Internal Compliance Committee and/or legal counsel;

   e. Review and oversee revision of the District's Administrative Code of Conduct;

   f. Receive and revise draft policies from the Chief Compliance Officer and Internal Compliance Committee for presentation and recommendation to the Board;

g. Review reports from the Internal Auditor, Chief Compliance Officer, **and** Internal Compliance Committee, and monitor implementation of corrective action as applicable;

h. Make programmatic recommendations to the Chief Compliance Officer, senior management, and Board.

2. **External Audit and Financial Reporting Oversight.** The Committee shall:

a. Review the accounting and financial reporting processes of the District and external audits of the District's annual financial statements;

b. Report to the Board regarding any issue involving the integrity and trustworthiness of the District's annual financial statements;

c. Report to the Board regarding any issue involving the District's compliance with financial reporting and, if applicable, legal and regulatory requirements with respect to District financing, as well as any applicable federal and state regulatory requirements relating to Medicaid, Medicare, and state insurance and charity care requirements;

d. Review the independence, qualifications and performance of the District's external auditors;

e. Monitor and report to the Board regarding the adequacy, efficacy, and adherence to policies and procedures related to accounting, internal accounting controls, ethical concerns, or auditing matters;

f. The Audit, Compliance & Ethics Committee Charter will be reviewed every three years.

II. Membership

The Committee shall consist of three (3) Directors of the District, one (1) physician on-staff at Tri-City Healthcare District, and a maximum of three (3) community members and an option for a subject matter expert who would not be a voting member and whose term would not expire. ~~up to four (4) community members~~.

Each Committee member shall have at least a basic understanding of finance and accounting, the ability to read and understand financial statements, and experience and familiarity with the specialized issues relating to health care financial issues. At least one member of the Committee shall have accounting or related financial management expertise, as evidenced by the certified public accountant designation or other education and/or work-related credentials. Each Committee member shall have a basic understanding of the design and operation of the Internal Audit Program and an Ethics & Compliance Program, by: (i) review of Office of Inspector General/AHLA materials for Boards; (ii) review of OIG compliance program guidance; and (iii) attendance at relevant educational sessions presented by the Chief Compliance Officer.

Term of Membership: Per Board Policy 15-031 members shall serve terms of two years, with an option to renew the appointment for one additional two-year term and shall continue to serve until a successor is appointed by the Board.

III. Meetings

The Committee is anticipated to meet in January, April, July and October for the compliance component; May and September for the audit component.~~no less than four times each year and as many times as may be needed.~~

IV. Minutes

The Committee will maintain written minutes of its meetings, which will be filed with the minutes of the meetings of the Board. Closed session minutes will be maintained consistent with Board procedures.

V. Reports

The Committee will report regularly to the Board regarding (i) all determinations made or actions taken per its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the Board for action.

VI. Conduct

Each Committee member shall comply with the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/.

Approved: Board of Directors: 9/29/11
Amended: Board of Directors: 4/26/12
Approved: Board of Directors: 3/28/13
Approved: Board of Directors: 5/30/13
Approved: Board of Directors: 5/29/14
Approved: Board of Directors: 8/25/16
Approved by Board of Directors: