Kaweah Delta Health Care District

Board of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

NOTICE

The Audit and Compliance Committee of the Kaweah Delta Health Care District will meet at the GME West Conference Room {520 W Mineral King Avenue, Visalia, CA} on Tuesday, November 18, 2025:

- 1:00PM Open meeting
- Closed meeting immediately following open meeting pursuant to Government Code 54956.9(d)(2)

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.

All Kaweah Delta Health Care District regular board meeting 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 near the Mineral King entrance.

The disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department/Executive Offices) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: kedavis@kaweahhealth.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

Governing Board, Legal Counsel, Executive Team, Chief of Staff, www.kaweahhealth.org

Kaweah Delta Health Care District
Board of Directors Committee Meeting

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AUDIT AND COMPLIANCE COMMITTEE

Meeting Held: Tuesday, November 18, 2025 • GME West Conference Room

Attending: Board Members: Michael Olmos – Committee Chair, Dean Levitan, M.D.; Gary Herbst, Chief Executive Officer; Malinda Tupper, Chief Financial Officer; Rachele Berglund, Legal Counsel; Ben Cripps, Chief Compliance & Risk Officer; Jill Berry, Director of Corporate Compliance; and Michelle Adams, Executive Assistant – Recording.

OPEN MEETING – 1:00 PM

CALL TO ORDER – Michael Olmos, Chair

PUBLIC / MEDICAL STAFF PARTICIPATION – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

1. Written Reports – Committee review and discussion of written reports.

2.1 Compliance Program Activity Report – *Jill Berry*

2.2 The Joint Commission Action Plan – *Ben Cripps*

2.3 Committee Charters for Review and Approval – *Jill Berry*

A. Operational Compliance Committee Charter

B. Policy and Procedure Committee Charter

2.4 Compliance Policies for Review and Approval – *Jill Berry*

A. CP.13 Federal and State False Claims Act and Employee Protection Provisions

B. CP.16 Compliance Risk Assessment and Annual Compliance Workplan Development

C. CP.17 Remote Non-Employee Electronic Medical Record System Access

3. Approval of Closed Meeting Agenda – Kaweah Health Executive Office Conference Room – immediately following the open meeting

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- Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (5 cases)

ADJOURN OPEN MEETING – Michael Olmos, Chair

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

CALL TO ORDER – Michael Olmos, Chair

1. MINUTES – Approval of the Quarterly November closed minutes

2. Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (5 cases) – *Ben Cripps and Rachele Berglund (Legal Counsel)*

ADJOURN CLOSED MEETING – Michael Olmos, Chair

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Compliance Program Activity Report – Open Session

August 2025 through October 2025

Ben Cripps, Chief Compliance & Risk Officer

Education

Live Presentations

- Compliance and Patient Privacy – New Hire Orientation
- Compliance and Patient Privacy – Management Orientation
- Compliance and Patient Privacy – Sequoia Surgery Center Competency Fair

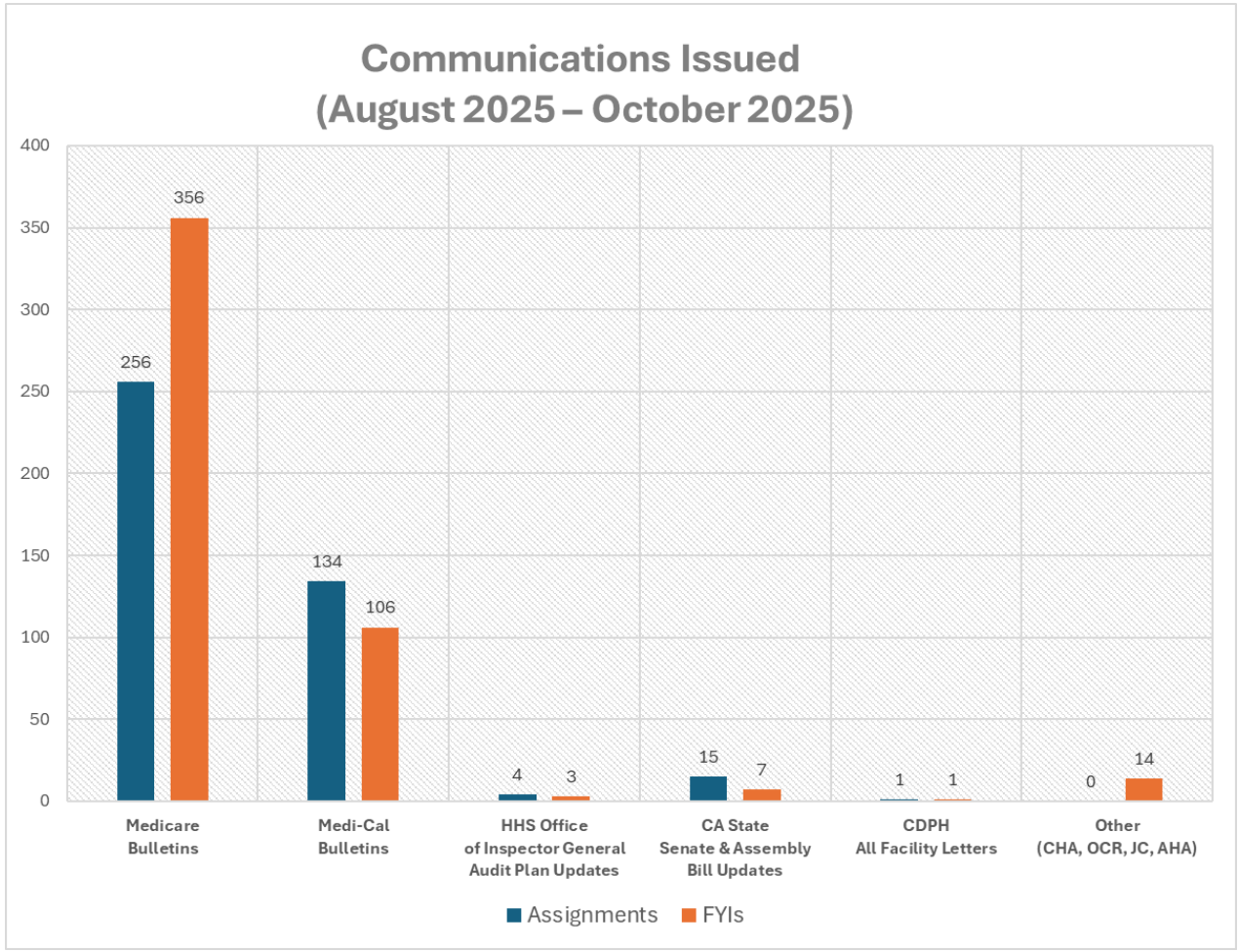
Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff

- Compliance Matters Minimum Necessary Requirement
- Compliance Matters Cell Phone Usage, Photography, and Videography
- AP.64 Confidentiality Security and Integrity of Health Information
    - Notification from employees to Compliance Department when accessing patient records of family members and co-workers for business purposes
- Medical Executive Committee
- PolicyTech system training

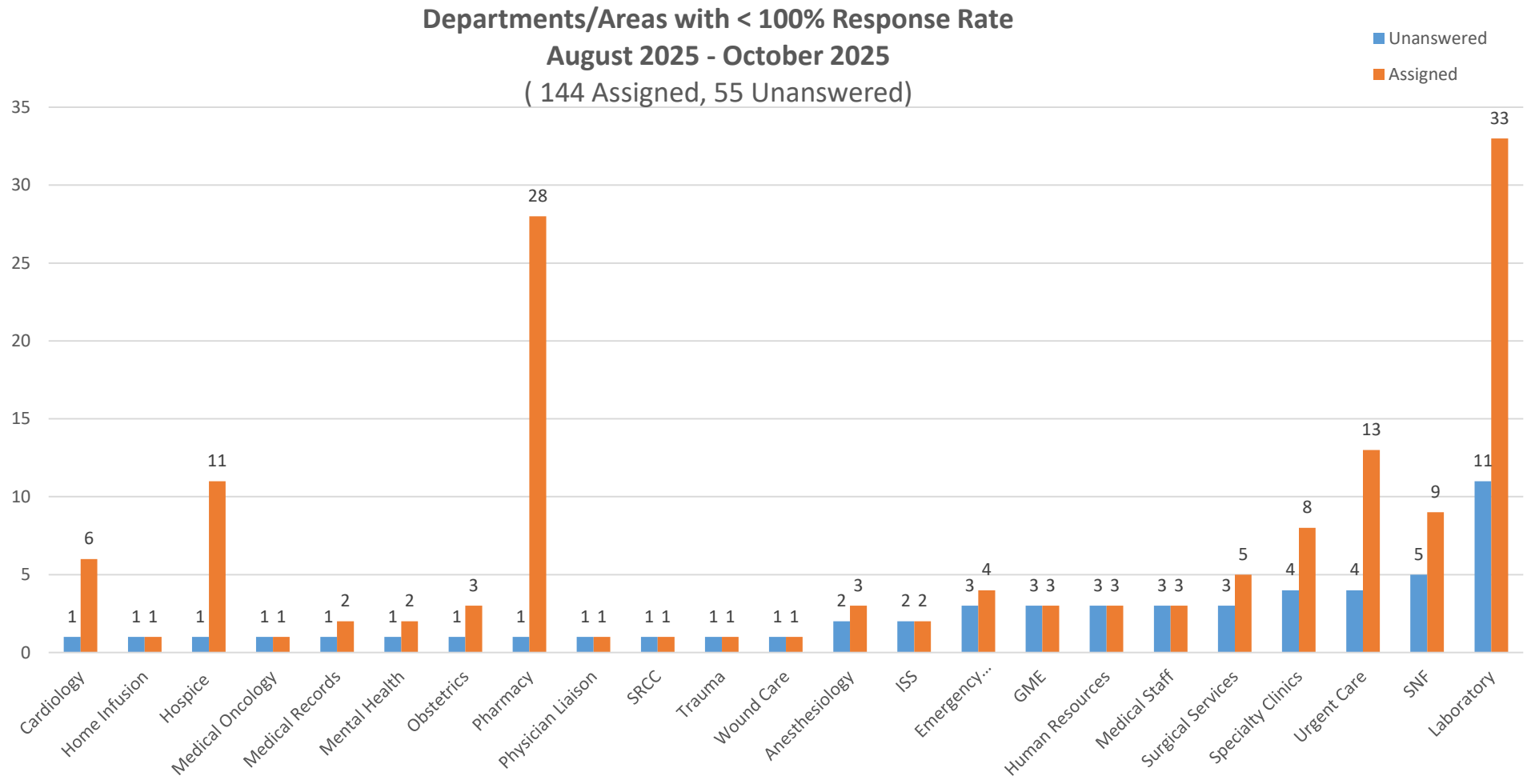
Prevention & Detection

- Review, Track, and Distribute Relevant Information Related to Regulatory Updates to Stakeholder Across the District
    - California Department of Public Health (CDPH) All Facility Letters (AFL)
    - Medicare Monthly Bulletins
    - Medi-Cal Monthly Bulletin
    - US HHS Office of Inspector General (OIG) Monthly Audit Plan Updates
    - California State Senate and Assembly Bill Updates
    - US HHS Office of Civil Rights Activities and Focus Areas
    - California Hospital Association Communications
    - American Hospital Association Communications
    - Joint Commission Communications

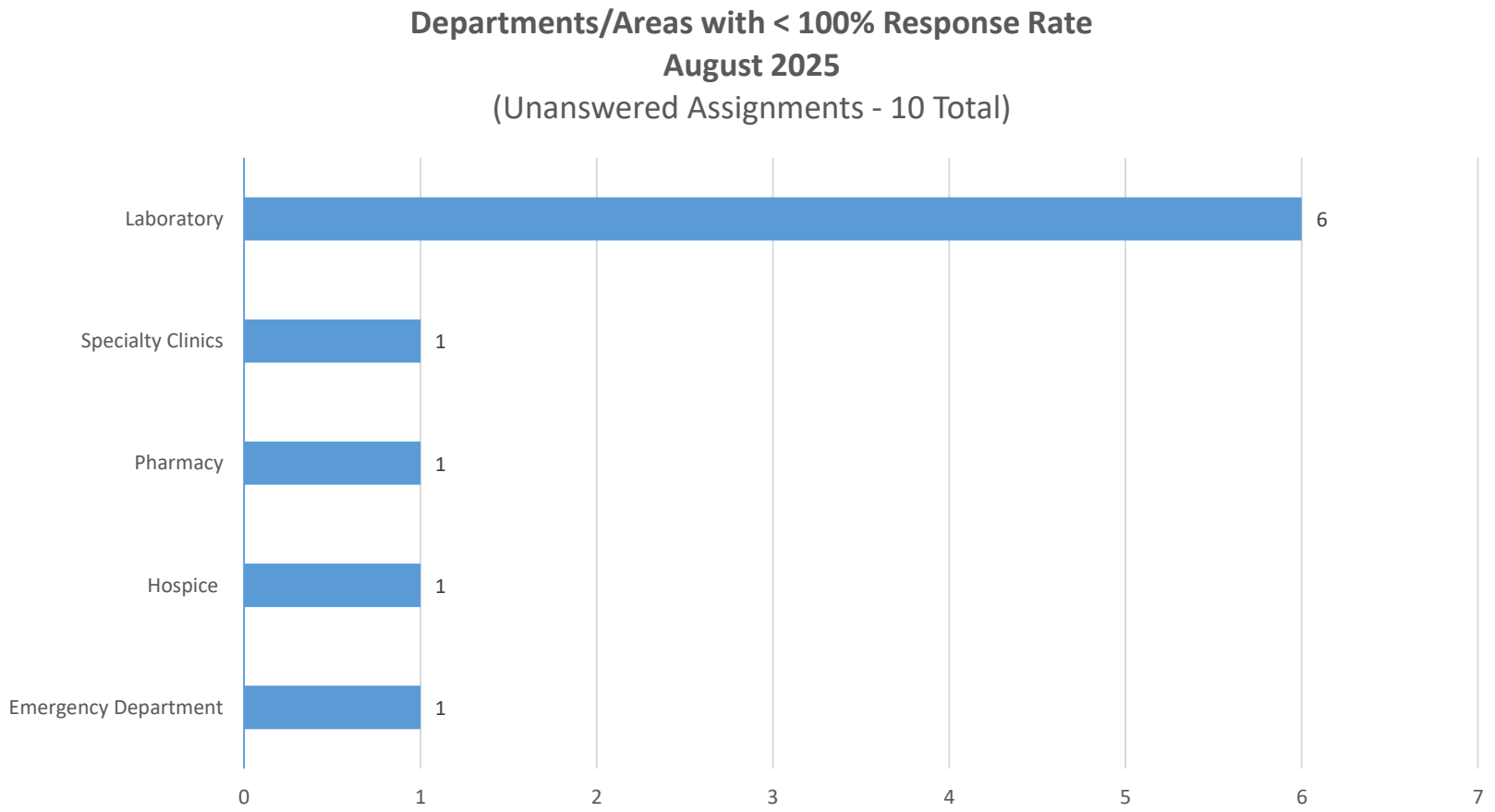
Prevention & Detection - Issuance



Prevention & Detection - Response

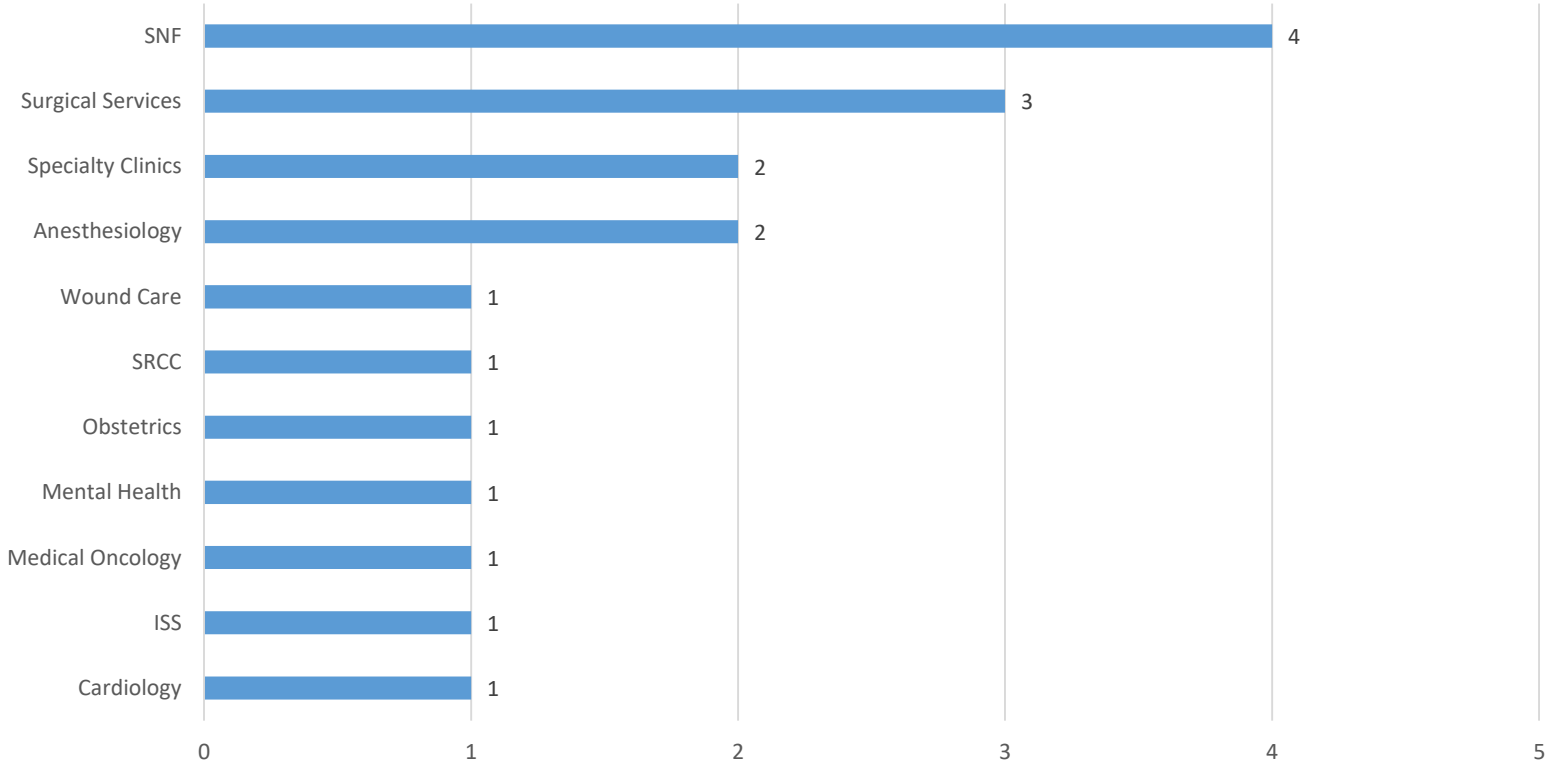


Prevention and Detection - Response

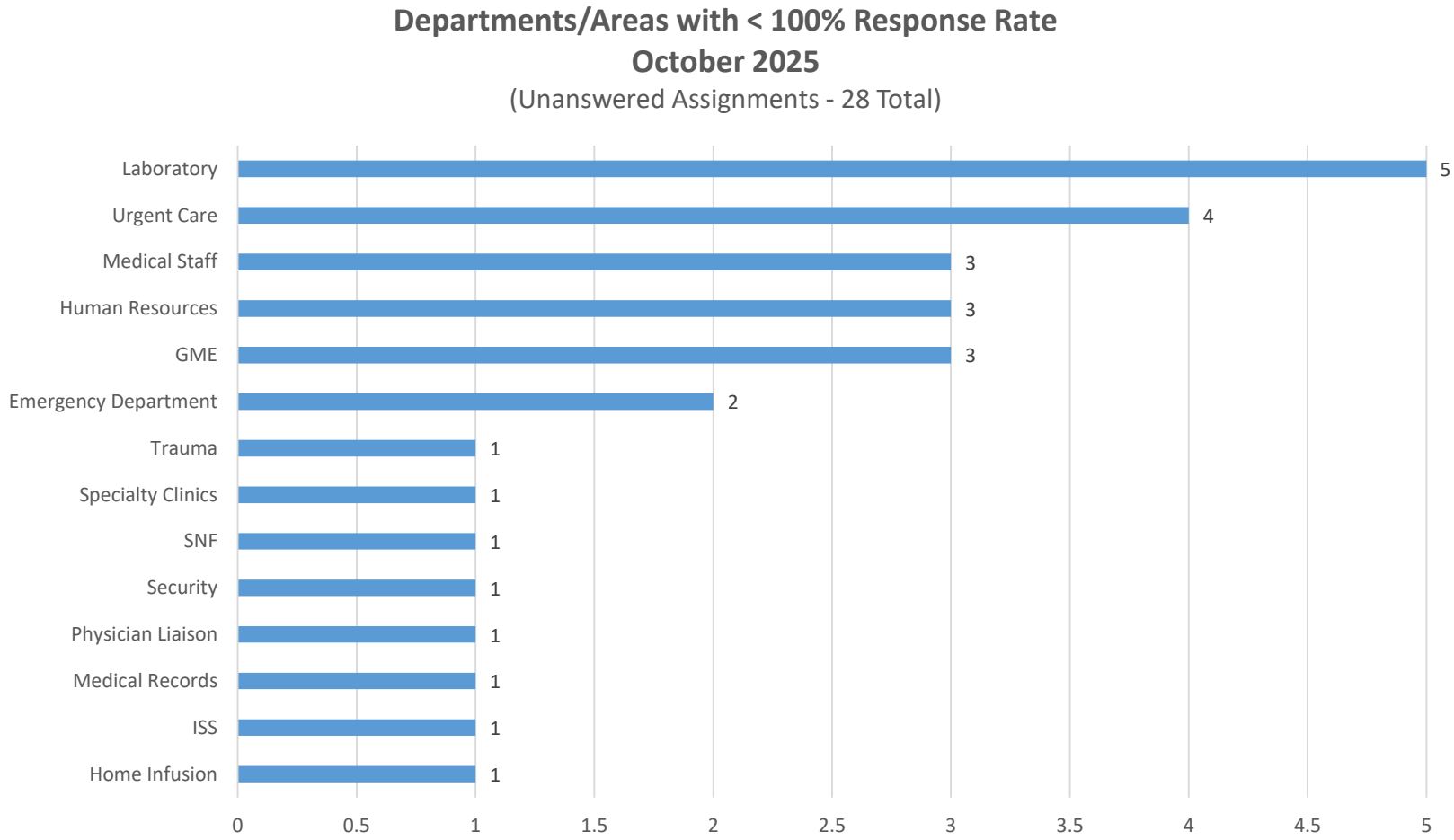


Prevention and Detection - Response

Departments/Areas with < 100% Response Rate
September 2025
(Unanswered Assignments - 18 Total)



Prevention and Detection - Response



Prevention & Detection - Response

Departments/Areas with 100% Response Rates

August 2025:

Cardiology
Dialysis
HIM
Imaging Center
Patient Access
Quality
RHC
SNF
Coding
Finance
Home Health
Mental Health Hosp.
Patient Accounting
Revenue Integrity
Sleep Center

September 2025:

Ben Maddox Clinic
Cardiothoracic
Centers for Mental Wellness
Finance
Hospice
Outpatient Therapy
Patient Accounting
Plaza Clinic
Radiology Oncology
Reimbursement / Contracting
RHC
Urology
Cardiology
Case Management
Emergency Department
Home Health
Laboratory
Patient Access
Pharmacy
Procurement and Logistics
Rehabilitation Hospital
Revenue Integrity
Urgent Care
Willow Clinic

October 2025:

Anesthesiology
Coding
Home Health
Kaweah Kids
Patient Accounting
Rehabilitation Hospital
Reimbursement / Contracting
Revenue Integrity
Cardiology
Finance
Hospice
Patient Access
Pharmacy
RHC

**** Bolded Departments/Areas were 100% for the quarter*

Oversight

- 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 Applications and Medicare/Medi-Cal Facility Enrollment – Forms preparation and submission of licensing applications to the California Department of Public Health (CDPH) and enrollment applications for Medicare or Medi-Cal. Ongoing communications and follow-up regarding status of pending applications. Five applications for licensure and/or government payor enrollment were completed between August 2025 – October 2025.
- Medicare Recovery Audit Contractor (RAC) Activity – Records preparation, tracking appeal timelines, and reporting.
  - The following RAC Audit Activity took place between August 2025 – October 2025:
    - Sixty-two (62) new RAC requests were received for the quarter
      - Twenty-three (23) were reviewed and closed with no recovery after review of the medical records submitted
      - Six (6) are denied, pending decision for appeal from Coding
      - Thirty-two (32) are pending review from the RAC
      - One (1) is pending review and shipment of medical records

Policies and Procedures and Program Related Processes

- New Policy Developments:
  - CP.16 Compliance Risk Assessment and Annual Compliance Workplan: Outlines the standard process for identifying and triaging compliance related-risks and for developing an annual Compliance Workplan focused on issues that present the greatest compliance-related risks to the organization.
  - CP.17 Remote Non-Employee Electronic Medical Record System Access: Establishes organization policy on access to Kaweah Health's electronic medical record system for remote non-employee users and includes guidelines for granting access, provides information on non-permitted uses and reporting requirements, and provides notice related to auditing and monitoring of activities and actions that may be taken in the event of a violation.

Policies and Procedures and Program Related Processes

- New Process Developments:
  - Operational Compliance Committee Charter: Establishes guidelines for the structure, composition, duties and responsibilities, meeting cadence, and reporting requirements for the Operational Compliance Committee that is being implemented.
  - Policy and Procedure Committee Charter: Establishes guidelines for the structure, composition, duties and responsibilities, and meeting cadence, and reporting requirements for the district-wide Policy and Procedure Committee that is being implemented.

- Policy Review and Revisions:
  - CP.13 Federal and State False Claims Act and Employee Protection Provisions: Removed federal penalty dollar amounts from policy to ensure amounts set out in Kaweah policy are not inconsistent with federal regulations, if changes to such regulations are implemented.

Auditing and Monitoring

- Electronic Medical Record (EMR) User Access Privacy Audits – Daily monitoring of EMR user access through the use of FairWarning electronic monitoring technology which analyzes user and patient data to detect potential privacy violations.
  - Average of one hundred and fifty (150) daily alerts received and reviewed between August 1, 2025 – October 31, 2025.
  - Types of Alerts Reviewed:
    - Same Last Name: 74.5%
    - Co-Worker: 21.1%
    - VIP: 3.0%
    - Self-Access: 0.8%
    - Same Household: 0.5%

- Office of Inspector General (OIG) Exclusion Report Verification – Quarterly monitoring of OIG exclusion reports and attestations.
  - Medical Staff and Advanced Practice Providers – Review of reports and certification by Medical Staff Office that screening was completed and no Excluded Individuals or Entities were identified.
  - Suppliers – Review of reports and certification by the Finance Department that screening was completed and no Excluded Individuals or Entities were identified.
  - One (1) non-credentialed provider was identified on the Medicare Opt-Out list between August 2025 – October 2025. Findings were tracked and logged into the system. No additional action required as providers were only referring and not treating.

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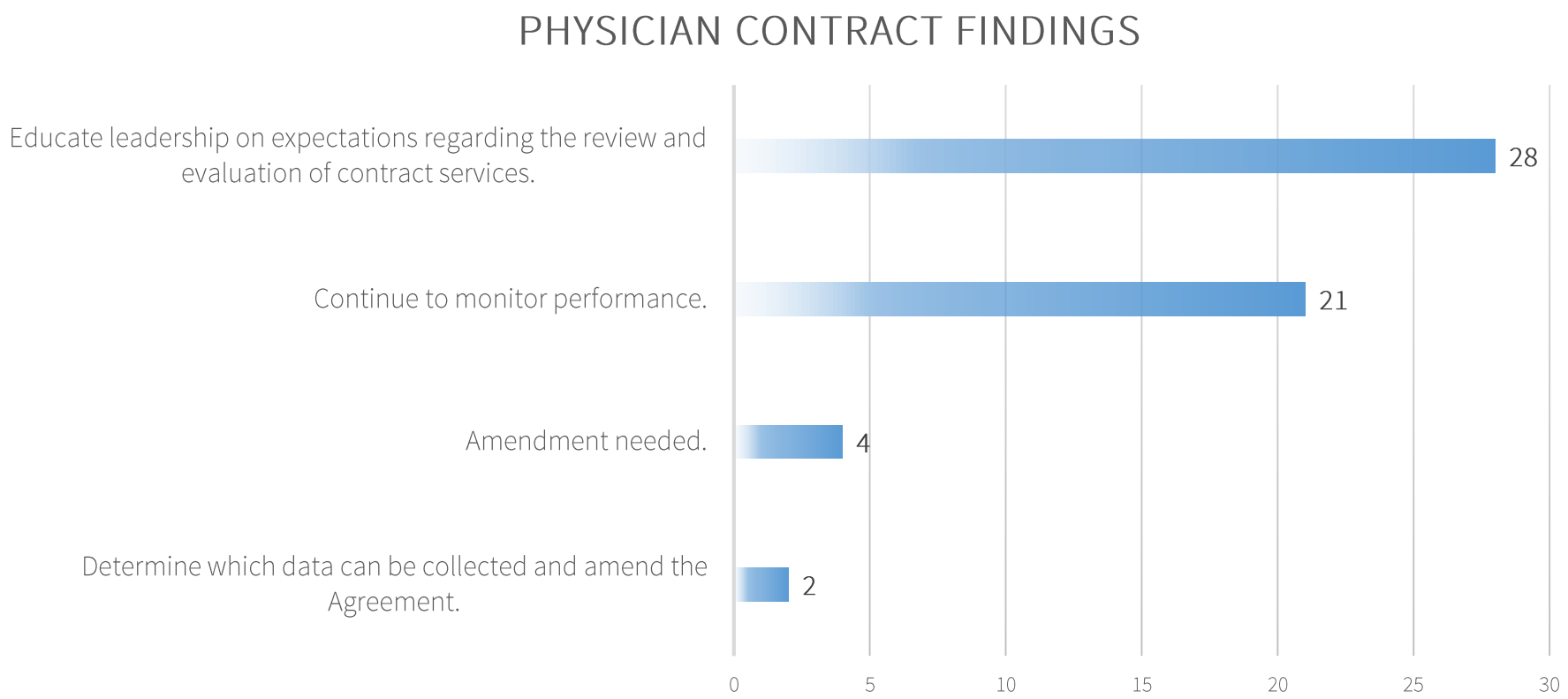
The Joint Commission Action Plan

Ben Cripps, Chief Compliance & Risk Officer

The Joint Commission Action Plan



Clinical Physician Contracts Evaluated

Contract Title	Annual Evaluation Checklist Sent	Annual Evaluation Checklist Returned	Physician Contract Department Findings	Action Plan	Action Plan Completion Date
Mack Medical Mgmt. (PSA).	6/4/2025	6/5/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Ester Flores, Inc.	10/9/2025	10/17/2025	Leadership does not understand The Joint Commission requirements	Educate leadership on expectations regarding the review and evaluation of contract services.	
Innovative Dermatology Alliance (Dr. Rex)	10/9/2025	11/7/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Kim, Jun DO	10/9/2025	11/3/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Roach, William MD	10/9/2025	10/17/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Said, Sarmad M.D.	10/9/2025	10/10/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Eye-Q (Vision Care Center, A Medical Group, Inc.)	6/4/2025	7/21/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Jason Jeter, DDS	10/9/2025	10/28/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
California Pediatric Hospitalists (Dr. Sine)	10/9/2025	10/14/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	

Clinical Physician Contracts Evaluated

Contract Title	Annual Evaluation Checklist Sent	Annual Evaluation Checklist Returned	Physician Contract Department Findings	Action Plan	Action Plan Completion Date
Quinn, Holly M.D.	10/9/2025	10/17/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Harleen Chahil, M.D.	10/9/2025	10/10/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Pantera, Richard L., M.D.	10/9/2025	10/14/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Thiagarajan, Ramu, M.D.	10/9/2025	10/14/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Aaronson, Craig DPM	10/9/2025	10/28/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Avadhanula, Shirisha MD	10/9/2025	11/7/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Dean MD, Ryan E (Ortho Traumatology)	10/9/2025	10/14/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Herriford, Carla M.D.	10/9/2025	11/7/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Innovative Dermatology Alliance (Dr. Rex)	10/9/2025	11/7/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	

Clinical Physician Contracts Evaluated

Contract Title	Annual Evaluation Checklist Sent	Annual Evaluation Checklist Returned	Physician Contract Department Findings	Action Plan	Action Plan Completion Date
Medina, Rocio MD	10/9/2025	11/7/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Oakstone Medical Group	10/9/2025	11/7/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Talamayan-Pa, Roxanne, M.D.	10/9/2025	10/28/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Family Healthcare Network	10/9/2025	10/21/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Feng, Frank DO (ED Call)	10/9/2025	10/14/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Ford, Joseph C. DO (ED Call)	10/9/2025	10/14/2025	Leaderhsip does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Mihalcin, Jason DO (ED Call)	10/9/2025	10/14/2025	Leaderhsip does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Nephrology ED Call	10/9/2025	11/10/2025	Leaderhsip does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Orthopedic ED Call	10/9/2025	10/14/2025	Leaderhsip does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	
Podiatry - ED Call Agreement	10/9/2025	10/14/2025	Leadership does not understand The Joint Commission requirements.	Educate leadership on expectations regarding the review and evaluation of contract services.	

Clinical Physician Contracts Evaluated

Contract Title	Annual Evaluation Checklist Sent	Annual Evaluation Checklist Returned	Physician Contract Department Findings	Action Plan	Action Plan Completion Date
Valley Hospitalist Medical Group, Inc.	6/4/2025	6/13/2025	Leadership is aware of performance objectives identified within the Agreement, but is not able to collect all data to monitor the performance.	Determine which data can be collected and amend the Agreement.	
Precision Psychiatric Services, Inc.	6/4/2025	7/23/2025	Leadership is aware of performance objectives identified within the Agreement, but is not able to collect all data to monitor the performance.	Determine which data can be collected and amend the Agreement.	
CEP - Urgent Care	6/4/2025	8/8/2025	Leadership, in collaboration with Medical Group, is working on establishing new performance standards.	Amendment needed.	
South Valley Vascular Associates, Inc.	6/4/2025	6/11/2025	Leadership is monitoring performance, but the objectives are not identified within the Agreement.	Amendment needed.	
Yosemite Pathology Medical Group	6/4/2025	6/13/2025	Leadership is monitoring performance, but the objectives are not identified within the Agreement.	Amendment needed.	
Mineral King Radiological Medical Group, Inc	6/4/2025	7/21/2025	Leadership is monitoring performance, but the objectives are not identified within the Agreement.	Amendment needed.	In Progress
Heart & Vascular Consultants of Central California, Inc.	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Sequoia Cardiology Medical Group, Inc.	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement	Continue to monitor performance.	N/A
Delta Doctors, Inc.	6/4/2025	8/8/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Key Medical Assoc. (RHC Services)	6/4/2025	8/8/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A

Clinical Physician Contracts Evaluated

Contract Title	Annual Evaluation Checklist Sent	Annual Evaluation Checklist Returned	Physician Contract Department Findings	Action Plan	Action Plan Completion Date
Kaweah Nurse Anesthesia Services	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Kaweah Cardiac Anesthesia Professionals, Inc.	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Kaweah Anesthesiologist Services, Inc.	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Center Neurorestoration Associates	6/4/2025	6/11/2025	Leadership is aware of and is monitoring performance objectives identified within the agreement.	Continue to monitor performance.	N/A
Visalia Orthopedic Co-Management	6/4/2025	6/11/2025	Leadership is aware of and are monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Sequoia Oncology Medical Associates, Inc.	6/4/2025	6/17/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Kaweah Rehab Group, Inc.	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Visalia Rehab Group, Inc.	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Valley Children's Med. Grp. (Maternal Fetal Medicine)	6/4/2025	7/21/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement	Continue to monitor performance.	N/A
Valley Children's Med. Group (NICU/PEDS Inpatient)	6/4/2025	7/21/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement	Continue to monitor performance.	N/A

Clinical Physician Contracts Evaluated

Contract Title	Annual Evaluation Checklist Sent	Annual Evaluation Checklist Returned	Physician Contract Department Findings	Action Plan	Action Plan Completion Date
Valley Children's Med. Group (Telemedicine)	6/4/2025	7/21/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement	Continue to monitor performance.	N/A
CEP - Emergency Department	6/4/2025	7/30/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement	Continue to monitor performance.	N/A
Sound Physicians (Inpatient Specialists of California)	6/4/2025	6/13/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement	Continue to monitor performance.	N/A
Howard, Ryan H. MD (PSA)	6/4/2025	6/5/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
OBHG California, P.C.	10/9/2025	10/21/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Golden Valley Cardiothoracic Institute	10/9/2025	10/10/2025	Leadership is aware of and is monitoring performance objectives identified within the Agreement.	Continue to monitor performance.	N/A
Mayer, Fredrick W. M.D.	10/9/2025	10/10/2025	Leadership is aware of and is monitoring performance objectives identifed within the Agreement.	Continue to monitor performance.	N/A

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Operational Compliance Committee Charter

Purpose: The Operational Compliance Committee ("OCC") is a multidisciplinary team consisting of organizational leaders established for the purpose of achieving organizational compliance and facilitating the operations of the Kaweah Compliance Program.

Duties and Responsibilities:

- Participate in the development and review of Kaweah policies, procedures and processes created to govern compliance.
- Support and advise the CCRO and Compliance Department concerning compliance program activities, including but not limited to gathering compliance data generated through internal monitoring and audits, conducting appropriate and timely risk assessments, developing and completing annual compliance work plans.
- Provide input and support needed to analyze and make recommendations regarding the legal and regulatory environment affecting Kaweah.
- Provide input on and help support compliance-related education for all Workforce Members.
- Provide input and recommendations on compliance-related auditing, monitoring, reporting, tracking, and trending.
- Assist in implementing action plans when deficiencies are identified.
- Serve as a "clearinghouse" and avenue for the sharing and distribution of information regarding Compliance.
- Support the evaluation and management of potential conflicts of interest that may affect Kaweah.
- Facilitate and coordinate Compliance activities and programs among and across all Kaweah departments, units, and locations.
- Promote a "culture of Compliance" across the organization.

Subcommittees, Workgroups, and Task Forces:

Certain responsibilities of the OCC, as appropriate, may be accomplished through the development of subcommittees, workgroups, and task forces designed to focus on specific compliance-related functions and goals.

In furtherance of this, the OCC may identify and select members throughout Kaweah that are best suited in relation to area oversight, job responsibilities and subject matter expertise to participate in the workgroups in order to accomplish the goals established by the OCC.

Some subcommittee, workgroup, and task force members and participants will be considered members of the OCC, as set out herein below. However, subcommittee, workgroup, task force members, and other Kaweah employees may be required to

attend, participate, and/or present information and data or respond to queries on assigned compliance-related projects as invited guests of the OCC; and such attendees shall not be considered members of the OCC.

Subcommittees, Workgroups, and Task Forces shall report their activities to the OCC, including tracking and trending data as assigned by and in a manner determined by the Chief Compliance and Risk Management Officer and Compliance Department.

Standing Subcommittees of the OCC shall include the following:

- Conflicts of Interest Subcommittee
- Policy and Procedure Subcommittee
- Privacy and Information Security Subcommittee

Standing Workgroups of the OCC shall include the following (any of which may be held in combination or separately):

- Care Management
- Clinical Documentation Improvement
- HIM
- Patient Access
- Patient Accounting and Revenue Integrity

Committees Reporting Information:

Kaweah has certain established committees that perform compliance-related functions in relation to their areas of expertise and oversight. Information sharing with the Operational Compliance Committee will help to ensure risks in these specialty areas is incorporated into the organization's overall compliance functions and shared with the Audit and Compliance Committee and Board, as necessary. Committees that should regularly report their compliance-related activities to the Operations Compliance Committee, include the following:

- HIM Committee
- 340B Committee

Structure and Composition:

The OCC shall be a standing committee comprised of members of Kaweah's leadership team and other individuals who (1) have significant responsibility for the administration of various aspects of Kaweah's Compliance Program, (2) manage or oversee compliance-related controls due to their assigned roles and responsibilities at Kaweah, or (3) are considered subject matter experts in areas with common compliance-related risks.

Chair: Chief Compliance and Risk Management Officer

Membership:

- Director of Corporate Compliance

- Compliance Manager
- Compliance Department Staff
- Director and Managers of Revenue Cycle and Patient Accounting
- Directors ISS (Technical and Applications)
- Director Finance
- Director Employee Relations
- Director Quality and Patient Safety
- Director HIM
- Director Care Management
- Director Nursing
- Director 340B Program

Chair Rights and Responsibilities:

- Develop a written charter.
- Establish an agenda for each meeting.
- Track and provide feedback on active participation of committee members.
- Facilitate committee discussions.
- Assist in identifying and triaging the priority of matters of the committee.
- Reporting OCC activities, subcommittee activities, and workgroup/task force activities to the Audit and Compliance Committee.

Agenda, Meeting Minutes, and Reports:

Meeting agendas will be prepared and distributed in advance of each meeting.

Meeting minutes will be prepared and distributed to the committee members for review and approval following each meeting.

Meeting minutes and reports will be submitted to the Audit and Compliance Committee to facilitate their oversight of compliance activities throughout Kaweah.

Meeting Cadence:

The OCC shall meet from time to time as needed or appropriate, but no less frequently than quarterly. The CCRO shall determine the frequency, date and time of meetings and give appropriate notice of such meetings to all members.

Policy and Procedure Committee Charter

Purpose: The Policy and Procedure Committee is established for the purpose of providing strategic advice on organizational policies and related policy resources. The Committee will support the development and enhancement of the common platform for managing organization policies designed to promote consistency and accountability.

Duties and Responsibilities:

- Serve as core superusers for the policy and procedure system.
- Evaluating and assigning Roles.
- Evaluating and establishing and/or removing Groups and Group membership.
- Evaluating processes related to the implementation of policies and procedures.
- Tracking and reporting policy and procedure review delinquencies to the Operational Compliance Committee and Executive Team.
- Identifying and facilitating training and education on the policy and procedure system.
- Coordinating the review and retirement of duplicative policies.
- Obtaining feedback from organizational stakeholders on process improvements for policy and procedure management.
- Providing feedback on policy and procedure system processes across the organization.
- Providing guidance as subject-matter experts (SMEs) in their respective areas on opportunities to improve policy operations across the organization.
- Reviewing and revise organization policy on policies as needed.
- Reviewing Policy and Procedure Committee Charter at least annually and recommend changes to the Compliance Committee as needed.

Structure & Composition:

Chair: Director of Corporate Compliance: Jill Berry

Membership:

- Compliance Support: Lisa Wass, Amy Valero
- Quality and Accreditation Lead: Pending
- Nursing Lead: Kari Knuedsen (Veritta Henry & Chris McRae, Interim)
- Risk Management Lead: Laree Irving
- Maribel: Maribel Aguilar
- HR Lead: Raleen Larez
- Clinics: Ivan Jara
- Administrative Procedures: Kelsie Davis
- IT – Policy System Administrator and Project Support: Pending
- P&P Project Manager: Pending

Agenda, Meeting Minutes, and Reports: A meeting agenda will be prepared and distributed in advance of each meeting. The Committee Chair may invite relevant SMEs to attend meetings when deemed appropriate or necessary. Meeting minutes shall be prepared and distributed to the Committee members and to the Compliance Committee following each meeting.

Reporting to Compliance Committee: The Policy and Procedure Committee shall be a subcommittee of the Compliance Committee, and the minutes of each meeting shall be submitted to the Compliance Committee. The Compliance Committee will review and recommend actions related to policies and procedures as needed.

Meetings: The Committee shall meet as needed but no less than quarterly. Meeting times and dates will be communicated by the Chair in advance. A majority of the Committee constitutes a quorum, and any action taken during a meeting with a quorum present shall be an action of the Committee. The Chair will determine whether meetings will be held in-person or virtually.

Policy Number: CP.13	**Date Created: 10/02/2023**
Document Owner: Jill Berry (Director of Corporate Compliance)	**Date Approved: 11/02/2025**
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance & Risk Management Officer)	

Federal and State False Claims Act and Employee Protection Provisions

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Purpose: Kaweah Delta Health Care District ("Kaweah Health") (herein after known as Kaweah Health) acknowledges its responsibilities to establish policies and procedures under the Federal Deficit Reduction Act to provide information and education to its employees, agents and contracted work force regarding the federal False Claims Act, the Federal Whistleblower's Act as well as California law on these subjects. The following policy is established in order to help our employees, agents and contractors understand the provisions of the federal and state laws regarding submitting false claims for reimbursement, as well as to further inform our employees of their right to report violations at the state and federal levels as well as to their supervisor or through Kaweah Health's Compliance structure.

Policy: Detailed information regarding both state and federal false claims laws and whistleblower laws will be distributed to employees via this policy as well as through the various educational courses and orientation programs ongoing throughout the system. Employees are strongly encouraged to report any observations they might make regarding potential violations to their supervisor, the Kaweah Health Chief Compliance and Risk Officer, or through the Kaweah Health Confidential Compliance Hotline (1-800-998-8050). Every concern will be investigated in accordance with policy CP.05 Compliance and Privacy Issues Investigation and Resolution.

Federal False Claims Act - The False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid (Medi-Cal) programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U. S. Government for payment.

The term "knowingly" is defined to mean that a person, with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The Act does not require proof of a specific intent to defraud the United States Government. Instead health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the Government, such as knowingly making false statements, falsifying records, or otherwise causing false claims to be submitted.

Claim - For purposes of the False Claims Act, a "claim" includes any request or demand for money that is submitted to the U.S. Government or its contractors.

Liability - Health care providers and suppliers (persons and organizations) who violate the False Claims Act can be subject to civil monetary penalties for each false claim submitted. In addition to this civil penalty, providers and suppliers can be required to pay three (3) times the amount of damages sustained by the U.S. Government (See 31 USC §3729(a)). If a provider or supplier is convicted of a False Claims Act violation, the Office of Inspector General (OIG) may seek to exclude the provider or supplier from participation in federal health care programs.

California False Claims Act - The California FCA, enacted in 1987, is a state statute that covers fraud involving state funded contracts or programs, including Medi-Cal. The act establishes liability for any person who knowingly presents or causes to be presented a false claim for payment or approval or causes to be made or used a false statement to get a false claim paid or approved.

The California FCA closely mirrors the structure and content of the Federal False Claims Act. However, the California FCA does contain some provisions that differ from the federal statute. For example, the California FCA imposes liability upon a provider for an inadvertent submission of a false claim when the provider subsequently discovers the falsity but fails to disclose it within a reasonable period of time after the discovery of the false claim. Further, the California FCA states that liability is triggered if a provider conspires to defraud by getting a false claim allowed or paid.

The term "knowingly" for the California FCA is identical to the federal False Claims Act. As with the federal statute, proof of specific intent to defraud is not required.

Damages for the California FCA are similar to its federal counterpart. Any provider who violates the California FCA is liable to the state for three (3) times the amount of damages. Such a provider is also responsible for the costs of a civil action to recover the penalties and damages. Finally, any provider who violates the state statute may be liable for a civil penalty for each false claim. A "claim" is defined as any request or demand for money or services.

***Employee Protection - Qui Tam* "Whistleblower" Provision -** To encourage individuals to come forward and report misconduct involving false claims, both the federal False Claims Act and the California FCA include "qui tam" or whistleblower provisions. These provisions allow a person who is the "original source" to file a *qui tam* action and the party bringing the action is known as the "relator." "Original source" is defined as direct and independent knowledge of the information on which

the allegations are based and has voluntarily provided the information to the Government before filing a lawsuit on behalf of the U.S. Government or State of California. There are many different types of health care fraud that can be the basis of a qui tam action. These include, but are not limited to: add-on services, up-coding and unbundling, kickbacks, false certification and information, lack of medical necessity, fraudulent cost reports, grant or program fraud, and billing for inadequate patient care.

Kaweah Health staff have the right to request the presence of their supervisor, the Director of Risk Management, and/or the Compliance and Privacy Officer during an interview with a government investigator/inspector. Additionally, employees, or an employee's representative, have the right to discuss possible regulatory violations and/or patient safety concerns with the California Department of Public Health's (CDPH) inspector(s) privately during the course of an investigation or inspection. (See AP.91 Unannounced Regulatory Survey Plan for Response).

The False Claims Act is an increasingly significant enforcement tool due to the whistleblower provisions which entitle relators to recover a percentage of the penalty imposed. Law enforcement officials are using these acts and the whistleblower protections to pursue high penalty fraud allegations against hospitals, physicians, and other health care providers. However, individuals seeking whistleblower status must meet several criteria (e.g. "original source") to prevail as outlined below.

Health Insurance Portability and Accountability Act (HIPAA) Exception – Section 164.502(j)(1) of HIPAA permits a member of a covered entity's workforce or a business associate to disclose PHI with a Government Agency and/or Attorney due to the workforce member or business associate's belief in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public.

***Qui Tam* Procedure -** The relator must file his or her lawsuit on behalf of the Government in a federal district court or for the State of California in the name of California if state funds are involved. The lawsuit will be filed "under seal," meaning that the lawsuit is kept confidential while the state and/or federal Government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

Rights of Parties to *Qui Tam* Actions - If the Government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the state proceeds with the action, it shall have the responsibility for prosecuting the action. If the federal government or state decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Award to *Qui Tam* Whistleblowers - If the federal and/or state lawsuit is successful, and provided certain legal requirements are met, the relator may receive a percentage award of the total amount recovered or settlement made. If the federal

and/or state does not proceed with the action and the *qui tam* plaintiff proceeds with the action, the relator may receive a percentage award of the penalties and damages. The whistleblower may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit. All such expenses, fees and costs will be awarded against the defendant and in no circumstances will they be the responsibility of the federal government or state.

No Retaliation - In addition to a financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a False Claims Act action. Additionally, non-retaliation and whistleblower protections are afforded to county patients' rights advocates who are contracted individuals or entities.

Reporting a Concern – Employees are required to report any concerns of suspected non-compliance pursuant to Compliance Policy Compliance Program Administration. Concerns should be reported immediately to Kaweah Health Leadership, the Chief Compliance and Risk Officer, the Compliance Hotline at 1(800) 998-8050, or the Kaweah Health Compliance Advocate at (559) 636-0200.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: CP.13	Date Created: 03/21/2022
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: 06/29/2022
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance & Risk Management Officer)	

Federal and State False Claims Act and Employee Protection Provisions

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Policy: Detailed information regarding both state and federal false claims laws and whistleblower laws will be distributed to employees via this policy as well as through the various educational courses and orientation programs ongoing throughout the system. Employees are strongly encouraged to report any observations they might make regarding potential violations to their supervisor, the Kaweah Health Chief Compliance and Risk Officer, or through the Kaweah Health Confidential Compliance Hotline (1-800-998-8050). Every concern will be investigated in accordance with policy CP.05 Compliance and Privacy Issues Investigation and Resolution.

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Claim - For purposes of the False Claims Act, a "claim" includes any request or demand for money that is submitted to the U.S. Government or its contractors.

Liability - Health care providers and suppliers (persons and organizations) who violate the False Claims Act can be subject to civil monetary penalties ~~from $11,803 and $23,607~~ for each false claim submitted. In addition to this civil penalty, providers and suppliers can be required to pay three (3) times the amount of damages sustained by the U.S. Government (See 31 USC §3729(a)). If a provider or supplier is convicted of a False Claims Act violation, the Office of Inspector General (OIG) may seek to exclude the provider or supplier from participation in federal health care programs.

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source" is defined as direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing a lawsuit on behalf of the U.S. Government or State of California. There are many different types of health care fraud that can be the basis of a qui tam action. These include, but are not limited to: add-on services, up-coding and unbundling, kickbacks, false certification and information, lack of medical necessity, fraudulent cost reports, grant or program fraud, and billing for inadequate patient care.

Kaweah Health staff have the right to request the presence of their supervisor, the Director of Risk Management, and/or the Compliance and Privacy Officer during an interview with a government investigator/inspector. Additionally, employees, or an employee's representative, have the right to discuss possible regulatory violations and/or patient safety concerns with the California Department of Public Health's (CDPH) inspector(s) privately during the course of an investigation or inspection. (See AP.91 Unannounced Regulatory Survey Plan for Response).

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***Qui Tam* Procedure -** The relator must file his or her lawsuit on behalf of the Government in a federal district court or for the State of California in the name of California if state funds are involved. The lawsuit will be filed "under seal," meaning that the lawsuit is kept confidential while the state and/or federal Government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

Rights of Parties to *Qui Tam* Actions - If the Government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the state proceeds with the action, it shall have the responsibility for prosecuting the action. If the federal government or state decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Award to *Qui Tam* Whistleblowers - If the federal and/or state lawsuit is successful, and provided certain legal requirements are met, the relator may receive

a percentage award of the total amount recovered or settlement made. If the federal and/or state does not proceed with the action and the *qui tam* plaintiff proceeds with the action, the relator may receive a percentage award of the penalties and damages. The whistleblower may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit. All such expenses, fees and costs will be awarded against the defendant and in no circumstances will they be the responsibility of the federal government or state.

No Retaliation - In addition to a financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a False Claims Act action. Additionally, non-retaliation and whistleblower protections are afforded to county patients' rights advocates who are contracted individuals or entities.

Reporting a Concern – Employees are required to report any concerns of suspected non-compliance pursuant to Compliance Policy Compliance Program Administration. Concerns should be reported immediately to Kaweah Health Leadership, the Chief Compliance and Risk Officer, the Compliance Hotline at 1(800) 998-8050, or the Kaweah Health Compliance Advocate at (559) 636-0200.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: CP.16	Date Created: No Date Set
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer), Jill Berry (Director of Corporate Compliance)	
Compliance Risk Assessment and Annual Compliance Workplan Development	

Policy:

The purpose of this policy is to establish a standard process for Kaweah Health ("Kaweah") to identify compliance risks and focus compliance auditing and monitoring efforts on issues that present risk to the organization.

It is the policy of Kaweah that services and business transactions be carried out and documented in accordance with applicable federal, state, and local laws and regulations. Kaweah has developed its Compliance Program to promote adherence to this policy, and an important element of the Compliance Program is the identification of compliance risk areas. In furtherance of the goals of the Compliance Program, Kaweah will conduct an annual risk assessment to identify and analyze risks to the organization that may stem from laws and regulations or policies and procedures designed to enhance compliance with such, (hereinafter referred to as a "Compliance Risk Assessment").

Procedure:

I. The Compliance Department will be responsible for conducting a Compliance Risk Assessment on an annual basis, or more often as needed, to identify risk areas and set priorities related to the review and remediation of those risk areas.

II. Risk identification: Both external and internal sources of information will be used to identify potential risks to Kaweah including, but not limited to, the following:

   a. Key external sources:
      i. Centers for Medicare and Medicaid Services ("CMS");
      ii. Medicare Administrative Contractors ("MACs", including Noridian;
      iii. The Health and Human Services Office of Inspector General ("OIG");
      iv. The Medi-Cal program;
      v. Governmental program auditors, including RACs, and UPICs, as applicable; and
      vi. Other relevant sources, including those identified in Kaweah policy CP.08, Regulatory Updates.

b. Key Internal Sources:
    i. Issues identified through Compliance Department auditing and monitoring activities;
    ii. Concerns submitted to the Compliance Department;
    iii. Previous investigations conducted by the Compliance Department; and
    iv. Information received through Anonymous Compliance Line reports.

c. Interviews and queries of key Kaweah leaders and feedback from the Operational Compliance Committee.

d. Emerging Risks:
    i. New laws and regulations impacting operations;
    ii. Amendment to existing laws and regulations; and
    iii. New technologies and business practices.

III. Risk Analysis: The Risk Assessment Scoring Matrix ("Scoring Matrix") will be used to analyze each identified risk, which considers the potential impact on the organization, as well as vulnerability and controls related to the risk. *See Attachment A.*

IV. Risk Scoring:

a. The Risk Calculation Tool ("Calculation Tool") will be used to assign each identified risk to a high, medium, and low risk category and to develop Kaweah's annual Compliance Workplan. *See Attachment B.*

b. Members of the Operational Compliance Committee and other Kaweah leaders shall assist the Compliance Department as needed to obtain the data and financial information needed to successfully assign risk scoring.

c. At least annually, the CCRO will present the Scoring Matrix, the Calculation Tool, and an initial draft of the Compliance Workplan to the Operational Compliance Committee for review and recommendations prior to finalization and presentation of the draft Compliance Workplan to the Audit and Compliance Committee.

d. At least annually, the CCRO will present a draft annual Compliance Workplan to the Audit and Compliance Committee and the Board of Directors for input, recommendations, and final approval.

Attachment A
Risk Assessment Scoring Matrix
(Scoring Definitions)

	Impact to the Organization			Vulnerability		Controls
Score	**Reputation/Impact on Strategy**	**Financial**	**Legal**	**Likelihood of Risk**	**Detectability**	**Controls**
1	Little or no reputational risk. Little to no impact on strategic goals.	Loss is less than $500,000 of gross revenue or $200,000 expense (excluding legal fines/penalties)	No violation or strictly technical violation of law or regulation. No associated fine. No risk of exclusion, CIA, and/or loss of accreditation or licensure.	Low risk. Unlikely to occur or only in exceptional circumstances. Historical and industry experience show low likelihood of occurrence.	No risk for process failures. Failure is likely to be detected. Process is directly supervised. Automated safeguards for identifying variations/errors.	Internal and/or automated controls proven to be highly effective in mitigating 'all risk.' Current policies and procedures. Regular mandatory training to identified responsible person(s) and training is documented. Regular management reviews.
2	Slight reputational risk. Possible bad press but no significant patient, physician, and/or constituent consequences. Minor impact to strategic goals possible.	Loss between $500,000-$1,500,000 of gross revenue or $300,000 expense	Civil fines and/or penalties up to $10,000 possible. Little risk of exclusion, CIA, and/or loss of accreditation or licensure.	Slight risk, historical and industry experience shows some likelihood, but not experienced in organization to date. Simple, well understood process. Competency demonstrated - less likely to fail.	Slight risk for process failures and risk that failures will not be detected. Moderate safeguards in place. Partially automated process with moderate management oversight.	Routinely audited and/or tested. Performance metrics are established, routinely reviewed, and show little variation. Current policies and procedures. Employee training and competency established. Well-prepared to manage this risk based on management reviews and implemented risk management plans.
3	Moderate reputational risk. Probable bad press. Probable modest physician, patient and/or constituent fallout. Impact on strategic goals likely.	Loss between $1,500,000-$2,000,000 of gross revenue or $500,000 expense.	Civil fines and/or penalties between $10,000-$50,000 possible. Modest risk of exclusion, CIA and/or loss of accreditation or licensure.	Moderate risk of occurrence within next 12 months. Complex process, but competency has been demonstrated and low likelihood of failure.	Moderate risk process failures will not be detected or limited safeguards in place to identify failures prior to occurrence. Partially automated process with limited management oversight.	Periodically audited and/or tested. Corrective action plans developed and tested for effectiveness. Limited performance metrics established.
4	Extensive negative press coverage. Significant patient, physician and/or constituent fallout. Significant impact on strategic goals.	Loss between $2,000,000-$3,000,000 of gross revenue or $750,000 expense.	Civil fines and/or penalties more than $50,000 probable. Hi risk of the loss of department/location/service and/or licensure or accreditation. Exclusion possible. CIA probable.	High risk of occurrence within next 12 months. Complex and/or manual process.	Significant risk process failures will not be detected prior to failure. Manual safeguards in place to identify failures. No automated processes. Periodic management oversight.	Responsible person(s) identified. No management review. Process not (or rarely) audited or tested or history of unsatisfactory results. Some limited policy or procedure guidance or policy and procedure is not updated regularly. Some training on process.
5	Extensive and prolonged negative press coverage. Significant sponsor/board questions of management. Extensive patient, physician, and/or constituent fallout. Inability to continue with strategic goals.	Loss greater than $3,000,000-$6,000,000 of gross revenue or $1,000,000 expense.	Criminal conviction and/or exclusion of hospital probable. Fines, penalties and or legal exposure in excess of 1% net revenue. CIA certain.	Significant risk of occurrence within next 12 months. Highly complex process with numerous hand-offs. Relies on extensive specialized skills.	Extremely hard to detect prior to failure. Highly automated with little or no human intervention, oversight or control. No built-in safeguards, cross-checks, or other mechanisms to identify errors/failures prior to submission/completion.	No formal controls in place. No policies or procedures, responsible person(s) identified, no training, no management review or approval required, no auditing or monitoring.

Attachment B
Risk Calculation Tool

Area	Topic	Reputation/Impact on Strategy		Financial	Legal	**Risk Impact**	Likelihood	Detectability	**Vunerability**	Controls	**Risk Prioritization Score (RPS)**	Comments
				0			0			0		
				0			0			0		
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Policy Number: CP.17	Date Created: No Date Set
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance & Risk Management Officer), Jill Berry (Director of Corporate Compliance)	

Remote Non-Employee Electronic Medical Record System Access

Purpose:

The purpose of this policy is to establish processes and procedures for permitting Medical Staff members and certain community health care providers and their respective delegees to access Kaweah Health's ("Kaweah's") electronic medical record system in order to enhance the continuum of care for mutual patients.

Definitions:

A. "Remote Non-Employee User" means any individual desiring to access Kaweah's System exclusively through an offsite remote connection who does not perform any portion of their business or job-related duties onsite at Kaweah Health facility. Employees of Kaweah and individuals credentialed or privileged through the Kaweah Medical Staff are not considered Remote Non-Employees under the definition of this policy, regardless of where the individuals perform their business or job-related duties.

B. "Authorized Entity" means the employer of a Remote Non-Employee User.

C. "Kaweah System" means the systems to which Remote Non-Employer User is granted access under this policy.

D. "Kaweah Information" means information contained in or obtained from any Kaweah System.

E. "Organized Health Care Arrangement" has the meaning assigned under HIPAA regulations at 45 CRF 160.103.

Policy:

I. Access

a. A Remote Non-Employee's access to Kaweah's EMR is dependent upon the initial and ongoing satisfaction of the requirements of this policy.
b. Kaweah's System shall only be accessed and used for the ongoing treatment of mutual patients.
c. Compelling Need: To be granted access to a Kaweah System under this policy, each requesting Authorized Entity and Remote Non-Employee User must demonstrate a compelling need for access.
    i. Factors that can be used to demonstrate a compelling need include the following:
        1. Employee of a Member of Kaweah' Medical Staff who is responsible for records retrieval on behalf of the physician's clinic;
        2. Community physician or a designee thereof, if the volume of mutual patients and associated medical record requests would place an undue burden on Kaweah's Medical Records Department and its staff;
        3. Another Covered Entity that has mutual patients with Kaweah Health including, but not limited to, Payors Conducting Chart Reviews or entities which are part of an Organized Health Care Arrangement with Kaweah Health; or
        4. Business Associate with which Kaweah Health has an active Business Associate Agreement.
d. Each Authorized Entity shall sign and submit a System Access Agreement for any of its employees to receive Remote Non-Employer User access. (*See Attachment A*)
e. Each Remote Non-Employee User shall sign and submit a User Confidentiality Statement and complete the assigned Kaweah Health Patient Privacy Education: Non-Employee/Affiliate learning module to receive access. (*See Attachment B*)
f. Remote Non-Employee User access will be limited to read-only access to KDHub Reach. Additional access privileges may be granted in certain circumstances when a compelling business need is demonstrated, and approval is granted by the Kaweah's Chief Compliance and Risk Officer or the Director of Corporate Compliance.
g. Kaweah will issue passwords and user identification credentials only after all required forms are submitted and training is completed.
h. Authorized Entities shall notify Kaweah within twenty-four (24) hours of the departure of a Remote Non-Employee User from their employment.
i. Authorized Entities shall complete an annual reauthorization process for their Remote Non-Employee Users to continue to retain their access. Kaweah's annual reauthorization process is completed once per year for all Remote Non-Employee Users, regardless of the date their initial access was granted. The failure to comply with the reauthorization process will result in access termination and possible non-renewal of access.

II. Non-Permitted Uses

a. Kaweah's System shall not be used for any purpose other than the ongoing treatment of mutual patients.
b. Remote Non-Employee Users shall not engage in the following activities:
    i. Access or attempt to access Kaweah's System for any purpose other than the ongoing treatment of mutual patients.
    ii. Access or attempt to access his/her own or another person's information in Kaweah's System for personal reasons.
    iii. Permit any other person or entity to access Kaweah's System under the Remote Non-Employee User's credentials.
    iv. Disclose to another person one's sign-on code and /or password to Kaweah's System.
    v. Use another person's sign-on code and/or password to access Kaweah's System.
    vi. Engage in the intentional or negligent mishandling or destruction of information contained in or obtained from Kaweah's System.
    vii. Attempt to access a secured application or restricted area without proper authorization or for purposes other than permitted under this policy.
    viii. Misuse Kaweah information.
    ix. Disclose Kaweah information without proper authorization.
    x. Alter Kaweah information.
    xi. Leave a Kaweah System unattended while signed on.

III. Confidentiality

a. All information in Kaweah's System is confidential.
b. Information accessed in Kaweah's System by Non-Employee User is confidential and shall be the minimum necessary to provide ongoing care to mutual patients.
c. Authorized Entity and Remote Non-Employee Users shall implement and maintain appropriate administrative, physical, and technical safeguards to prevent the use or disclosure of information obtained from Kaweah System's for any reason other than permitted by this policy.
d. Authorized Entity and Remote Non-Employee Users shall implement and maintain information security safeguards as necessary to protect Kaweah's System from information security threats.

IV. Reporting Unauthorized Use or Disclosure

a. Authorized Entity or Remote Non-Employee User shall report unauthorized uses and disclosures that are not specifically permitted under this policy to the Kaweah Compliance Department within twenty-four (24) hours of occurrence.
b. Reports of unauthorized uses and disclosures shall be made by telephone call to the Compliance Department at 559-624-2154.

c. Authorized Entity and Remote Non-Employee User shall mitigate, to the extent possible, any harmful effect that occurs as a result of unauthorized uses and disclosures.
d. Authorized Entity and Remote Non-Employee User shall work cooperatively with Kaweah in investigating, mitigating, and engaging in any corrective action that is required as a result of any unauthorized use or disclosure.

V. Auditing and Monitoring

a. Authorized Entity and Remote Non-Employee User shall not expect any privacy rights while utilizing Kaweah Systems.
b. Kaweah may track and monitor Non-Employee User's access and activity in Kaweah Systems.
c. Kaweah will conduct random and targeted monitoring and auditing of Kaweah's Systems.
d. Authorized Entity and Remote Non-Employee User shall cooperate with Kaweah with any resulting investigation involving potential inappropriate access, use, and/or disclosure.

VI. Violations

a. Authorized Entity and Remote Non-Employee User shall ensure compliance with all the terms of conditions of this policy and access granted hereunder.
b. Violations of this policy and access grated hereunder may result in immediate and permanent termination of access.
c. Access, use, and disclosure violations may result in violations of state and federal privacy laws and regulations.
d. Authorized Entity and Remote Non-Employee User will be responsible for any damages incurred as a result of inappropriate access, use, or disclosure of Kaweah Information obtained through access to Kaweah Systems.

Related Documents:

A. MS57 Guidelines for Privacy Violations (Refer to Medical Staff Policy for privacy violations involving Members of Kaweah Health's Medical Staff)
B. AP53 Patients' Rights and Responsibilities
C. AP04 Access and Release of Protected Health Information (PHI)

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

KAWEAH DELTA HEALTH CARE DISTRICT

SYSTEM ACCESS AGREEMENT

This Systems Access Agreement ("AGREEMENT") made and entered into effective _____ ("Effective Date"), is by and between **Kaweah Delta Health Care District** ("KAWEAH HEALTH"), a local health care district organized and existing under the laws of the State of California, Health and Safety Code §§ 32000 et seq., and _____, ("AUTHORIZED ENTITY").

If and to the extent, KAWEAH HEALTH and AUTHORIZED ENTITY hereby agree to the following with respect to Protected Health Information (PHI), obtained by AUTHORIZED ENTITY in connection with its performance of services for KAWEAH HEALTH pursuant to any AGREEMENT for services ("AGREEMENT") the parties may enter into from time to time.

RECITALS

(A) KAWEAH HEALTH wishes to provide AUTHORIZED ENTITY and its employees/agents, electronic systems access to KAWEAH HEALTH electronic health information records pursuant to the terms of this AGREEMENT, some of which may constitute Protected Health Information ("PHI") (defined below).

(B) KAWEAH HEALTH and AUTHORIZED ENTITY intend to protect the privacy and provide for the security of PHI disclosed to AUTHORIZED ENTITY pursuant to this AGREEMENT in compliance with the Health Insurance Portability and Accountability ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("the HITECH Act"), and applicable California State laws.

In consideration of the mutual promises below and the exchange of information pursuant to this AGREEMENT, the parties agree as follows:

1. **Definitions**

   a. **Breach** shall have the meaning given to such term under the HITECH Act, HIPAA Regulations, and the California Health and Safety Code.

   b. **Breach Notification Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D and the California Health and Safety Code.

   c. **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

   d. **Electronic Protected Health Information** means PHI that is maintained in, or transmitted by, electronic media.

   e. **Electronic Health Record** shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

f. **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

h. **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; (ii) the provision of health care to an individual; (iii) the past, present, or future payment for the provision of health care to an individual; or (iv) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule. Protected Health Information includes Electronic Protected Health Information as defined above.

i. **Protected Information** shall mean PHI provided by KAWEAH HEALTH to AUTHORIZED ENTITY or created, maintained, received, or transmitted by AUTHORIZED ENTITY on KAWEAH HEALTH's behalf.

j. **Security Incident** shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

k. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

l. **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

m. **Unauthorized Access** shall have the meaning given to such term under the California Health and Safety Code Section 130201 and any other applicable guidance issued. Generally, this shall have the meaning inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by any statute or regulation governing the lawful access, use, or disclosure of medical information.

2. **Obligations of AUTHORIZED ENTITY**

a. **Permitted Uses.** AUTHORIZED ENTITY shall not use Protected Information except for the purpose of performing AUTHORIZED ENTITY's obligations under this AGREEMENT and as permitted under this AGREEMENT. Further, AUTHORIZED ENTITY shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule, the HITECH Act, or California law if so used by KAWEAH HEALTH. However, AUTHORIZED ENTITY may use Protected Information (i) for the proper management and administration of AUTHORIZED ENTITY; or (ii) to carry out the legal responsibilities of AUTHORIZED ENTITY.

b. **Permitted Disclosures.** AUTHORIZED ENTITY shall not disclose Protected Information except for the purpose of performing AUTHORIZED ENTITY's obligations under this AGREEMENT and as permitted under this AGREEMENT. AUTHORIZED ENTITY shall not disclose Protected Information in any manner that

would constitute a violation of the Privacy Rule, the HITECH Act, or California law if so disclosed by KAWEAH HEALTH. However, AUTHORIZED ENTITY may disclose Protected Information (i) for the proper management and administration of AUTHORIZED ENTITY; (ii) to carry out the legal responsibilities of AUTHORIZED ENTITY; or (iii) as required by law.

b. **Prohibited Uses and Disclosures.** AUTHORIZED ENTITY shall not use or disclose Protected Information for fundraising or marketing purposes. AUTHORIZED ENTITY shall not disclose Protected Information to a health plan for payment or Health Care Operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates.

    a. Access shall be limited to patient information that pertains to a past or current medical condition for which the patient is under current treatment of the AUTHORIZED ENTITY.

        NOTE: PRIOR approval by the office manager or Physician is required when accessing a family member or friend's record that is a patient of record; office manager/Physician must validate the business purpose and confirm the patient is under active treatment by the physician office.

    b. Users/employees of the AUTHORIZED ENTITY shall not access their own medical record.

    c. Users/employees of the AUTHORIZED ENTITY shall maintain unique user credentials. Sharing user credentials may result in termination of this AGREEMENT and systems access for the AUTHORIZED ENTITY.

d. **Appropriate Safeguards.** AUTHORIZED ENTITY shall implement appropriate safeguards as are necessary to prevent the access, use or disclosure of Protected Information otherwise than as permitted by this AGREEMENT, including, but not limited to, administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Protected Information.

j. **Minimum Necessary.** AUTHORIZED ENTITY shall access, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure.

k. **Data Ownership.** AUTHORIZED ENTITY acknowledges that AUTHORIZED ENTITY has no ownership rights with respect to the Protected Information.

l. **Notification of Possible Breach.** AUTHORIZED ENTITY shall notify KAWEAH HEALTH ***within twenty-four (24) hours*** of any suspected or actual breach or UNAUTHORIZED ACCESS of Protected Information. AUTHORIZED ENTITY shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws.

m. **Notification of Termination of Employment.** AUTHORIZED ENTITY shall notify KAWEAH HEALTH ***within twenty-four (24) hours*** of any terminated employee with access to Kaweah HEALTH systems.

3. **Indemnification**

Each party shall defend, indemnify and hold the other party, its officers, directors, partners, employees, agents and subcontractors harmless from and against any and all liability, loss, expense, attorneys' fees or claims for injury or damages arising out of its own performance of this AGREEMENT but only in proportion to and to the extent such liability, loss, expense, attorneys' fees or claims for injury or damages are caused by or result from the acts or omissions of itself, its officers, partners, directors, employees, or agents. This section shall survive the expiration of the term of this AGREEMENT.

AUTHORIZED ENTITY agrees to reimburse KAWEAH HEALTH for all fines, penalties, legal expenses, damages, and other costs or expenses incurred by KAWEAH HEALTH arising from or caused by a breach of PHI by the AUTHORIZED ENTITY, its employees, or its agents.

4. **Disclaimer**

KAWEAH HEALTH makes no warranty or representation that compliance by AUTHORIZED ENTITY with this AGREEMENT, HIPAA, the HITECH Act, the HIPAA Regulations or California security or privacy laws will be adequate or satisfactory for AUTHORIZED ENTITY's own purposes. AUTHORIZED ENTITY is solely responsible for all decisions made by AUTHORIZED ENTITY regarding the safeguarding of PHI.

5. **Amendment to Comply with Law**

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this AGREEMENT may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that KAWEAH HEALTH must receive satisfactory written assurance from AUTHORIZED ENTITY that AUTHORIZED ENTITY will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this AGREEMENT embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. KAWEAH HEALTH may terminate this AGREEMENT upon ***thirty (30) calendar days written notice*** in the event (i) AUTHORIZED ENTITY does not promptly enter into negotiations to amend this AGREEMENT when requested by KAWEAH HEALTH pursuant to this section; or (ii) AUTHORIZED ENTITY does not enter into an amendment to this AGREEMENT providing assurances regarding the safeguarding of PHI that KAWEAH HEALTH, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

6. **Interpretation**

This AGREEMENT shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations, and other state and federal laws related to security and privacy. The parties agree that any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the HIPAA regulations, and other state and federal laws related to security and privacy.

7. **Termination**

Violation of this AGREEMENT may result in the immediate and indefinite termination of the KAWEAH HEALTH systems access for the user. Repeated violations by AUTHORIZED ENTITY may result in a suspension or immediate termination of system access AUTHORIZED ENTITY and all of its employees. Unauthorized use or release of confidential information may also subject the violator to personal, civil, and/or criminal liability and legal penalties.

Kaweah Health reserves the right to approve, deny, or revoke user access based on the need for system access.

IN WITNESS WHEREOF, the parties hereto have duly executed this AGREEMENT as of the Effective Date.

COVERED ENTITY	AUTHORIZED ENTITY
Kaweah Delta Health Care District	_____
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date:_____	Date:_____

User Confidentiality Statement

As a user of information of Kaweah Delta Health Care District ("Kaweah Health") electronic/computer systems, you may develop, use, or maintain: (1) patient information (for health care, quality improvement, peer review, education, billing, reimbursement, administration, research, or for other purposes); and (2) confidential business information of Kaweah Health and/or third parties, including third-party software and other licensed products or processes. This information from any source and in any form, including, but not limited to, paper record, oral communication, audio recording, and electronic display, is strictly confidential. Access to confidential information is permitted only on a need-to-know basis and limited to the information necessary to accomplish the intended purpose of the use, disclosure, or request.

Users of Kaweah Health electronic/computer systems shall respect and preserve the privacy, confidentiality and security of confidential information. **Violations of this statement include, but are not limited to:**

Initial Below

_____ Accessing information that is not within the scope of your duties;

_____ Accessing your own health information;

_____ Accessing the health information of your family and/or friends without a legitimate business purpose;

_____ Disclosing to another person your sign-on code and/or password for accessing electronic or confidential information or for physical access to restricted areas;

_____ Using another person's sign-on code and/or password for accessing electronic confidential information or for physical access to restricted areas;

_____ Leaving a secured application unattended while signed on;

Violation of this statement will constitute grounds for immediate and **indefinite loss of information system security access**, and/or loss of contractual or affiliation rights. Unauthorized use or release of confidential information may also subject the violator and their employer to personal, civil, and/or criminal liability and legal penalties.

I attest that I have received, reviewed, and agree to abide by the terms of this "Confidentiality Statement" and Kaweah Health privacy and security Policies, copies of which have been provided.

Name (Print)_____

Signature/Date: _____ / _____
Date

Office/Company Name: _____

Affiliation:
[ ] Student
[ ] Volunteer
[ ] Vendor
[ ] Contract Employee
[ ] Other_____

Agenda item intentionally omitted