SPECIAL AUDIT AND COMPLIANCE COMMITTEE MEETING

MONDAY, May 18, 2015

Conference Center Located at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Marla Cox, Clerk of the Board
(510) 535-7515

LOCATION:

Open Session: HCP Conference Center

COMMITTEE MEMBERS

Patricia Scates, ***Chair***
Kirk E. Miller
Valerie D. Lewis, Esq.
James Lugannani

Minutes - Draft

OPEN SESSION – The meeting was called to order at 5:30 p.m.

ROLL CALL was taken and the following Trustees were present:

Patricia Scates, Kirk E. Miller and James Lugannani

TAB #1 ACTION: Consent Agenda

The minutes were discussed and it was agreed to modify one sentence on the February 12, 2015 minutes. A motion was made and seconded to approve the minutes of the January 13, 2014, February 12, 2015, March 11, 2015 and April 14, 2015 Audit and Compliance Committee meetings as amended.

TAB #2 REPORT: External Audit Reporting

Linda Hurley, Partner, Macias Gini & O'Connell

A. REPORT: External Financial Audit Update

Linda Hurley, MGO Partner provided an update on the audit status. Interim field work was started earlier today. The audit team will be on-site for 2 weeks and will be testing their understanding of internal controls. An entrance conference was held today with members of management to confirm timelines and expectations. Ms. Hurley is working with the County audit team to understand their timetables and she has asked to attend their entrance conference which will be scheduled in about 2 weeks.

As part of their audit planning, MGO is doing a risk assessment with members of the Audit and Compliance Committee. She is working with the Clerk of the Board to schedule conference calls; however, if a person-to-person meeting is desired, they can accommodate that also. A written audit plan will be completed by the end of June and will be available for discussion at the July meeting.

At the April meeting, Ms. Hurley was asked to develop an "Audit Primer". She will work with Mr. Kibler to develop a presentation.

Discussion ensued regarding the Toyon Report, audit timing and the audit primer. The audit primer should explain what they do and what they are trying to accomplish. This may be a helpful presentation to the entire Board. Ms. Hurley reported that they have received the Toyon report and are reviewing it currently. Discussions with management focus on the report issues and the valuation of the Accounts Receivable. She also reported the audit would be completed by the end of October and reported at the November meeting.

TAB #3 Report: Internal Audit Reporting

Rick Kibler, Director, Internal Audit

A. REPORT: Status on External Financial Audit Management Letter

In conjunction with the Annual Financial Audit by the CPA firm of Macias Gini & O'Connell LLP (MGO), two (2) issues were identified during the FY2014 audit and two (2) issues were identified as part of the Single Audit. Corrective action plans have been identified by management and progress is being made on resolving these issues.

According to the test work performed during the audit, the three (3) issues identified during the FY2013 audit and the one (1) outstanding issue from the FY2010 audit had been partially completed. Additional action has been taken on these items and two issues from FY2013 have been completed pending follow-up by MGO. The remaining issue from FY2013 and the outstanding issue from FY2010 remain open and plans are being pursued to close those items later this year.

Dave Gravender, CIO was asked to comment on the outstanding items relating to IT. Mr. Gravender reported that IT was having some success in finding candidates for the Security Program Manager with the technical backgrounds needed, but wanted to ensure they had the appropriate change management skills to be successful at AHS. They have conducted second round interviews and are at the final step in making an offer. He expects to have the position filled by the end of June.

Regarding the 2010 Finding, the disaster recovery plan was tested by accident last week. The desktop system lost a hard drive and required the back-up restore process. A number of issues occurred during this process, but resulted in a good outcome. A debrief meeting is scheduled for next week to address the results of this effort.

B. REPORT: Update on FY2015 Internal Audit Plan

At this time, the Annual Audit Plan is considered on time.

Final reports have been issued for the DSRIP DY9, IT System Access, Workers Compensation, Encounters with Missing Charges, Plant Operations and Charge Capture Implants audits. Audits are currently in progress for ACERA, Charge Capture Surgery and Meaningful Use with draft reports issued for ACERA and Surgery audits. The System Penetration review is a joint project with IT and

was delayed pending completion of the new firewall. In its place will be an audit of the disposal of IT equipment process. The new project will be added to the project schedule for the next meeting.

C. REPORT: DSRIP DY9 Audit

The DSRIP project has been underway since November 2010 and the DSRIP Administrator has continued use of the file structure developed during DY6 to maintain documentation demonstrating the achievement of the DSRIP milestones. For the 65 milestone categories reviewed for DY9, documentation was considered sufficient to support the reported accomplishments for 59 milestones. The remaining 6 milestones did not fully meet the achieved target and related to 3 primary categories that included: 1) Expanding primary care for Newark; 2) Assigning patients in ED and Specialty Clinics a medical home if one is needed; and 3) Achieving HIV health outcomes. These 3 areas did receive partial credit for funds available and the remaining milestones are expected to be completed during DY10.

There were 2 milestones that were carried over from DY8 and completed in DY9 that included: 1) Improve Patient Flow in the Emergency Department/Rapid Medical and 2) two HIV milestones related to HAART and Cervical Cancer Screening. There was sufficient documentation to support the completion of these milestones. As referenced above, an additional $0 .9M was collected in DY9 which now fully completes all of the DY8 milestones.

Discussion ensued regarding this program and have we actually improved clinical operations. Mark Fratzke, Acting CEO responded with a number of examples of how the clinical operations had improved. He also reported that October 1, 20116 was the end of formal DSRIP funding. Efforts were underway to continue this funding program as a new initiative.

D. REPORT: Follow-Up to Past Audit Reports

Internal Audit periodically performs follow-up on past report issues to ensure that corrective action plans proposed by management have been executed and that corrective action was sufficient to resolve identified issues. Management has been responsive to correcting items noted in audit reports. Attached is a summary of the audit issues identified and the current status of each issue. Internal Audit will continue to perform follow-up testing as needed to ensure all identified issues have been resolved and as all findings for a report are resolved and reported to the Committee, that report would be removed from the follow-up status report

For the system access audit, all findings have been resolved except for item 3 relating to the Identity management System. That finding is scheduled for completion by 6/30/15.

The Workers Compensation audit had 4 outstanding findings and Internal Audit has not yet performed follow-up. Jeanette Louden-Corbett, Chief HR Officer was asked for comment on these items and she reported that item 1. Supervisor Reports has been an issue everywhere she has worked. A single training approach is not effective and her staff is is currently meeting with all areas individually for training. She considers this issue complete. Item 2 relates to the OSHA safety program and was assigned to a director that has left the organization. The work has been reassigned, but will not be complete until July 31, 2015. Item 3, the new Workers Comp policy has been drafted and is in review. Item 4, Payroll Coding is in process with individual training of managers with staff on Workers Comp. Overall, Workers Comp claims total about $5Million a year and is down from about $9Million a few years ago.

Mr. Kibler reported that Encounters without Charges and Plant Operations findings are all considered complete and will be dropped from the next report. The Charge Capture Implant audit is a more recent audit and work is continuing to resolve findings.

TAB #3 REPORT: Compliance Program

Rick Kibler, Director, Internal Audit

Mark Fratzke announced that changes had been made in compliance to move administratively from Legal to Finance. The direct reporting relationship is still to the Audit and Compliance Committee of the Board. Rick Kibler will be leading the compliance function and in the next few months should have the Compliance Program built out. As the department comes together we will assess the FTE needs for this area. Management will reassess this reporting structure at a later date.

A. REPORT: Compliance Program Report

Mr. Kibler reported that the Legal Department had done a lot of work regarding the establishment of the Compliance Program; however, efforts had not been focused on implementing the infrastructure of the program.

The following page identifies the components of a compliance program and actions currently in process to implement the infrastructure. Once the infrastructure is built, compliance staff can begin a more detailed assessment of the regulatory road-mapping, organizational risk and corrective action needed.

1. An initial review of applicable policies identified some outdated policies and some gaps. Mr. Kibler is working with management to update policies as needed. Policies are expected to be in place by 8/1.
2. The Compliance Officer is now in place with the appointment of Mr. Kibler.
3. Employee education and training is in process. Mr. Kibler is working on a communication plan with the Corporate Communications Department on the appointment of the Compliance Officer and the establishment of an Ethics and Compliance hotline. Work has commenced with HR to develop a training module for all employees as part of the annual competency training. The education plan should be executed by the time of the next meeting and the training program rolled out at the beginning of 2016.
4. A full compliance risk assessment is in process. A basic compliance work plan has been developed and will be discussed later in the meeting. The work plan is tentative at this point based on the unknowns of the results of the risk assessment and the volume of reports that could occur.
5. Hotline proposals were reviewed for 5 independent hotline service providers and the contract is being finalized with the selected vendor. The hotline, a web portal, and email reporting features should be implemented by 6/1.
6. Disciplinary guidelines are being researched and should be finalized by the next meeting.
7. Effective and timely follow-up will be dependent on the number of issues raised. An experienced Compliance Manager has been transferred to the Compliance Department and will provide support investigating compliance reports. Internal Audit is also available for support if needed.

Significant discussion ensued regarding the components of the program, reporting of results to the committee and measuring the results of the program. Mr. Kibler reported that the components of the program as documented here were established by the Office of Inspector General (OIG) and

adopted by Medicare. Reporting of compliance issues needs to be developed as part of the program infrastructure, but may require closed sessions based on the nature of the issue.

B. REPORT: Compliance Steering Committee

The committee had requested more information on the composition and purpose of the corporate Compliance Steering Committee (CCSC). The CCSC is a cross functional management group that provides expertise and oversight on compliance issues. Page 46 of the packet identifies the composition of the committee and its functions. Additionally, the report identifies the types of issues that have been worked by the committee.

Discussion of the committee membership identified the membership was aligned with financial functions and lacked representation from operations or clinical areas. Mr. Kibler agreed to address this.

C. REPORT: Compliance Annual Plan

The initial work plan for compliance is shown on page 48. The initial work is focused on the action steps to build the infrastructure discussed previously. Additionally, a number of projects were identified for the year from the OIG work plan. As noted previously, the work plan is tentative and will be addressed at future meeting.

D. REPORT: Current Regulatory Activity

On April 22, 2015, Internal Audit was notified of an audit of California's Medicaid electronic health record (EHR) incentive payments by the Office of Inspector General (OIG). The objective of the audit is to determine that the State of California Department of Health Services made Medicaid incentive payments in accordance with Federal and State requirements.

During the time period covered by the audit, AHS received approximately $5.2M in EHR incentive payments and we have been asked to provide documentation substantiating our right to participate in the program. Internal Audit is coordinating the collection of data requested by OIG.

Requested information has been provided to the OIG and we are waiting to hear if they have any questions or require additional information. We do not believe past or future EHR funding is in jeopardy as a result of this audit.

E. REPORT: Follow-Up to Past Audit Reports

Compliance will periodically perform follow-up on past issues to ensure that corrective action plans proposed by management have been executed and that corrective action was sufficient to resolve identified issues. Attached is a summary of the issues identified during the SOA Project Assessment and the current status of each issue. Status has not changed significantly from the last Committee meeting. Follow-up will continue until all issues are resolved.

TAB #5 INFORMATION: Annual Audit and Compliance Committee Agenda Calendar and Follow-Up

Patricia Scates, Chair

A. Audit and Compliance Committee Master Calendar and Follow-up Worksheet

The audit calendar was reviewed and was determined sufficient for future meetings.

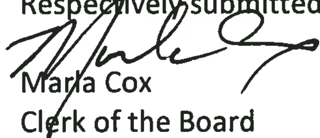
The issue tracking sheets were discussed and it was agreed that with the alignment of Internal Audit and Compliance, the tracking sheets should be consolidated and completed items removed.

Public Comment: No public comments.

Board of Trustees Remarks: No additional comments.

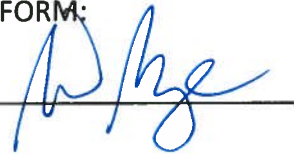
ADJOURNMENT: 7:05 pm

Respectively submitted by:



Marla Cox
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: 
Mike Moye, Esq.
Interim General Counsel