Northern Inyo Healthcare District

Board Meetings

June 19, 2024 Regular Board of Directors Meeting

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

June 19, 2024 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

The Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom.

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are **limited to three (3) minutes per speaker**, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
   A. Resolution 24-03 Continuing Budget Resolution for 2024 *(Action item)*
   B. Compliance Officer Report.
      1. Quarterly Compliance Report *(Action Item)*
      2. Presentation: Governing Board Compliance Updates *(Information item)*

C. Governance Committee Report:

1. Governance Committee Updates
2. Board Policies & Procedures bi-annual review *(Action item):*
    a) Appointment/Election of Board Member to Fill Unexpired Term of a Board Member
        a. New policy, combined the following:
            i. Appointments to the NIHD Board of Directors
            ii. Board Member Resignation and Filling of Vacancies
            iii. Suggested Guidance to Fill a Board Vacancy by Appointment
            iv. Work Flow for Appointments to Fill Board Vacancy
    b) Attendance at Meetings
    c) Authority of the Chief Executive Officer for Contracts and Bidding
    d) Conflicts of Interest
    e) Election Procedures and Related Conduct
    f) Guidelines for Business by the Northern Inyo Healthcare District Board of Directors
    g) Meeting Public Comment Policy
    h) Onboarding and Continuing Education of Board Members
    i) Reimbursement of Expenses
    j) Requests for Public Funds, Community Grants, Sponsorships
    k) Use by NIHD Directors of Directors of District email accounts

    No suggested changes on the following:

    l) Basis of Authority: Role of Directors
    m) Chief Executive Officer Compensation Philosophy
    n) Compensation of the Chief Executive Officer
    o) Governance Committee Charter
    p) Meeting Minutes
    q) Meetings
    r) Officers and Committees of the Board of Directors
    s) Public Records Requests
    t) Teleconference Recordings, Retention and Destruction of Board Meetings
3. 2024 Governance Committee Meeting Minutes *(Information item)*:

a) January 30, 2024
b) February 5, 2024
c) February 12, 2024
d) February 26, 2024
e) April 1, 2024
f) May 6, 2024
g) May 14, 2024

D. Chief Executive Officer Report *(Board will receive this report)*
   1. CEO Leader Board Reports
   2. CEO Report

E. Chief Financial Officer Report
   1. Financial & Statistical Reports *(Board will consider the approval of these reports*)
   2. Revenue Cycle Director Search
   3. Associate CFO Search

F. Chief Operations Officer (COO) / Chief Nursing Officer (CNO) Report

G. Chief of Staff Report, Sierra Bourne MD:
   1. Policies (*Board will consider the approval of these Policies and Procedures*)
      a) Health Care Worker (HCW) Influenza Vaccination
      b) Injury and Illness Prevention Program
      c) Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs
      d) Safe Patient Handling – Minimal Lift Program
      e) Cesarean Delivery
      f) Induction of Labor Including Cervical Ripening
      g) Newborn & Pediatric Security and Abduction Policy
      h) Standards of Care for the Neonate in the Perinatal Department
   2. Extension of Temporary Privileges for Good Cause *(Action item)*
      a) Talia Luc, PMHNP (psychiatric mental health nurse practitioner) – 60 day extension to allow for coverage of the mental health service line
   3. Medical Executive Committee Report *(Board will receive this report)*

4. **Consent Agenda -** *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*
   A. Approval of minutes of the May 15, 2024 Regular Board Meeting
   B. CEO Credit Card Statements
   C. Approval of Policies and Procedures
      1. Payroll Check Advances
      2. Auditing of Workforce Access to Confidential Information
      3. District Issued Cell Phone/Electronic Communication Device Use by Employees
      4. Regulatory Survey Security
      5. Nondiscrimination Policy
      6. False Claims Act Employee Training and Prevention
      7. Designated Record Set – Legal Health Record
      8. Meal and Rest Periods
      9. Billing and Coding Compliance Committee Charter
      10. Language Access Services Policy
      11. Subpoena and Legal Summons for Workforce
      12. Unusual Occurrence Reporting
      13. Non-Retaliation Policy
      14. Lost and Found Items
      15. Compliance with Information Blocking Rule
      16. California Public Records Act – Information Requests
      17. Development, Review and Revision of Policies and Procedures
      18. Communicating Protected Health Information Via Electronic Mail (Email)
      19. Disclosures of Protected Health Information Over the Telephone
      20. Medical Staff Department Policy – Emergency Medicine (v.1)

   D. General Information from Board Members (*Board will provide this information*)
   E. Public comments on closed session items.
   F. Adjournment to Closed Session to/for:
      1. Conference with Legal Counsel - Anticipated Litigation (Government Code §54956.9(d)(2)) Number of potential cases (1). Facts and circumstances: Notice of intent to take action by Marland dated June 10, 2024.
   G. Return to open session and report on any actions taken in closed session.
   H. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 24-03
CONTINUING BUDGET RESOLUTION FOR 2024

WHEREAS, California Health and Safety Code, Division 23, §32000 et seq. established Health Care Districts; and

WHEREAS, the Board of Directors of Northern Inyo Healthcare District does establish and approve a budget that conforms to generally accepted accounting and budgeting procedures for special districts annually in June; and

WHEREAS, California Health and Safety Code §32139 (a) requires the Board of Directors adopt an annual budget in a public meeting, on or before September 1 or each year;

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of Northern Inyo Healthcare District does hereby authorize continuation of the approved fiscal year 2024 budget until presented with the fiscal year 2025 budget.

BE IT FURTHER RESOLVED by the Board of Directors of Northern Inyo Healthcare District that the fiscal year 2025 budget will be presented and approved by the Board of Directors of Northern Inyo Healthcare District no later than August 31, 2024.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 19th day of June 2024 by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

By: _____
Melissa Best-Baker, Chair of the Board
Northern Inyo Healthcare District

ATTEST: _____
Clerk of the Board
Northern Inyo Healthcare District

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: June 7, 2024

Title: **Compliance Department Report**

Synopsis: The Compliance Department Quarterly Report provides information needed for the Board of Directors to provide the oversight required by the Health and Human Services Office of Inspector General (OIG). It provides specific insight into the work occurring in all areas of the seven essential elements of a Compliance Program as outlined by the HHS OIG. All information in the report has been summarized, however, additional details will be provided to the Board of Directors upon request.

This report provides the Northern Inyo Healthcare District Board of Directors with insight into NIHD's compliance with the NIHD Compliance Program.

Prepared by: Patty Dickson, Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

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Quarterly Compliance Report –Q2 2024
June 5, 2024

Comprehensive Compliance Program review summary:

1. **Audits** - A wide variety of audits in the Compliance Program review for privacy concerns, language access issues, and fraud, waste, and abuse. Auditing and monitoring is one of the seven essential elements of an effective Compliance Program.
2. **Security Risk Assessment** - District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment is completed annually, and as needed, by Compliance and IT Security.
3. **SAFER** - Office of National Coordinator of Health Information Technology SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) is completed annually by IT, Informatics, and Compliance.
4. **Compliance Workplan** - The Compliance Workplan is updated annually, and as needed, to adjust the focus of certain audits, in alignment with the Office of Inspector General of the Department of Health and Human Services, and our local Medicare Administrative Contractor (MAC), Noridian's audit priorities.
5. **Conflicts of Interest** – This component of the Compliance Program ensures that no parties use or conduct District business for personal financial gain.
6. **Privacy Investigations –** Privacy investigations can arise due to complaints, access audits, HIMS audits, and anonymous reporting.
7. **Investigations –** Other compliance related investigations are conducted to avoid regulatory non-compliance and respond to regulatory agency inquiries and investigations.
8. **Compliance Committees –** This section provides a brief overview of the work of the Compliance committees and sub-committees.
9. **Issues and Prevention** – The compliance team researches numerous questions, concerns and regulatory issues to allow other NIHD team members to take a proactive approach.
10. **California Public Records Act (CPRA) Requests** – The Compliance Officer is responsible for intake and review of public records requests, and research, investigation, redaction and fulfillment of those requests.

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11. **Policies and Procedures –** Policies and procedures are vital to the organization as they outline expectations and processes for members of the workforce. Having written policies and procedures is one of the seven essential elements of an effective Compliance Program.
12. **Unusual Occurrence Reports** – The Compliance Team processes and tracks all unusual occurrence reports for the District. Compliance provides the quality data to leadership and teams for monitoring and trending. Compliance manages the software, reporting, user configuration and resolution of all UORs.

The Compliance Department consists of a team of two full time employees, Conor Vaughan, Compliance Analyst, and Patty Dickson, Compliance Officer.

Report

1. Audits

A. Electronic Health Record Access Audits - The Compliance Department Analyst, Conor Vaughan, completes audits for access of patient information systems to ensure employees, providers, and vendors access records only on a work-related, need-to-know, and minimum necessary basis.
   i. Cerner semi-automated auditing software tracks all workforce interactions and provides a summary dashboard for the compliance team. The dashboard provides "flags" for unusual activity. Flags require further investigation and review by the Compliance Team.
   ii. The following is CY24 Q1 activity
      a. New Employee Audits: 26
         I. Flags: 0
         II. Flags resulting in policy violations: 0
      b. For Cause Audits: 13
         I. Flags: 3
         II. Flags resulting in policy violations: 2
         III. Flags resulting in disciplinary action: 2
      c. In "own" chart flags: 15
         I. Flags resulting in policy violations: 10
            i. Provided education and training: 9

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ii. Repeat violations: 0

d. Same Last Name Search Flags: 246
   I. Resulted in follow up with employee: 7
   II. Flags resulting in policy violations: 0
e. 3rd Party Vendors (ex. Our billing or coding company): 64
   I. Flags: 0
   II. Flags resulting in policy violations: 0
f. High Profile Persons: 21
   I. Flags: 0
   II. Flags resulting in policy violations: 0

B. Business Associates Agreements (BAA) audit
   i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor meets the strict governmental regulations regarding how to handle, transmit, and store protected information to protect NIHD and NIHD patient information.
   ii. NIHD BAAs need to be reviewed for current regulatory terms. Some BAAs are many years old, and need to be renegotiated in the current cybersecurity risk environment.

C. Compliance Department Contract and Agreement reviews/audit
   i. Documents processed for CY 24 (through May)
      a. 95 Agreements, Amendments or Termination Notices have been completed.
      b. ~17 are currently in progress

D. HIMs (Health Information Management) scanning audit
   i. To be conducted by HIMS and summary reports will be sent to Compliance

E. Email security audit/reviews
   i. Reviewed at least once a month
   ii. Review email security systems for violations of data loss prevention rules
      a. Typically results in reminder emails to use email encryption sent to members of workforce.

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b. Occasionally results in full investigations of potential privacy violations.

F. Language Access Services Audit

i. Interpretive (spoken word) services are provided via telephone and video interpreting units from third parties, CyraCom and Language Line.
   a. NIHD has provided a total of 34,242 minutes of interpreting services to our patients at a cost to the District of $43,239.87. (See attached Language Access Services spreadsheet)

ii. Translation services (written word) services are provided via Language Line Translation Services.

iii. NIHD provided services in the following languages in 2024
   a. Spanish (21 countries claim Spanish as an official language),
   b. American Sign Language,
   c. Mandarin (China, Taiwan, and Singapore),
   d. Gujarati (India/Pakistan),
   e. Thai (Thailand)
   f. Arabic (25 countries claim Arabic as an official language),
   g. Armenian (Armenia)
   h. Vietnamese (Vietnam)
   i. Quechua (Andean regions of South America

iv. Laws require providing language access services to all limited English proficiency patients at no cost to the patient.

v. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.

G. 340B program audits

i. The 340B drug program is designed to provide rural and underserved communities access to discount drug prices, allowing the facility to save several hundred thousand dollars annually. Those funds are used by the District to improve services provided to the community.

ii. Annual 340B audit has been completed by SpendMend (formerly TurnKey)
   a. Conducted between October 2023 and March 2024.
   b. The pharmacy 340B team has implemented the few recommended actions from the external audit.

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c. The Compliance Department recognizes Becky Wanamaker and Jeff Kneip for their excellent work on the 340B program.

H. Narcotic Administration/Reconciliation Audit
   i. Working in conjunction with Pharmacy to review narcotic administration.

I. Vendor Diversity Audit – NIHD has approximately 1400 vendors.
   i. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information (HCAI, formerly OSHPD) to develop and administer a program to collect hospital supplier diversity reports, including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.
   ii. There are currently no regulatory requirements for utilizing diverse vendors or outreach to diverse vendors.

J. Provider Verification Audits
   i. More than 200 referring providers were verified and were checked for state and federal exclusions so far in calendar year 2024
   ii. No exclusions were found for verified providers.
   iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

K. Coding Audits and Charge Master Audits
   i. Evaluation and Management (E & M) code audit completed for providers. Information shared with leadership team to discuss with coding trainers and providers.
      a. UASI has provided coding quality reports quarterly.
   ii. Charge Master Audit
      a. Conducted by CliftonLarsonAllen identified areas of opportunity in the multiple areas. These are the focus of multiple revenue cycle committees.
   iii. Collectively in 2024, NIHD employees have read 98.2% of assigned Compliance and Privacy policies.
   iv. Information Technology, Human Resources, and Compliance are currently (June 2024) conducting a review of job roles, assigned titles and groups in Policy Manager to ensure all employees receive all policies that should be

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assigned to them. We are also ensuring that we are not assigning policies that are not relevant to the role with the District.
    a. This helps lower costs for the District.

2. **HIPAA Security Risk Assessment (SRA)** – Due in October 2024
    A. This is a mandatory risk assessment under the jurisdiction of the HHS OIG
    B. Will work with the Cybersecurity Officer to perform an update due to the March 2024 unsuccessful cybersecurity event.
3. **Office of National Coordinator of Health Information Technology SAFER Audit** ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience))
    A. 9 of 9 sections of the SAFER audit were completed by June 1, 2024.
    B. Completion of all 9 sections is required for MIPS data submission.
    C. MIPS data is the quality data being submitted by the Quality Team. It documents improvement in patient care measures and outcomes, and also is worth potential millions of dollars for NIHD.
4. **Compliance Work Plan** – Updated June 2024 see attached
5. **Conflicts of Interest**
    A. All new employees complete and return COI questionnaire forms.
    B. Compliance has been working with Project Management (Lynda Vance) to create an intake form link on the Intranet to update automatically the information entered by each employee. This is significantly reduce processing time, allow the Business Compliance Team to complete the work via Smartsheet notifications 95% of the time, and generate letters for management of conflicts in a semi-automated fashion. This should save the District significant cost in labor hours.
        i. Roll-out should occur in July 2024
        ii. This information will also be provided to Board members, as they are also required to complete NIHD COI forms annually.
    C. No COI forms submitted to the Compliance Department noted any knowledge or concern for the following:
        i. Business transactions with an aim for personal gain.
        ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
        iii. Use of NIHD resources for purposes other than NIHD business, NIHD sponsored business activities, or activities allowed by policy.
        iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.

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v. Use of NIHD money, goods, or services to influence government employees, or for special consideration or political contribution.
vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.

6. Privacy Investigations- see attached

A. Privacy investigations/potential breaches through May 31, 2024
   i. Reported to Compliance – 15
   ii. Reported to CDPH/OCR – 4
   iii. Investigations still active in the Compliance Department 4
   iv. Investigations closed by the Compliance Department with no reporting required - 7

B. CDPH reported breach case status update
   i. CDPH has notified NIHD that the Medical Breach Enforcement Section (MBES) will begin investigating their backlog of breaches. MBES can review and investigate breaches for 7 years. The MBES team were reassigned to contact tracing during the pandemic, and are now working to resolve oldest reported potential breaches first.
      a. Privacy investigations from 2023
         I. Reported – 10
            i. 3 are closed
      b. Privacy investigations from 2022
         I. Reported – 6
            i. 2 is closed
      c. Privacy investigations from 2021
         I. Reported – 4
            i. 3 are closed
         II. CDPH changed their reporting requirements to more closely mirror federal regulations, which explains the significant drop in the number of reportable cases.
      d. Privacy investigations from 2020
         I. Reported – 17
            i. 11 are closed
            ii. 3 may be assigned administrative penalty or fine
      e. Privacy investigations from 2019

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I. Reported - 11
    i. 7 are closed

f. Privacy investigations from 2018
    I. Reported - 23
        i. 21 are closed

g. Privacy investigations from 2017
    I. Reported -22
        i. 17 are closed

h. Privacy investigations from 2016
    i. 1 is still being investigated by CDPH
    ii. 1 may be assigned administrative penalty or fine

ii. CDPH Status definitions
    a. Closed – CDPH investigation completed and a determination has been rendered.
    b. In Progress – CDPH has assigned an intake ID and may have completed some portion of the investigation.
    c. Submitted – CDPH has not assigned an intake ID or reviewed the case.

iii. CDPH Determination definitions
    a. Unsubstantiated – CDPH was unable to prove a violation of the privacy laws occurred (or the privacy law was updated in the interim between submission and their processing of the report)
    b. Substantiated without deficiencies – CDPH found that a violation of the privacy laws occurred, but NIHD had the correct policies/procedures, training/education, and took corrective actions to ensure any harm had been mitigated and reduced risk for recurrence.
    c. Substantiated with deficiencies – CDPH has found that a violation of the privacy laws occurred. CDPH has determined that further action by NIHD is needed to ensure reduced risk for recurrence. CDPH requires a corrective action plan to be submitted within a few days of receipt of the determination letter. Once the corrective action plan has been accepted, CDPH sends the case to CDPH Administration to determine if fines and administrative penalties will be assessed.

7. Investigations

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A. Compliance conducted or assisted with around 20 investigations/reviews that were not related to privacy/breach allegations through May 2024 including, but not limited to, the following:
    i. California Department of Labor, Department of Industrial Relations
        a. Response to investigation regarding California Labor Code, Division 2, Part 7 relating to a contractor participating in the Pharmacy/Infusion Construction Project.
        b. In progress
    ii. Health and Human Services Office of Inspector General
        a. Compliance and legal counsel (Best Best & Kreiger) submitted a nearly 700 page document containing all NIHD responses and associated documentation for the breach by our Business Associate, Keenan.
    iii. California Department of Public Health, Licensing and Certification

B. Regulatory Submissions
    i. Health Care Access and Information (HCAI – formerly OSHPD)
        a. Vendor Diversity – On June 3rd, 2024, Compliance reported the information for the required vendor diversity reporting that was due by July 1, 2024. NIHD had 3 certified diverse vendors. NIHD spent ~$66k with certified diverse vendors, which is approximately 0.08% of NIHD total procurement.
        b. Hospital Fair Billing Practices – On June 11, 2024, Compliance reported NIHD's Financial Assistance and Charity Care Programs, along with postings in all registration areas of the District to HCAI. Additionally, all information was submitted explaining how NIHD complies with all language access regulations, as required.

C. Subpoenas
    i. The Compliance Department also accepts and completes service for subpoenas for cases related to District business. This includes subpoenas for NIHD business records and appearances. Subpoenas for Medical Records are usually sent to the Health Information Department (HIM) for processing.
    ii. The Compliance team has facilitated 25 Subpoenas for records or appearances through 05/31/2024.

8. Compliance Committees

A. Compliance and Business Ethics Committee (CBEC)

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i. No meetings since March 17, 2023

B. Billing and Coding Compliance Committee (BCCC) reports to the CBEC committee.
   i. This group reviews billing/coding issues, chargemaster changes, and policies that affect billing/coding/accounting. Chair of this meeting is in the process of transitioning to the Billing Office Manager for this bi-weekly meeting.

C. Business Compliance Team (BCT) reports to the CBEC Committee.
   i. This group reviews all Conflict of Interest questionnaires with potential conflicts to determine the appropriate and consistent method to address the conflict. This subcommittee is chaired by the Compliance Officer and meets on an ad hoc basis.

D. Forms Committee
   i. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. There are standardized templates, designated fonts, official translations, and mandatory non-discrimination and language access information.
   ii. All forms and public information documents used at the District for patient care, regulatory requirements, orders, down-time documentation, standardized workflows, and process improvement are submitted to the Forms Committee. Once approved they are maintained in a location on the NIHD Intranet (a quick link named “Approved Forms”) for access by NIHD workforce.
   iii. The team will begin requesting postings and signage to be approved through the Forms Committee, as there is problem with “signage fatigue,” inconsistency, failure to meet Affordable Care Act Section 1557 standards, failure to use consistent District branding, and failure to obtain appropriate translations.
   iv. We have added Barbara Laughon to this committee to ensure her review and approval of all signage and postings, other than those posters legally required by employment law.
   v. One meeting has been held in 2024. District reorganization has slowed the Forms development and approval process.

9. Issues and Prevention

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A. Compliance researched over 40 issues for the District in 2024. They include adolescent privacy regulations, billing issues, sentinel event reporting, Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, confidentiality issues, release of information and information blocking regulations, regulatory updates, mandatory reporting, regulatory issues, and many other areas of interest and concern. The compliance team takes a proactive approach for all issues brought to our attention.

10. CPRA (California Public Records Act) Requests

A. Compliance has received five (5) CPRA thus far in CY 2024.
   i. Four completed timely.
   ii. One in progress

11. Policy and Procedures

A. Clear and current policies are the basis of an effective and efficient organization.
B. Having written policies and procedures is one of the 7 essential elements of an effective Compliance Program, per the Health and Human Services Office of Inspector General. User set up, policy administration, and other software optimization is managed by the Compliance Officer.
A. Policy and Procedure Audits:
   i. NIHD has approximately 1200 policies.
   ii. 330 Policies and procedures have not been reviewed in over 3 years.
   iii. Executive leadership was made aware of policies and procedures significantly overdue for review on June 5th, 2024.
B. Leaders can also use reporting from the system to ensure NIHD team members are current with reviewing policies.
C. There is an administrative group that tracks policy life-cycle and approval process, consisting of Katie Manuelito, Sarah Rice, Dianne Picken, Cori Stearns, Patty Dickson, and Veronica Gonzalez.

12. Unusual Occurrence Reports (UOR)

A. UOR quality report data for January 1, 2024 through May 31, 2025, see attached
   i. Notable trends out of 225 UORs received so far in CY 2024:
      a. UORs regarding complaints and requests to review billing and care continue to be the highest volume. Communication issues and complaints represent 80 of the 225 UORs (~36%).
      b. Specimen and test issues are the second highest in volume.

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c. Medication Occurrences and errors are the third highest volume in UORs. Medication Errors are administration errors that reach the patient. See additional (see attached) data for NIHD Medication Administration accuracy following the UOR report.
d. Multiple systemic changes have been put into place based on action plans developed during UOR review and investigation.

B. The UOR process involves significant work and time from the Compliance team.
   i. All UORs in Complytrack are currently received by the Compliance Team.
      a. Many patient complaint and concern phone calls are transferred to the Compliance team for intake and assistance.
      b. The Compliance team provides response letters for the patient complaints, although the CMO assists on specific clinical matters.
   ii. UORs are triaged and assigned to appropriate department leaders for review. Emails and phone calls are placed to leaders for urgent UORs.
   iii. The Compliance team reviews replies, ensures thorough responses and corrective actions, provides follow up letters to patients, and ensures the executive team is aware of all areas of concern.
   iv. The Compliance Officer follows up with leaders who are having difficulty with timely responses and attempts to assist them with resolution.
   v. The Compliance team ensures UORs are closed after thorough review, corrective actions and, in most cases, resolution.

Language Acess Services

Interpreting	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Total
Language Line - Phone minutes provided	1,221	1,453	1,626	1,705	1,630	
Language Line - Phone - cost	$1,159.95	$1,380.35	$1,544.70	$1,619.75	$1,548.50	
Language Line - Video - minutes provided	3,689	2,952	4,247	4,948	5,861	
Language Line - Video - Cost	$5,533.50	$4,426.00	$6,366.65	$7,422.00	$8,800.50	
Cyracom - Phone - minutes provided	1,415	1,201		959	719	
Cyracom - Phone - Cost	$1,035.03	$855.15		$616.65	$469.14	
Cyracom - Video - minutes provided	154	142		77	243	
Cyracom - Video - Cost	$115.50	$106.50		$57.75	$182.25	
Total Minutes of interpretive services provided	**6479**	**5748**	**5873**	**7689**	**8453**	**34242**
Total Cost of interpretive services provided	**$7,843.98**	**$6,768.00**	**$7,911.35**	**$9,716.15**	**$11,000.39**	**$43,239.87**
Translation						
Language Line Translation Services - Cost	$713.82	$0.00	$107.55	$210.23	$1,161.60	**$2,193.20**
						$45,433.07

COMPLIANCE ANNUAL WORKPLAN - 2024

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Due Quarter 3 CY 2024
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	Presentation in June 2024
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		In progress
4.	District Policy and Procedure management		Policy Audit completed June 2024
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		Policies for Compliance are in the review process as of May 2024
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		Scheduled for August 2024
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Ongoing in conjunction with HR. Current to date.
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.		Relias reports, Policy Manager Reports due July 2024
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		Deferred to claims processing companies - 2024
9.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		In progress – also reviewing census lists access (May 2024
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or	Completed at Orientation.	Completed at orientation. False Claims Act Policy assigned annually.

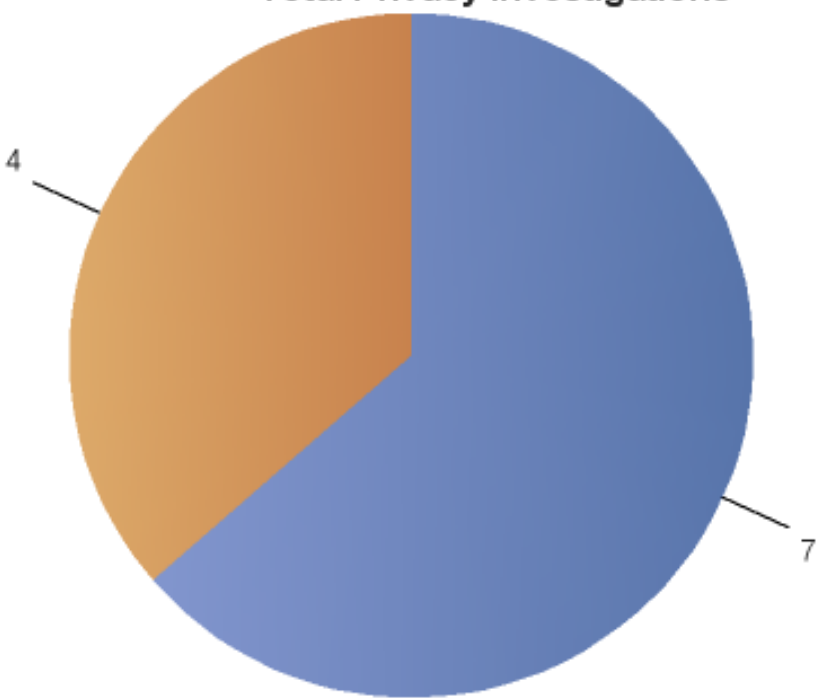
	receiving remuneration to induce referrals and other current legal standards.		
Compliance Communication			
11.	Review unusual occurrence report trends and compliance concerns. Prepare summary report for Compliance Committee on types of issues reported and resolution		Annual and quarterly reports submitted to appropriate committees and Board of Directors.
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Complytrack	Annual and quarterly reports submitted to appropriate committees and Board of Directors.
13.	Document test and review of Compliance Hotline.		Completed 02/2024 Due 08/2024
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Due 09/2024
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against Office of Inspector General (OIG) List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new referring providers. Medical Staff Office (MSO) verifies all medical staff. Accounting and Compliance verifies all vendors.	Current through 5/31/2024 Annual re-validation for vendor exclusions completed for 2023.
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		On hold due to current reorganization.
17.	Audits		
	a. Arrangements with physician (database)	Physician Contracts are now in a review cycle. All templates created/reviewed in conjunction with legal counsel (BBK).	Review in Q4 CY 2024
	b. EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 05/31/2024

	c. Financial Audits	FY 2024	CLA Audit completed. Cost Report and audit completed.
	d. Payment patterns		Due quarter Q3 CY 2024
	e. Bad debt/ credit balances, AR days		Monitored weekly by Revenue Cycle and Business Office
	f. DME (Durable Medical Equipment)	HHS OIG target	NIHD may provide and charge for "off-the-shelf, non-customized" medical equipment. Chargemaster being updated. Review Q3 2024
	g. Lab services	MAC target	Deferred
	h. Imaging services (high cost/high usuage)	MAC target	Deferred
	i. Rehab services	HHS OIG workplan	Deferred
	j. Language Access Audits	OIG target	Due Q3 2024 – in progress
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Security risk assessment November 2024 with Cybersecurity Officer.
	a. Annual Security Risk Assessment		Due Oct/Nov 2024
	b. Periodic update to Security Risk Assessment		As needed
	c. Monthly employee access audits		Daily, ongoing
19.	Audit required signage		Deferred to 2024
20.	Audit HIMS (Health Information Management) scanned document accuracy		Deferred
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		Deferred
22.	Review CMS Conditions of Participation		Ongoing
Response to Detected Problems and Corrective Action			
23.	Verify that all identified issues related to potential fraud are promptly investigated and documented		Current through May 2024
24.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		Monitored by Revenue Cycle Team and Accounting. Reporting to Compliance as needed.

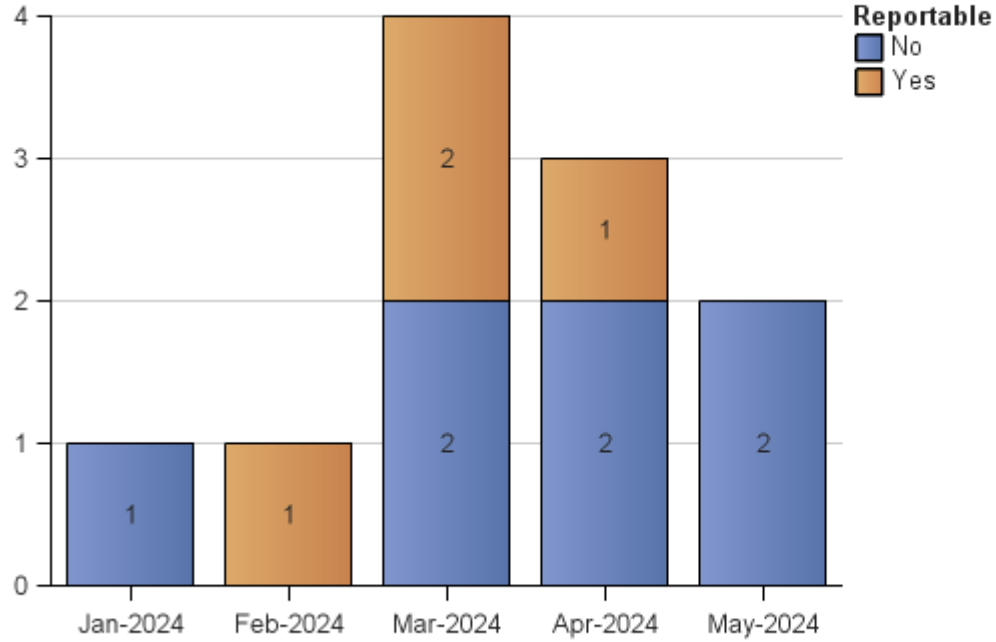
25.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Board Report for Q2 CY 2024, attached.
	a. Provide trend feedback to leadership to allow for data driven decision-making		Quarterly
	I. Overall UOR process		May 2024
	II. Workplace Violence		May 2024
	III. Falls		May 2024
26.	Patient complaints		Documented and tracked in Unusual Occurrence Reporting system
27.	Breach Investigations	HIPAA, HITECH, CMIA	4 ongoing privacy investigations as of 6/6/2024. CDPH has starting completing reported breach investigations from before 2021.

2024 Compliance Workplan – updated June 7, 2024

Total Privacy Investigations

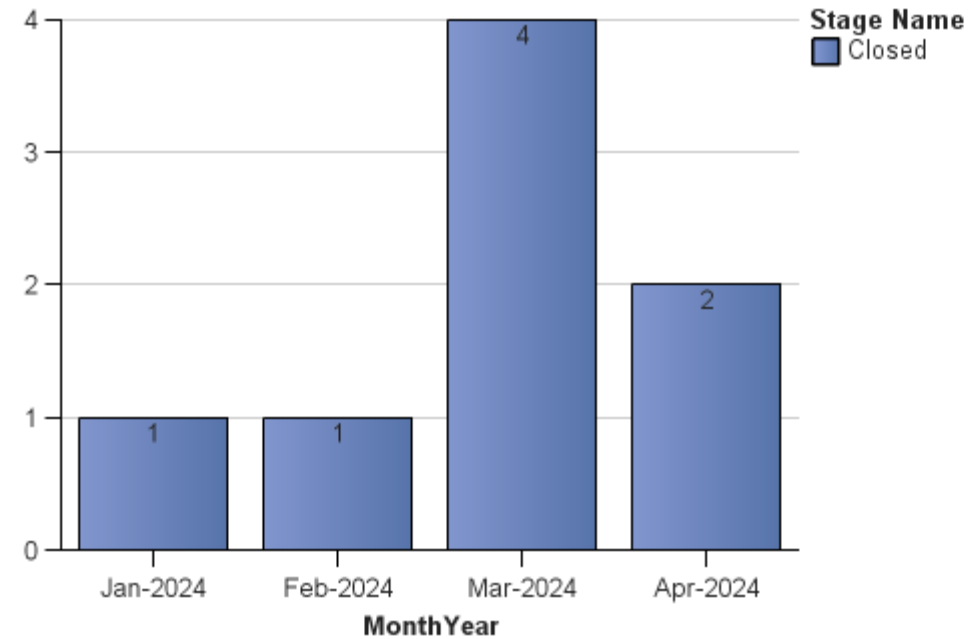


Privacy Investigations by Month/Year

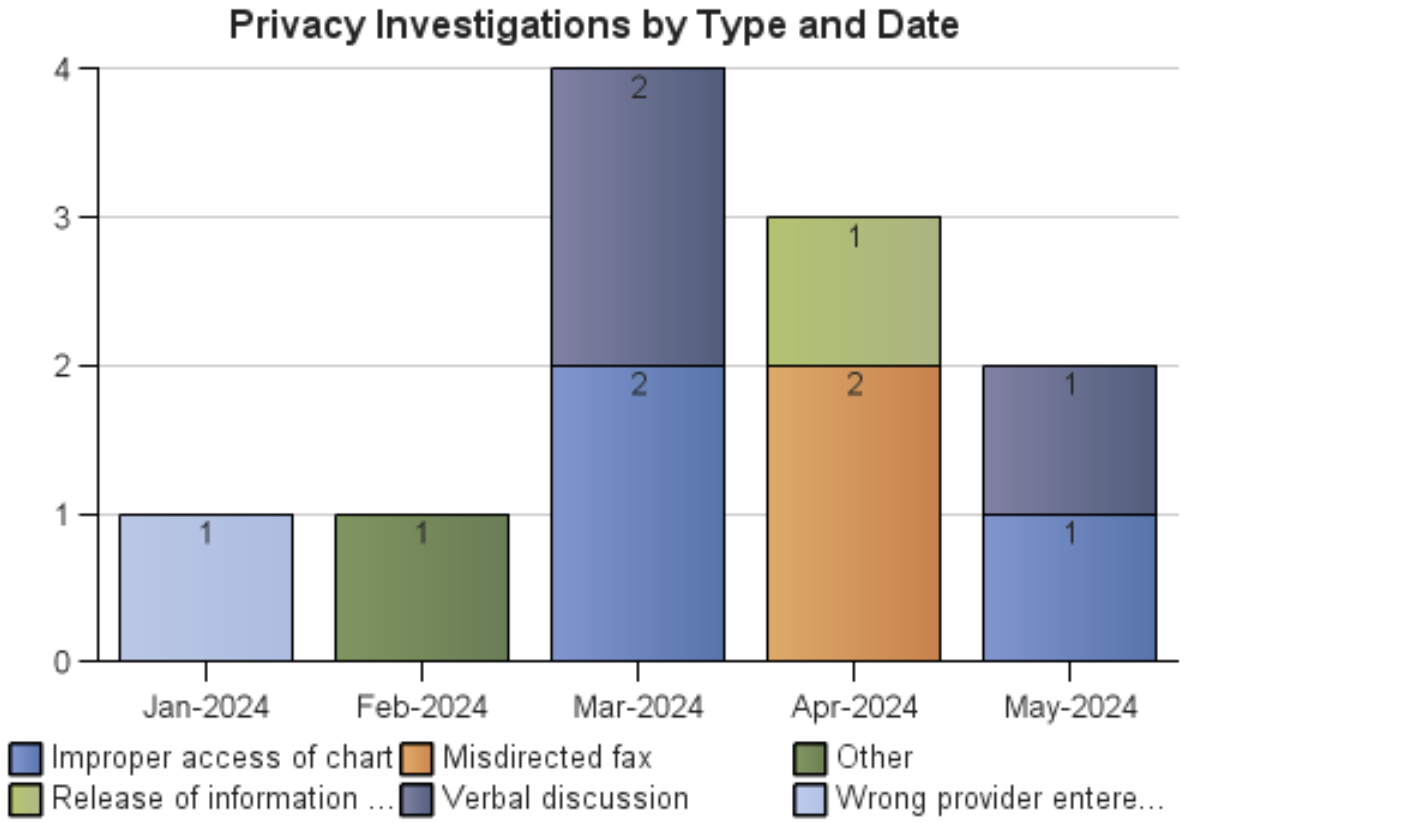


	No	Yes	Total
Jan-2024	1		1
Feb-2024		1	1
Mar-2024	2	2	4
Apr-2024	2	1	3
May-2024	2		2
Total	**7**	**4**	**11**

Number of Closed Investigations

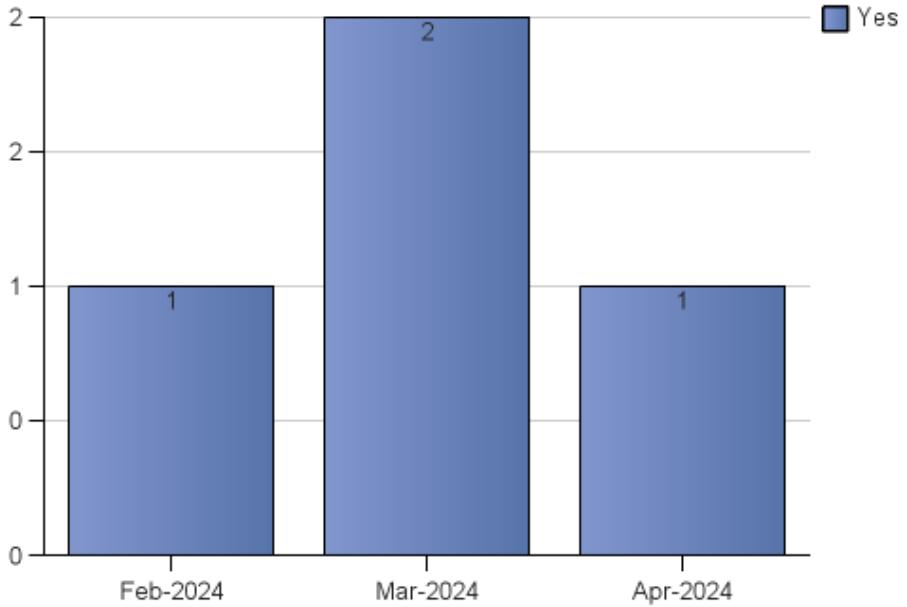


	Closed	Total
Mar-2024	4	4
Jan-2024	1	1
Feb-2024	1	1
Apr-2024	2	2
Total	**8**	**8**
Total	**8**	**8**



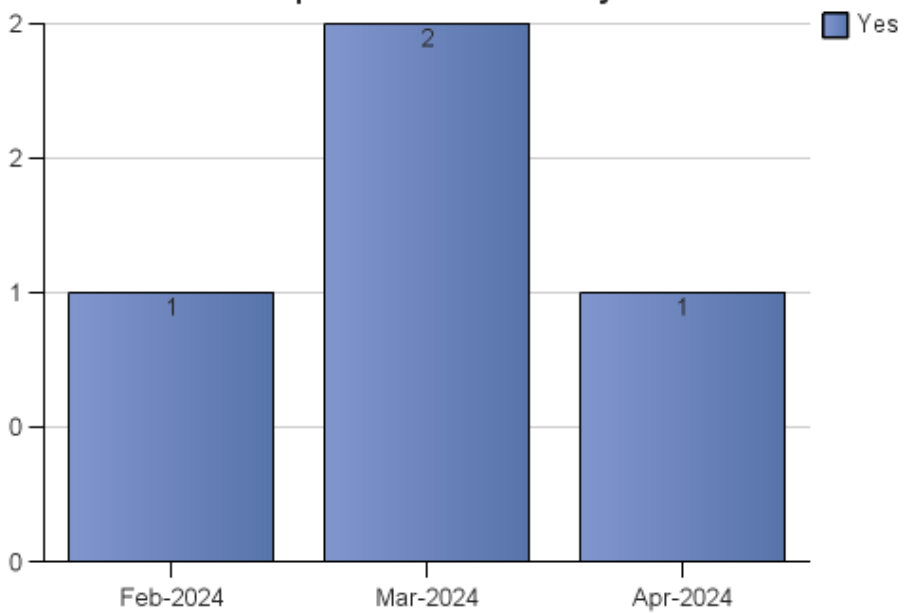
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Total
Improper access of chart			2		1	3
Misdirected fax				2		2
Other		1				1
Release of information concern				1		1
Verbal discussion			2		1	3
Wrong provider entered/selected	1					1
Total	**1**	**1**	**4**	**3**	**2**	**11**

Reported to OCR timely



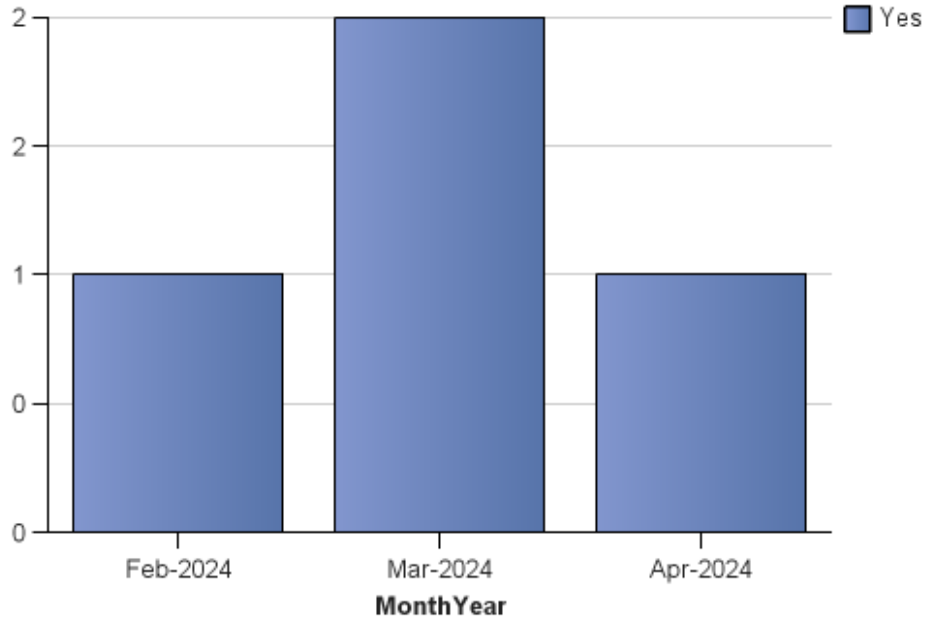
	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	1	1
Total	**4**	**4**

Reported to CDPH timely



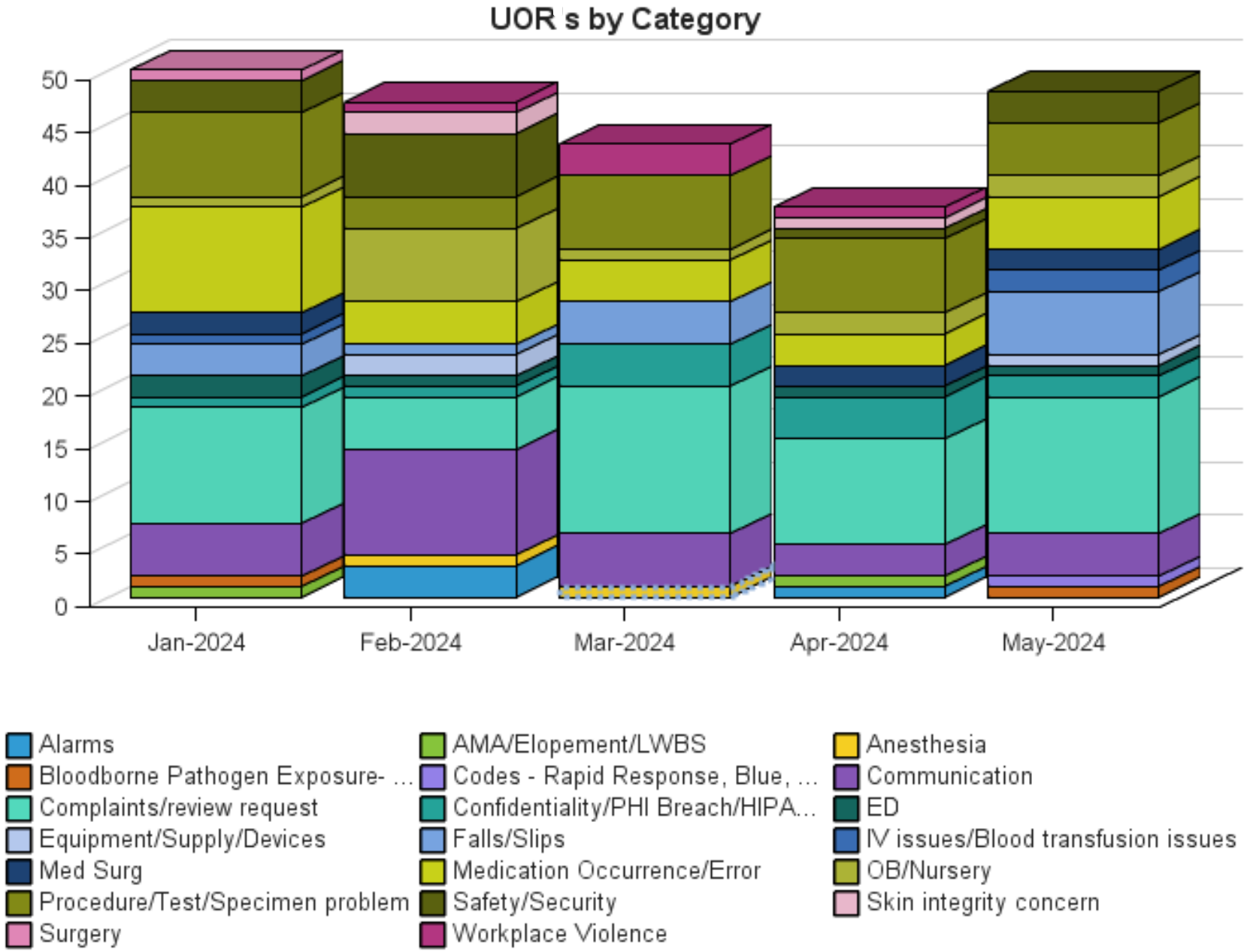
	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	1	1
Total	**4**	**4**

Investigations with on time notification of Patient



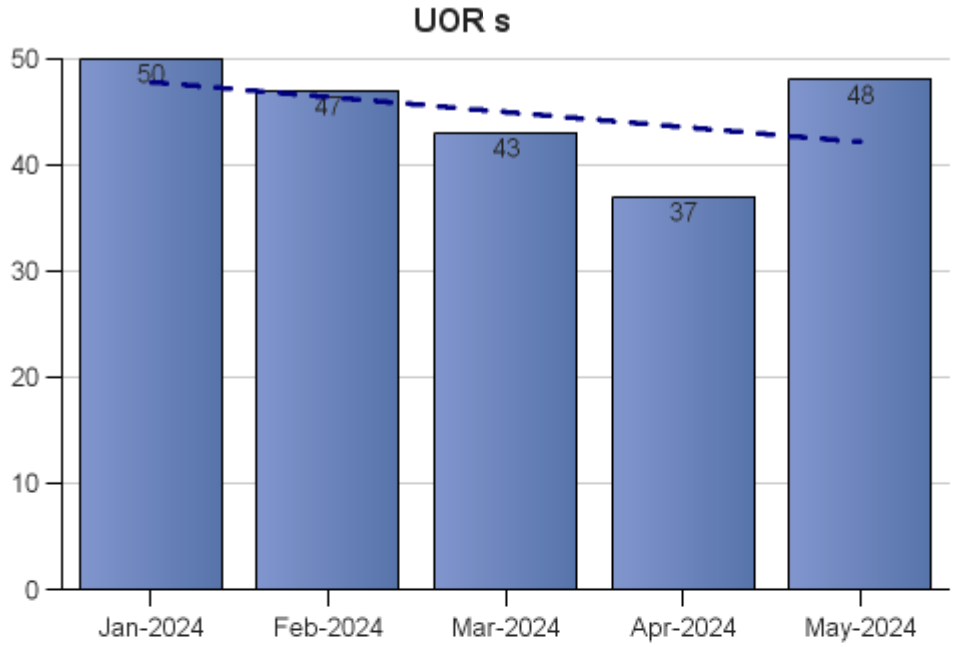
	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	1	1
Total	**4**	**4**

Calendar Year 2024
Unusual Occurrence Report (UOR) Data

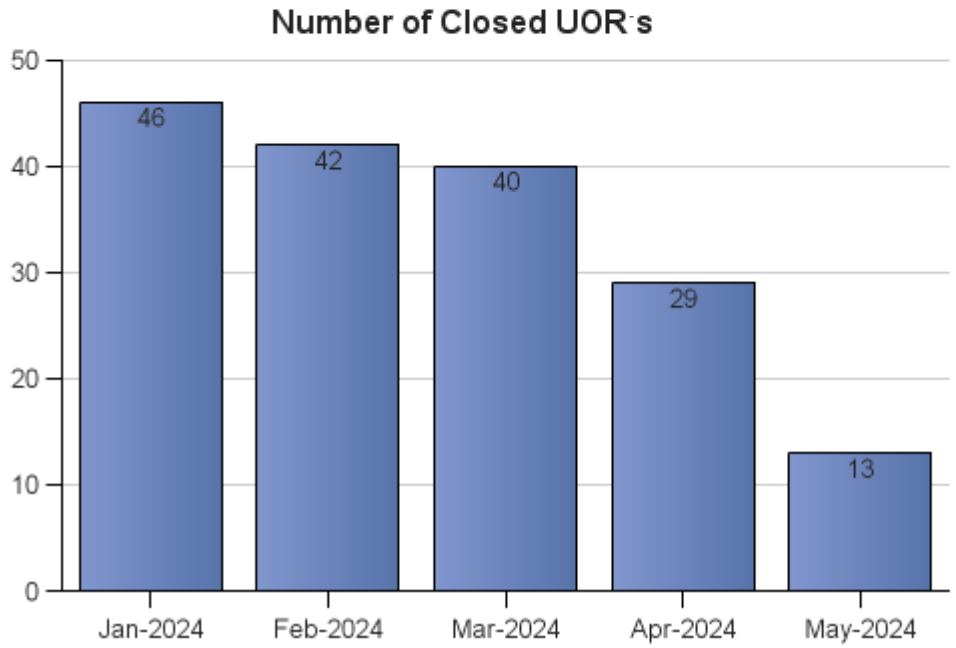

UOR s by Category
50
45
40
35
30
25
20
15
10
5
0
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
ED
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Workplace Violence

Data for previous slide

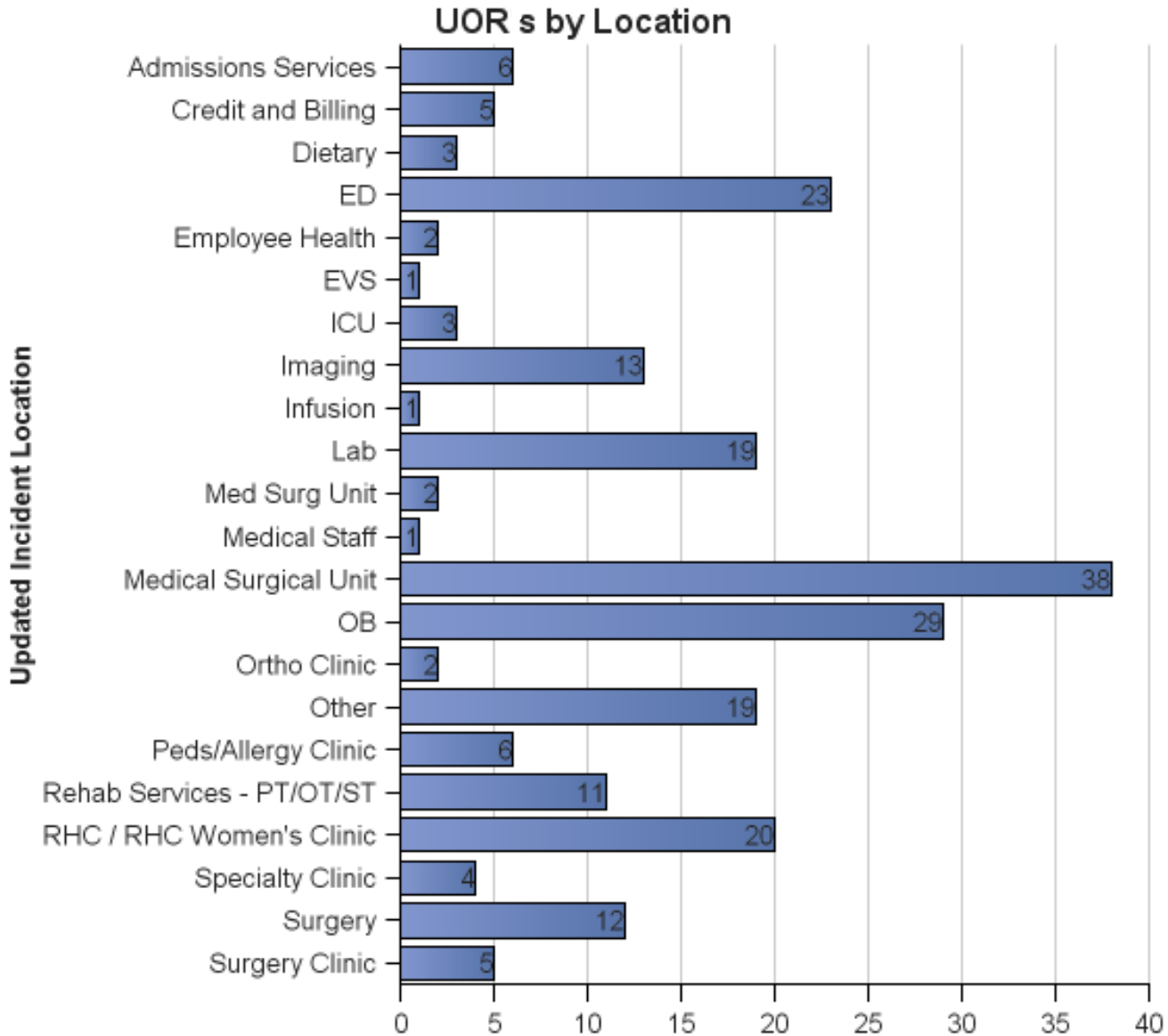
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Total
Alarms		3		1		**4**
AMA/Elopement/LWBS	1			1		**2**
Anesthesia		1	1			**2**
Bloodborne Pathogen Exposure- Sharps Injury	1				1	**2**
Codes - Rapid Response, Blue, Deescalation					1	**1**
Communication	5	10	5	3	4	**27**
Complaints/review request	11	5	14	10	13	**53**
Confidentiality/PHI Breach/HIPAA violation	1	1	4	4	2	**12**
ED	2	1		1	1	**5**
Equipment/Supply/Devices		2			1	**3**
Falls/Slips	3	1	4		6	**14**
IV issues/Blood transfusion issues	1				2	**3**
Med Surg	2			2	2	**6**
Medication Occurrence/Error	10	4	4	3	5	**26**
OB/Nursery	1	7	1	2	2	**13**
Procedure/Test/Specimen problem	8	3	7	7	5	**30**
Safety/Security	3	6		1	3	**13**
Skin integrity concern		2		1		**3**
Surgery	1					**1**
Workplace Violence		1	3	1		**5**
Total	**50**	**47**	**43**	**37**	**48**	**225**



Jan-2024	50
Feb-2024	47
Mar-2024	43
Apr-2024	37
May-2024	48
Total	**225**



	Closed
Jan-2024	46
Feb-2024	42
Mar-2024	40
Apr-2024	29
May-2024	13
Total	**170**

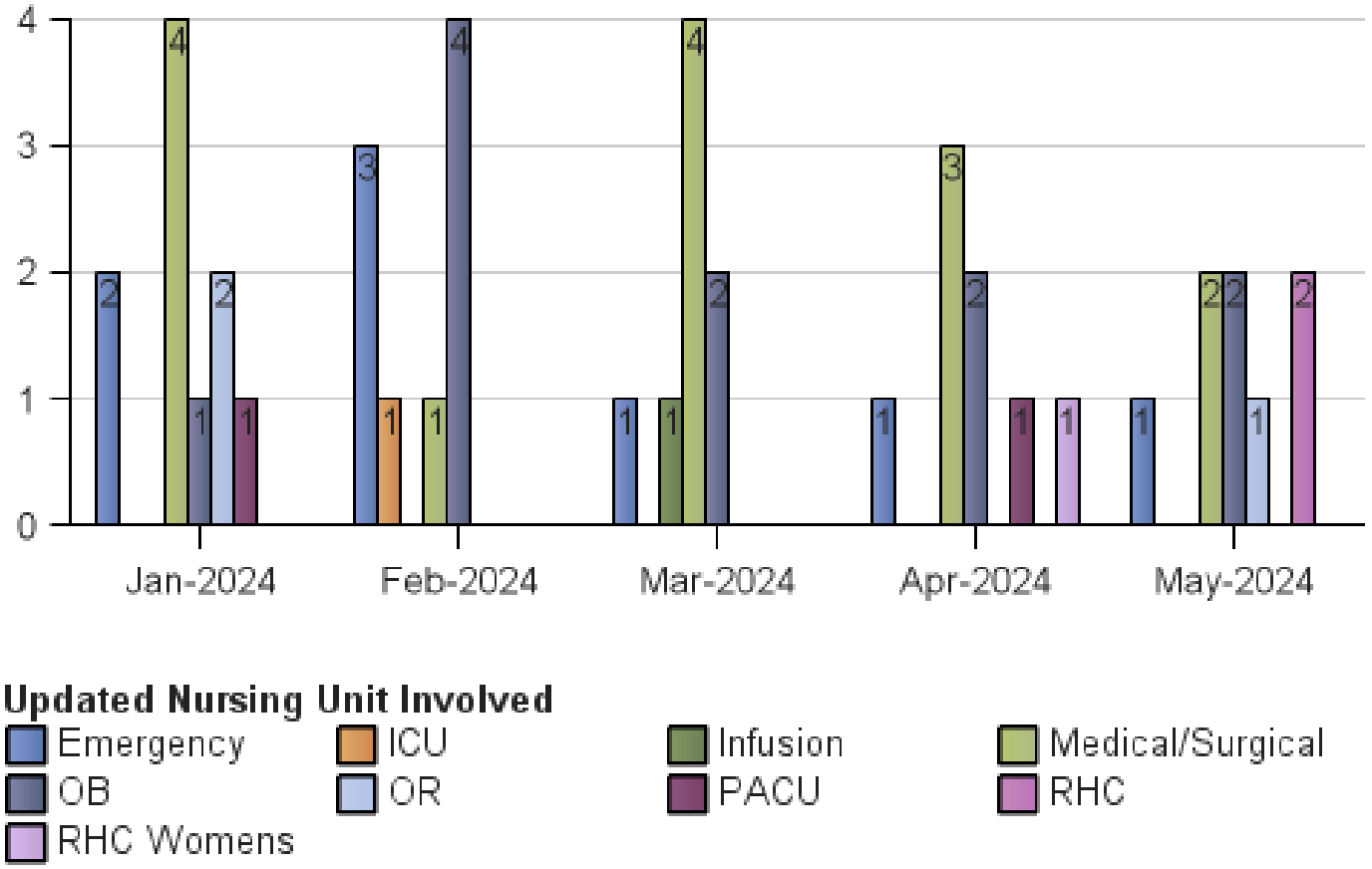

UOR s by Location
Updated Incident Location
Admissions Services
Credit and Billing
Dietary
ED
Employee Health
EVS
ICU
Imaging
Infusion
Lab
Med Surg Unit
Medical Staff
Medical Surgical Unit
OB
Ortho Clinic
Other
Peds/Allergy Clinic
Rehab Services - PT/OT/ST
RHC / RHC Women's Clinic
Specialty Clinic
Surgery
Surgery Clinic
6
5
3
23
2
1
3
13
1
19
2
1
38
29
2
19
6
11
20
4
12
5
0
5
10
15
20
25
30
35
40

Data for previous slide

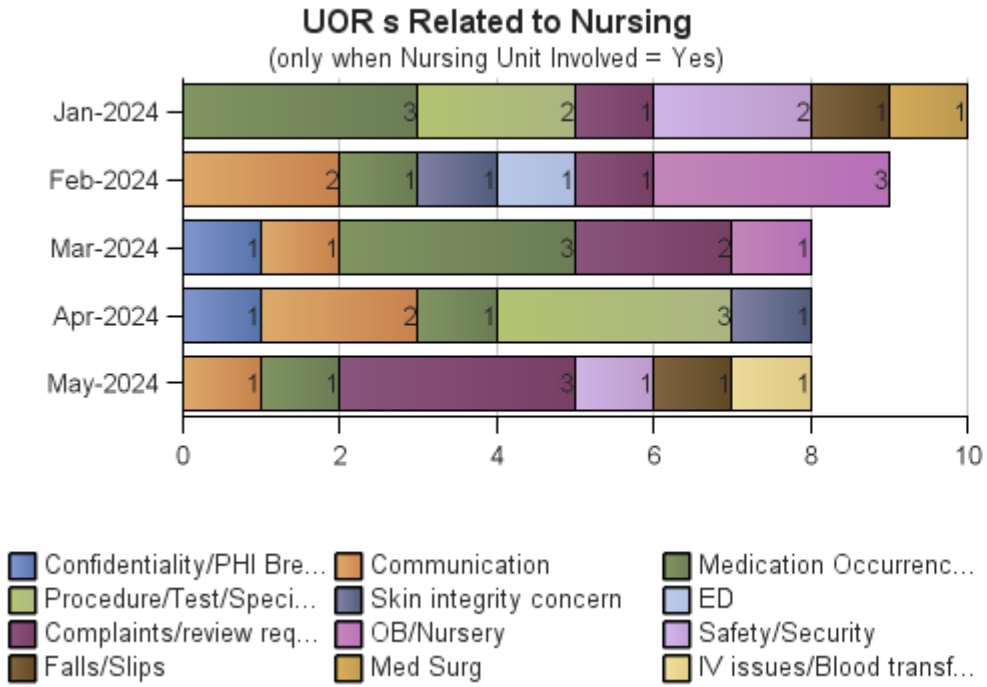
Admissions Services	6
Credit and Billing	5
Dietary	3
ED	23
Employee Health	2
EVS	1
ICU	3
Imaging	13
Infusion	1
Lab	19
Med Surg Unit	2
Medical Staff	1
Medical Surgical Unit	38
OB	29
Ortho Clinic	2
Other	19
Peds/Allergy Clinic	6
Rehab Services - PT/OT/ST	11
RHC / RHC Women's Clinic	20
Specialty Clinic	4
Surgery	12
Surgery Clinic	5
Total	**225**

UOR s Related to Nursing by Nursing Unit Involved

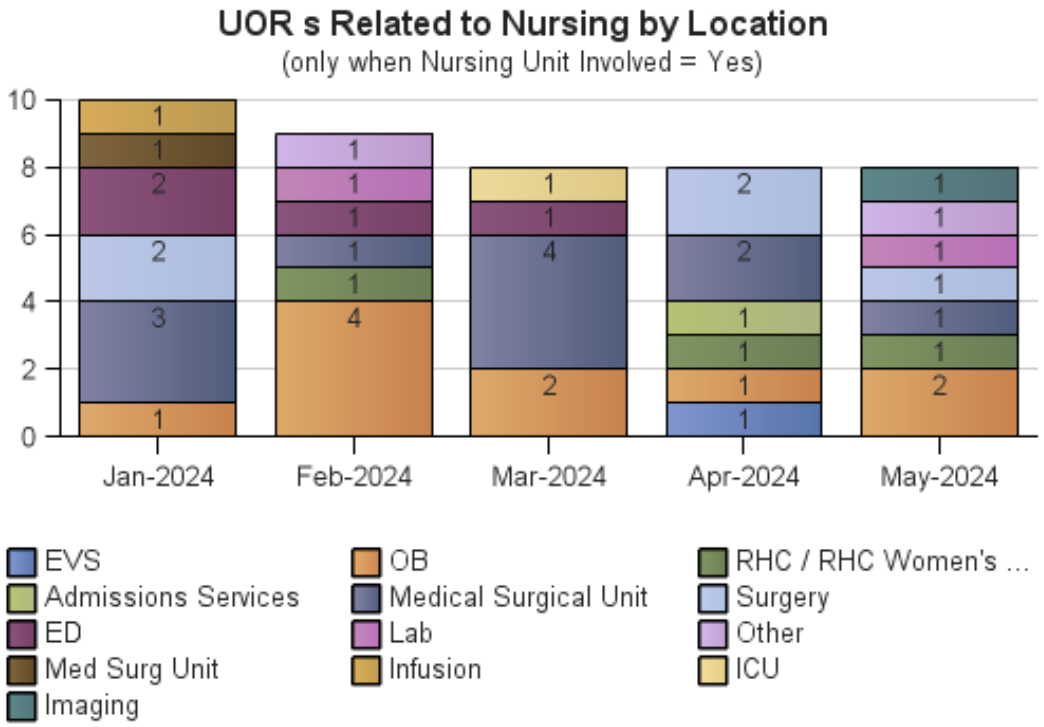
(only when Nursing Unit Involved = Yes)



	Yes
Emergency	8
ICU	1
Infusion	1
Medical/Surgical	14
OB	11
OR	3
PACU	2
RHC	2
RHC Womens	1
Total	**43**

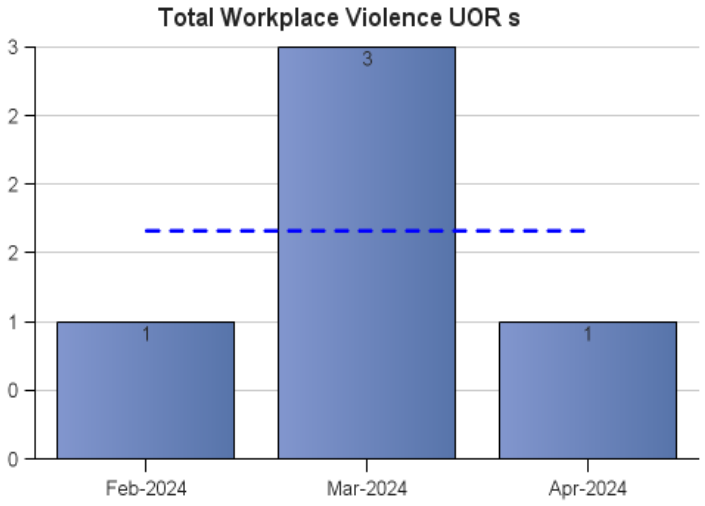


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Total
Confidentiality/PHI Breach/HIPAA violation			1	1		**2**
Communication		2	1	2	1	**6**
Medication Occurrence/Error	3	1	3	1	1	**9**
Procedure/Test/Specimen problem	2			3		**5**
Skin integrity concern		1		1		**2**
ED		1				**1**
Complaints/review request	1	1	2		3	**7**
OB/Nursery		3	1			**4**
Safety/Security	2				1	**3**
Falls/Slips	1				1	**2**
Med Surg	1					**1**
IV issues/Blood transfusion issues					1	**1**
Total	**10**	**9**	**8**	**8**	**8**	**43**

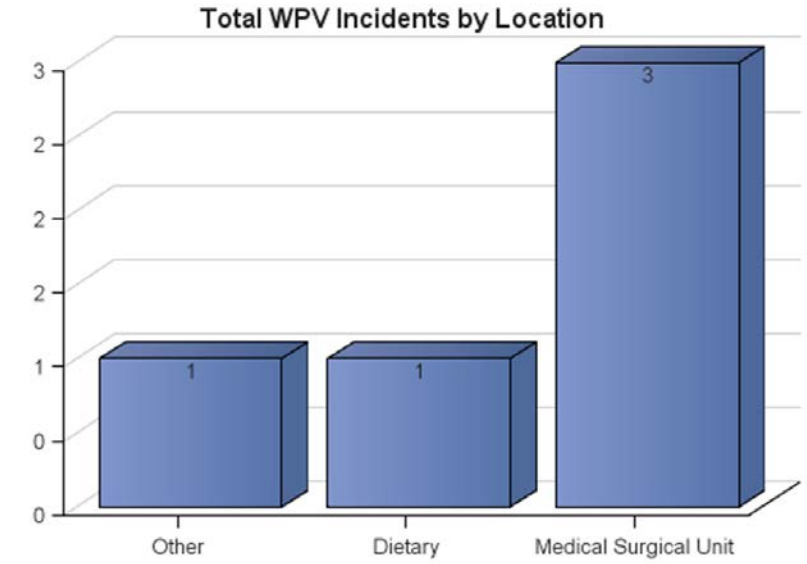


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Total
EVS				1		**1**
OB	1	4	2	1	2	**10**
RHC / RHC Women's Clinic		1		1	1	**3**
Admissions Services				1		**1**
Medical Surgical Unit	3	1	4	2	1	**11**
Surgery	2			2	1	**5**
ED	2	1	1			**4**
Lab		1			1	**2**
Other		1			1	**2**
Med Surg Unit	1					**1**
Infusion	1					**1**
ICU			1			**1**
Imaging					1	**1**
Total	**10**	**9**	**8**	**8**	**8**	**43**

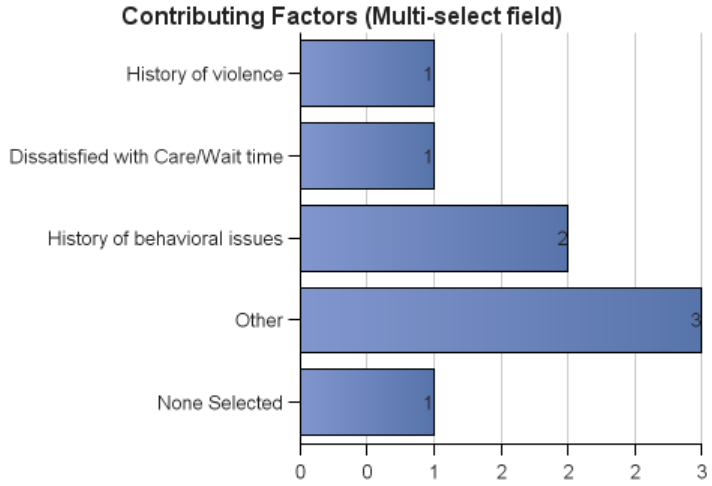
WORKPLACE VIOLENCE



	Feb-2024	Mar-2024	Apr-2024	Total
Workplace Violence	1	3	1	5
Total	**1**	**3**	**1**	**5**

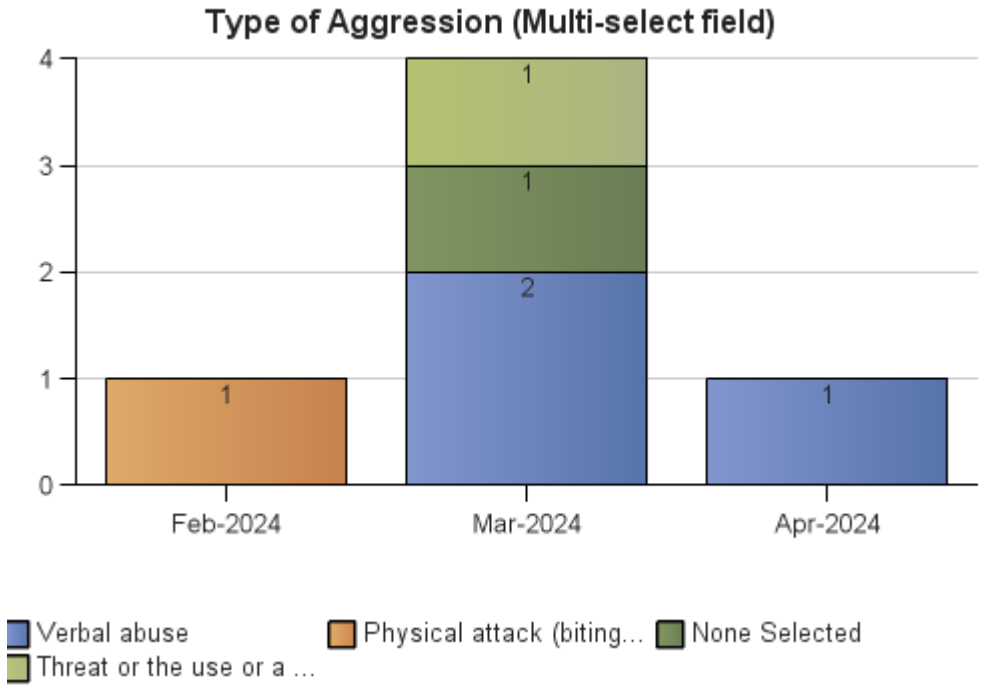


Other	1
Dietary	1
Medical Surgical Unit	3
Total	**5**



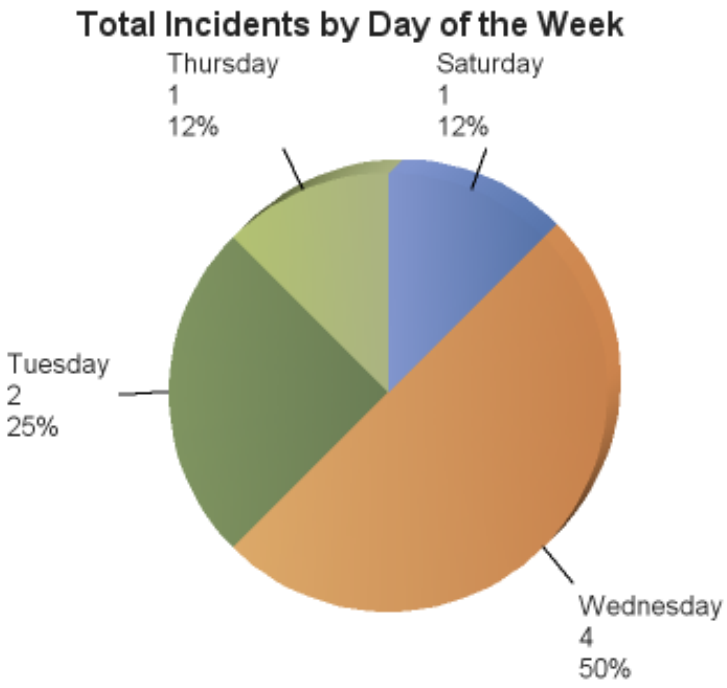
None Selected	1
Dissatisfied with Care/Wait time	1
History of behavioral issues	2
History of violence	1
Other	2
Total	**7**

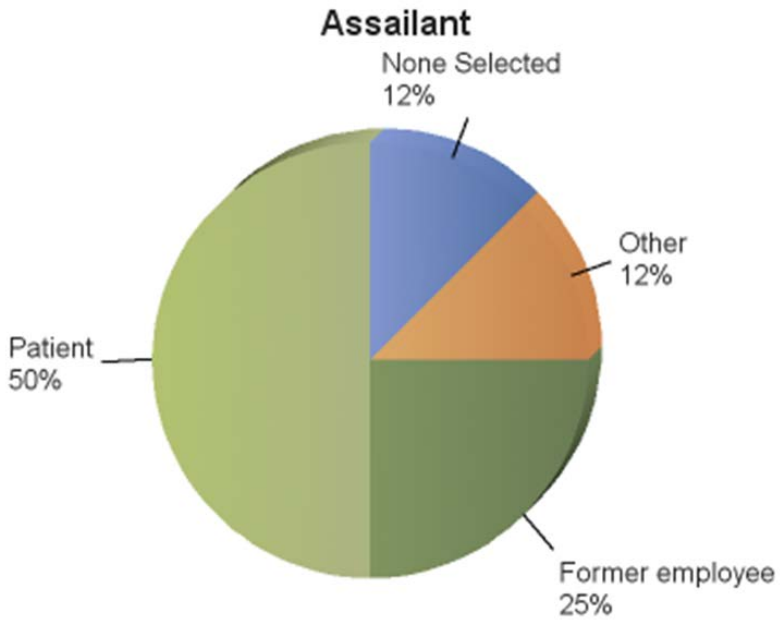
WORKPLACE VIOLENCE

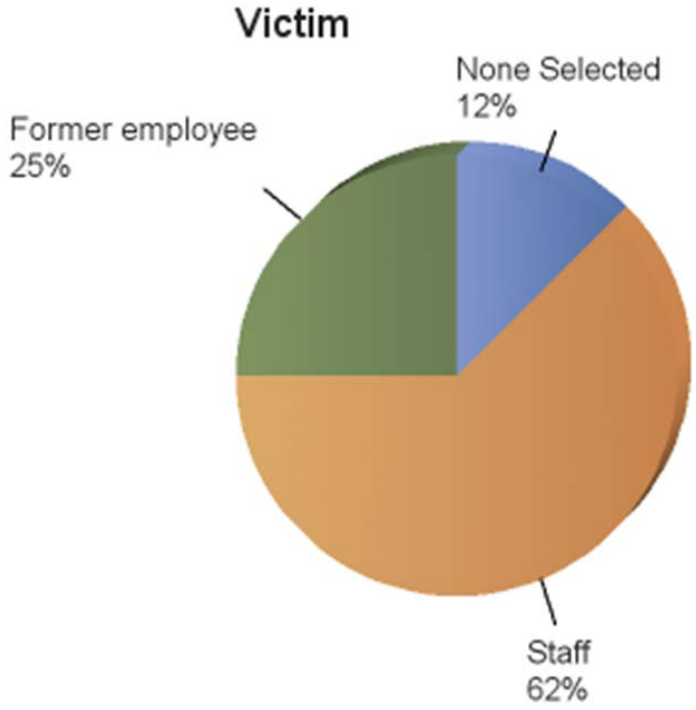


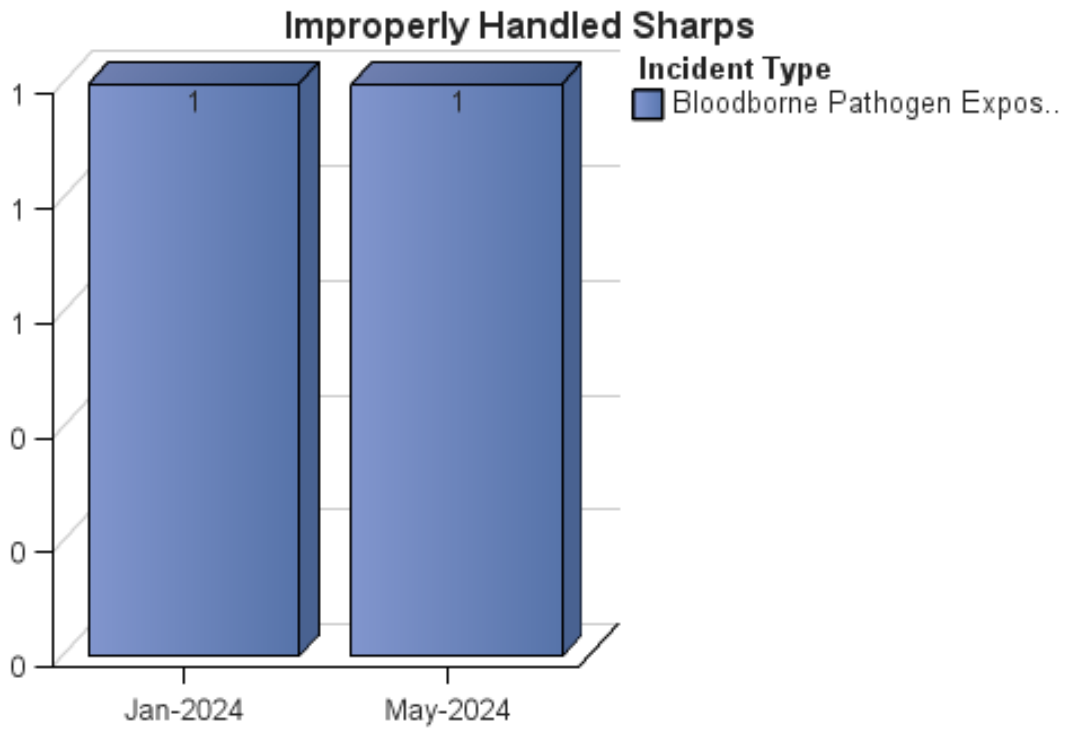
	Feb-2024	Mar-2024	Apr-2024	Total
Verbal abuse		2	1	3
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1			1
None Selected		1		1
Threat or the use or a weapon/object		1		1
Total	**1**	**4**	**1**	**6**

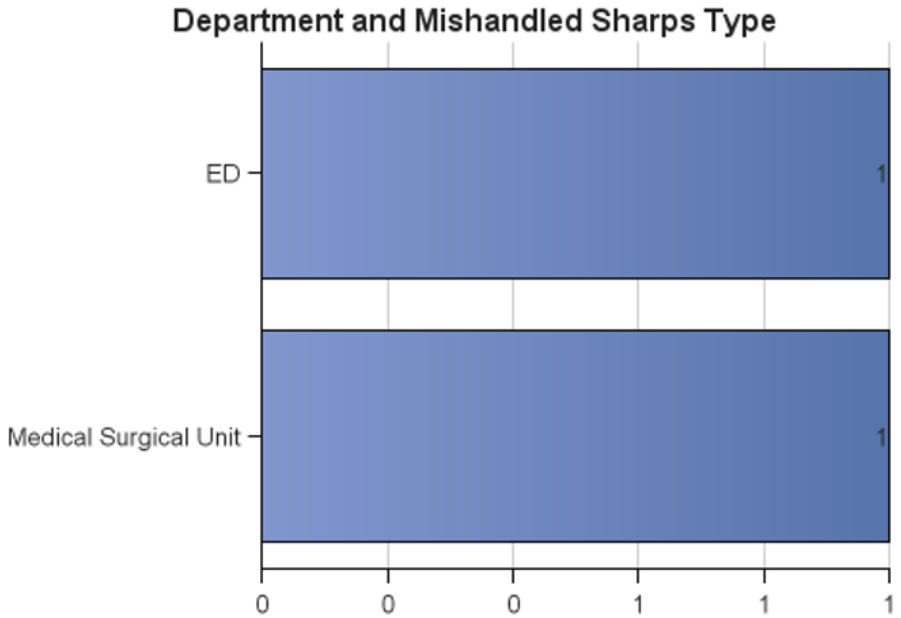
WORKPLACE VIOLENCE





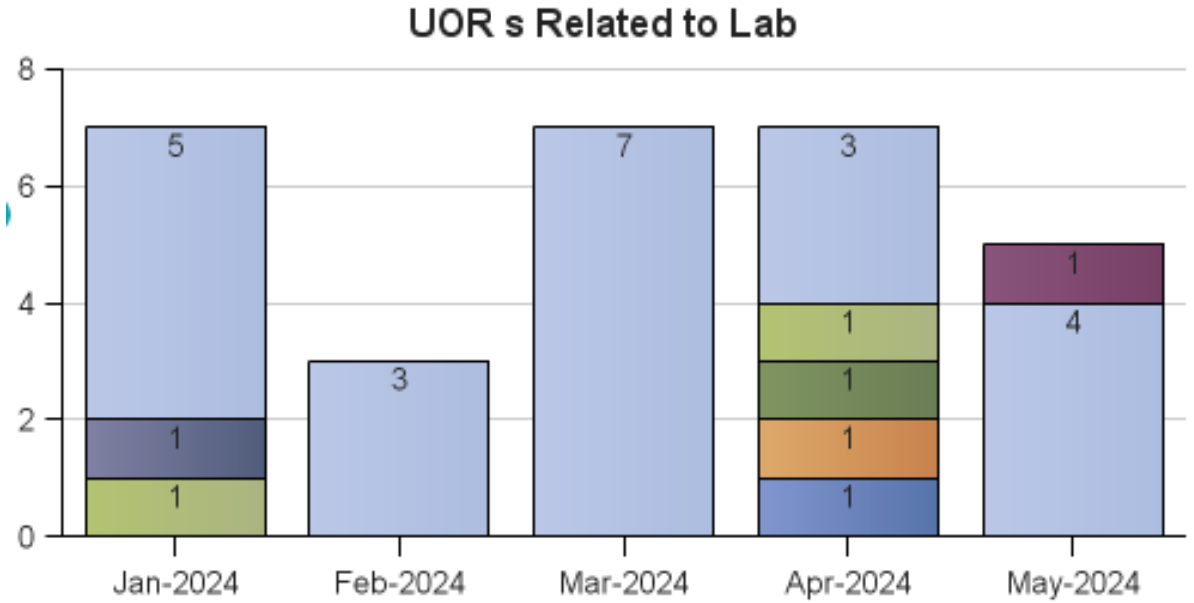






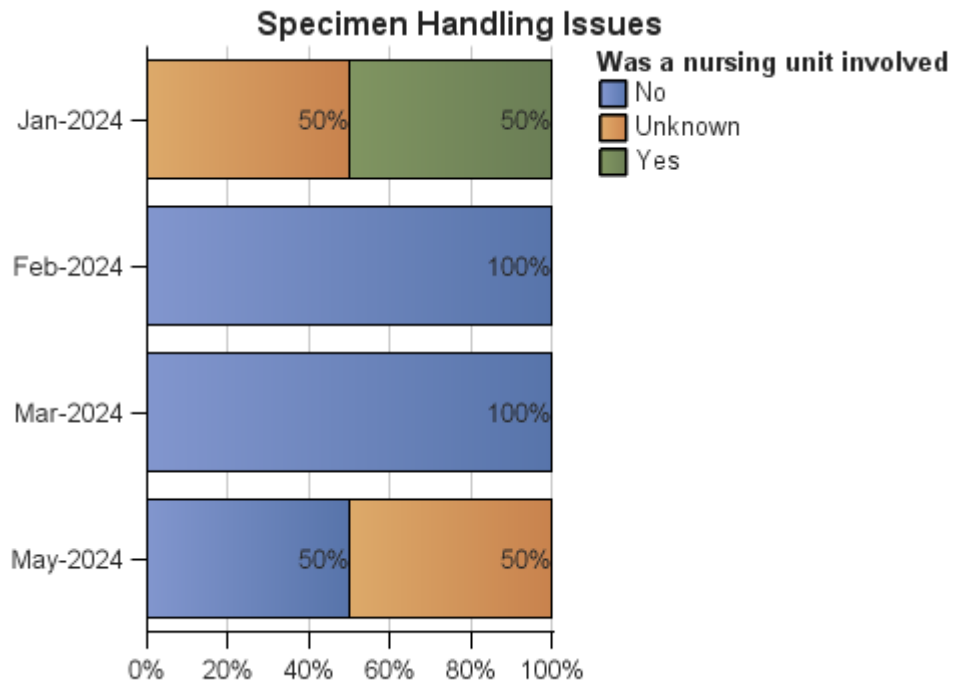
	Jan-2024	May-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	2
Total	**1**	**1**	**2**

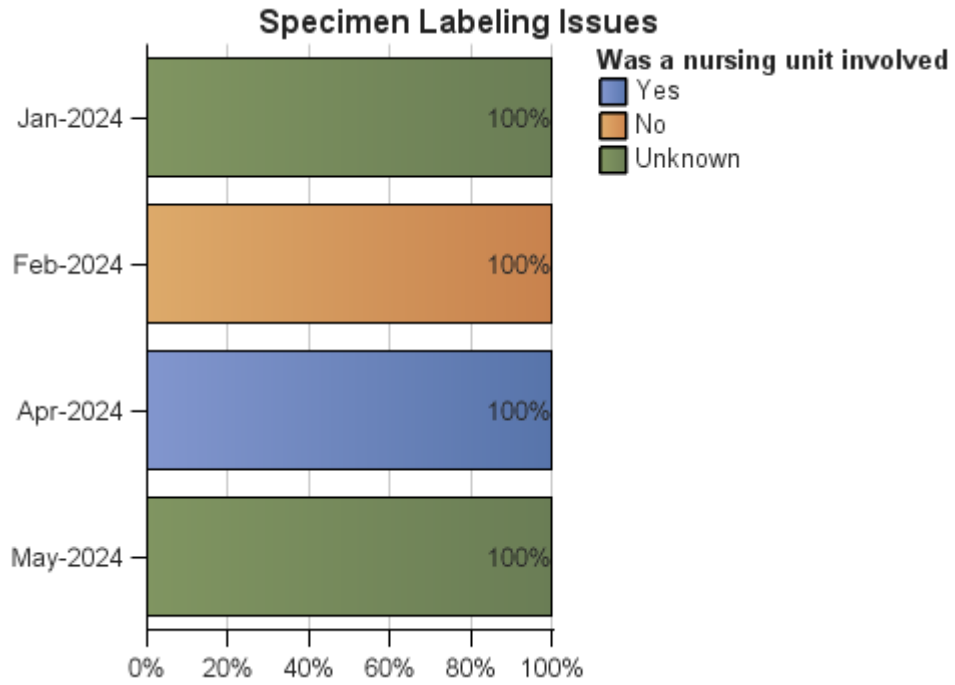
	Mishandled Sharps Type	Total
	None Selected	
Medical Surgical Unit	1	1
ED	1	1
Total	**2**	**2**



	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Total
Delay				1		1
Omitted a test or procedure				1		1
Order Issue				1		1
Other	1			1		2
Performed wrong procedure	1					1
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	5	3	7	3	4	22
Unexpected complications					1	1
Total	**7**	**3**	**7**	**7**	**5**	**29**

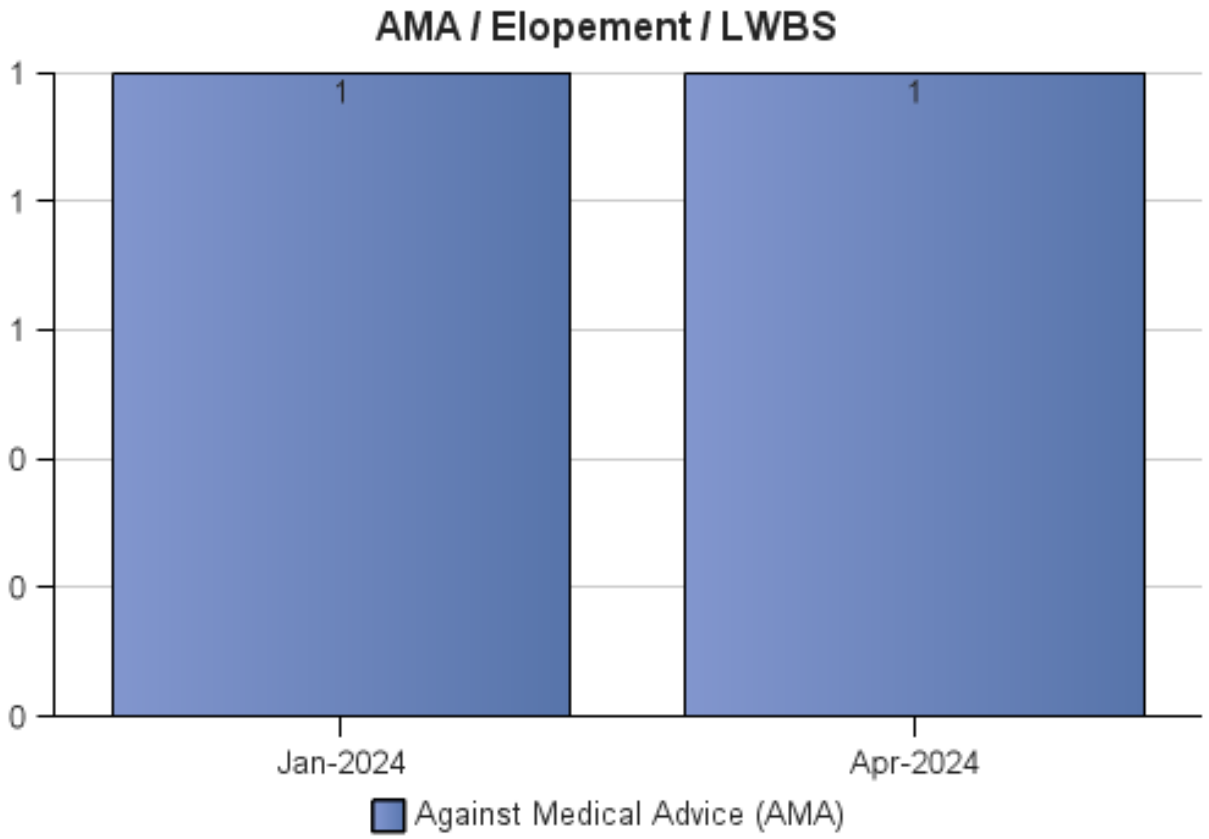
We are working with the vendor to develop additional reporting specific to “Specimen Problems.” We collect much more specific data about the problems that affect the lab team.





	Jan-2024	Feb-2024	Mar-2024	May-2024	Total
No		1	7	1	9
Unknown	1			1	2
Yes	1				1
Total	**2**	**1**	**7**	**2**	**12**

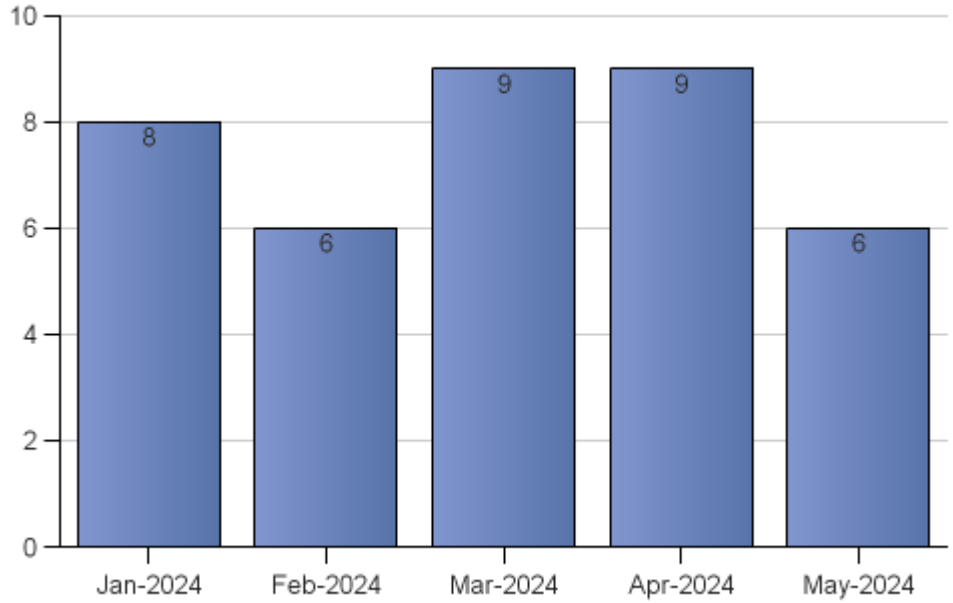
	Jan-2024	Feb-2024	Apr-2024	May-2024	Total
Yes			2		2
No		1			1
Unknown	1			2	3
Total	**1**	**1**	**2**	**2**	**6**



	Jan-2024	Apr-2024	Total
Against Medical Advice (AMA)	1	1	2
Total	**1**	**1**	**2**

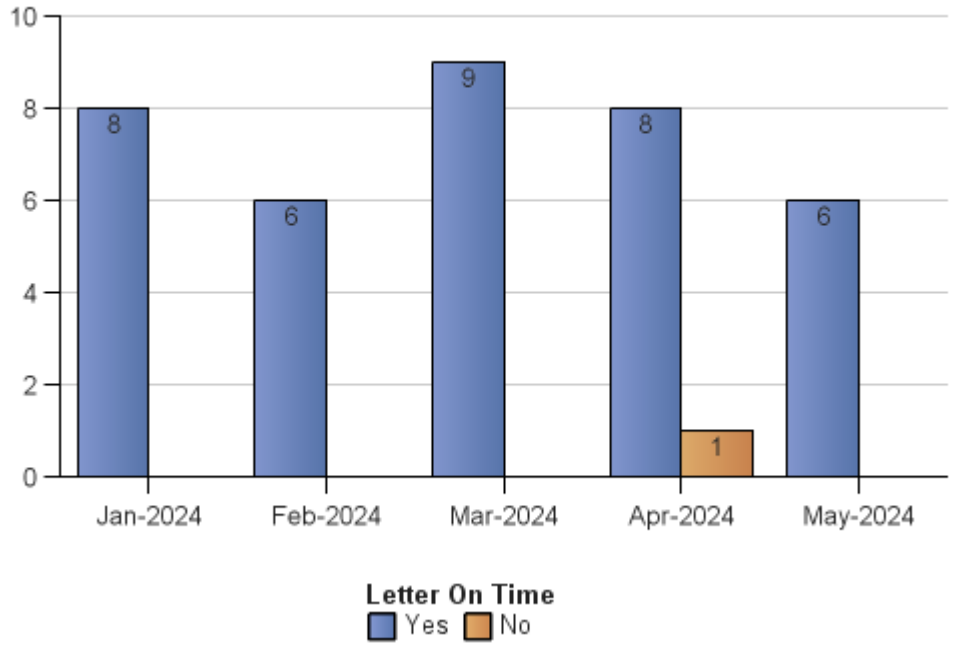
AMA – Against Medical Advice
LWBS – Left Without Being Seen

UOR s with Complaint Response Required



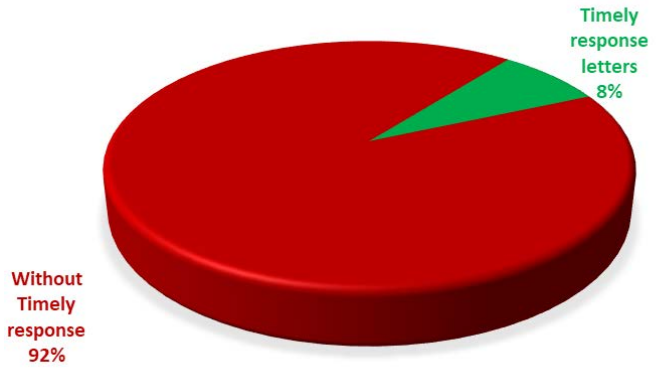
Jan-2024	8
Feb-2024	6
Mar-2024	9
Apr-2024	9
May-2024	6
Total	**38**

UOR s with On Time Responses

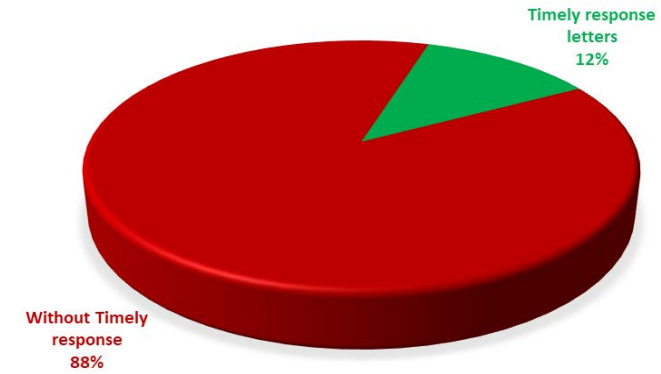


	Yes	No	Total
Jan-2024	8		**8**
Feb-2024	6		**6**
Mar-2024	9		**9**
Apr-2024	8	1	**9**
May-2024	6		**6**
Total	**37**	**1**	**38**

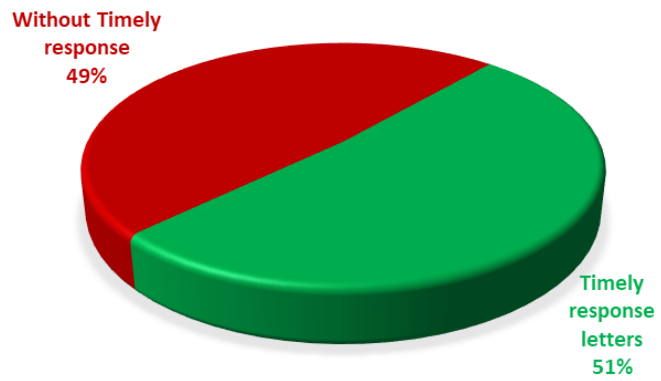
COMPLAINT RESPONSES 2019



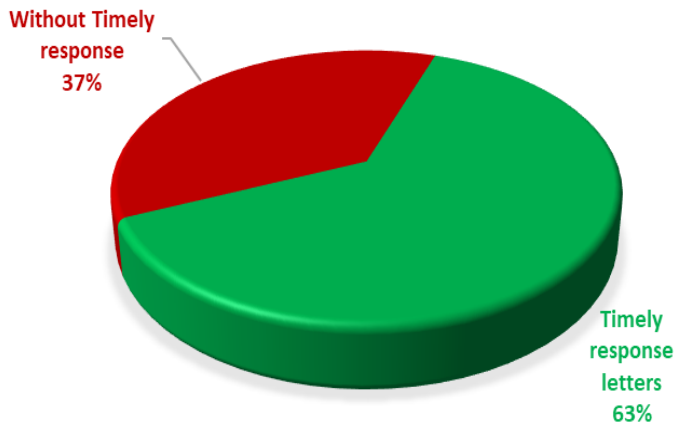
COMPLAINT RESPONSES 2020



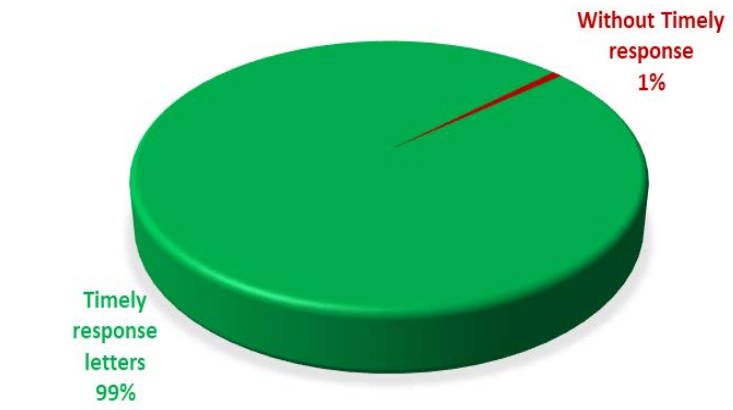
COMPLAINT RESPONSES 2021



COMPLAINT RESPONSES 2022



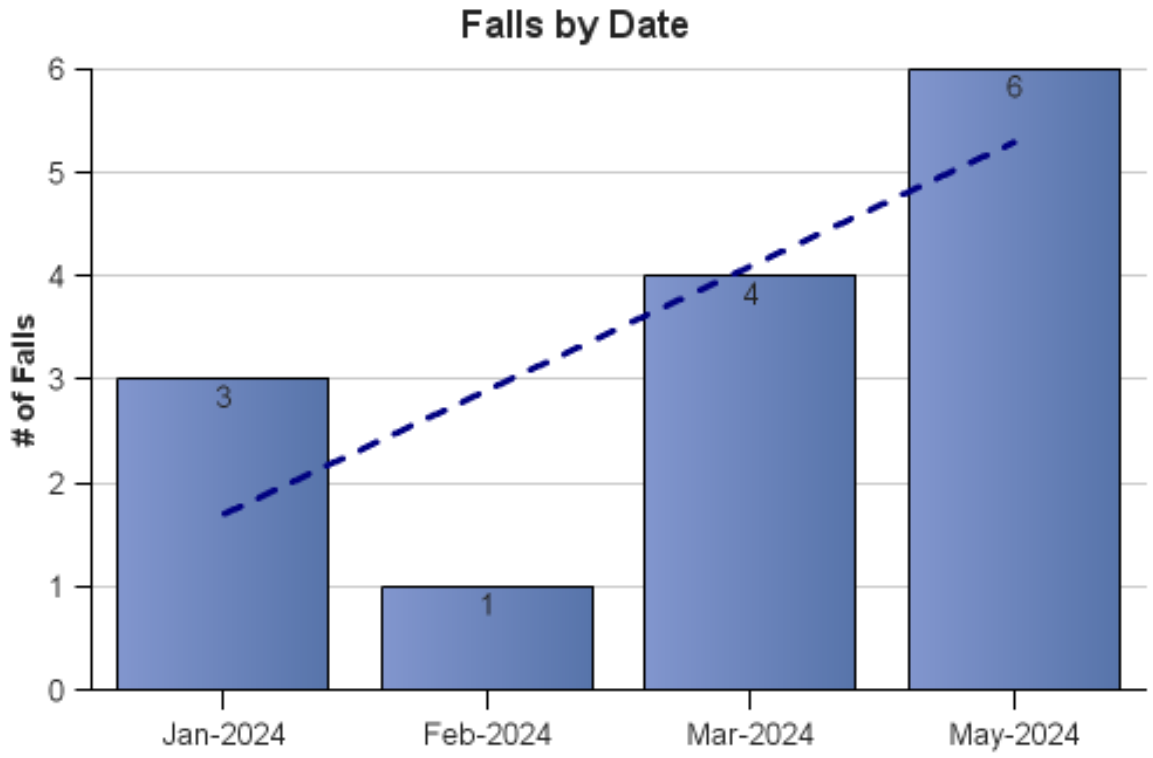
COMPLAINT RESPONSES 2023



COMPLAINT RESPONSE 2024 (5 MONTHS)

Goal is 100% Green (timely responses)

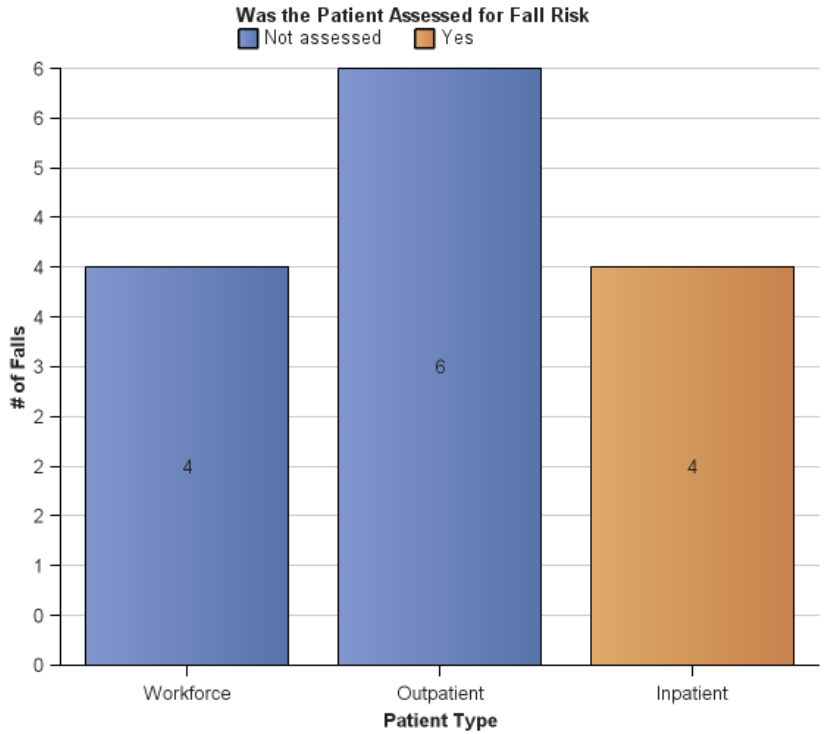
On average, a time frame of seven (7) business days for the provision of the response is the NIHD standard. (Requirement from NIHD POLICY)



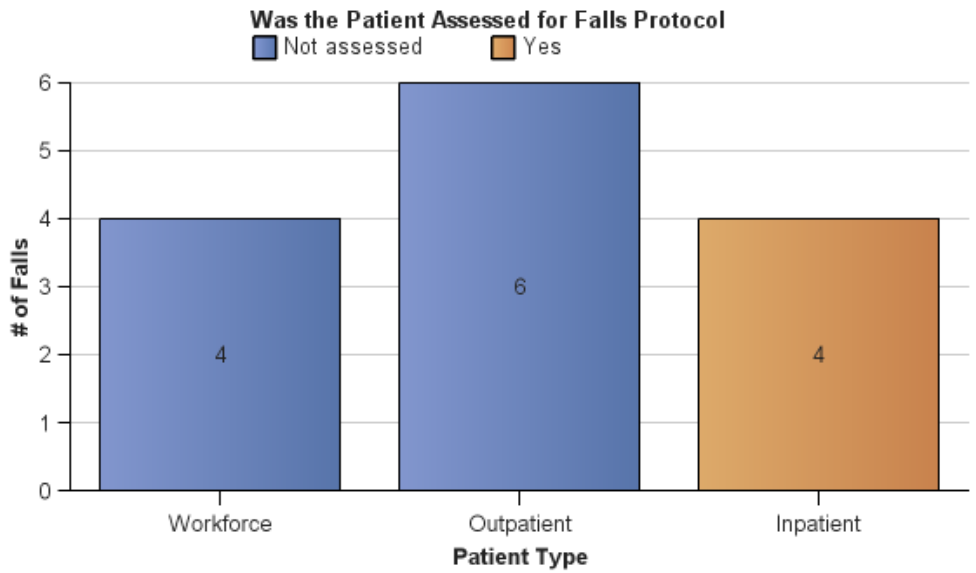
# of Falls	Was there any injury?			
	Not Identified	Unknown	No	Total
Not Identified	4			4
Inpatient		1	3	4
Outpatient	6			6
Total	**10**	**1**	**3**	**14**

# of Falls	Falls/Slip Problem(s)						Total
	Ambulating	Bathroom	Bed/Crib	Grounds/floor issues	Other	Other Person	
Not Identified	2		1	5	1	1	**10**
Confused	1						**1**
Oriented		2	1				3
Total	**3**	**2**	**2**	**5**	**1**	**1**	**14**

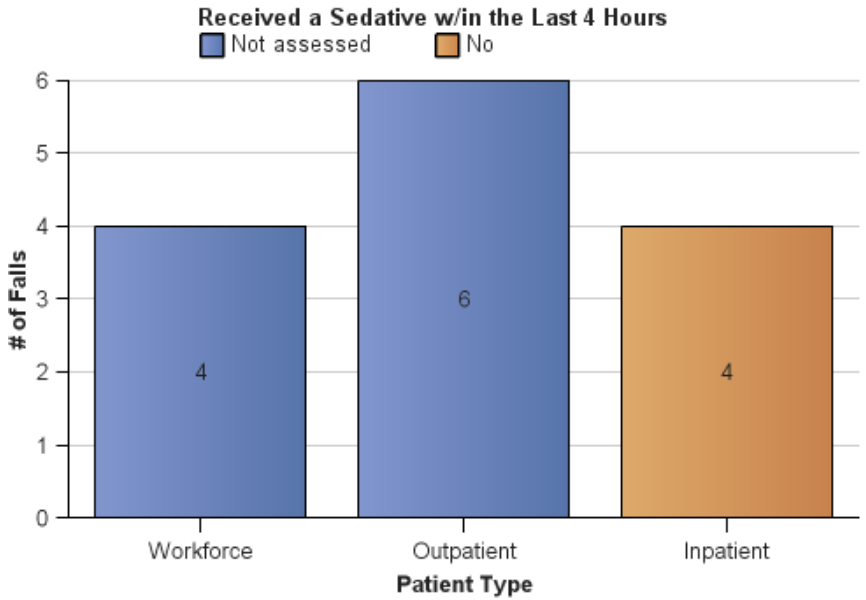
# of Falls	Falls/Slips	Total
Imaging	1	**1**
Medical Surgical Unit	4	**4**
OB	1	**1**
Other	2	**2**
Rehab Services - PT/OT/ST	6	**6**
Total	**14**	**14**



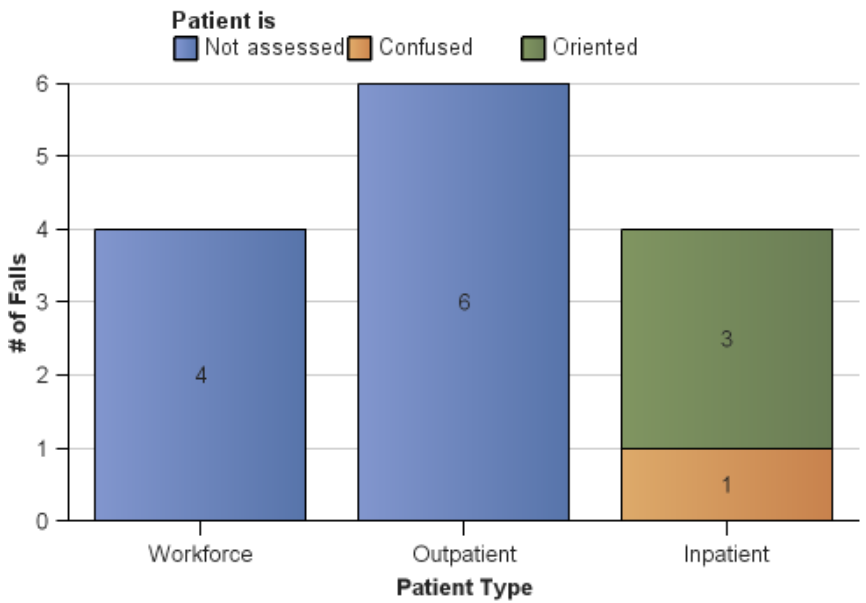
# of Falls	Was the Patient Assessed for Fall Risk				
	Not assessed	Yes	Unknown	No	Total
Workforce	11				11
Outpatient	5				5
Inpatient		5			5
Other	1				1
ED	1	2	2	1	6
Swing	1				1
Total	**19**	**7**	**2**	**1**	**29**



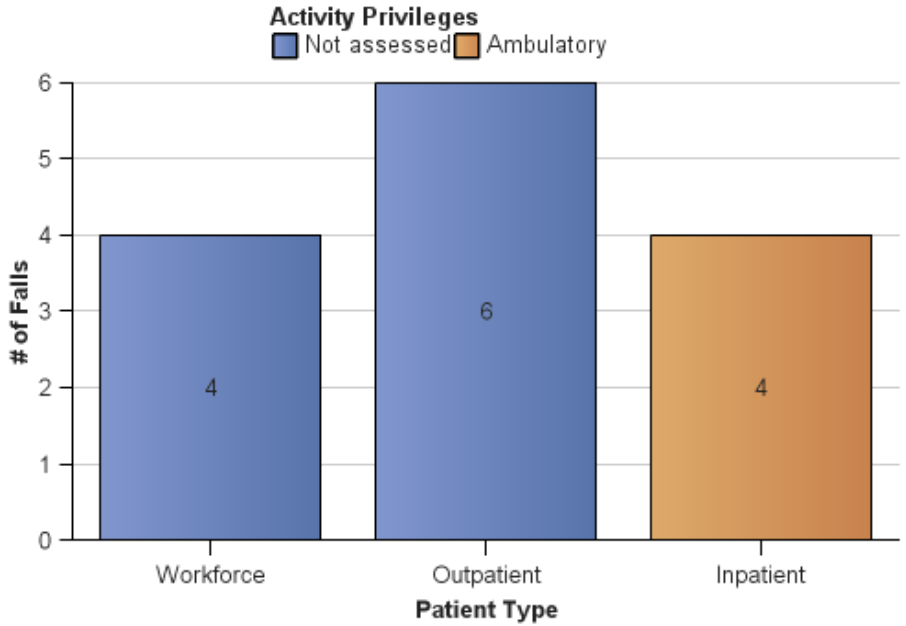
# of Falls	Was the Patient Assessed for Falls Protocol		
	Not assessed	Yes	Total
Workforce	4		4
Outpatient	6		6
Inpatient		4	4
Total	**10**	**4**	**14**



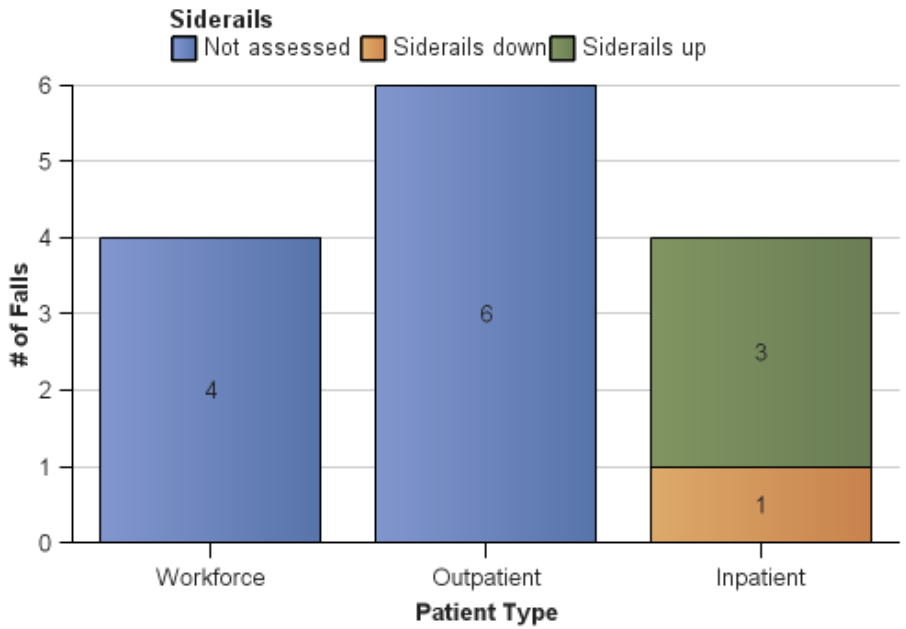
# of Falls	Received a Sedative w/in the Last 4 Hours		
	Not assessed	No	Total
Workforce	4		4
Outpatient	6		6
Inpatient		4	4
Total	10	4	14



# of Falls	The Patient Is			
	Not assessed	Confused	Oriented	Total
Workforce	4			4
Outpatient	6			6
Inpatient		1	3	4
Total	10	1	3	14

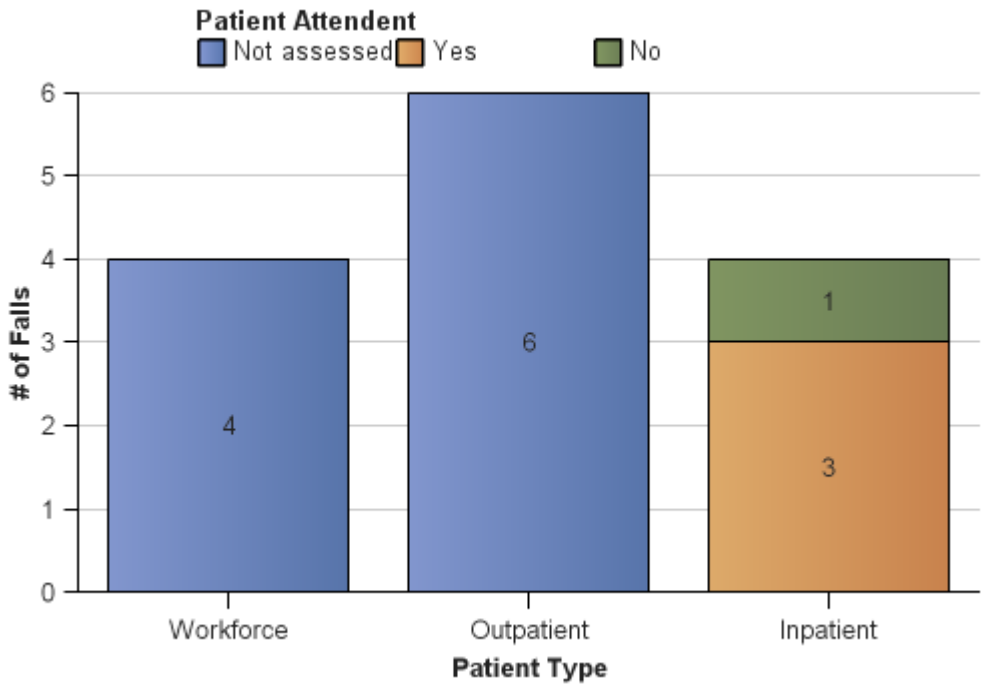


# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	4		4
Inpatient		4	4
Outpatient	6		6
Total	**10**	**4**	**14**

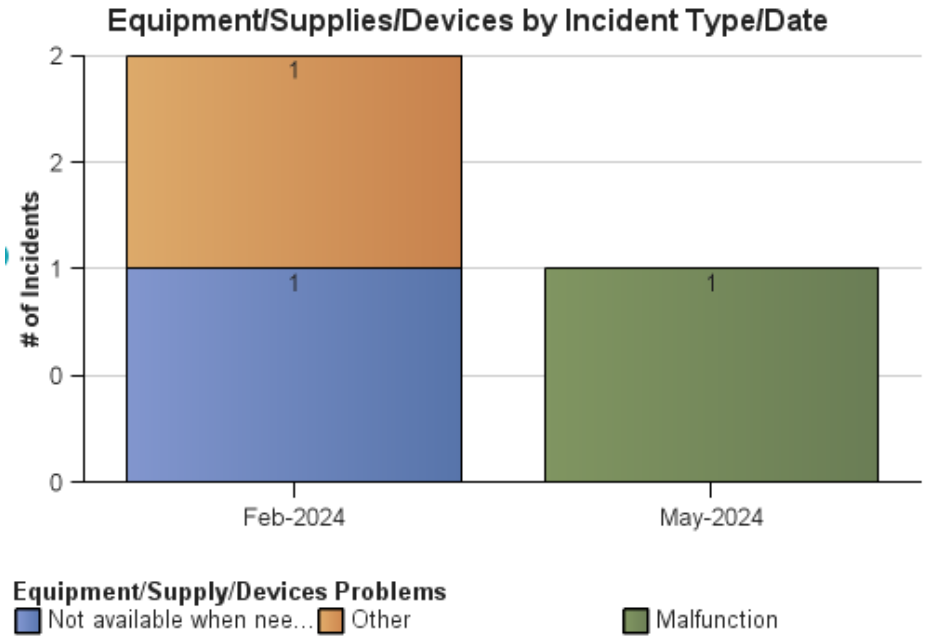


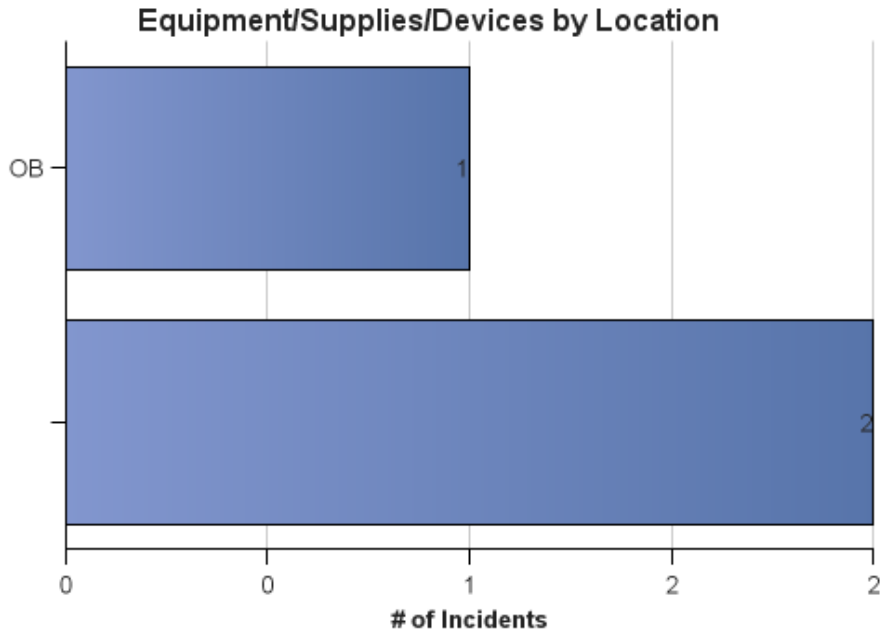
# of Falls	Siderails			
	Not assessed	Siderails down	Siderails up	Total
Workforce	4			4
Outpatient	6			6
Inpatient		1	3	4
Total	**10**	**1**	**3**	**14**

# of Falls	Fall Witnessed				Fall Alleged			Assisted to Floor			Found on Floor			
	Not Identified	No	Yes	Total	Not Identified	Yes	Total	Not Identified	No	Total	Not Identified	No	Yes	Total
Not Identified	4			4	4		4	4		4	4			4
Inpatient	1	2	1	4	2	2	4	2	2	4	2	1	1	4
Outpatient	6			6	6		6	6		6	6			6
Total	**11**	**2**	**1**	**14**	**12**	**2**	**14**	**12**	**2**	**14**	**12**	**1**	**1**	**14**

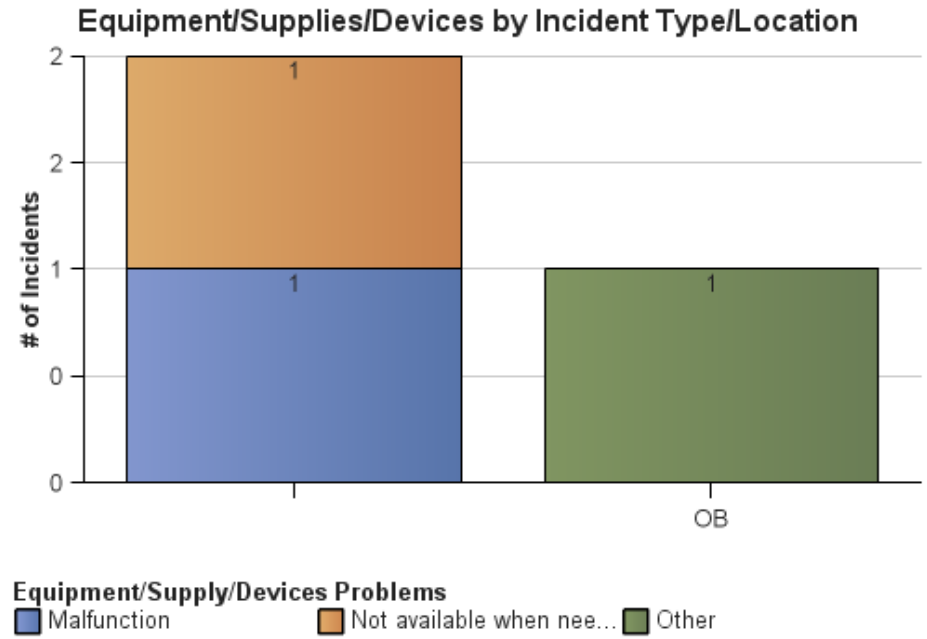


# of Falls	Patient Attendent			
	Not assessed	Yes	No	Total
Workforce	4			4
Outpatient	6			6
Inpatient		3	1	4
Total	**10**	**3**	**1**	**14**

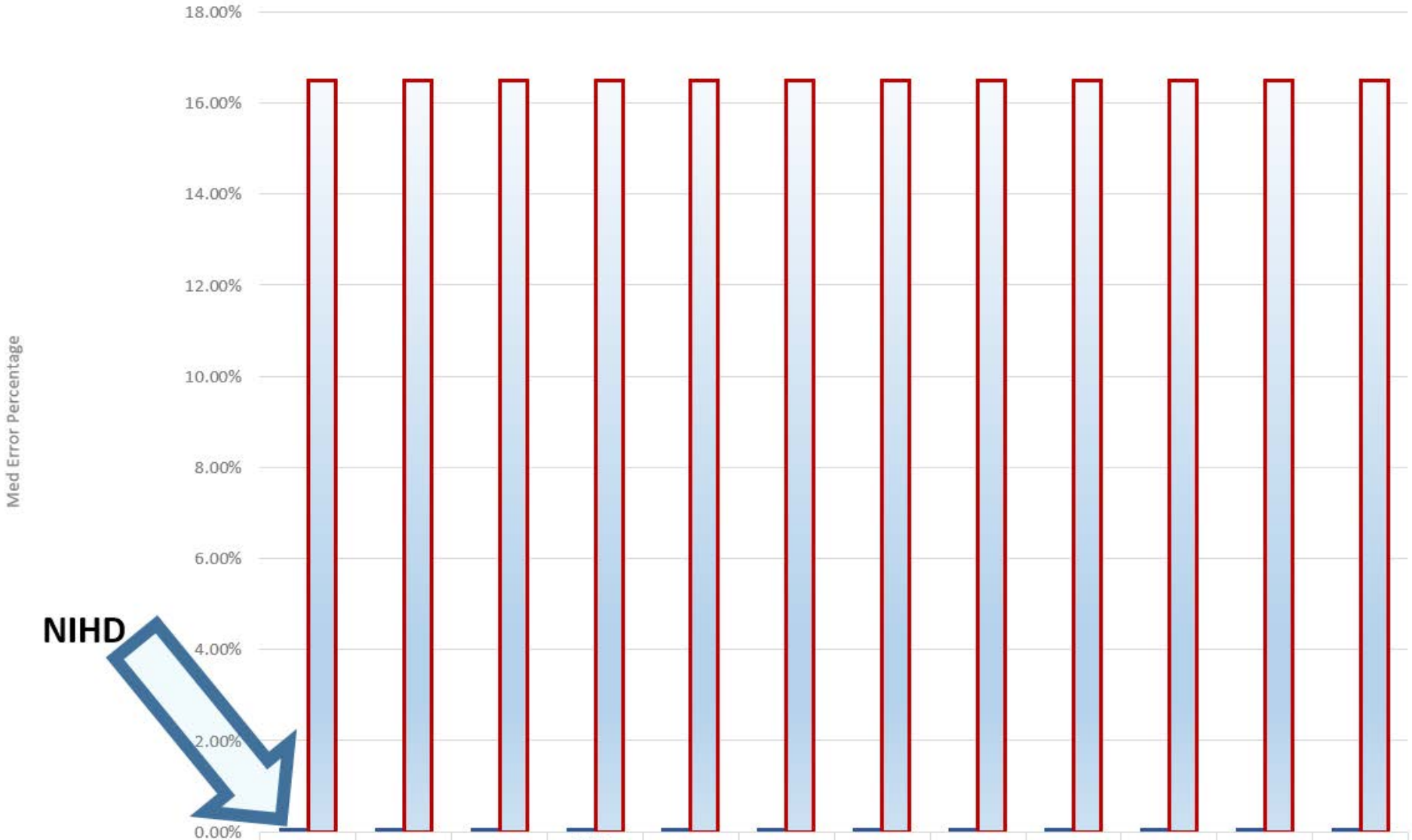




No Data Available



NIHD Medication Error Rate vs. National Medication Error Rate

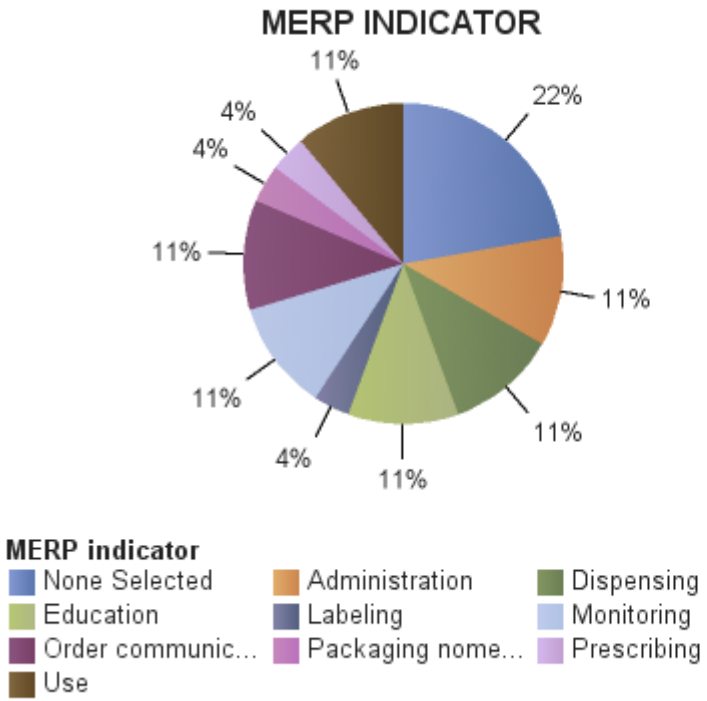


	2023 - June	2023 - July	2023 - August	2023 - September	2023 - October	2023 - November	2023 - December	2024 - January	2024 - February	2024 - March	2024 - April	2024 - May
NIHD % error rate	0.03%	0.02%	0.03%	0.02%	0.01%	0.02%	0.03%	0.05%	0.02%	0.04%	0.05%	0.04%
Mean National % Med Error	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%

Data for previous slide

Month/Year	Total number of Medications administered	NIHD Total number of errors	NIHD % error rate	National % Medication Error	Mean National % Med Error	NIHD % Medication Administration accuracy	References
2023 - June	11,375	2	0.02%	8%-25%	16.50%	99.98%	During medication administration, there is about an 8%-25% median medication error rate (Patient Safety Network, March 2021).
2023 - July	14,485	4	0.03%	8%-25%	16.50%	99.97%	
2023 - August	14,263	7	0.05%	8%-25%	16.50%	99.95%	
2023 - September	12,669	2	0.02%	8%-25%	16.50%	99.98%	
2023 - October	16,208	6	0.04%	8%-25%	16.50%	99.96%	In a review of 91 direct observation studies of medication errors in hospitals and long-term care facilities, investigators estimated median error rates of 8%–25% during medication administration.
2023 - November	13,327	6	0.05%	8%-25%	16.50%	99.95%	
2023 - December	14,162	6	0.04%	8%-25%	16.50%	99.96%	
2024 - January	16,772	7	0.04%	8%-25%	16.50%	99.96%	
2024 - February	12,671	4	0.03%	8%-25%	16.50%	99.97%	reference for above: https://psnet.ahrq.gov/primer/medication-administration-errors#:~:text=In%20a%20review%20of%2091,%E2%80%9325%25%20during%20medication%20administration.
2024 - March	13,815	2	0.01%	8%-25%	16.50%	99.99%	
2024 - April	14,886	2	0.01%	8%-25%	16.50%	99.99%	Occurrences not included, as they are not errors that are administered to a patient.
2024 - May	15,273	2	0.01%	8%-25%	16.50%	99.99%	

Medication Error Reduction Plan (MERP)

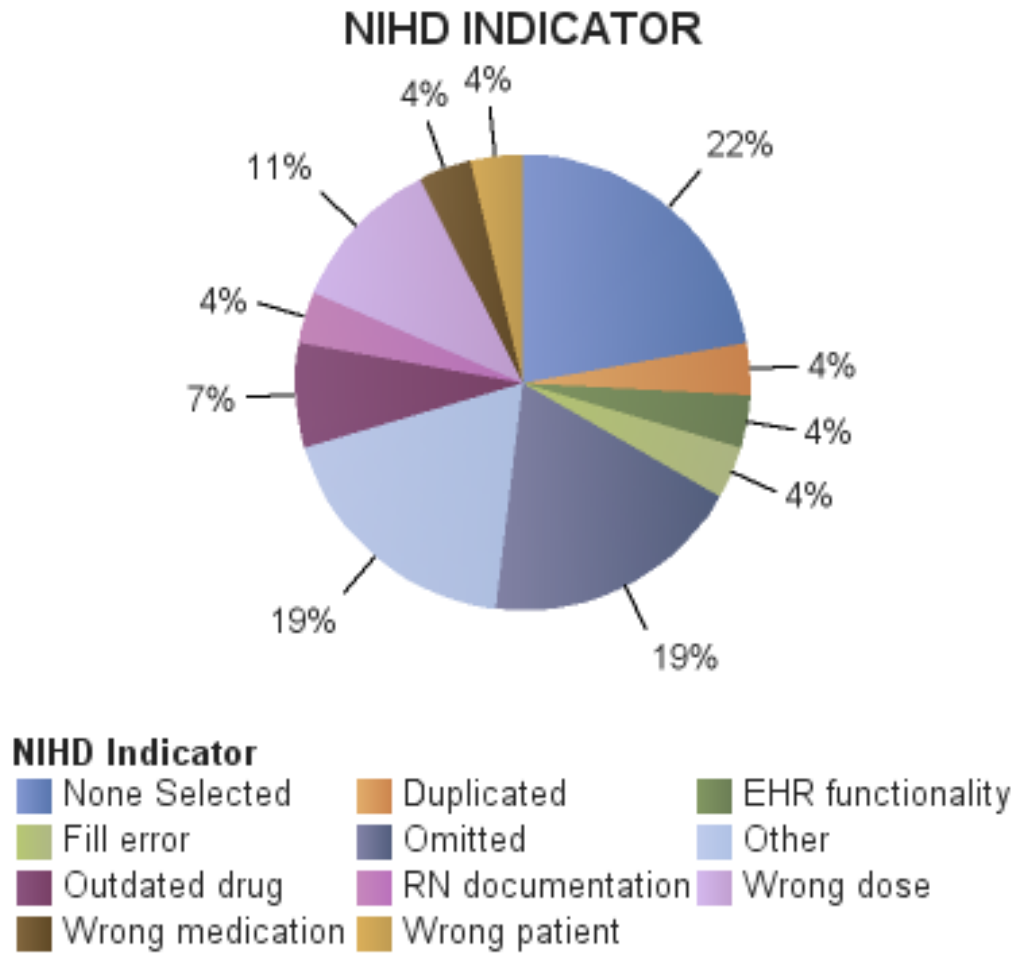


None Selected	6
Administration	3
Dispensing	3
Education	3
Labeling	1
Monitoring	3
Order communication	3
Packaging nomenclature	1
Prescribing	1
Use	3
Total	**27**

	# of Errors	# of Occurrences	Total
Jan-2024	7	3	**10**
Feb-2024	4		**4**
Mar-2024	2	1	**3**
Apr-2024	2	1	**3**
May-2024	2	3	**5**
Total	**17**	**8**	**25**

All medication errors and occurrences are reviewed by the Medication Administration Improvement Committee. The MERP and NIHD Indicators (following page) allow NIHD to categorize errors in order to focus on high frequency error reasons to create a plan for reduction.

Medication errors are errors that reach the patient. Medication occurrences are “near miss” and did not reach the patient.



None Selected	6
Duplicated	1
EHR functionality	1
Fill error	1
Omitted	5
Other	5
Outdated drug	2
RN documentation	1
Wrong dose	3
Wrong medication	1
Wrong patient	1
Total	**27**

Total numbers of errors and occurrences are not equal to the indicators since some error/occurrences have more than one indicator.

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: June 7, 2024

Title: **Information regarding Board Oversight of the Compliance Program**

Synopsis: The information on the following pages will provide valuable insight to prepare the Board for the updated guidance information that will be presented to the Board at the meeting. The information presented at the Board meeting will be based on the Department of Health and Human Services Office of Inspector General's November 2023 General Compliance Program Guidance.

Prepared by: Patty Dickson
Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

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Compliance
and
the role of the
Board of Directors

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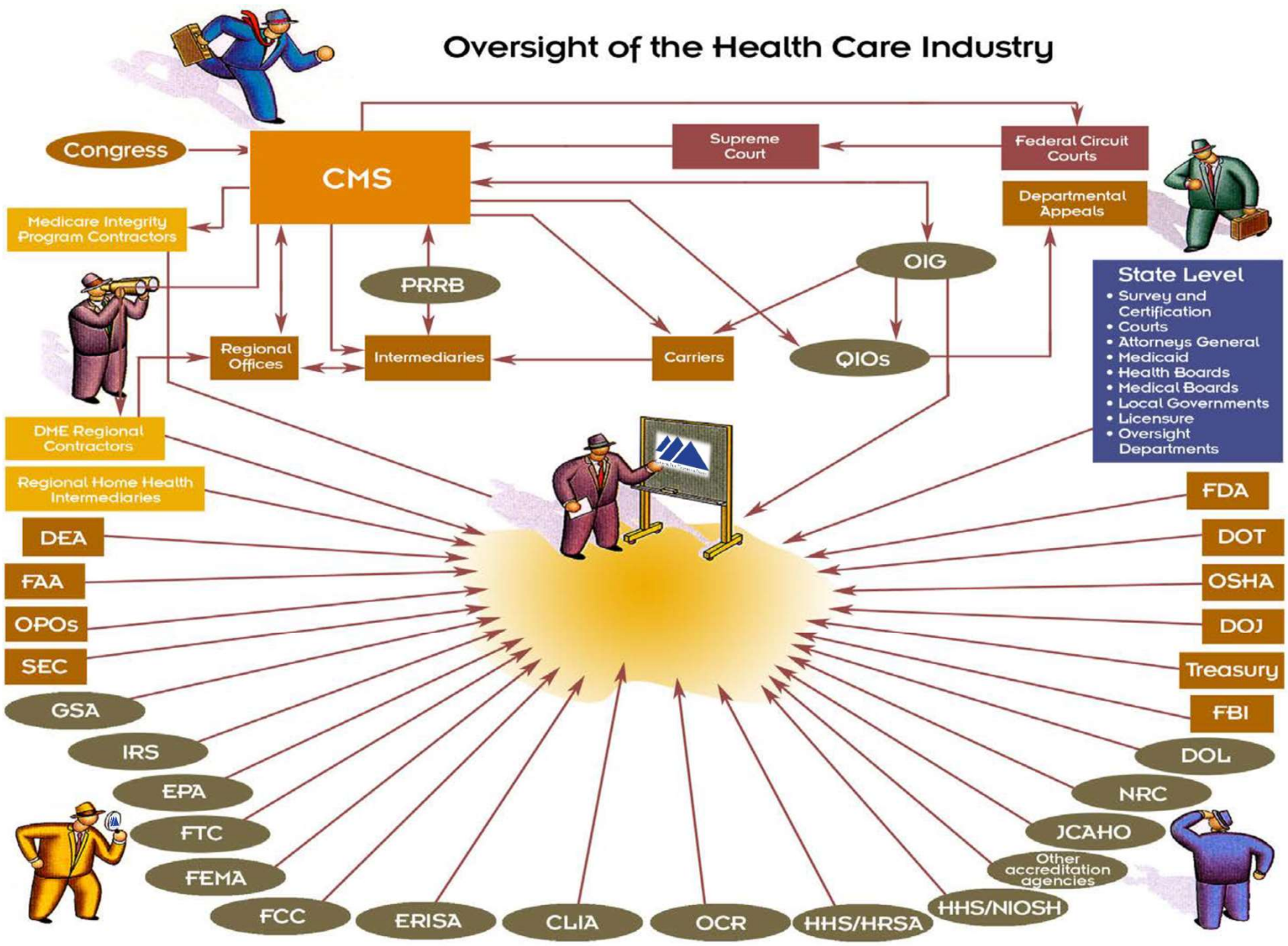
Why develop a Compliance Program?

- Promotes a culture of ethics and spells out compliance obligations
- Aids in preventing and detecting wrong - doing
- Recommended by the HHS OIG
- An effective Compliance Program demonstrates
  - Willingness to comply with regulations
  - Efforts to comply with regulators
  - Commitment to comply
  - Awareness of expectations
- Builds and protects reputation

- Why develop a compliance program?
- We want to do the right thing, and a compliance program outlines our commitment to doing the right thing.
- Compliance programs guide a hospital's governing body, Chief Executive Officer, managers, employees, physicians and other healthcare professionals. Compliance programs help provide the structure that allows us all to focus on our Mission: Improving our communities, one life at a time.
- Our focus is to prevent wrong-doing before it occurs. If wrong-doing is detected, we correct it and report it as appropriate.
- By putting our commitment in writing and organizing a plan, we demonstrate a willingness to comply, efforts to comply, and awareness of expectations.
- HHS OIG Federal Sentencing Guidelines Chapter 8 provides guidance for Compliance Programs. Why is it in the Federal Sentencing Guidelines?
- Sentencing credit may be given for an effective compliance program – in other words – If you are already trying to do the right thing, following the guidance, committed to an effective compliance program – it may reduce penalties in the event that wrong-doing is detected and reported. Penalties may be reduced by 2-3 times.


Oversight of the Health Care Industry
Congress
CMS
Supreme Court
Federal Circuit Courts
Departmental Appeals
Medicare Integrity Program Contractors
OIG
PRRB
State Level
• Survey and Certification
• Courts
• Attorneys General
• Medicaid
• Health Boards
• Medical Boards
• Local Governments
• Licensure
• Oversight Departments
Regional Offices
Intermediaries
Carriers
QIOs
DME Regional Contractors
Regional Home Health Intermediaries
DEA
FAA
OPOs
SEC
GSA
IRS
EPA
FTC
FEMA
FCC
ERISA
CLIA
OCR
HHS/HRSA
HHS/NIOSH
Other accreditation agencies
JCAHO
NRC
DOL
FBI
Treasury
DOJ
OSHA
DOT
FDA

- These are some of the regulatory agencies that oversee healthcare operations. This is not a comprehensive list, but you get the idea.
- If you don’t have a compliance program, and wrong-doing is detected, the OIG is very helpful. They will give you options –
- You can be excluded from participating in CMS (Medicare/Medi-caid) and other government programs
- or you can accept their version of a compliance program – a Corporate Integrity Agreement (CIA).
- They also monitor compliance with the CIA . I don’t recommend this path.

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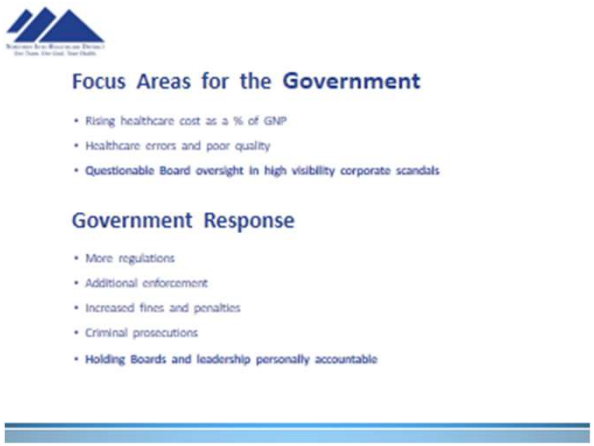
Focus Areas for the Government

- Rising healthcare cost as a % of GNP
- Healthcare errors and poor quality
- **Questionable Board oversight in high visibility corporate scandals**

Government Response

- More regulations
- Additional enforcement
- Increased fines and penalties
- Criminal prosecutions
- **Holding Boards and leadership personally accountable**



- So why has healthcare become a focus area for the government?
- Healthcare costs are a significant percentage of the gross national product.
- On a national level, quality measures and outcome data show lots of room for process and quality improvement.
- Scandals like Lincoln Savings & Loan, Enron, and “Bernie Madoff” made the government take notice of the governing bodies –
- Their response:
- More regulations and actions by Federal agencies,
- Multi- million dollar fines, and penalties. The Department of Justice recovered more than $3.4 Billion dollars in (Federal) fiscal year 2022 – by intensifying focus on waste, fraud, and abuse. And…
- Criminal prosecution for those leaders who knowingly condoned wrong-doing or those that “hid their head in the sand”
- So, what does all of this mean for those of us in healthcare? More regulations, additional enforcement, increased fines and penalties, criminal prosecutions, and Boards and leadership have been held personally accountable. This doesn’t mean there is a need to worry. It means there is a need to provide appropriate oversight.

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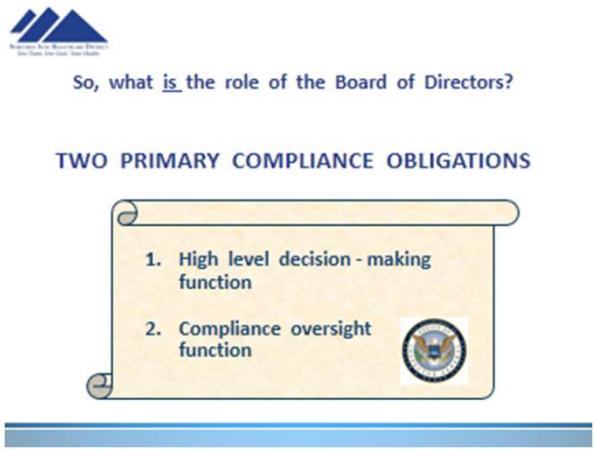
So, what is the role of the Board of Directors?

TWO PRIMARY COMPLIANCE OBLIGATIONS

1. High level decision - making function
2. Compliance oversight function



- The Board has two primary compliance obligations:
- High level Decision-making – applying duty of care principles to a specific decision or Board action

- Compliance Oversight – Applying duty of care principles with respect to the compliance oversight of general activity in day-to-day business activities of the organization

- What is “duty of care?”

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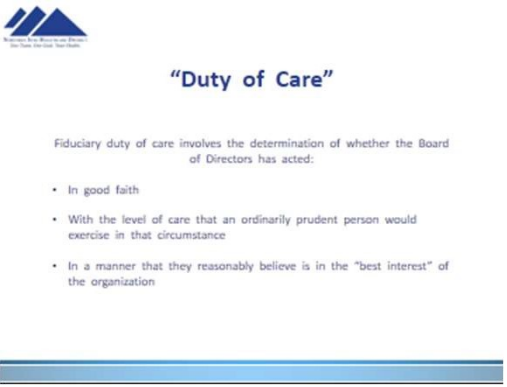
"Duty of Care"

Fiduciary duty of care involves the determination of whether the Board of Directors has acted:

- In good faith
- With the level of care that an ordinarily prudent person would exercise in that circumstance
- In a manner that they reasonably believe is in the "best interest" of the organization



- "Duty of care" is a legal obligation, a requirement that a person act toward others and the public with watchfulness, attention, caution and prudence that a reasonable person in the circumstances would

- Directors should make inquiries to management and compliance to obtain information necessary to satisfy their duty of care. This is well illustrated in the Caremark decision.

- Caremark is the prescription benefit management subsidiary of CVS. Caremark's employees were indicted for violating healthcare fraud statues, ultimately resulting in $250 million in fines. Shareholders sued the Board of Directors for breach of fiduciary duty. Eventually, the parties came to a settlement agreement.

- The Court found that the Caremark Board did not breach its fiduciary duty but the judges rendered important precedent in case law, expanding the vision of the duty of oversight in three ways:

    - Specifically, Directors' obligations include a duty to attempt in good faith to assure that a corporate information and reporting system exists, the Board concludes is adequate, and "*failure to do so under some circumstances, may, in theory at least, render a director liable for losses caused by non-compliance with applicable legal standards.*"
    - Board cannot assume their organization is complying with the law. A Board of Directors must ask for and receive appropriate information about the organization's compliance program.

    - The Board has an obligation to implement a monitoring system that is sufficient to identify legal breaches in a "sustained and systematic fashion"
        - The monitoring system may fail – but the design of the system cannot be a failure.
            - Audit program – for example – different departments audited on a schedule. Inspection happens prior to regularly scheduled audit – if a violation is noted during the inspection, the system failed – but the design did not. The irregularity *would* have been detected.

- HHS OIG offers guidance for Health Care Boards of Directors. I have listed the website at the end of this presentation.

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The Yates Memo

"One of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing."

Deputy Attorney General Yates listed several reasons:

- deters future illegal activity
- Incentivizes changes in corporate behavior
- Ensures proper parties are held responsible
- Promotes the public's confidence in our justice system.

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Compliance Programs
Seven Essential Elements

- The OIG guidance for compliance programs lists 7 distinct elements
- Standards and procedures are vital because they outline the expectations for individuals.
- Oversight is provided by the governing authority to ensure accountability.
- Education and training is provided so that everyone fully understands the expectations.
- Monitoring and auditing are put in place to ensure that the standards are followed. This allows us to report on the successes. It also allows us to detect areas which need improvement.
- Enforcement and discipline assists in prevention and deterrence by providing incentives and consistency. There are two primary areas for remediation – education due to lack of knowledge, and policies and procedures that are unclear or not written.
- Response and prevention details how we triage risks, how we handle them, and how we track them to resolution.
- The Reporting component of the Compliance Program details the ways we encourage reporting of areas of concern, potential wrong-doing, and / or seeking help and guidance. It makes very clear that we will NOT retaliate for any reports made in good faith.

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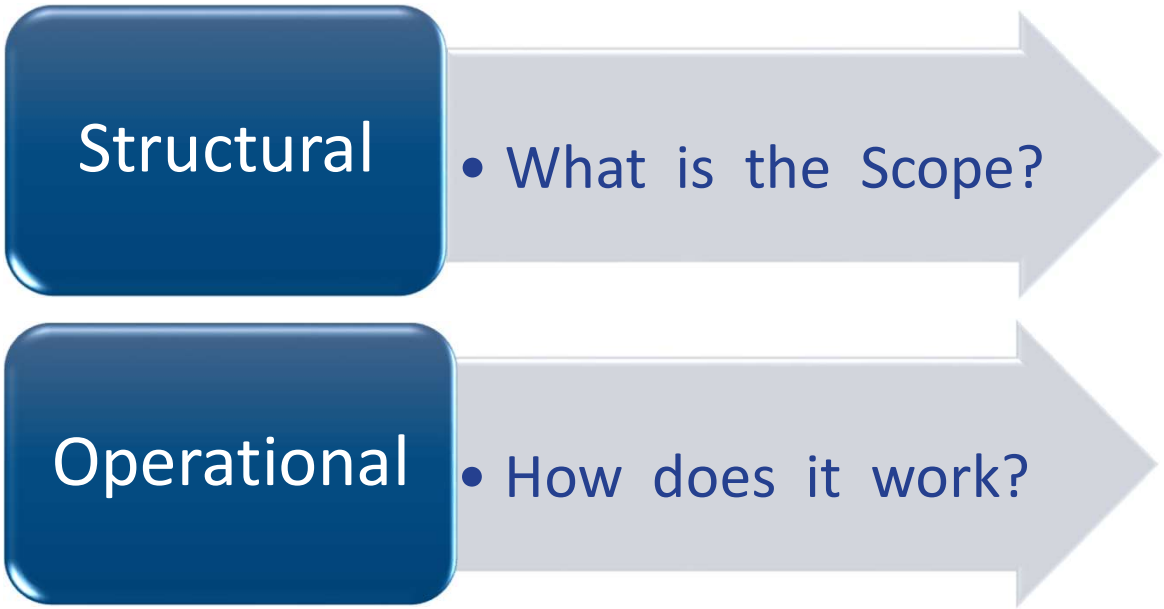
Compliance Program
Focus Areas for the Board of Directors



- What does all of this mean for the Board?
- The Office of Inspector General has provided clear guidance for a Compliance Program. They have outlined their expectations.
- In November 2023, the OIG released its first new compliance guidance in over a decade. It mentions the Board over 120 times.
- The Board should provide oversight:
- Structure – you should understand the organization's internal reporting system.
  - Determine if the structure of the CP is appropriate to the size and complexity of operations. Determine whether appropriate resources are committed to adequately address the compliance risks.
- Operations:
  - OIG makes it clear that it is NOT the Board's responsibility to know every detail of compliance activities or individually ferret out allegations, however, they should periodically ask questions and inquire about the status of the compliance program and activities.
- For example:
  - Is the Board receiving periodic reports from the CO? Are there periodic risk assessments and mitigation plans in place? Is there a formal audit and monitoring plan? Are there appropriate policies, procedures or other formal internal controls to address potential risks? Is there open communication or is there fear of retaliation?

Abbreviations:

CP – Compliance Program

CO – Compliance Officer

OIG – Office of Inspector General

Structural Questions (examples)

- How is the compliance program structured and who are the key employees responsible for its implementation and operation?
- How is the Board structured to oversee compliance issues?
- How frequently does the Board receive reports about compliance issues?
- Does the compliance program address the significant risks of the organization?
- How were those risks determined and how are new compliance risks identified and incorporated into the program?

Operational Questions (examples)

- How do we know that the Code of Conduct is understood and accepted across the organization?
- Has the organization implemented policies and procedures that address compliance risk areas, and established internal controls to counter those vulnerabilities?
- Has management provided the Compliance Officer with the autonomy and sufficient resources necessary to perform assessments and respond appropriately to misconduct?
- Are employees held accountable for meeting compliance - related objectives during performance reviews?
- What is the process by which the organization evaluates and responds to suspected compliance violations?

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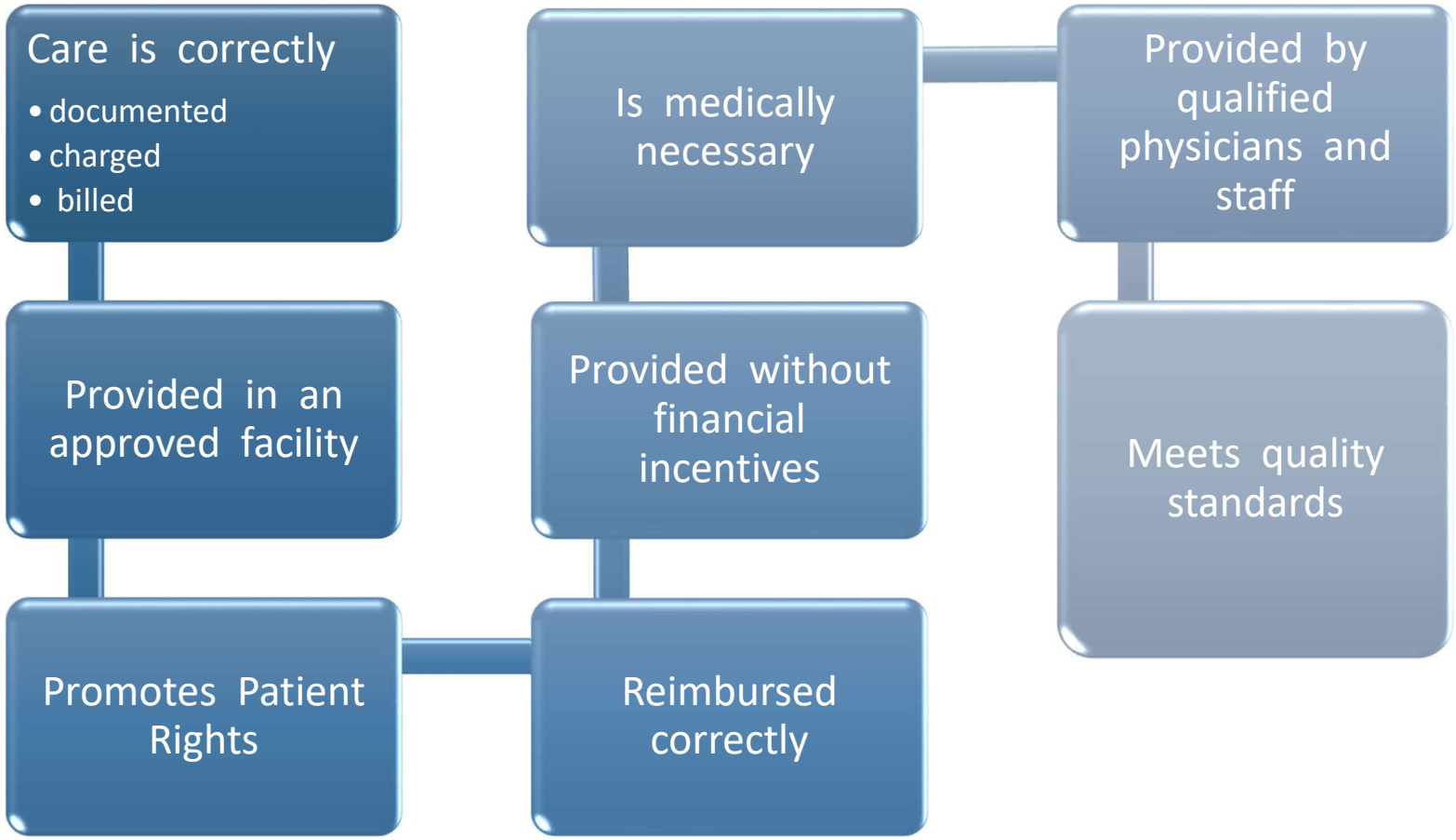
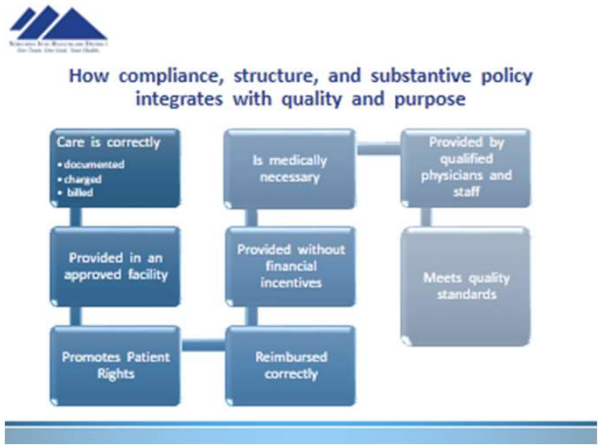
How compliance, structure, and substantive policy integrates with quality and purpose





- This slide shows how compliance, structure, and policy integrate to provide quality to our purpose. Our Mission is “Improving our communities, one life at a time. One team, One goal, Your health."

- Compliance oversight helps ensure care is correctly documented, charged and billed; provided in an approved facility in a manner that promotes patient rights, is reimbursed correctly; provided without financial incentives; is medically necessary and provided by qualified physicians and staff in a way the meets quality standards.

NORTHERN INYO HEALTHCARE DISTRICT

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Compliance is *everyone's* responsibility!

Confidential Report Line

1 – 888 – 200 - 9764

or contact

Patty Dickson, Compliance Officer

760 – 873 - 2022

Patty.Dickson@NIH.org

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Questions ?

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Resources and Information

- https://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf
- “Practical Guidance for Health Care Boards in Compliance Oversight” (OIG, AHLA, AHIA, HCCA)
- “Corporate Responsibility and Corporate Compliance” A Resource for Health Care Boards of Directors (DHHS OIG and American Health Lawyers Assn.)
- U.S. Sentencing Commission, Federal Sentencing Guidelines, Chapter 8 “Effective Compliance Program”

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More Resources and Information

The link below will take you to the page:
Https://oig.hhs.gov/compliance/101/index.asp
About halfway down the page, you will find the area for Board resources.

https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp#hcb-guidance

This 4 minute and 20 second video has some important information from the OIG with regard to Board oversight.

An article discussing OIG guidance to the Board:
https://www.healthcentercompliance.com/subscriber/compliance-connection/1625

Excellent article on Board engagement and training on compliance standards:
http://compliancestrategists.com/csblog/wp-content/uploads/2014/01/August-2010-%E2%80%93-SCCE-CE-Manual-%E2%80%93-PDF-Download.pdf