May 2, 2023

NOTICE

The Kaweah Delta Health Care District Board of Directors will meet in an Audit and Compliance Committee meeting at 1:00 PM on Tuesday, May 9, 2023 in the Kaweah Health Support Services Building - Copper Conference Room {520 W. Mineral King Ave., Visalia}.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Audit and Compliance Committee meeting immediately following the 1:00 PM meeting on Tuesday, May 9, 2023 in the Kaweah Health Support Services Building – Copper Conference Room {520 W. Mineral King Ave., Visalia} pursuant to Government Code 54956.9(d)(2).

All Kaweah Delta Health Care District regular board and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk
Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff
http://www.kaweahhealth.org/about/agenda.asp

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
AUDIT AND COMPLIANCE COMMITTEE

Tuesday, May 9, 2023

Kaweah Health Support Services Building, Copper Conference Room
520 West Mineral King Ave, Visalia, CA 93291

ATTENDING: Directors; Mike Olmos (Chair) & Garth Gipson; Gary Herbst, Chief Executive Officer; Malinda Tupper, Chief Financial Officer; Rachele Berglund, Legal Counsel; Ben Cripps, Chief Compliance & Risk Officer; Amy Valero, Compliance Manager; Michelle Adams, Executive Assistant

OPEN MEETING – 1:00PM

Call to order – *Mike Olmos, Audit and Compliance Committee Chair*

Public / Medical Staff participation – Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

1. **Verbal Reports** –
   1.1 Oversight for Governing Boards: Compliance Program Expectations – Provide guidance for Governing Boards oversight of a Compliance Program – *Ben Cripps*

2. **Written Reports** – Committee review and discussion of written reports
   2.1 Compliance Program Activity Report – *Amy Valero*
   2.2 Audit and Compliance Program Mission and Purpose – *Ben Cripps*
   2.3 Annual Compliance Plan 2022 and 2023 – *Amy Valero*
   2.4 The Joint Commission Action Plans – *Ben Cripps*

3. **Approval of Closed Meeting Agenda** – Kaweah Health Support Services Building, Copper Conference Room – immediately following the open meeting
   - Conference with Legal Counsel – Anticipated Litigation
     Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (7 cases) – *Ben Cripps and Rachele Berglund (Legal Counsel)*

Adjourn Open Meeting – *Mike Olmos, Audit and Compliance Committee Chair*

CLOSED MEETING – Immediately following the 1:00PM open meeting

Call to order – *Mike Olmos, Audit and Compliance Committee Chair*

1. **Conference with Legal Counsel - Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (7 cases) – *Ben Cripps and Rachele Berglund (Legal Counsel)*

Adjourn – *Mike Olmos, Audit and Compliance Committee Chair*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

Oversight for Governing Boards: Compliance Program Expectations

May 2023

Ben Cripps, Chief Compliance & Risk Officer

7 Elements of an Effective Compliance Program

1. Policies & Procedures; Code of Conduct
2. Oversight - Chief Compliance [and Risk] Officer; Audit and Compliance Committee, Board of Directors
3. Effective Training & Education
4. Ongoing Auditing & Monitoring; Periodic Evaluation of Program Effectiveness
5. Anonymous Reporting Mechanism; No Retaliation
6. Program promoted and enforced consistently – Appropriate incentives – Appropriate disciplinary measures
7. Respond promptly to detected offenses with corrective action

Fundamental Duties of Directors

A Director has three basic duties:

- Duty of Loyalty
- Duty of Care
- Duty of Obedience

This means a Director must perform his/her duties:

- In good faith
- In a manner he/she reasonably believes to be in the best interests of the corporation, and
- With the care an ordinarily prudent person would exercise under similar circumstances

A Director can reasonably rely on information presented by officers, employees, legal counsel, accountants and other experts, unless he/she knows such reliance is unwarranted

Resources Available For Compliance Program Benchmarking

There are many resources available for Boards to utilize in the benchmarking of their organization. A few of the most widely recognized compliances resources, include:

- **The Federal Sentencing Guidelines (Guidelines):** The Guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program. "

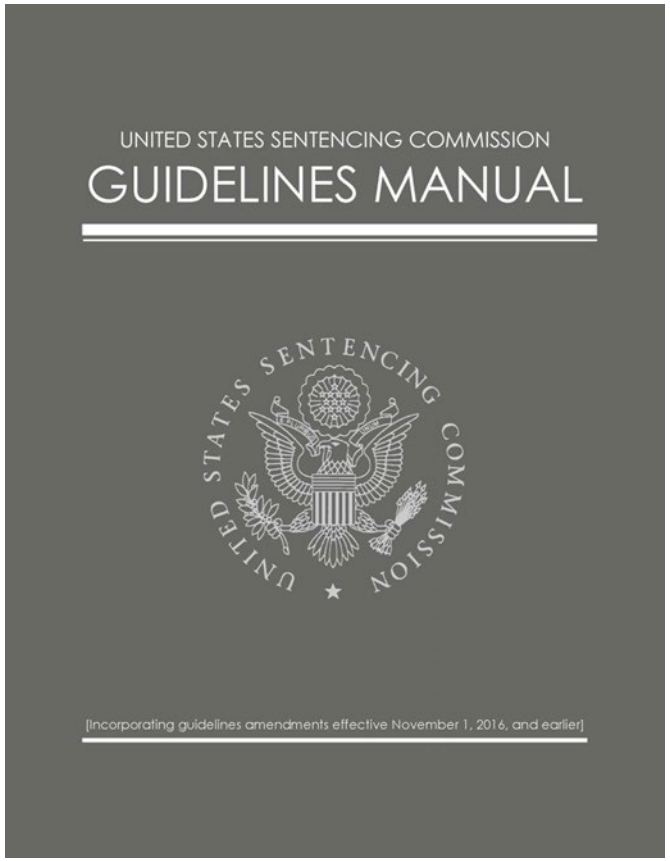
- **OIG's voluntary compliance program guidance documents :** Developed by the Office of Inspector General (OIG) to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements.

- **OIG Corporate Integrity Agreements (CIAs):** CIAs impose specific structural and reporting requirements to promote compliance with Federal health care program standards at entities that have resolved fraud allegations. Review of CIAs may be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program.

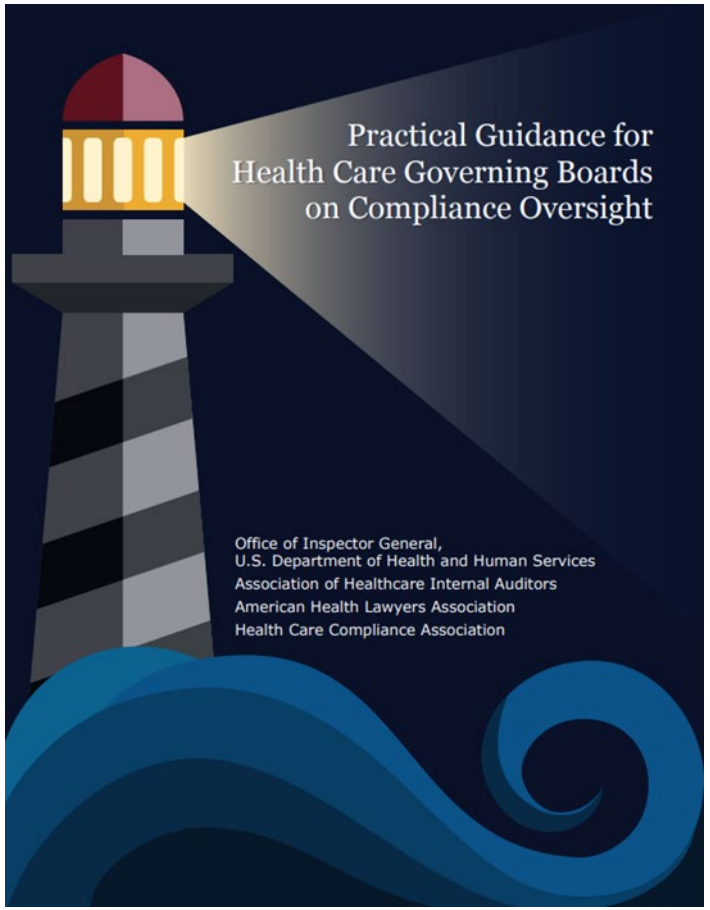
Federal Sentencing Guidelines

"The organization's governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program."

- Federal Sentencing Guidelines," Sentencing of Organizations" at Sec. 8B2.1(b)(2)(A)



2015 Practical Guidance for Healthcare Governing Boards



Addresses issues relating to the Board's oversight and review of compliance – Expectations – Roles and responsibilities – Issue reporting – Regulatory risk – Accountability

"A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management."

Department of Justice Guidance

3 Fundamental Questions

1. Is the Program Well-Designed?
2. Is the Program Being Implemented Effectively?
3. Does the Program Work in Practice?

"[A critical factor] in evaluating any program are whether the program is adequately designed for maximum effectiveness in preventing and detecting wrongdoing by employees and whether corporate management is enforcing the program or is tacitly encouraging or pressuring employees to engage in misconduct."

Compliance Program Benchmarking

Kaweah Health Process:
The Kaweah Health Compliance Program was established in accordance with OIG Compliance Program Guidance. The seven elements of an effective Compliance program as outlined by the OIG is the foundation by which the Kaweah Health Compliance Program operates. Rachele Berglund, Kaweah Health attorney, provides substantive expertise with respect to regulatory matters and is a valued member of the Audit and Compliance Committee, as well as Ben Cripps, Chief Compliance and Risk Officer. Rachele is often consulted for regulatory guidance and to assist the Board in fulfilling its oversight responsibilities. Ben Cripps oversees the compliance program for the organization.

Opportunities:
A more consistent review of current Corporate Integrity Agreements in place and conducting risk analysis based on review findings to ensure compliant processes are in place within our organization.

To collaborate with the Board to review OIG guidance and develop analysis to ensure the scope and adequacy of our compliance program, in regard to size and complexity of our organization.

Risk Assessment Process

Risk Management Process

- ❑ Methodology used to identify, analyze, and address particular risks?
- ❑ Information or metrics collected and used to help detect the type of misconduct in question

Risk-Tailored Resource Allocation

- ❑ Does the company devote a disproportionate amount of time to policing low-risk areas instead of high- risk areas?
- ❑ Does the company give greater scrutiny, as warranted, to high-risk transactions (for instance, a large- dollar contract with a government agency in a high-risk country) than more modest and routine hospitality and entertainment?

Updates and Revisions

- ❑ Is the risk assessment current and subject to periodic review?
- ❑ Have there been any updates to policies and procedures in light of lessons learned?
- ❑ Do these updates account for risks discovered through misconduct or other problems with the compliance program?

Identifying and Auditing Potential Risk Areas

Expectation:
Compliance requires monitoring of organizational activities that are vulnerable to fraud, waste and abuse, as well as other violations. Examples of high-risk activities, include:

- ❑ Referral relationships and arrangements
- ❑ Revenue Cycle
- ❑ Specific areas of concern: upcoding, false claims, medical necessity
- ❑ Privacy Rule / HIPAA Compliance
- ❑ Quality-related matters

Both internal and external resources are deployed in the risk identification process.

- ❑ Internal Sources: Employee reports, compliance hotline, internal audits, claim denials
- ❑ External Sources: Medicare claim reviews (RAC's, TPE's, CERT's), OIG-issued guidance, professional organization publications

Kaweah Health Process:
Kaweah Health relies on a number of resources to develop an annual audit plan, prioritized by risk. Resources such as claim denials, employee reports, Medicare claim reviews, internal service-line audits, and OIG Guidance is used to generate a list of high-priority audit topics. An annual audit risk assessment is conducted to determine the order and necessity of each audit. The audit plan is dynamic and reassessed as new risks are identified. Each topic is assessed with a risk score and completed in order of highest risk. Audits are conducted internally within the compliance department as well as outsourced to third-party auditors. Results are shared with service-line leaders and are treated as attorney-client privilege (when appropriate). Results of audits with accompanying corrective action plans are shared quarterly with the Board during the Audit and Compliance Committee meeting.

Opportunities:
Opportunity exists to include the Board in the audit risk assessment process to allow for the review of criteria and input regarding prioritization and generation of audit topic. Opportunity exists to provide more thorough education to Board regarding high-risk areas that require audits and desired outcomes for each.

Roles and Relationships

Expectation:
The Committee/Board Charter should include a process to ensure that the Board has access to relevant corporate information. To operate effectively, the compliance, legal, and internal audit functions should also have access to appropriate and relevant corporate information and resources. The formal charter document should be approved by the Audit Committee of the Board.

Boards should evaluate and assess how management works together to address risk, including the following considerations:

- ❑ Identifying compliance risks
- ❑ Investigating compliance risks and avoiding duplication of effort
- ❑ Identifying and implementing appropriate corrective actions and decision-making
- ❑ Communicating between the various functions throughout the process.

Kaweah Health Process:
The Kaweah Health Audit and Compliance Committee Mission and Purpose serves as the Committee/Board Charter. The document outlines the oversight responsibility for compliance risks, corrective actions, decision making and obligations to fulfill the Compliance Program requirements. The Charter also provides the Chief Compliance and Risk Office the unencumbered access to the company's information to conduct investigations. The Audit and Compliance Committee Mission and Purpose is presented and approved by the Board annually.

Opportunities:
Opportunity exists to better outline the specific role of the Compliance, Legal and Internal Audit functions separately as well as where each of the functions overlap to ensure the Board's awareness and comfort of each responsibility when addressing compliance matters.

Reporting to the Board

Expectation:
The Board should expect to receive regular updates regarding the management and execution of the compliance program, mitigation of risks, and implementation of corrective action plans. Separately, additional updates should include involvement from key leaders responsible for audit, compliance, human resources, legal, quality, and information technology. Updates should also include:

- ❑ Reporting of internal and external investigations
- ❑ Results of internal and external audits
- ❑ Hotline/Anonymous call activity
- ❑ Allegations of material fraud or senior management misconduct
- ❑ Management exceptions to the organization's code of conduct
- ❑ Suspected violations along with updates regarding the execution of remedial efforts.

Executive Sessions: Executive sessions, which exclude senior management, shall be scheduled regularly to encourage direct communication amongst compliance, legal, and internal audit leaders. Implementing a regular cadence of executive sessions will reduce suspicion when a special meeting is called to order.

Kaweah Health Process:
The Compliance Department tracks various measurable elements within compliance program dashboard. The Board is made aware of pertinent compliance activities during the quarterly Audit and Compliance Committee meeting. Investigations surrounding non-compliance are reported and addressed with the board, as well as corrective action plans and risk mitigation strategies. Executive sessions are held with the Board between compliance and legal representatives periodically.

Opportunities:
Opportunity exists to develop a Compliance Program scorecard to measure the effectiveness of each measure, as well as work collaboratively with compliance program leaders to develop objectives based on trending data. A heightened focus on Board involvement and decision-making surrounding corrective action plans for non-compliance and risk mitigation strategies remain an opportunity.

Commitment by Senior and Middle Management

Conduct at the Top

- ❑ How have senior leaders, through their words and actions, encouraged or discouraged compliance?
- ❑ What concrete actions have they taken to demonstrate leadership in the company's compliance and remediation efforts?
- ❑ How have they modelled proper behavior to subordinates?
- ❑ Have managers tolerated greater compliance risks in pursuit of new business or greater revenues?
- ❑ Have managers encouraged employees to act unethically to achieve a business objective, or impeded compliance personnel from effectively implementing their duties?

Shared Commitment

- ❑ What actions have senior leaders and middle-management stakeholders taken to demonstrate their commitment to compliance or compliance personnel, including their remediation efforts?
- ❑ Have they persisted in that commitment in the face of competing interests or business objectives?

Oversight

- ❑ What compliance expertise has been available on the board of directors?
- ❑ Have the board of directors and/or external auditors held executive or private sessions with the compliance and control functions?
- ❑ What types of information have the board of directors and senior management examined in their exercise of oversight in the area in which the misconduct occurred

Encouraging Accountability and Compliance

It is the responsibility of the entire organization to uphold a culture of ethical conduct and compliance. In an effort to promote awareness and recognize each individual's contribution to an overall compliant organization, the Board shall encourage compliance-related assessments throughout the employment cycle. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards are incentivized by the Government to self-disclose compliance failures. One example of this incentive is the "60 Day Rule" . Providers enrolled in Medicare or Medicaid are required to report and refund any overpayments within 60 days from the date when the overpayment is identified, or within 60 days of the date when any corresponding cost report is due. Failure to comply with this regulation can result in False Claims Act or civil monetary liability. Boards should be comfortable with the organization's policies for complying with the 60 Day Rule.

Organizations that discover a violation and self-disclose timely realize certain benefits, such as:

- ❑ Faster resolution of the case; the average OIG self-disclosure is resolved in less than one year
- ❑ Lower payment; OIG settles most self-disclosure cases for 1.5 times damages rather than double or treble damages and penalties under the False Claims Act
- ❑ Exclusion release as part of settlement with no CIA or other compliance obligations

Boards should gain comfort around the organization's culture to encourage employees of all levels to raise compliance questions, concerns and complaints without fear of retaliation. The Board should understand management's approach regarding employee inquiries, as well as the organization's response to identified compliance matters and self-disclosure to Federal and State Government.

Encouraging Accountability and Compliance (continued)

Kaweah Health Process:

As outlined in policy CP.01, Compliance Program Administration, upholding a culture of compliance is the responsibility of each employee, agent, and Medical Staff member. Matters of suspected wrongdoing and non-compliance are required to be reported to leadership, the compliance department, or the anonymous compliance line, without fear of retaliation or retribution. All matters are investigated in accordance with policy CP.05, Compliance and Privacy Issues Investigation and Resolution. Kaweah Health employees are required to receive annual compliance education to ensure understanding of a compliant culture and the obligation to report any suspected non-compliance. Kaweah Health follows federal and state guidelines pertaining to self-disclosure of identified billing errors and overpayments. All investigations regarding suspected non-compliance are shared with the board quarterly, including findings and corrective action plans (when necessary).

Opportunities:

Opportunity exists for compliance elements to be implemented into employee job descriptions as well as annual performance evaluations of employees within the organization. Doing so will establish a set of defined compliance goals and objectives which may be measured and increase accountability amongst all levels of the organization. Opportunity exists to educate the board on handling of internal compliance matters, including the steps of the investigation rather than solely sharing results, and to engage the Board for input regarding measurable compliance metrics and expectations of employees, agents and Medical Staff members.

Conclusion

- Health care Boards should stay abreast of the ever-changing regulatory landscape that govern the organization.
- Boards should remain knowledgeable of emerging risks, as well as the role and function of the organization's compliance program to mitigate and respond to each matter.
- Boards should encourage a level of compliance accountability across the organization, and ensure appropriate resources for the compliance oversight responsibilities, and ultimately protect patients and public funds.

Does the Program Work in Practice

Continuous Improvement and Sustainability

- ❑ Actual implementation of controls in practice will necessarily reveal areas of risk and potential adjustment
- ❑ Survey of employees to gauge the compliance culture and evaluate the strength of controls
- ❑ Conducting periodic audits to ensure that controls are functioning well
- ❑ How often has the company updated its risk assessments and reviewed its compliance policies, procedures, and practices?
- ❑ Has the company undertaken a gap analysis to determine if particular areas of risk are not sufficiently addressed in its policies, controls, or training?
- ❑ What steps has the company taken to determine whether policies/procedures/practices make sense for particular business segments/subsidiaries?

Periodic Testing

- ❑ Internal Audit
- ❑ Control Testing
- ❑ Evolving Updates

DOES THE PROGRAM WORK IN PRACTICE? – In evaluating whether a particular compliance program works in practice, prosecutors should consider revisions to corporate compliance programs in light of lessons learned.

Resources

Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors. Office of the Inspector General, US Department of Health and Human Services and the American Health Lawyers Association. 2004.

Practical Guidance for Health Care Governing Boards and Compliance Oversight. Office of the Inspector General, US Department of Health and Human Services, Association of Healthcare Internal Auditors, American Health Lawyers Association and Health Care Compliance Association. April 2015.

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Compliance Program Activity Report – Open Session

February 2023 through April 2023

Ben Cripps, Chief Compliance & Risk Officer

Education

Live Presentations

- Compliance and Patient Privacy - Management Orientation
- Emergency Medicine Admin Rotation – Regulatory & Fair Market Value (FMV) Overview

Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff

- No Info Patient Directory
- Cody of Conduct Poster Obligation to Report
- Compliance with Documentation

Prevention & Detection

- Californian Department of Public Health (CDPF) All Facility Letters (AFL) – Review and distribute AFLs to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk.

- Medicare and Medi-Cal Monthly Bulletins – Review and distribute bulletins to areas potentially affected by the regulatory change; department responses reviewed and tracked to address the regulatory change and identify potential/current risk.

- Office of Inspector General (OIG) Monthly Audit Plan Updates – Review and distribute OIG Audit Plan issues to areas potentially affected by audit issue; department responses reviewed and tracked to identify potential current/future risk.

- California State Senate and Assembly Bill Updates – Review and distribute legislative updates to areas potentially affected by new or changed bill; department responses reviewed and tracked to address regulatory change and identify potential current/future risk.

Prevention & Detection

- Patient Privacy Walkthrough – Observation of regulatory signage and privacy practices throughout Kaweah Health; issues identified communicated to area management for follow-up and education.

- User Access Privacy Audits – Fairwarning daily monitoring of user access to identify potential privacy violations.
  - Kaweah Health Employees
  - Non-employee users

- Office of Inspector General (OIG) Exclusion Attestations – Quarterly monitoring of department OIG exclusion list review and attestations.

- Medicare PEPPER Report Analysis – Quarterly review of Medicare Inpatient PEPPER statistical reports to identify outlier and/or areas of risk; evaluate with Kaweah Health leadership quarterly at PEPPER Review meeting; Distribution of Rehabilitation, Hospice, Home Health, and Mental Health PEPPER Reports to leadership for evaluation.

- COVID-19 Blanket Waivers – Development of comprehensive tracking tool and correspondence with leadership to ensure compliance practices following the termination of each 1135 Blanket Waivers. Continued monitoring of the CMS COVID-19 temporary blanket waivers which provide health care providers with extra flexibilities required to respond to the COVID-19 pandemic.

Oversight, Research & Consultation

New

Medicare Promoting Interoperability Program – Antibiotic Use – Oversight to ensure compliance with new requirements established in the Final Rule effective January 1, 2024 relative to Antimicrobial Utilization using the National Healthcare Safety Network (NHSN) portal for data exchange with CMS. It was determined that a Module from Cerner, Ucern, may need to be purchased. Compliance will continue to provide oversight until project completion.

Tuberculosis (TB) Test UD Modifier – Research to determine if TB tests should be on the Not Covered Outpatient Drugs (NCODs) list because they have a 340B available for purchase opportunity. It was determined that a rebill of the Medi-Cal and Managed Care Plans is necessary to ensure notification that a discount was received upon purchase, and it is not necessary for Medi-Cal or Managed Care Plans to obtain a discount from the manufacturers. It was determined TB Tests have an available 340b purchase opportunity and should not be on the NCODs list.

COVID Test Urgent Cares – In December 2022, it was identified that patients were not billed for Covid tests in the Urgent Care Facilities. Due to the expiration of county-provided funding for Covid tests in March 2022, the cost of Covid tests became patient responsibility, but failed to be added to claims. Compliance is providing support to ensure affected claims are reprocessed for billing. Rebills have been completed.

Oversight, Research & Consultation

Ongoing

Fair Market Value (FMV) Oversight – Ongoing oversight and administration of physician payment rate setting and contracting activities including Physician Recruitment, Medical Directors, Call Contracts, and Exclusive and Non-Exclusive Provider Contracts.

Licensing & Enrollment

New

Licensing Applications – Forms preparation and submission of licensing application to the California Department of Public Health (CDPH); ongoing communication and follow-up regarding status of pending applications.

Enrollment – Forms preparation and submission of licensing application to CDPH, as well as Medicare and Medi-Cal Facility Payor Enrollment; ongoing communication and follow-up regarding status of pending applications.

- *Kaweah Health Medical Clinic – Ben Maddox*
- *Kaweah Health Cardiology Center – Tulare*
- *Center for Mental Wellness*
- *Hospice*
- *Skilled Nursing*
- *Kaweah Health Medical Clinic - Willow*
- *Neurosciences*

Auditing & Monitoring
Update

CPT Psychotherapy Rural Health Clinics

Situation: CMS is required by the Social Security Act to ensure payment is made only for those medical services that are reasonable and necessary. A post-payment review was conducted by Compliance based on Comprehensive Error Rate Testing (CERT) contractor identified errors focusing on Psychotherapy CPT Codes 90837 (60 minutes) and 90832 (30 minutes) with patients.

Assessment: An internal review of twenty-five (25) randomly selected accounts containing Medicare Psychotherapy CPT codes for dates of service from January 2022 – September 2022 was conducted. The review noted a 68% compliance rate. Eight (8) accounts contained documentation on the proper CPT code; however, the billing statement inappropriately reflected a telehealth CPT Code (G2025). Procedure code G2025 is not to be used for psychotherapy telehealth visits. The eight (8) accounts coded with CPT G2025 inappropriately resulted in an underpayment and have been rebilled. The findings of the review have been shared with Patient Accounting, Coding, and Rural Health Clinic leadership for review.

Recommendation: Based on the findings, the Compliance Department noted a follow-up review shall be conducted in calendar year 2023. This issue has been referred to the Compliance Log for rebilling, monitoring, and corrective action.

Auditing & Monitoring
Update

Noridian Cardiovascular Nuclear Medicine Probe

Situation: On November 10, 2022, Noridian notified Kaweah Health of its intent to complete a prepayment review of cardiovascular nuclear medicine with procedure code 78452 due to an increased utilization of 27% compared to previous utilization data.

Assessment: A review of twenty-eight (28) randomly selected accounts for the period of November 9, 2022 through April 18, 2023 noted zero denials resulting in a compliance rate of 100%.

Recommendation: Noridian has closed this audit. Based on the findings, no further assessment is required at this time.

Auditing & Monitoring

Update

Noridian Targeted Probe and Educate (TPE) Upper Gastrointestinal Endoscopy

Situation: On December 20, 2022, Noridian notified Kaweah Health of its intent to complete a prepayment review of upper gastrointestinal endoscopy with procedure code 43239 due to an increased utilization of 15% compared to previous utilization data.

Assessment: A review of twenty-two (22) randomly selected accounts for the period of December 14, 2022 through April 21, 2023 identified one (1) claim denial resulting in a payment compliance rate of 95.4%.

Recommendation: Noridian has closed this audit. Based on the findings, no further assessment is required at this time.

Projects

New

Privacy Rule, HIPAA Review, and Gap Analysis Development

Situation: The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996, and many changes have taken place over the last two decades. With advancements in technology, changes in the environment of care and an increased desire for ease of access to information, the Privacy Rule and HIPAA have evolved to meet the current landscape. In December 2020, The Department of Health and Human Services (HHS) issued a notice of Proposed Rulemaking that detailed several proposed changes expected to be signed into law in 2023.

Assessment: The Compliance Program is conducting a thorough review of the HIPAA Privacy Rule at both a federal and state level to assess organizational compliance with all elements. A gap analysis will be generated to identify areas of opportunity within the organization's policies and procedures. The results of the HIPAA Privacy Rule review and gap analysis will be used to identify risk areas of opportunity to ensure compliance with state and federal laws. Policies and procedures will be amended as deficiencies are identified, as well as projected changes to take place based on the notice of Proposed Rulemaking. The review and analysis are expected to be completed by June 2023.

Outcome: Not known at this time.

Projects
Update

Compliance Program Effectiveness Tool

Situation: In 2017, compliance professionals from the Department of Health and Human Services (HHS) and Office of Inspector General (OIG) published the results of a roundtable discussion surrounding effective methods for measuring the effectiveness of the seven (7) elements of compliance programs. A resource document was made public and is now widely used as an annual assessment conducted by healthcare organizations to measure the effectiveness of the organization's compliance program.

Assessment: The effectiveness tool is used to identify potential gaps and risks within a compliance program. The Compliance Program Effectiveness Assessment has been completed.

Outcome: The results of the Effectiveness Assessment will be used to identify risks and opportunities to enhance the organization's Compliance program and direct action plans and work outlined within the Compliance Program goals.

Projects

Update

Business Associate Agreement Validation

Situation: Review, validation and collection of Business Associate Agreements (BAA) within the Compliance 360 Contract Database System. A BAA is defined as a legal document between a healthcare provider and a third party vendor who creates, receives, maintains, or transmits Protected Health Information (PHI) of our patients on our behalf. BAAs are crucial in protecting the privacy of our patients and protecting the organization against liability in the event of a breach of PHI committed by a Business Associate.

Assessment: In collaboration with the Materials Management Department (who oversees all non-provider contracts) Compliance has initiated a validation process to ensure accurate storage of BAAs within the system and removal of expired or invalid agreements.

Outcome: Leadership has been re-educated to ensure BAAs are acquired, when appropriate, when executing new agreements. The result of the extensive review is intended to identify and execute (when necessary) agreements for all required vendors and ensure an organized process through the contracts management system for ease of access. This project is anticipated to be completed by the end of July 2023.

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Kaweah Health Medical Center

AUDIT AND COMPLIANCE COMMITTEE

MISSION AND PURPOSE: To promote an organizational culture that encourages ethical conduct and a commitment to compliance with laws, rules, and regulations and provide oversight of the structure and operation of the Compliance and Internal Audit Programs.

To assist Kaweah Health's Board of Directors in fulfilling its responsibility for the oversight and governance of Compliance Program Administration, Kaweah Health's Audited Financial Statements, systems of internal controls over financial reporting, operations, and audit processes, both internal and external.

Kaweah Health's Board of Directors is committed to full implementation of effective Compliance and Internal Audit Programs. Creating and reinforcing compliance and a system of appropriate internal controls is a priority of the Board of Directors, Chief Executive Officer, Compliance and Internal Audit Leadership, and Senior Management.

AUTHORITY: The Compliance and Audit Committee has the authority to conduct or authorize investigations into matters within The Committee's scope of responsibilities, retain independent counsel, consultants or other resources to assist in investigations and audits, seek information it requires from employees or external parties, and to meet with Kaweah Health Officers, consultants, or outside counsel as needed.

COMPOSITION: The Compliance and Audit Committee is comprised of the following Members:

- Board Members (2) – The Board President or Secretary/Treasurer and Board Member Appointee
- Senior Leadership – Chief Executive Officer and Chief Financial Officer
- Legal Counsel/Compliance Advocate – Rachele Berglund
- Chief Compliance and Risk Officer
- Internal Audit Manager
- Compliance Manager

MEETINGS: The Committee shall meet at regularly scheduled intervals, with the authority to convene additional meetings as necessary. The Committee is authorized to request attendance from members of Management or others to provide information that would be relevant to The Committee.

The Committee may meet in executive session when necessary and permissible by applicable laws.

SPECIFIC RESPONSIBILITIES:

1. Review developments of the Compliance and Internal Audit Programs to enable The Committee to make recommendations to the Board of Directors when appropriate
2. Provide oversight as needed to ensure that the Compliance and Internal Audit Programs effectively facilitate the prevention and/or detection of violations of law, regulations, and Kaweah Health policies
3. Ensure autonomy and review resources assigned to the Compliance and Internal Audit Programs to assess their adequacy relative to the program's effectiveness
4. Ensure annual review of the Office of Inspector General's Work Plan and other relevant resources to identify potential risk areas and assess their impact on Kaweah Health
5. Monitor physician contracts and payments made to physicians to ensure appropriateness and compliance with laws and regulations
6. Convene the Executive Fair Market Value Committee, a sub-Committee of the Compliance Committee, as necessary to ensure that physician contracts are established within fair market value
7. Review the Compliance and Internal Audit Annual Plans, activities, staffing and structure; ensure that the Chief Compliance and Risk Officer's (or designee(s)) access to information, data and systems is not restricted or limited in any way
8. Select or dismiss independent accountants responsible for completing Kaweah Health's Financial Statement and Retirement Plan Audits (subject to approval by the Kaweah Health Board of Directors); review and approve fees paid to independent accountants; approve or disapprove consulting services provided by independent accountants to ensure independence and objectivity
9. Meet with the independent accountants prior to, during, and after the annual audit to evaluate, understand and report to the Board on the various aspects and findings of the audit as follows:
    a. Audit scope and procedural plans
    b. Significant areas of risk and exposure and management's actions to minimize them
    c. Adequacy of Kaweah Health's internal controls, including computerized information system controls and security
    d. Significant audit findings and recommendations made by the independent accountants

e. The annual Audited Financial Statements, related Footnotes Disclosure, and the Independent Accountant's Report thereon

f. The independent auditor's qualitative judgments about the appropriateness, not just the acceptability, of accounting principles and financial disclosures and how aggressive (or conservative) the accounting principles and underlying estimates are or should be

g. Serious difficulties or disputes with management encountered during the course of the audit

10. Reviews and evaluates management's written response to the independent accountants' management letter. Instructs the Internal Audit Leadership to confirm complete implementation of any Management action required by external auditor's Management Letter

11. Review legal and regulatory matters that may have a material effect on the organization's financial position, financial statements, and/or reputation

12. Monitor effectiveness and timeliness of responses to identified issues

13. Monitor education, training, and preventive activities

14. Review and evaluate the effectiveness of the Kaweah Health Compliance and Internal Audit Programs

15. Recommend, review, and approve revisions to the Compliance Program's Code of Conduct and Compliance Policies Manual

16. Report Committee actions and recommendations to the Kaweah Health's Board of Directors

Presented to the Compliance and Audit Committee on May 9, 2023 for approval.

Kaweah Delta Health Care District Compliance Program Work Plan Calendar Year 2022	
Tasks and Activities	**Comments**
Compliance Oversight and Management	
Complete comprehensive review of the Compliance Program - Program Effectiveness Tool / Risk	Complete
Develop Overpayment Policy	Carry-Over 2023
Operational Compliance Committee Expansion: Radiology	Complete
Operational Compliance Committee Expansion: Laboratory	Not Complete: Determined not to initiate at this time
Operational Compliance Committee Expansion: Pharmacy	Not Complete: Determined not to initiate at this time
Operational Compliance Committee Expansion: Rural Health Clinics	Complete
Operational Compliance Committee Expansion: Urgent Care & SHWC	Complete
Operational Compliance process restructure	Complete
KHMG Compliance Program continued development to include:	
Develop Audits	Complete
Forms Review and Standardization	Complete
Policy cleanup and standardization (alignment with KH)	Complete
STARK and Anti-Kickback Oversight:	
Physician Payment Testing Monitoring (annual)	Carry-Over 2023
Physician Contracts Billing and Collection Audits (external)	Carry-Over 2023
Physician Contract Compliance Audits (IQ Surgical, Precision Psychiatry)	Carry-Over 2023
Physician Time Study Database Research	Carry-Over 2023
Develop efficiencies in physician payment processing such as: streamling approval process, payment request verification & automation, medical director reporting	Carry-Over 2023
Implement a physician contract onboarding team for new providers	Carry-Over 2023
Streamline processes related to and utilization of Compliance 360	Carry-Over 2023
Create physician contract checklist to provide guidance in payment process, renewal status, and appropriate leadership review	Carry-Over 2023
Provider recruitment agreement acknowledgment form and onboarding process improvement	Carry-Over 2023
Licensing and Certification:	
MediCare & Medi-Cal Facility Enrollment Manual	Complete
Reviews and Audits:	
Physician Recredentialing List	Complete
Audit Risk Assessment	Complete
Inpatient Medicare Claims (Exhausted Part A Benefits)	Carry-Over 2023
Review of Advanced Beneficiary Notices and Processes	Complete
Patient Status (OIG WP 9)	Complete
Medicare Secondary Payer (Claims and Questionnaire)	Complete
Orders/Order Requirements	Complete
OIG Audit - Patient Accounting/ Medicare Transfer Policy	Complete
End Stage Renal Disease (ESRD) AKI Billing (Code 84)	Complete
Inpatient Psychiatric Facility Services	Complete
Vitamin D - KHMG	Complete
Admit Source D	Complete
Physician Reappointments	Complete
COA Minors	Complete
Non Monetary Compensation	Complete
External: MRA/AAPC	
MCC & CC Audit (VBP) Pneumonia, Sepsis, COPD, CVA 50) IP	Complete
Inpatient Cardiac DRG (25), OP Audit Ambulatory Surgery (25)	Complete
Critical Care Matter	Complete
E & M Outpatient Services (45) Rehab (5)	Complete
KHMG E & M Coding Audit	Complete
Malnutrition	Complete

Kaweah Delta Health Care District Compliance Program Work Plan Calendar Year 2022	
Tasks and Activities	**Comments**
Patient Privacy:	
Business Associate Agreement: Update	Carry-Over 2023
Business Associate Agreement process reform	Carry-Over 2023
Develop ZixCorp Email Encryption Monitoring Process	Carry-Over 2023
New process for Non-Employee User Access Forms and Education	Complete
Develop process/training materials for non-employees accessing KHMG systems (includes Scribes)	Not Complete: N/A
Student Compliance & Privacy Training	Carry-Over 2023
Create Privacy Manual (include policies and forms: Policy Tech)	Carry-Over 2023
Development & implementation of focused privacy re-eduation and process improvement for departments with habitual privacy incidents	Complete
Privacy & Compliance Training Video	Carry-Over 2023
Education:	
Nursing Education: Patient Privacy Potpourri	Not Complete: N/A
Compliance Program re-branding: Develop "Compliance Star" of the month; branded articles circulating throughout the organization	Not Complete
Compliance Today Article	Not Complete
Leadership Team Ted Talks	Complete
Physician Contract Training with Directors	Carry-Over 2023
Development of Four Corners Report	Not Complete
Department rounding of high-compliance risk departments; one per month	Complete
Area Specific Education: Visit Departments 1-2 Times a Year/ 1-3 hours per year	**OIG requires 1-3 hours of Compliance education annually**
Physician Office Staff Meeting	Complete
Health Information Management (HIM)	Complete
Patient Accounting	Complete
Patient Access	Complete
Case Management	Complete
Revenue Integrity	Complete
CDI	Complete
Sequoia Surgery Center	Complete
Sequoia Health and Wellness Centers - Family Medicine Center	Not Complete
Kaweah Health Medical Group	Complete
Laboratory	Not Complete
Radiology	Complete
Pharmacy	Not Complete
Rural Health Clinics	Complete
Urgent Care Clinics	Complete
Prevention and Monitoring:	
Preventive Compliance Bulletins on OneDrive	Complete
Service Line Review of Medi-Cal Bulletins and Local Coverage Determinations/Department Review of Billing Manuals / Local Coverage Determinations (LCDs)	Complete
Create Internal Data Mining Report	Carry-Over 2023
Monitor COVID Regulatory changes: CARES Act Funding, Healthcare Requirements	Carry-Over 2023

Kaweah Delta Health Care District Compliance Program Work Plan Calendar Year 2023		
Tasks and Activities	**Responsible Party**	**Comments**
Effectiveness Tool Opportunities		
Element 1: Standards, Policies, Procedures		
Element 2: Compliance Program Administration		
Element 3: Screening and Evaluation of Employees, Physicians, Vendors and other Agents		
Element 4: Communication, Education, and Training on Compliance Issues		
Element 5: Monitoring, Auditing, and Internal Reporting Systems		
Element 6: Discipline for Non-Compliance		
Element 7: Investigations and Remedial Measures		
Compliance Oversight and Management		
Complete comprehensive review of the Compliance Program - Program Effectiveness Tool / Risk Assessment		
Develop Overpayment Policy		
Review and Update Code of Conduct		
New Service Line / Facility Orientation Program: Ensure Compliance resoinsibilities are understood and implemented in the new clinics/facilities; Opportunity to be proactive		
STARK and Anti-Kickback Oversight:		
Physician Contracts Billing and Collection Audits (external)		
Physician Contract Compliance Audits (IQ Surgical, Precision Psychiatry)		
Develop efficiencies in physician payment processing		
Refine processes related to and utilization of Compliance 360		
Create physician contract checklist to provide guidance in payment process, renewal status, and appropriate leadership review		
Provider recruitment agreement acknowledgment form and onboarding process improvement		
Develop contract summaries for leadership		
Attestation process for recruitment agreements		
Reviews and Audits:		
Patient Status		
Diagnostic Testing in the Emergency Room		
Infusion Center Medical Necessity Orders and Services Provided, Pumps, Medications		
Charge Posting Audit		
Urology: New Service Line Audit		
Seq Cardiology Heart Cath Process		
Sequoia Cardiology- Venous Flow Study 93971, arterial Study 93923		
Medicare Trauma Claims		
Home Health Value Based Purchasing		
Annual Wellness Visits within 12 months		
External Audits		
Urgent Care	MRA	
High Cost OP Surgery	MRA	
IP DRG various without MCC or CC	MRA	
Telehealth	MRA	
Perioteneal Dialysis	MRA	
Undetermined: Consider new service Lines: Tulare Cardiology/Willow Clinics, Industrial	*AAPC*	
Undetermined: Ncoder; Low Provider Usage; Decreased Providers	*AAPC*	
Undetermined: Continue to watch PEPPER; Coder Results; Probes; RAC issues	*AAPC*	
Patient Privacy:		
Business Associate Agreement: Update Template		
HIPAA/Privacy Rule Gap Anaylsis		
Workday Implementation: Contingent Workers/User Access		
Create Privacy Manual (include policies and forms: Policy Tech; Internal Privacy Processes)		
Development & implementation of focused privacy re-eduation and process improvement for departments with habitual privacy incidents		
Privacy & Compliance Training Video		
Education:		
Leadership Team Ted Talks		
Physician Contract Training with Directors		
Development of Four Corners Report		
Area Specific Education: Visit Departments 1-2 Times a Year/ 1-3 hours per year		
Physician Office Staff Meeting		
Health Information Management (HIM)		
Patient Accounting		
Patient Access		
Case Management		
Revenue Integrity		
CDI		
Sequoia Surgery Center		
Sequoia Health and Wellness Centers - Family Medicine Center		
Kaweah Health Medical Group		
Laboratory		
Radiology		
Pharmacy		
Rural Health Clinics		
Urgent Care Clinics		
Prevention and Monitoring:		
Covid-19 Public Health Emergency Waiver Tracking		
Create Internal Data Mining Report		
Monitor COVID Regulatory changes: CARES Act Funding, Healthcare Requirements		

Evidence of Standard Compliance (ESC)

Standard & EP IM.02.01.01 EP 1	Short Description PHI		Due Date to Org Accreditation 4/5/2023
SAFER Placement	Moderate Limited	**Executive Sponsor**	Chief Compliance Officer
Chapter	IM	**Observations/Dept**	ED
Chapter Lead	Chief Financial Officer		
Responsible Owner	Director of Emergency Services	**Team Members**	Emergency Services Manager, Emergency Services Assistant Nurse Manager, Emergency Services Business Service Coordinator
Oversight Committee	Compliance Committee		

Observation:
1). Observed in Individual Tracer at Kaweah Delta Medical Center (400 West Mineral King, Visalia, CA) site. The facility did not protect the privacy of health information as evidenced by an unattended work station in a triage check-in area with a computer screen displaying patient information that was clearly visible to patients and anyone walking past the computer. This observation was confirmed by the Emergency Department Nurse Manager.

1. Corrective Action:
On March 8th ED leadership (Director, manager, assistant nurse manager (ANM), and business services coordinator (BSC)) met to discuss protecting PHI on workstations. Corrective actions identified were to place privacy screens on workstations, add to weekly update to ensure to minimize, lock, or log off workstations, ensure education 2023 MAT Compliance and Privacy module will be completed by all ED staff by 4/25/2023.

A review of policy ISS.002 "Password Access Management" was reviewed by ED Director on 3/10/2023 and determined no revision to policy was required.

Privacy screens were procured on 4/10/23 and installed between 4/11/23 and 4/25/23.

ANM added to the weekly update on 3/9/2023 to ensure the team is locking, minimizing, or logging off when leaving a workstation.

3/10/2023 Director and Manager met to determine a monitoring, compliance, and reporting plan. Leadership will monitor compliance through the monthly reporting at Compliance committee meetings.

A computer-based learning module was completed by staff by 4/25/23. ED Providers were provided education by the Manager Medical Staff Services.

Final date all corrective actions were complete:

4/25/23

Evidence of Standard Compliance (ESC)

2. What procedures or activities have been identified to monitor your compliance with the element of performance?
The ED Nurse Manager or designee will conduct 5 audits per week of all 9 areas (6 zones, Intake, PAT, Waiting Room) ensuring that workstations that are in patient care areas in the ED that are logged in are attended to or were locked, minimized, or logged out.

3. What is the frequency of the monitoring activities:
Weekly

4. What data will be collected from these activities:

# of compliant areas/ # areas audited

5. To whom and how often, will this data be reported?
The data will be reported to the Compliance Committee, and ED staff monthly until 100% compliant for 3 consecutive months.

THE BELOW QUESTIONS ARE COMPLETED ONLY FOR FINDINGS THAT ARE PLACED IN THE SAFER MATRIX IN THE FOLLOWING RISK CATEGORIES:

High Widespread **High Pattern** **High Limited** **Moderate Widespread** **Moderate Pattern**

Leadership Involvement: *Please describe how the above leadership involvement is helping to sustain compliance with this Element of Performance in the future. Describe what actions were taken by senior leadership to correct the non-compliance and how they will ensure that compliance is sustained moving forward.*
Not required

Preventative Analysis - What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution) but also any underlying reasons for the failure were addressed as well? *An important component of process improvement involves not just fixing the issue at hand, but also ensuring that all underlying reasons that caused the issue (root causes) are identified and addressed as well, in an effort to prevent future occurrences of the issue. In order to assist your organization in reducing potential future risk, detail surround Preventive Analysis for high risk findings is required (e.g. What went wrong? Why did this happen? What process failed? What is the underlying reason why this went wrong?). Within this section, responses should be process focused and not people focused.*
Not required

Examples can be viewed at the following link Post Survey Response Writing

If the link does not work, cut ant past the following into your browser:

https://kaweahdelta.sharepoint.com/sites/OrganizationalAccreditation2/Surveyhub/SitePages/Post-Survey-Response-Writing.aspx

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Evidence of Standard Compliance (ESC)

Standard & EP LD.04.03.09 EP 6	**Short Description** Physician contract evaluation		**Due Date to Org Accreditation** 4/5/2023
SAFER Placement	High Limited	**Executive Sponsor**	Chief Compliance Officer
Chapter	LD	**Observations/Dept**	Physician Contracts
Chapter Lead	Director of Quality and Pt. Safety		
Responsible Owner	Chief Compliance Officer		
Oversight Committee	Compliance Committee		

Observation:

1). Observed in Document Review at Kaweah Delta Medical Center (400 West Mineral King, Visalia, CA) site. In one of three clinical contracts reviewed there was not evidence that leaders were evaluating the services in relation to the organization's expectations. The contract was for physician services in the organization's urgent care facilities and the organization could not provide evidence of leadership review of performance data.

1. Corrective Action:

The Chief Compliance and Risk Officer along with the Physician Contract Department reviewed the finding during a meeting on March 7, 2023 and directed corrective actions and monitoring plans be developed.

The Physician Contract Department met on March 7, 2023 to discuss leadership involvement in evaluating the Performance Objectives defined within Physician Contracts. It was determined that leadership was not reviewing performance data consistently as outlined in the clinical contracts. The Chief Compliance and Risk Officer along with the Physician Contract Department met on March 29, 2023, and developed and approved a new process that verifies leaders are reviewing performance data as well as evaluating the services in relation to the organization's expectations.

The Annual Clinical Contract Evaluation Checklist was developed by the Physician Contract Department and approved by the Chief Compliance and Risk Officer on March 30, 2023.

Communication of the Annual Clinical Contract Evaluation Checklist was sent by the Chief Compliance and Risk Officer to the Leaders that directly oversee clinical contracts via the District email server on April 3, 2023 with Read Receipt. Leaders will be required to return the completed checklist within thirty (30) days.

Final date all corrective actions were complete:

April 3, 2023

2. What procedures or activities have been identified to monitor your compliance with the element of performance?

The Physician Contract Department will require annual evaluations to ensure leaders are reviewing performance data as well as evaluating the services in relation to the organization's expectations as required, with a 100% compliance rate.

Evidence of Standard Compliance (ESC)

3. What is the frequency of the monitoring activities:

Evaluations will be reviewed and analyzed by the Physician Contract Department and the Chief Compliance and Risk Officer annually, to address instances of non-compliance.

4. What data will be collected from these activities:

The data collected from these activities will consist of the annual evaluation forms acknowledging leadership review of performance data and evaluation of services.

annual evaluation forms completed / # annual evaluation forms required

5. To whom and how often, will this data be reported?

Data will be reported annually to the Audit and Compliance Committee.

THE BELOW QUESTIONS ARE COMPLETED ONLY FOR FINDINGS THAT ARE PLACED IN THE SAFER MATRIX IN THE FOLLOWING RISK CATEGORIES:

High Widespread **High Pattern** **High Limited** **Moderate Widespread** **Moderate Pattern**

Leadership Involvement:

The Chief Compliance and Risk Officer along with the Physician Contract Department reviewed the finding during a meeting on March 7, 2023 and directed corrective actions and monitoring plans be developed.

Corrective actions identified were to develop an Annual Clinical Contract Evaluation Checklist. Leadership will monitor compliance through annual reporting at the Audit and Compliance Committee meeting.

Leadership members of the Audit and Compliance Committee include:
Board of Directors Secretary/Treasurer
Board of Directors Board Member
Executive Sponsor – Chief Compliance and Risk Officer
Chief Executive Officer
Chief Financial Officer
Legal Counsel
Compliance Manager

The Chief Compliance and Risk Officer is the champion for communicating changes throughout the multidisciplinary team and other organizational leaders, development of standardized forms and documentation processes, and establishing a monitoring system for continued compliance.

The Chief Compliance and Risk Officer along with the Physician Contract Department reviewed the finding during a meeting on March 7, 2023 and directed corrective actions and monitoring plans be developed.

The Chief Compliance and Risk Officer along with the Physician Contract Department participated in meetings that determined the plan of correction for Leaders that directly oversee clinical contracts.

The Chief Compliance and Risk Officer will receive annual compliance reports and facilitate immediate corrective actions.

Evidence of Standard Compliance (ESC)

Preventative Analysis - What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution) but also any underlying reasons for the failure were addressed as well?

The Physician Contract Department met on March 7, 2023 to discuss leadership involvement in evaluating the Performance Objectives defined within Physician Contracts. It was determined that leadership was not reviewing performance data consistently as outlined in the clinical contracts. Corrective actions identified were to develop and approve a new process that verifies leaders are reviewing performance data, and determine a monitoring, compliance and reporting plan. Leadership will monitor compliance through annual reporting at the Audit and Compliance Committee meeting.

Examples can be viewed at the following link Post Survey Response Writing

If the link does not work, cut ant past the following into your browser:

https://kaweahdelta.sharepoint.com/sites/OrganizationalAccreditation2/Surveyhub/SitePages/Post-Survey-Response-Writing.aspx

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Evidence of Standard Compliance (ESC)

Standard & EP LD.04.03.09 EP 7	**Short Description** Physician contract improvements		**Due Date to Org Accreditation** 4/5/2023
SAFER Placement	High Limited	**Executive Sponsor**	Chief Compliance Officer
Chapter	LD	**Observations/Dept**	Physician Contracts
Chapter Lead	Director of Quality and Pt. Safety		
Responsible Owner	Chief Compliance Officer		
Oversight Committee	Compliance Committee		

Observation:
1). Observed in Document Review at Kaweah Delta Medical Center (400 West Mineral King, Visalia, CA) site. In one of three clinical contracts reviewed there was not evidence that leaders were taking steps to improved clinical services which were not meeting expectations. The contract for physician services in the organization's urgent care facilities and data was not being collected on all the required metrics listed in the contract. The data which was collected demonstrated performance which did not consistently meet targets in the contract and there was no evidence the actions that leadership took related to this data.

1. Corrective Action:

The Chief Compliance and Risk Officer along with the Physician Contract Department reviewed the finding during a meeting on March 7, 2023 and directed corrective actions and improvement efforts be developed.

The Physician Contract Department met on March 7, 2023 to discuss improvements in evaluating contracted services that do not meet expectations defined within Physician Contracts. It was determined that all required metrics and data were not being collected, reviewed, or actions being taken related to the findings. The Chief Compliance and Risk Officer along with the Physician Contract Department met on March 29, 2023, and developed and approved a new process that ensures leaders are collecting, reviewing, and responding to the performance metrics within the agreement.

The Contract Performance Review Attestation was developed by the Physician Contract Department and approved by the Chief Compliance and Risk Officer on March 31, 2023.

Communication of the Contract Performance Review Attestation process was sent by the Chief Compliance and Risk Officer to the leaders that directly oversee clinical contracts via the District email server on April 14, 2023 with Read Receipt. Additionally, the Contract Performance Review Attestation will be communicated to appropriate leadership during a meeting with the Chief Compliance and Risk Officer and the Physician Contract Department. The new process and expectations will be outlined at this time. Leaders will be required to collect data and develop a corrective action plan related to performance objectives and data/report needs within the contract and implemented within thirty (30) days. Once a corrective action plan is established leaders will have ninety (90) days to become compliant with expectations and will submit their Contract Performance Review Attestation.

Final date all corrective actions were complete:

April 14, 2023

Evidence of Standard Compliance (ESC)

2. What procedures or activities have been identified to monitor your compliance with the element of performance?
The Physician Contract Department will require an annual attestation to ensure leaders are reviewing all required metrics and data at the intervals outlined within each agreement with a 100% compliance rate.

3. What is the frequency of the monitoring activities:

Attestation will be reviewed and analyzed by the Physician Contract Department and the Chief Compliance and Risk Officer annually to address instances of non-compliance.

4. What data will be collected from these activities:

The data collected from these activities will consist of the annual evaluation form attesting the leaders are reviewing all required metrics and data at the intervals outlined within each agreement.

attestations completed / # attestations required

5. To whom and how often, will this data be reported?

Data will be presented annually to the Audit and Compliance Committee.

THE BELOW QUESTIONS ARE COMPLETED ONLY FOR FINDINGS THAT ARE PLACED IN THE SAFER MATRIX IN THE FOLLOWING RISK CATEGORIES:

High Widespread **High Pattern** **High Limited** **Moderate Widespread** **Moderate Pattern**

Leadership Involvement:

The Chief Compliance and Risk Officer along with the Physician Contract Department reviewed the finding during a meeting on March 7, 2023 and directed corrective actions and improvement efforts be developed. Corrective actions identified were to develop the Contract Performance Review Attestation that ensures leaders are collecting, reviewing, and taking action on all required metrics within the agreement. Leadership will monitor compliance through annual reporting at the Audit and Compliance Committee meeting.

Leadership members of the Audit and Compliance Committee include:

- Board of Directors Secretary/Treasurer
- Board of Directors Board Member
- Executive Sponsor – Chief Compliance and Risk Officer
- Chief Executive Officer
- Chief Financial Officer
- Legal Counsel
- Compliance Manager

The Chief Compliance and Risk Officer is the champion for communicating changes throughout the multidisciplinary team and other organizational leaders, development of standardized forms and documentation processes, and establishing a monitoring system for continued compliance.

The Chief Compliance and Risk Officer along with the Physician Contract Department reviewed the finding during a meeting on March 7, 2023 and directed corrective actions and monitoring plans be developed.

Evidence of Standard Compliance (ESC)

The Chief Compliance and Risk Officer along with the Physician Contract Department participated in meetings that determined the plan of correction for Leaders that directly oversee clinical contracts.

The Chief Compliance and Risk Officer will receive annual compliance reports and facilitate immediate corrective actions.

Preventative Analysis - What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution) but also any underlying reasons for the failure were addressed as well?

The Physician Contract Department met on March 7, 2023 to discuss improvements in evaluating contracted services that do not meet expectations defined within Physician Contracts. It was determined that all required metrics and data were not being collected, reviewed, or actions being taken related to the findings. Corrective actions identified were to develop the Contract Performance Review Attestation that ensures leaders are collecting, reviewing, and taking action on all required metrics within the agreement. Leadership will monitor compliance through annual reporting at the Audit and Compliance Committee meeting.