Bartlett Regional Hospital

Board Compliance & Audit Committee Agenda
Date: February 15, 2022 Time: 12:30 PM
BRH Boardroom and Zoom/Videoconference

Board members and designated staff will meet in person to the extent possible.
Public, staff and Board members wishing to attend virtually may access the meeting via the following link
https://bartletthospital.zoom.us/j/92394337325
or call
1-877-853-5247 **and enter webinar ID** 923 9433 7325

Mission Statement
Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

CALL TO ORDER
APPROVAL OF AGENDA
APPROVAL OF THE MINUTES – December 20th BOD Compliance & Audit Committee meeting
INFORMATIONAL – February 10th Hospital Compliance Committee draft meeting minutes

TRAINING

How the Compliance Program is associated with the Risk Program — 10 minutes
Nathan Overson, CO

NEW BUSINESS

A. Risk Management Plan review for approval — 30 minutes
   (motion to move to the BOD as a whole for review and approval) — Committee Discussion
B. Compliance Officer Report
   a. New Compliance dashboard
   b. Compliance initiatives update
C. Annual Board Compliance Training for March 2nd
   a. Are there any requested topics from the BOD Compliance Committee
D. COVID update

EXECUTIVE SESSION

Motion by xx, to recess into executive session:

- *To discuss information presented that the immediate knowledge of which would clearly have an adverse effect upon the finances of BRH; that being a discussion about campus planning. (Unnecessary staff and Medical Chief of staff are excused from this portion of the session.)*

FUTURE AGENDA ITEMS — 5 minutes

A. Next Committee Education and Training

COMMITTEE MEMBER COMMENTS
ADJOURN - Next scheduled meeting: May

Draft Minutes, BOD Compliance

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Board Compliance & Audit Committee Meeting
Draft Minutes
December 20, 2021

Called to order at 1:05 PM., by Board Compliance Committee Chair, Iola Young

Compliance Committee and Board Members:
**Board Members: ***Iola Young, Committee Chair; *Hal Geiger; *Deborah Johnston

Staff/Other: Nathan Overson, Compliance Officer; Jerel Humphrey, CEO; Karen Forrest, CBHO; Kevin Benson, CFO; Kim McDowell, CNO; Vlad Toca, COO; Dallas Hargrave, HR Director; Beth Mow, Contracts Manager

Previous Board Compliance Meeting Minutes Approval: ***Mr. Geiger made a MOTION to approve the November 15th 2021 Board Compliance and Audit Committee Meeting minutes as submitted. Ms. Johnston seconded the motion, and hearing no objection, Ms. Young approved the meeting minutes without change.***

Committee Compliance Training:
Mr. Overson gave an overview of how the Compliance Program should interface with operations in the development of new or materially changing service lines of the hospital. Mr. Overson shared a compliance checklist document with the committee as a tool that allows for tracking compliance elements throughout the development process to assure critical compliance elements of the service line are not overlooked or omitted. Considerations for regulatory requirements, medical staff, documentation, medical records, contracting, billing, coding etc. are covered in the checklist. Mr. Overson also gave a status update on the creation of the "New Service Line Policy & Procedure".

Compliance Officer Report:
Mr. Overson presented the compliance dashboard that compared 2020 to 2021. Ms. Young pointed out the increase of "compliance consults" this year over last year as a positive thing. Mr. Overson also presented the PYA sample dashboard for format comparison to the current dashboard and for discussion on the committee's preference between the two dashboards. The committee discussed the benefit of seeing quarterly and prior year comparisons and opted to change the dashboard report to the PYA sample format with some minor changes.

The committee discussion turned to the annual board compliance training. In November's Board Compliance Committee meeting, it was proposed that the board explore the option of receiving their annual training from an outside organization. Ms. Young mentioned the last annual training

was in October 2019, and moving the training interval to the beginning of the year would mean no annual board compliance training will have been held in calendar year 2020. The committee discussed a training proposal submitted by PYA, the same firm that performed the Compliance Program review and risk assessment. The committee agreed that the cost of travel proposed by PYA was high and that virtual training would fit the need. The committee agreed that the details of the training arrangement could be worked out by Mr. Overson and Mr. Humphrey.

Executive session: This meeting did not go into executive session.

Meeting Adjourned: 1:54 PM

Next Meeting: February

Draft Minutes, Hospital Compliance

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Hospital Compliance Committee Meeting
Draft Minutes
February 02, 2022

Called to order at 1:00 PM., by Compliance Committee Chair, Nathan Overson, CO

Hospital Compliance Committee Members in attendance: Nathan Overson, Beth Mow, Scott Chille, Rachael Stark, Angelita Rivera, Jeanette Lacey, Jerel Humphrey, Karen Forrest, Gail Moorehead, Dallas Hargrave, Sara Dodd, Kim McDowell, Ursula Iha, Anita Moffitt, Tami Lawson-Churchill

Education and Training:
Mr. Overson briefly discussed the role of the board of directors as it relates to the Compliance Program of the hospital. He also invited the Hospital Compliance Committee to attend the annual board of director's compliance training that will be held on March 2nd at 5:30 PM, and presented by PYA the same firm that oversaw the Compliance Program Review and Risk Assessment. Though the training will be centric to the board, it would be useful context for the Hospital Compliance Committee members to know for their role as well.

Compliance Program Activities Update:
Ms. Iha gave an overview of the current activities of the 340B Oversite Committee and the work toward completing the 340B program recommendations. She gave some specific examples of the monthly monitoring and auditing processes, looking for potential diversion or risk of diversion. She also gave an update on the policy and procedures manual revisions, which is almost complete.

Ms. Stark gave the HIPAA Privacy Officer update that included an overview of how the new "Fair Warning" software was doing at tracking and monitoring appropriate access into BRH's electronic medical record system.

Mr. Chille gave the HIPAA Security Officer update on BRH's HIPAA security risk assessment of threats and vulnerabilities along with the types of controls in place such as administrative, physical, and technical controls as part of our cyber security program. He reported that Bartlett is in great shape, and is continuing to implement new and updated measures to keep the likelihood and consequence of compromised cyber systems low.

Ms. Lawson-Churchill gave an overview of some of the new requirements enacted by BRH to comply with the new surprise billing rules. There are additional layers of complexity to work through since many providers that provide services at BRH are not BRH employees. The team is working hard to make sure the all the elements of the new rules are covered.

Mr. Overson discussed forming a Service Line Advisory Workgroup that has started meeting and is helping develop and define the functions of a Service Line Committee that will be led by operations. A draft service line committee policy has circulated through senior leadership and other stakeholders for review and input. The workgroup is also simultaneously reviewing current service line requests.

Compliance Officer Report:
Mr. Overson mentioned in his report that Mr. Humphrey has approved the hire of a new full time Compliance position. Mr. Overson mentioned that this role would be key in the monitoring and auditing functions of the Compliance Plan. The new position would also allow the Compliance Program to be more proactive in assessing compliance risks throughout the organization.

Meeting Adjourned: 1:55 PM
Next Meeting Scheduled: April 20th at 2:00 PM

Draft Risk Management Plan

Bartlett Regional Hospital
RISK MANAGEMENT PLAN
CY 2022

Deleted: 2021

Revised: February 11, 2022
Submitted by: Nathan Overson, CHC

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Deleted: January 8, 2021

AUTHORITY AND RESPONSIBILITY

Board of Directors

The Board of Directors of Bartlett Regional Hospital is responsible for the quality and effectiveness of the patient care provided by the medical staff and other professional and support staff. It sets expectations, directs, and supports Bartlett Regional Hospital's (BRH) governance and management activities which include supporting the Risk Management Program to minimize preventable harm to patients, employees, visitors and property. It has the final authority and responsibility for the program, but delegates the authority and accountability for the operation of the program to the Administrative and Medical Staff of BRH. It appoints, through the Chief Executive Officer, a Director of Compliance and Risk. The Director of Compliance and Risk is responsible for the Risk Management program. It recognizes the importance of a Risk Management Program and provides resources and support to prevent such events that may result in injury to patients, staff, or visitors, property damage, financial loss, or damage to the facility's reputation.

Risk Management Supervision

The Director of Compliance and Risk is also the acting Risk Manager. The Risk Manager works closely with the Lead Security Officer, and the Quality Director who is also the Patient Safety Officer. The Risk Manager acts as a designee of the Chief Executive Officer. S/He has the responsibility for monitoring, coordinating, planning, and implementing all loss prevention activities and programs that have as their goal a safe environment for patients, employees, and visitors to the hospital. Trending and tracking of potential problems are included in this responsibility as well as the integration of information with the Patient Safety Committee and the Environment of Care (EOC) Committee.

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Medical Staff

The Medical Staff actively participates in peer review via the identification of potential risk in clinical areas that represent a significant source of actual or potential patient injury. This is achieved through the close coordination with the Quality Director who helps facilitate the peer review process as a representative of hospital administration. The Quality Director in conjunction with the Medical Staff identifies specific patient cases with potential risk in the clinical aspects of patient care and safety.

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PURPOSE AND PHILOSOPHY

The purpose of the Risk Management Plan is to support the mission and vision of Bartlett Regional Hospital to provide patient centered quality care in a sustainable manner. Risk Management fulfills this by acting to protect, patients, staff and

visitors from injury, physical property from damage and financial assets from being wasted. Risk Management acts to support BRH's reputation and standing in the community.

The focus of the risk management plan is to provide an ongoing, comprehensive, and systematic approach to reducing vulnerabilities. Risk management activities include identifying, investigating, analyzing, and evaluating risks, followed by selecting and implementing the most appropriate methods for correcting, reducing, managing, transferring and/or eliminating these vulnerabilities.

The philosophy of the Risk Management Program is that patient safety and risk management is the responsibility of each employee of Bartlett Regional Hospital. Teamwork and active participation among management, providers, and staff are essential for an efficient and effective risk management program. The Risk Management Program plays an important role in directing the organization towards fulfilling the mission and vision of BRH to provide patient centered sustainable quality care.

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SCOPE

Risk Management is a systematic process of identifying, evaluating and alleviating practices and/or situations that pose risk of harm to patients, visitors and staff of BRH. Emphasis is placed on advocating the exercise of loss prevention strategies intended to preserve the resources of Bartlett Regional Hospital and its professional staff from loss attributed to professional liability.

The Risk and Quality Management activities at BRH are mutually compatible and interdepartmental and are part of the organization's performance improvement system. BRH's Risk Management Program is designed to comply with all federal and state regulatory requirements. Resources are provided to the Quality Department and the Compliance & Risk Department via the Director of Quality and the Compliance & Risk Department. The integration of hospital risk management with quality assurance activities ensures information about patient care and safety are exchanged.

STRUCTURE

Risk management activities are established by BRH leaders, based on needs assessments, as guided by the mission, vision, and core values, and as defined by strategic and operational plans, budgets, resource allocation, and standards.

Board of Directors

The Board of Directors receives and reviews reports through the performance improvement structure, summarizing the findings of the Risk Management Program via the Hospital Performance Improvement Committee (HPIC), the Environment of Care (EOC) Committee, and reports by the Risk Manager or Director of Quality. The Board of Directors designates the Chief Executive Officer the responsibility for the patient grievance process who delegates to the Compliance Director the responsibility of managing the patient and visitor complaint process. The Hospital Performance Improvement Committee (HPIC) serves as the Grievance Committee for a system analysis approach to investigate system concerns or issues.

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Senior Leadership Team:

The Senior Leadership Team(SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief Clinical Officer, Chief Behavioral Health Officer and Director of Human Resources, ensures that an integrated patient safety program is operationalized, and assumes responsibility for the strategic direction and integration of all Risk Management activities. Patient safety culture survey results provide feedback on workplace patient safety practices, communication, teamwork, adverse event reporting, and leadership to help guide vision and goals of the organization. The SLT is responsible to assure that key strategies and/or processes of the organization are identified and prioritized, and that the efforts of Risk Management support and integrate the strategic objectives of the organization and feedback from all community and hospital connections. SLT supports transparency in communication related to the risk management process.

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Departments

Individual departments are responsible for quality management, regulatory compliance, and risk management activities relative to the services they provide. Progress on departmental risk management activities are submitted in writing when warranted to the Compliance/Risk Department or the Patient Safety Officer depending on the activity.

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RISK MANAGEMENT PROCESS

Risk management and quality improvement are complementary and continuous processes that link activities to BRH's mission and strategic plan. The risk management process ensures all employees have a risk management philosophy and are the first line of defense. The process should be outcome oriented; Compliance/Risk will work closely with Quality to ensure change elements are measured by quality indicators and dashboards.

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METHODS

Establishing a consistent definition and measurement process supports the goal of preventing harm or loss and delivering safe care to patients by allowing rapid identification of Serious Safety Events, quick mitigation to prevent further harm, and consistent evaluation of prevention methods. A clear and consistent plan for conducting investigations is imperative along with establishing common definitions and a shared mental model.

Risk Management and patient safety activities include:

1. Review and triage occurrence reports completed by staff and providers in the occurrence reporting software system.
2. Prioritize events, hazards, and system vulnerabilities.
3. Measure and report frequency and severity of events to transform risk management into a pro-active program.
4. Ensure timely execution of Root Cause Analysis, mitigation, and corrective action plans using RCA best practice guidelines and tools.
5. Collaborate with the Director of Quality identifying near misses or trends and utilizing evidence-based tools for process improvement and quality assessment activities.
6. Collaborate with the Director of Quality to communicate data and investigation findings to the BOD, SLT and staff.
7. Participation in litigation processes by attending depositions, supporting staff, providing documentation, and acting as liaison to BRH legal counsel.
8. Report potential medical malpractice liabilities to the risk manager at the City and Borough of Juneau and appropriate insurance liability carriers and agents.
9. Identify, investigate, and report Sentinel Events as required by Joint Commission standards.
10. Identify, investigate and report Serious Reportable Events required by the National Quality Forum.
11. Model and support evidence-based risk reduction concepts and tools to improve communication, and other high risk areas.
12. Review quality performance indicators to evaluate risks and strategies.
13. Review of patient grievances and responding following BRH policy, Centers for Medicare and the Medicaid Conditions of Participation.
14. Evaluate grievance data using system analysis with a grievance function of the HPIC committee and incorporate into QAPI
15. Collaborate with the Director of Quality in completing a patient safety culture survey and developing risk and quality plans that incorporate staff input and participation.
16. Collaborate with the City and Borough of Juneau (CBJ) risk managers in litigation, property damage, and employee events and attend and participate in Joint Safety meetings.

COMMUNICATION

Communication of risk management availability and outcomes to all levels of BRH is vital. Conclusions, recommendations, and actions are communicated to leadership, and/or individuals responsible for implementing and coordinating improvements through various presentations or reports. Examples of meetings where relevant information may be reported include:

1. Medical Staff meetings
2. Individual Department Staff meetings (when appropriate)
3. Board and/or Hospital Quality Committee reports
4. Management Team meeting
5. Patient Safety Committee Meeting
6. Hospital Performance Improvement Committee (HPIC)

An annual review and revision of the risk management plan and objectives are provided to the Hospital Performance Improvement Committee (HPIC) and the Board of Directors.

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New Compliance Dashboard

Element/Metric	Q1	Q2	Q3	Q4	Annual
Oversight					
% Completion of Board members compliance training	0%				
% Quarterly reports to Board	100%				
Compliance issues addressed as an outcome of education	32				
Code of Conduct/Policies and Procedures					
% Completion of CoC attestation: physicians	N/A				
% Completion of CoC attestation: employees	N/A				
% Policy and procedure receipt sign-off: new employees	100%				
% Compliance policies and procedures reviewed per schedule	5%				
Exclusion Screening					
% OIG/SAM physician screening: prior to hire/contract	100%				
% OIG/SAM vendor screening: prior to hire/contract	100%				
% OIG/SAM employee screening: prior to hire/contract	100%				
% OIG/SAM physician screening: monthly	100%				
% OIG/SAM vendor screening: monthly	100%				
% Open screening/requires additional documentation	N/A				
Education					
% Completion of compliance training within 30 days of hire	100%				
% Completion of HIPAA training	100%				
% Completion of role-specific training	100%				
Annual re-training	0%				
Compliance Investigations					
Number of hotline calls	0				
Number of issues reported other than hotline	3				
Total	3				
Number of issues requiring compliance investigation	11				
Number of issues closed	9				
Number of issues pending	6				
Number of compliance surveys returned	0				
Average time to initiate compliance investigation	2				
Average time to complete compliance investigation	14				
Top three concerns reported: #1	340B				
Top three concerns reported: #2	HIPAA				
Top three concerns reported: #3	Billing				
Departmental Monitoring and Auditing					
% Denied claims requiring resubmission	N/A				
Average % of billing accuracy	N/A				
Number of inappropriate IS access or logins	0				
Number of employees disciplined for compliance violations	0				

Element/Metric	Q1	Q2	Q3	Q4	Annual

Regulatory/Policy Updates

Regulatory requirements: new or revised Follow-up required	N/A				
Policies: new or revised Follow-up required	N/A				

Repayments/Overpayments

Discovered by auditing and monitoring

Number of claims	N/A				
Repayment amount	N/A				
Paid within 60 days	N/A				

Discovered by internal investigation

Number of claims	0				
Repayment amount	0				
Paid within 60 days	0				

Government audits

Number of claims	N/A				
Repayment amount	N/A				
Paid within 60 days	N/A				

Comments/Suggested Action Items

N/A's represent areas where the process still needs to be developed, such as the Code of Conduct (CoC) attestations for physicians, or the process for the collection data for this new report still needs to be developed.