Health Care District
PALM BEACH COUNTY

Quality, Patient Safety & Compliance Committee
Meeting Agenda
November 27, 2018
10:00 A.M.

Meeting Location
1515 N. Flagler Dr., Ste. 101
West Palm Beach, FL 33401

Health Care District
PALM BEACH COUNTY

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
AGENDA
November 27, 2018 at 10:00 a.m.
1515 N. Flagler Dr., Suite 100
West Palm Beach, FL 33401

1. **Call to Order – Dr. Alina Alonso, Chair**

   A. Roll Call

2. **Agenda Approval**

   A. Additions/Deletions/Substitutions

   B. Motion to Approve Agenda

3. **Awards, Introductions and Presentations**

4. **Disclosure of Voting Conflict**

5. **Public Comment**

6. **Meeting Minutes**

   A. **Staff recommends a MOTION TO APPROVE:**
   Committee Meeting Minutes from September 25, 2018. [Pages 1-8]

7. **Consent Agenda- Motion to Approve Consent Agenda Items**

   A. **ADMINISTRATION**

   7A-1 **RECEIVE AND FILE:**
   Internet Posting of District Public Meeting.
   http://www.hcdpbc.org-Resources-Public Meetings

   7A-2 **RECEIVE AND FILE:**
   Committee Attendance.
   [Page 9]

   7A-3 **RECEIVE AND FILE:**
   Compliance and Privacy Dashboard.
   (Ellen Pentland) [Pages 10-15]

   7A-4 **RECEIVE AND FILE:**
   Proposed Schedule for 2019 Committee Meetings.
   (Belma Andric) [Pages 16-17]

8. Regular Agenda

A. CORPORATE QUALITY & PATIENT SAFETY DASHBOARDS

8A-1 **RECEIVE AND FILE:**

- Patient Relations Dashboard, School Health.
  (Andrea Steele/Ginny Keller) [Page 20]

- Patient Relations Dashboard, Primary Care Clinics.
  (Andrea Steele/Noelle Stewart, M.D.) [Page 21]

- Patient Relations Dashboard, Healey Center.
  (Andrea Steele/Terretha Smith) [Pages 22-23]

- Patient Relations Dashboard, Lakeside Medical Center.
  (Andrea Steele/Janet Moreland) [Pages 24-25]

8A-2 **RECEIVE AND FILE:**

- Quality & Patient Safety Report, Aeromedical.
  (Andrea Steele/Gerry Pagano) [Pages 26-27]

- Quality & Patient Safety Report, Primary Care Clinics.
  (Andrea Steele/Noelle Stewart, M.D.) [Pages 28-32]

- Quality & Patient Safety Report, Healey Center.
  (Andrea Steele/Terretha Smith) [Page 33]

- Quality & Patient Safety Report, Lakeside Medical Center.
  (Andrea Steele/Janet Moreland) [Pages 34-36]

- Quality and Patient Safety Report, Pharmacy.
  (Andrea Steele/Hyla Fritsch) [Page 37]

- Quality & Patient Safety Report, Trauma Program.
  (Andrea Steele/Sandra Smith) [Page 38]

B. COMPLIANCE

8B-1 **RECEIVE AND FILE:**
Annual Report on Compliance and Privacy.
(Ellen Pentland) [Pages 39-48]

C. CORPORATE RISK MANAGEMENT CLOSED MEETING
[Under Separate Cover]

Health Care District
PALM BEACH COUNTY

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
SUMMARY MEETING MINUTES
September 25, 2018, 10:00 a.m.
1515 N. Flagler Drive
West Palm Beach, FL 33401

1. Call to Order

Phil Ward called the meeting to order at 10:00 a.m.

A. Roll Call

Committee Members present included: Phil Ward, Mary Weeks, Sharon Larson, James Elder, Sean O'Bannon, Dianne King, Dr. David Bohorquez. Dr. Alina Alonso and Steven Seeley were absent.

Staff present included: Darcy Davis, Chief Executive Officer; Valerie Shahriari, General Counsel; Ellen Pentland, Chief Compliance and Privacy Officer; Dr. Belma Andric, Chief Medical Officer; Alyssa Tarter, Risk Manager; Lisa Hogans, Corporate Quality Manager; Ginny Keller, Administrator of School Health; Terretha Smith, Risk Manager; Stephanie Dardanello, Lakeside Medical Center Administrator; Karen Harris, Vice President of Field Operations; Sandra Smith, Admin-Trauma Services; Luis Rodriguez, Quality and Compliance Pharmacist; Gerry Pagano, Director of Medical Transport and Aeromedical Facilities; Victoria Pruitt, Corporate Director of Risk Management; Janine Lambe, Nurse Chart Auditor; Dr. Noelle Stewart, FQHC Medical Director; Leticia Stinson, Senior Compliance and Privacy Analyst; Kristine Macaya, Assistant Director of Pharmacy; Sylvia Hall, Quality Improvement Coordinator; Shelly Ann Lau, Healey Center Administrator; Dr. Ken Scheppke, Aeromedical Agency Medical Director; Dawn Richards, Chief Financial Officer; Junelle Cox, HIPAA/Privacy Analyst; David Speciale, Quality Manager; Lisa Sulger, HIM Manager. Thomas Cleare, VP of Strategy; Dr. Hyla Fritsch, Director of Pharmacy Services; Janet Moreland, Director of Quality and Patient Safety; Roseann Webb, Director of HIM; Marcia Young, Director of Clinic Operations were absent.

Recording/Transcribing Secretary: Heidi Bromley / David Speciale

2. Agenda Approval

A. Additions/Deletions/Substitutions

None.

B. Motion to Approve Agenda

CONCLUSION/ACTION: Ms. Weeks made a motion to approve the agenda as presented/amended. The motion was duly seconded by Ms. Larson. There being no opposition, the motion passed unanimously.

3. Awards, Introductions and Presentations

A. C. L. Brumback Primary Care Clinics – Dr. Andric

a. Fiscal Year 2018 Health Center Quality Improvement Award – Silver
b. Enhancing Access to Care Award – a PCMH Recognition
c. Dental Award – John Rosetti Center of Excellence Award for patient access and outcomes.
d. Substance Abuse Award. Received $330,000 ($25,000 more than we applied for). Funding will be used to add two Social Workers and minor renovations to the new clinic.

B. Lakeside Medical Center Emergency Department Update - Dr. Scheppke

a. Total census is 1,933 per month average which represents a 7.5% decrease annually. This decrease has been slowing down the past two months at a rate of 2.5%.
b. Admissions have increased by 18% per month on average.
c. Transfers have increased by 75% and are transferring 88 patients from the emergency room on average.
d. "Overall Treatment" (now known as left without triage and treatment) and "left without being seen" measures are meeting the goals of less than 0.5% and in compliance with national standards.
e. AMA's (Against Medical Advice) have increased slightly to 8.8% but when compared to the fractions of admissions have decreased. As a total percentage of admissions have decreased to 1.2% of the total. The national average is 0.5 – 1%.
f. Transfers – Breakdown by Department presented.
g. Patient Satisfaction (Press Gainey Scores)
    i. At 80-90% (national benchmark is 60 - 70%)
    ii. Patient testimony presented
    iii. Transfers – average 6 hours turnaround because we are not serviced well enough by emergency transports (except the Trauma Hawk). Plan for corrective action is to partner with American Medical Response (AMR) to stay at the ER Department. Medics will support ER Department for 12 hours of their 24 hour shifts. AMR unit on site will decrease the transfer turnaround time. This agreement is in process.

4. Disclosure of Voting Conflict

None.

5. Public Comment

None.

6. Meeting Minutes

A. Staff Recommends a MOTION TO APPROVE:
Committee Meeting Minutes from May 22, 2018.

CONCLUSION/ACTION: Mr. Elder made a motion to approve the committee meeting minutes from May 22, 2018 as presented. The motion was duly seconded by Ms. Weeks. There being no opposition, the motion passed unanimously.

7. Consent Agenda – Motion to Approve Consent Agenda Items

CONCLUSION/ACTION: Mr. Elder made a motion to approve the Consent Agenda items. The motion was duly seconded by Ms. Larson. There being no opposition, the motion passed unanimously.

A. ADMINISTRATION

7A-1 RECEIVE AND FILE:
Internet Posting of District Public Meeting
http://www.hcdpbc.org-Resources-Public Meetings

7A-2 RECEIVE AND FILE:
Committee Attendance

7A-3 RECEIVE AND FILE:
Compliance and Privacy Dashboard

8. Regular Agenda

A. ADMINISTRATION

8A-1 **Staff recommends a MOTION TO APPROVE:**
Ms. Ellen Pentland presented the Amendment to the Quality, Patient Safety and Compliance Committee Charter.

CONCLUSION/ACTION: Mr. O'Bannon made a motion to approve the Amendment to the Quality, Patient Safety and Compliance Committee Charter as presented. The motion was duly seconded by Ms. Weeks. There being no opposition, the motion passed unanimously.

8A-2 **Staff recommends a MOTION TO APPROVE:**
Ms. Darcy Davis presented the Annual Evaluation for the Chief Compliance and Privacy Officer.

CONCLUSION/ACTION: Mr. O'Bannon made a motion to approve the Annual Evaluation for the Chief Compliance and Privacy Officer as presented. The

motion was duly seconded by Ms. Weeks. There being no opposition, the motion passed unanimously.

B. CORPORATE QUALITY & PATIENT SAFETY DASHBOARDS

8B-1 **RECEIVE AND FILE:**

- Patient Relations Dashboard, School Health

  Dr. Andric presented the patient relations dashboard for the third trimester of the 2017 – 2018 school year. During the third trimester (April – June of 2017-2018 school year) there were two complaints, no grievances and two compliments.

- Patient Relations Dashboard, Primary Care Clinics

  Dr. Andric presented the Patient Relations Dashboard for Quarter 2 (April – June 2018). During Quarter 2 there were seven complaints, five grievances and twenty-nine compliments. Compliments decreased over last quarter primarily due to transition to the new EMR and interface with the risk reporting system.

- Patient Relations Dashboard, Healey Center

  Dr. Andric presented the Patient Relations Dashboard for Quarter 2 (April – June 2018). During Quarter 2 there were a total of sixty grievances all of which were resolved within seventy-two hours. Trends reported with no outliers. There were a total of fourteen compliments related to excellent customer service and overall care provided by staff.

- Patient Relations Dashboard, Lakeside Medical Center

  Dr. Andric presented the Patient Relations Dashboard for Quarter 2 (April – June 2018). During Quarter 2 there were a total of three grievances and seventeen complaints. Trends reported with no outliers. There were a total of nineteen compliments related to ER services. All issues addressed timely with no outliers.

CONCLUSION/ACTION: Received and filed.

8B-2 **RECEIVE AND FILE:**

- Quality & Patient Safety Report, School Health

  Dr. Andric presented the Quality and Patient Safety report for the third trimester of the 2017-2018 school year. This included student demographics, return rates, continuum of care measures, and mandated screenings. Data is fairly consistent throughout the year with no outliers.

- Quality & Patient Safety Report, Aeromedical

  Dr. Andric and Gerry Pagano presented the Quality and Safety Report for the second quarter (April, May, and June 2018). The report provided details on the number of flights and number of transports. For Quarter 2 there were a total of 145 patient transports of which 62 originated in the western community (43%). This is equal compared to last year's numbers. For quarter 2 there were a total of sixty-five occurrence's categorized as "missed, cancelled, aborted calls". This was attributed to county coverage reasons, weather-related, and cancellations by referral agency. There were a total of 145 patients transported. Most flights were from facilities compared to scene related transports.

  Dr. Shepkee updated the committee on the status of staging a helicopter at Lakeside Medical Center. Dr. Shepkee reported that he had met with all the decision makers including Union workers, fire chiefs, and HCD Leadership. The Palm Beach County Fire Rescue team has visited the Lakeside Medical Center facility along with the HCD Information Technology Team to assess additional needs. Next steps to meet with all stakeholders to discuss details of this plan and establish timelines.

- Quality & Patient Safety Report, Primary Care Clinics

  Dr. Andric presented the quality indicators / UDS measures in a revised table for June 2018. Select underperforming measures reviewed including Asthma, Colorectal Cancer Screening, A1C / Diabetes. Findings and Interventions of these measures presented.

- Quality & Patient Safety Report, Healey Center

  Dr. Andric presented the Quality & Patient Safety Report for the second quarter (April, May, and June 2018). The underperforming measures were discussed in more detail which included: Pressure ulcers, patients who received antipsychotic medication, and patients who report moderate to severe pain. Findings and Interventions of these measures presented.

- Quality & Patient Safety Report, Lakeside Medical Center

Dr. Andric presented the Quality Core Measure Report for the second quarter (April, May, and June 2018). There were five underperforming measures which were discussed in more detail and included: median time from decision to admit time to ED departure for admitted patients, caesarian births, breast feeding, median time to transfer to another facility for acute coronary interventions, and median time from ED arrival to discharge home or transferred. Findings and Interventions of these measures presented.

- Quality & Patient Safety Report, Pharmacy

  Dr. Andric presented the Pharmacy Services Quality Report for the second quarter (April, May, and June 2018). Underperforming issues discussed in detail which included prescriptions returned to stock and prescriptions designated as waiters. Findings and Interventions of these measures presented.

- Quality & Patient Safety Report, Trauma

  Dr. Andric presented the Trauma Quality Report for the second quarter (April, May, and June 2018). One underperforming measure reported, Total Number of Records Entered Beyond three Business Days. The decrease has been attributed to change of staff at the Trauma Center which has caused delays on entering recordings within the established timeframes. Additional training provided to staff and the issue has since been corrected.

CONCLUSION/ACTION: Received and filed.

C. COMPLIANCE

8C-1 RECEIVE AND FILE:
Summary of Compliance and Privacy Activities

Ms. Pentland presented the Summary of Compliance Activities from April 1 through August 31. Highlights discussed included the following.

Training and Education - The Compliance and Privacy Department continues to provide all employees trainings. Revisions to training modalities have been and consist of small modules and workgroups. Training completed include: New hire orientation, quarterly non-discrimination in healthcare meetings, Billing and HIPAA workgroups, and HIPAA Primacy training for G4s Security staff. The Security Trainings are now completed by the Information Technology Department staff. The E.J. Healey Center received their annual compliance education training and the Compliance team has been integrated into the clinics staff orientation. The Code of Conduct training has been revised to include workplace violence. The Compliance team is currently working on the Medication-Assisted Treatment program compliance training.

Communications – 28% of time spent is inclusive of communication including review of Policies and Procedures and communication with staff. A Clinical Compliance Officer is being added to the team to improve communication.

Hotline Activity - Hotline activities for this reporting period included thirty-three calls. The majority of these call were related to Human Resources. The Department is working with compliance to resolve any issues including issues related to discrimination. Call received from Lakeside Medical Center, Primary Care Clinics, and the Home Office.

HIPAA Privacy Incidents – During this reporting period there were thirty-five privacy concerns, of which five resulted in a breach that required patient notification. These five included two from pharmacy, one from the West Boca clinic, one from Aeromedical, and one form the Home Office. There were sixteen privacy concerns that were investigated and resolved with no findings. There were fourteen privacy concerns that were unsubstantiated. Corrective actions included staff retraining.

Privacy Walkthroughs - Quarterly privacy walkthroughs were completed. The main findings included employees not wearing name badges, unlocked computers with PHI, and PHI exposures (on paper). Corrective actions included staff retraining and detailed letter to Managers. Ms. Davis added that during the period the Jerome Golden Center clinic was closed due to low volume and high costs. Patients are being seen at the Lewis Center, the West Palm Beach Clinic, and the Mobile clinic.

Auditing and Monitoring – Activities included an audit of Athena consents, controls / policies and procedures over opioid treatment programs, discharge disposition, limited data sets and data use agreements, joint commission mock survey (Lakeside Medical Center), Asset inventory, uses and disclosures of facility patient directory review, and skilled nursing national background screening.

Quarter 4 plans

CONCLUSION/ACTION: Received and filed.

8C-2 Staff Recommends a MOTION TO APPROVE:
Revised Compliance Work Plan 2018.

Ms. Pentland presented changes to the 2018 Compliance Work plan. Changes included moving the Aeromedical Billing Audit has been moved to the first quarter of 2019 as billing is now outsourced and Policies and Procedures are still in progress. The Lakeside Medical Center's Financial Assistance Policy was moved to the first quarter of 2019 at the request of the CFO. The Volunteer, Student, and Resident Onboarding Process Review was moved to the fourth quarter at the request of the VP of Field Operations. The Referral Clerk Record Audit was added to the work plan and is currently in process.

CONCLUSION/ACTION: Mr. O'Bannon made a motion to approve the Revised Compliance Work Plan as presented. The motion was duly seconded by Ms. Larson. There being no opposition, the motion passed unanimously.

D. CORPORATE RISK MANAGEMENT CLOSED MEETING

The meeting was closed pursuant to Sections 395.0197, 400.119, 400.147, 766.101, and 768.28, Florida Statutes and other relevant statutes and regulations. The closed portion of the meeting is to address risk management matters. All persons currently present must exit the meeting except the following: Quality, Patient Safety and Compliance Committee members, Risk Management Department personnel and key clinical and leadership personnel who are directly involved in risk and quality management issues, legal counsel to the committee, and District Board members.

9. CEO Comments

None.

10. Committee Member Comments

None.

11. Establishment of Upcoming Meetings

- November 27, 2018

12. Motion to Adjourn

There being no further business, the meeting was adjourned at 11:35 a.m.

Philip Ward **Date**

HEALTH CARE DISTRICT OF
PALM BEACH COUNTY
QUALITY, PATIENT SAFETY & COMPLIANCE COMMITTEE

12 Month Attendance Tracking

	1/23/18	3/27/18	5/22/18	9/25/18	11/27/18	3/26/19	5/28/19	9/24/19	11/26/19				
Philip Ward	N/A	✓	x	✓									
Mary Weeks	N/A	✓	✓	✓									
Sharon Larson	N/A	✓	x	✓									
Alina Alonso	N/A	✓	✓	x									
James Elder	N/A	✓	✓	✓									
Sean O'Bannon	N/A	✓	✓	✓									
Dianne King	N/A	x	✓	✓									
Steven Seeley	N/A	x	x	x									
Dr. Daniel Kairys	N/A	Excused	x										
Dr. David Bohorquez				✓									

HEALTH CARE DISTRICT
Quality, Patient Safety and Compliance Committee
November 27, 2018

1. Description: **Compliance and Privacy Dashboard**

2. Summary:

This item presents the Compliance and Privacy Dashboard for FY 2018.

3. Substantive Analysis:

The OIG believes that every effective compliance program must begin with a formal commitment by the governing body to include all the elements based on the seven steps of the Federal Sentencing Guidelines. In order to effectively manage the oversight of the Compliance Program, the Compliance Department has created a Compliance and Privacy Dashboard to report activities on a quarterly basis.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

Dawn L Richards

Dawn Richards
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Quality, Patient Safety, and Compliance Committee receive and file the Compliance and Privacy Dashboard for FY 2018.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Ellen Pentland
Chief Compliance and Privacy Officer

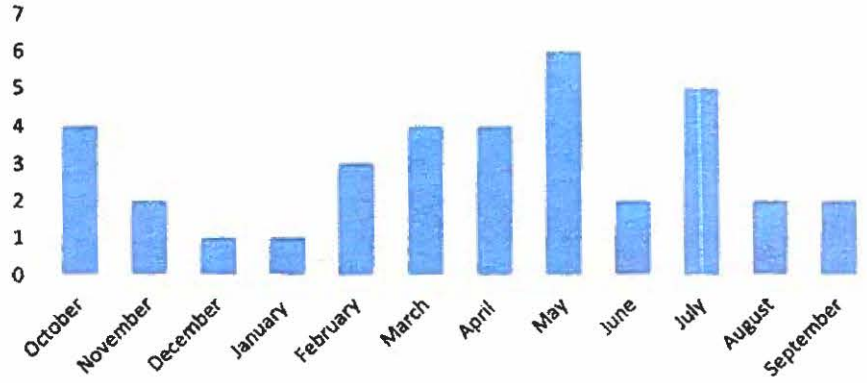
Darcy J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

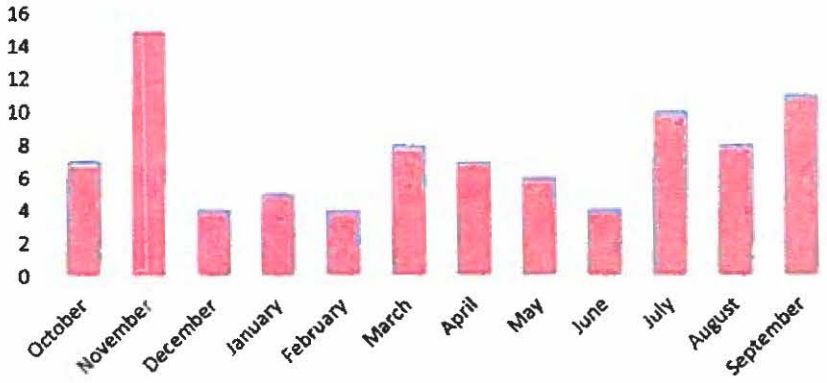
Compliance & Privacy Dashboard

Year to Date: October 1, 2017 – Septmber 30, 2018

Compliance Inquiries by Month



Privacy Concerns by Month



Compliance Inquiries by Month and Entity	C.L. Brumback Clinics	Health Care District	Healthy Palm Beaches	Home Office	Healey	Lakeside Medical Center	Total
October	2	0	0	1	0	1	4
November	1	0	0	0	0	1	2
December	1	0	0	0	0	0	1
January	1	0	0	0	0	0	1
February	0	1	2	0	0	0	3
March	3	0	0	1	0	0	4
April	2	1	0	0	0	1	4
May	3	1	0	0	0	2	6
June	1	1	0	0	0	0	2
July	3	1	0	0	0	1	5
August	1	0	0	0	1	0	2
September	2	0	0	0	0	0	2
Total	20	5	2	2	1	6	36

Privacy Concerns by Month and Entity	Lakeside Medical Center	C.L. Brumback Clinics	E.J. Healey	School Health	Home Office	Total
October	1	4	0	0	2	7
November	1	4	2	0	1	8
December	2	0	0	0	0	2
January	0	2	0	0	3	5
February	0	1	1	0	1	3
March	2	6	0	0	0	8
April	0	4	0	0	3	7
May	2	3	0	0	1	6
June	2	1	0	0	1	4
July	0	4	1	0	5	10
August	1	6	1	0	0	8
September	1	5	1	1	3	11
Total	12	40	6	1	20	79

Health Care District
PALM BEACH COUNTY

Compliance & Privacy Dashboard

Year to Date: October 1, 2017 – Septmber 30, 2018

COMPLIANCE AND PRIVACY REVIEWS AND PROJECTS	October	November	December	January	February	March	April	May	June	July	August	September	Total
Internal Risk Assessment	2	0	1	1	2	3	4	3	3	0	2	1	22
OCR Investigation	0	0	0	1	0	0	0	0	0	0	0	0	1
Risk Assessment	0	0	0	0	0	0	1	0	0	0	0	0	1
OIG Work Plan FY 2018	0	0	0	0	0	0	0	0	2	0	0	0	2
External Audits	3	1	1	1	0	1	0	0	0	0	0	1	8
Total	5	1	2	3	2	4	5	3	5	0	2	2	34

Privacy Walkthroughs	Home Office	C.L. Brumback Clinics	Lakeside Medical Center	Eligibility Office	Healey Center	Total
October	0	0	0	0	0	0
November	0	0	1	0	0	1
December	0	5	0	0	1	6
January	1	1	0	0	0	2
February	0	1	0	1	0	2
March	0	2	0	0	0	2
April	0	1	0	0	0	1
May	0	3	0	1	0	4
June	0	0	0	0	0	0
July	0	0	1	0	0	1
August	0	1	0	1	0	2
September	0	0	0	0	1	1
Total	1	14	2	3	2	22

Health Care District
PALM BEACH COUNTY

Compliance & Privacy Dashboard

Year to Date: October 1, 2017 – Septmber 30, 2018

Compliance Call Activity	
Entity	# of Calls
LMC	9
Healey	0
District	27
Clinics	19
School Health	0
Managed Care	0
Pharmacy	0

Compliance Exit Interviews
4

IT Security	
Security Incidents	2 Incident Reported

Breach Notifications	
Entity	# of Letters
LMC	1
Healey	3
District	3
Clinics	40
Pharmacy	2
School Health	0
Aeromedical	1

Regulatory Inquiries	OIG/SAM CHECK
5 Regulatory Inquiries Processed	Monthly Check 0 Matches

Medical Record Amendments Processed	1 Medical Record Amendments Requested

Compliance and Privacy Education	Health Care District	Lakeside Medical Center	Healey Center	C.L. Brumback Clinics	School Health	Total
October	3	1	1	1	1	7
November	3	2	1	1	0	7
December	1	2	0	0	0	3
January	2	2	0	2	0	6
February	2	0	0	0	0	2
March	2	0	0	0	0	2
April	2	0	0	0	0	2
May	1	0	0	0	0	1
June	1	0	1	0	0	2
July	1	0	1	0	0	2
August	1	0	1	1	1	4
September	2	0	0	1	0	3
Total	21	7	5	6	2	41

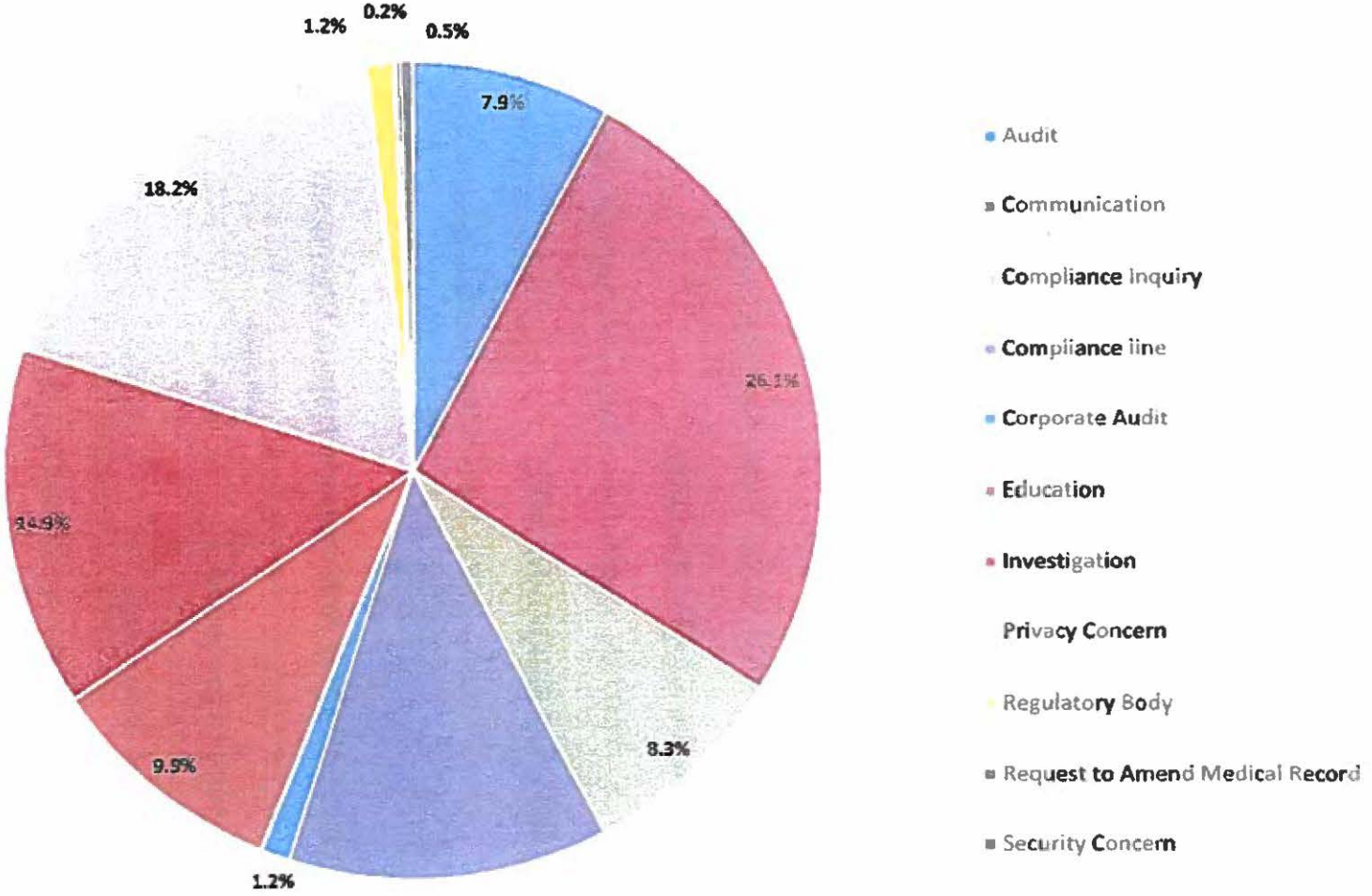
Health Care District
PALM BEACH COUNTY

Compliance & Privacy Dashboard

Year to Date: October 1, 2017 – Septmber 30, 2018

Compliance and Privacy Activity

October 1, 2017- September 30, 2018



HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
November 27, 2018

1. Description: Proposed Schedule for 2019 Committee Meetings

2. Summary:

This agenda item provides the Quality, Patient Safety and Compliance Committee with the proposed schedule for 2019 Committee Meetings. The meetings have been scheduled to accommodate all business unit reporting cycles.

3. Substantive Analysis:

We would like to propose the following:

March 26, 2019 (Q4 2018)

- 10:00AM, Quality, Patient Safety and Compliance Committee Meeting

May 28, 2019 (Q1 2019)

- 10:00AM, Quality, Patient Safety and Compliance Committee Meeting

September 24, 2019 (Q2 2019)

- 10:00AM, Quality, Patient Safety and Compliance Committee Meeting

November 26, 2019 (Q3 2019)

- 10:00AM, Quality, Patient Safety and Compliance Committee Meeting

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

Dawn L Richards

Dawn Richards
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

6. Recommendation:

Staff recommends the committee receive and file the schedule for 2019 Committee Meetings.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Belma Andric, MD, MPH
CMO, VP & Executive Director of Clinical Services

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
November 27, 2018

1. Description: Patient Relations Dashboards

2. Summary:

This agenda item provides the patient relations dashboard for the 1st Trimester of the 2018-2019 school year for School Health and 3rd Quarter of 2018 for C. L. Brumback Primary Care Clinics, Edward J. Healey Nursing and Rehabilitation Center, and Lakeside Medical Center.

3. Substantive Analysis:

See attached reports.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☒
Annual Net Revenue	N/A	Yes ☐ No ☒
Annual Expenditures	N/A	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

Dawn Richards
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Quality, Patient Safety, and Compliance Committee

Date Approved

6. Recommendation:

Staff recommends the Committee receive and file this information.

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
November 27, 2018

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Belma Andric, MD
CMO, VP & Executive Director of Clinical Services

Darcy J. Davis
Chief Executive Officer

Health Care District

PATIENT RELATIONS DASHBOARD

School Health 1st Trimester

Jul-Dec 2018

COMPLAINTS/GRIEVANCES

CATEGORY	2018/2019 TOTAL	JUL #	AUG #	SEP #	OCT #	NOV #	DEC #	T1 2018 TOTAL	JAN #	FEB #	MAR #	T2 2019 TOTAL	APR #	May #	Jun #	T3 2019 TOTAL	2017/2018 TOTAL
Care & Treatment																	3
Communication																	5
TOTAL:	0	0	0	0	0			0									8
Complaints/No Letter Required																	7
Grievances/Letter Sent ≤ 7 days																	1
Grievances/Letter Sent > 7 days																	0
Total Completed Events:		231,601															715,371

SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

July:	NONE
Aug:	NONE
Sept:	NONE
Oct:	NONE
Nov:	
Dec:	

COMPLIMENTS

	2018/2019 TOTAL	JUL #	AUG #	SEP #	OCT #	NOV #	DEC #	T1 2018 TOTAL	JAN #	FEB #	MAR #	T2 2019 TOTAL	APR #	MAY #	JUN #	T3 2019 TOTAL	2017/2018 TOTAL
# COMPLIMENTS RECEIVED	0	0	0	0	0			0									6

SUMMARY OF COMPLIMENTS

JUL:	NONE
AUG:	NONE
SEPT:	NONE
OCT:	NONE
NOV:	
DEC:	

C.L. Grumbacher Primary Care Clinics
Health Care District Palm Beach County

PATIENT RELATIONS DASHBOARD

3rd Quarter 2018

July through September

COMPLAINTS/GRIEVANCES

CATEGORY	2018 TOTAL	Jul #	AUG #	Sept #	Q3 2018 TOTAL	APR #	MAY #	JUN #	Q2 2018 TOTAL	JAN #	FEB #	MAR #	Q1 2018 TOTAL	OCT #	NOV #	DEC #	Q4 2017 TOTAL	2017 TOTAL
Care & Treatment	16	1	1	2	4	2			2	1	6	6	10	5	5		10	28
Communication	3		1		1			1	1	2	1	1	1	1	1	1	3	7
Environmental	0				0				0				0	1			1	1
Nursing Related	1				0				0	1		1	1				0	4
Clinical Support Staff	0				0				0				0				0	27
Other	10	2	1	3	6	1	1	2	4	1	1	1	0			2	2	15
Pharmacy Related	4	2	1	1	4				0				0		1		1	3
Physician Related	3				0		1		1			2	2	1			1	21
Respect Related	7			3	3		1	1	2	1		2	2			2	2	3
TOTAL:	47	5	4	10	19	4	4	4	12	6	8	13	16	8	7	5	20	66
Complaints/No Letter Required	27	3	2	4	9	2	3	2	7	3	5	3	11	3	3	2	8	20
Grievances/Letter Sent ≤ 7 days	17	2	2	6	10	2	1	2	5	2	1	9	12	4	4	3	11	22
Grievances/Letter Sent > 7 days	0				0				0				0	1			1	12
LETTERS NOT SENT FOR GRIEVANCES	4				0				0	1	2	1	4				2	11

Q3 encounters: 36,664 | Q2 encounters: 36,264 | Q1 encounters: 35,946 | Q4 encounters: 33,713

SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

JUL:	Of the 5 Occurrences there were 3 Complaints and 2 Grievances which occurred across 4 clinic locations (1 Dental and 4 Primary Care). Top category was related to Pharmacy services.
AUG:	Of the 4 Occurrences there were 2 Complaints and 2 Grievances which occurred across 3 clinic locations (1 Women's Health and 3 Primary Care). Top category was wait time compliant from a 3rd party payor.
SEP:	Of the 10 Occurrences there were 4 Complaints and 6 Grievances which occurred across 3 clinic locations (2 Behavioral Health, 1 Substance Abuse Services, 2 Dental, and 5 Medical). Top category was related to lack of respect perceived by patient.

COMPLIMENTS

	2018 TOTAL	Jul	AUG	Sept	Q3 2018 TOTAL	APR #	MAY #	JUN #	Q2 2018 TOTAL	JAN #	FEB #	MAR #	Q1 2018 TOTAL	OCT #	NOV #	DEC #	Q4 2017 Total	2017 TOTAL
# COMPLIMENTS RECEIVED	167	15	24	23	62	22	3	4	29	18	29	29	76	10	15	10	35	318

JUL:	15 compliments were received across 4 clinics of which: 1 was specific to a Dental employee, 2 were related to Women's Health Services, and 12 were related to Primary Care Clinic Services of which 4 were for specific employees and 8 were for overall care.
AUG:	24 compliments were received across 7 clinics of which: 1 was related to a Behavioral Health Provider, 1 was specific to a Dental employees, 3 were regarding overall Dental Clinic Team & Service, 3 were specific to Primary Care Providers, 5 were related to Primary Care Employees, and 11 were for Primary Care Clinic Teams & Service.
SEP:	23 compliments were received across 7 clinics of which: 2 were related to a Behavioral Health Provider, 2 were related to Dentists, 4 were specific to Primary Care Providers, 11 were related to Primary Care Employees, and 4 were for Primary Care Clinic Teams & Service.

Healey Center

PATIENT RELATIONS DASHBOARD

Healey Center

3rd Quarter (July-September 2018)

REGULATORY

Survey Type & Date	Survey Findings Summary & Actions: Complaint Survey on August 23, 2108 all complaints were unsubstatiated.

Average number of residents: 119

GRIEVANCES

CATEGORY	JAN	FEB	MAR	Q1	APRIL	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	2018
	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
Care & Treatment	9	2	7	18	3	4	5	12	2	2	3	7				0	37
Communication	4	3	1	8	1	1		2			1	1				0	11
Discharge	1			1				0				0				0	1
Environmental	1	7	3	11		2		2	3	1		4				0	17
Noise Issue	1	1		2		2		2				0				0	4
Nursing Related	5	1	4	10	4	2		6	1	2	2	5				0	21
Nutrition	6	3	4	13	1	3	2	6	5	2	1	8				0	27
Other	4		3	7	6	4	6	16	4	7	7	18				0	41
Pain Management				0				0			1	1				0	1
Personal Belongings	5	3	3	11	6	5	3	14	2	7	6	15				0	40
Physician Related	1			1				0				0				0	1
Respect Related				0				0		1	1	2				0	2
TOTAL GRIEVANCES:	37	20	25	82	21	23	16	60	17	22	22	61	0	0	0	0	203
SOURCE OF CONCERNS																	
Verbal: Patient/Family	37	20	25	82	21	22	13	56	16	21	21	58				0	196
Written: Patient/Family				0		1	3	4	1	1	1	3	0	0	0	0	7
RESOLUTION TURN AROUND TIME																	
# Resolved w/i 72 Hrs. Per Policy	37	17	23	77	21	21	16	58	17	19	21	57				0	192
# Not Resolved w/i 72 Hrs. Per Policy	0	3	2	5	0	2	0	2	0	3	1	4	0	0	0	0	11

July: Nutrition	A review of the grievances revealed Nutrition with the highest number of concerns for the quarter. Further investigation indicated a Food Survey was conducted during this period, summary of improvement opportunities were temperature, flavor, and appearance of food served. Random audits conducted by the Registered Dietitian and Dir. Food & Nutrition Service to ensure compliance is met and resident satisfaction. None of the grievances indicated abuse, neglect, exploitation or misappropriation and all were resolved with satisfactory resolution.

August: Personal Belonging & Other	A summary of the grievance included missing clothing items such as; pants, shirts, and socks. All items were either found or replaced. It has been noted that some residents repeatedly report missing items with the expectancy of facility to reimburse. A daily pick up log for personal clothing initiated for those residents identified frequently missing clothing. A summary of the "Other" grievances included residents' concerns such as; not wanting to provide destination for LOA, request for LOA, and a resident felt there were not enough portable oxygen. 3 were resolved within 96 hours due to weekend and multiple attempts to reach family member. None of the grievances indicated abuse, neglect, exploitation or misappropriation and were resolved with satisfactory resolution.
September: Other	A summary of the grievances "Other" includes' request to use an extension cord, resident upset not getting extra crackers, and broken reacher. 4 residents account for 12 of 22 grievances submitted. 1 resolved within 96 hours due to resident at hospital. None of the grievances indicated abuse, neglect, exploitation or misappropriation and were resolved with satisfactory resolution.

COMPLIMENTS

	JAN	FEB	MAR	Q1	APRIL	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	2018
	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
# COMPLIMENTS	2	3	1	6	5	4	5	14	4	4	5	13				0	

SUMMARY OF COMPLIMENTS

July:	A summary of a the compliments during the quarter details gratitude for excellent customer service and overall care provided by staff.
August:	
September:	

PATIENT RELATIONS DASHBOARD

Lakeside Medical Center

July - Septemeber 2018

GRIEVANCES

	JAN #	FEB #	MAR #	Q1 TOTAL	APR #	MAY #	JUN #	Q2 TOTAL	JUL #	AUG #	SEP #	Q3 TOTAL	OCT #	NOV #	DEC #	Q4 TOTAL	2018 TOTAL
Admitting/Registration	1	0	0	1	0	0	0	0	0	0	0	0				0	1
Care & Treatment	0	1	1	2	3	2	0	5	2	0	1	3				0	10
Communication	0	0	0	0	1	0	1	2	2	0	0	2				0	4
Discharge	0	0	0	0	1	1	0	2	0	1	0	1				0	3
Environmental	1	0	0	1	1	1	0	2	0	0	0	0				0	3
Nursing Related	3	1	0	4	0	0	0	0	1	0	0	1				0	5
Nutrition	0	1	0	1	0	0	0	0	1	0	1	2				0	3
Other	1	0	1	2	0	0	1	1	1	1	1	3				0	6
Pain Management	0	0	0	0	0	0	1	1	2	1	0	3				0	4
Personal Belongings	0	0	0	0	0	0	1	1	0	0	1	1				0	2
Physician Related	5	1	0	6	2	1	2	5	1	0	1	2				0	13
Respect Related	0	0	1	1	0	0	1	1	0	1	0	1				0	3
TOTAL CATEGORIES:	11	4	3	18	8	5	7	20	10	4	5	19	0	0	0	0	57

SOURCE OF CONCERNS

Verbal: Patient/Family	10	3	3	16	8	5	7	20	9	4	5	18				0	54
Written: Patient/Family	1	0	0	1	0	0	0	0	0	0	0	0				0	1
Employee	0	1	0	1	0	0	0	0	1	0	0	1				0	2
TOTAL # OF CONCERNS:	11	4	3	18	8	5	7	20	10	4	5	19	0	0	0	0	57

TOTAL NUMBER OF CONCERNS

Complaints/No Letter Required	10	4	3	17	8	4	5	17	6	4	5	18				0	52
Grievances/Letter Sent ≤ 30 days	1	0	0	1	0	1	2	3	4	0	0	1				0	5
Grievances/Letter Sent > 30 days	0	0	0	0	0	0	0	0	0	0	0	0				0	0
TOTAL # OF CONCERNS:	11	4	6	18	8	5	7	20	10	4	5	19	0	0	0	0	57

SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

JUL:	ER complaint regarding long wait time for transfer, working on ambulance situation; Unsubstantiated complaint about inappropriate care; Miscommunication between family member and switchboard handled by Nursing Supervisor to everyone's satisfaction; Patient concerned about medical record documentation resolved; Nursing-related complaint was an HR issue; Pain medication administration issue was unsubstantiated; Second pain management issue was service recovered by Patient Advocate and Director of Nursing, nurse counseled; Diabetic patient educated about CHO 1800 calorie diabetic diet; ER complaint about Facebook photo was unsubstantiated; ER physician issue was resolved by Dr. Padron

AUG:	Patient readmitted at family's request; Pain management during a c-section sent to Risk Management for investigation and resolution; Issue between nursing and security sent to Director for resolution; Patient upset about medically appropriate Baker Act
SEPT:	Patient complained about presentation, manager addressed it with staff; Patient reported a missing ring, found and returned; Patient complaint about a physician, sent to Risk for investigation and resolution; Nursing Assistant complaint about a patient's inappropriate behavior, Dr. Padron resolved issue; ER patient's unrealistic expectation that her children would be seen by ER doctor because she was an ER patient

COMPLIMENTS

	JAN #	FEB #	MAR #	Q1 TOTAL	APR #	MAY #	JUN #	Q2 TOTAL	JUL #	AUG #	SEP #	Q3 TOTAL	OCT #	NOV #	DEC #	Q4 TOTAL	2018 TOTAL
# COMPLIMENTS RECEIVED	8	3	4	15	3	12	4	19	3	1	0	4				0	38

Comments on Compliments	**JUL:** Staff complimented on teamwork, professionalism and compassion; Staff complimented for helping with emergency translation for multiple Creole speaking patients; Nursing Supervisor complimented for being "very supportive, resourceful, and professional".
	AUG: Admin Assistant was complimented on her organization, attention to detail and calm demeanor.
	SEPT:

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
November 27, 2018

1. Description: Quality & Patient Safety Reports

2. Summary:

This agenda item provides quality and patient safety reports for the 3rd Quarter of 2018 for Aeromedical, C. L. Brumback Primary Care Clinics, Edward J. Healey Nursing and Rehabilitation Center, Lakeside Medical Center, Pharmacy, and Trauma.

3. Substantive Analysis:

See attached reports.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☒
Annual Net Revenue	N/A	Yes ☐ No ☒
Annual Expenditures	N/A	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

Dawn L. Richards

Dawn Richards
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Quality, Patient Safety, and Compliance Committee

Date Approved

6. Recommendation:

Staff recommends the Committee receive and file this information.

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
November 27, 2018

Approved for Legal sufficiency:

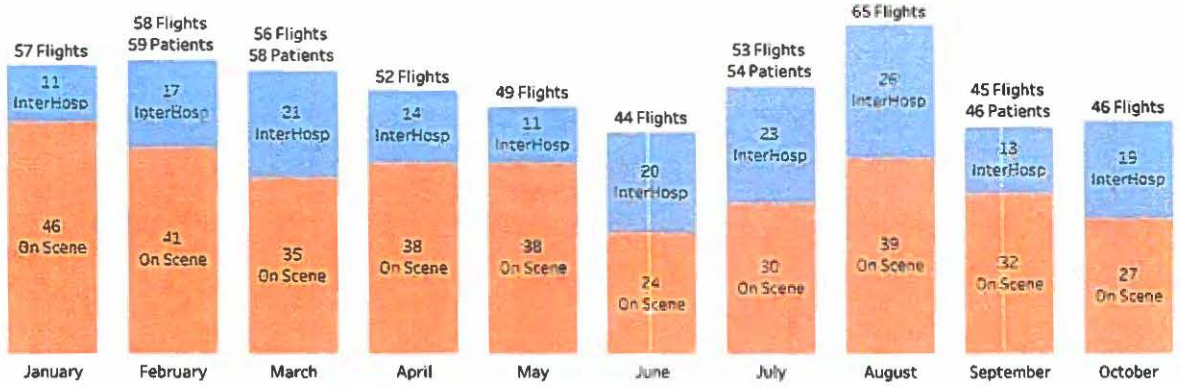
Valerie Shahriari
VP & General Counsel

Belma Andric, MD
CMO, VP & Executive Director of Clinical Services

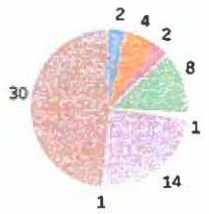
Darry J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

Aeromedical Quality Report Q3



Missed, Cancelled or Aborted Flights



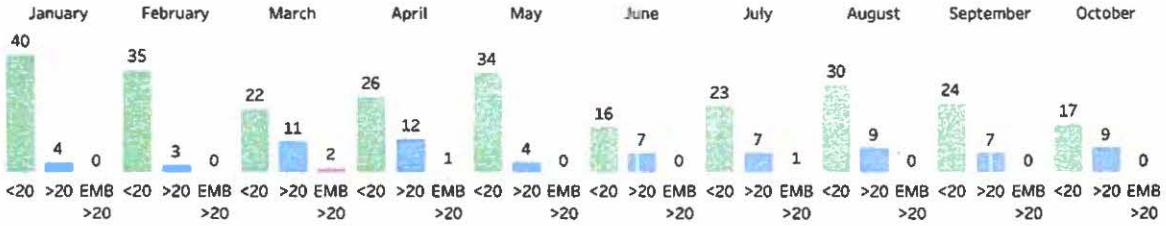
Month Of Missed Flight: Jul, Aug, Sep

Missed Reason
- Admin
- County Coverage
- Maintenance
- Medical Team Declined
- No Backup
- Referring Agency
- Simultaneous Flight
- Weather

62

Go to Detail

Call To Scene (minutes) for Scene Flights with 3 legs or more



Utilization

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Hours Utilized	74	84	82	55	60	69	74	102	62	74
% Hours Utilized	6.8%	8.3%	7.4%	5.2%	5.7%	6.4%	6.6%	9.3%	6.8%	6.9%
Available Hours	1,089	1,008	1,116	1,044	1,053	1,080	1,113	1,092	909	1,070
% Available Hours	98%	93%	100%	97%	94%	100%	100%	98%	84%	96%

Average Times for Scene Flights

Month of Fl.	On Scene	Dispatch To Enro.	Dispatch To On Scene
January	8m 59s	5m 14s	14m 5s
February	7m 44s	5m 23s	13m 51s
March	9m 22s	5m 21s	17m 28s
April	9m 1s	5m 8s	16m 19s
May	8m 12s	3m 45s	11m 52s
June	8m 9s	5m 5s	15m 37s
July	7m 56s	5m 23s	15m 4s
August	8m 38s	4m 36s	14m 2s
September	7m 47s	5m 5s	14m 40s
October	9m 14s	4m 51s	15m 9s

*EMB - East of 20 Mile Bend

Health Care District
PALM BEACH COUNTY

MISSED FLIGHTS REASONS

Medical decision - Medical team declined for a medically related issue
No Backup – 1 aircraft was available and in use and another transport request was received and declined.
Simultaneous flights – 2 aircraft were available and in use and another transport request was received and declined.
County coverage – a request for transport was declined based on the Districts policy not to transport patients that going from or to Palm Beach County
Admin – Declined for an Aviation related issue other than maintenance
Maintenance – aircraft is not or has become unavailable for a maintenance issue resulting in an inability to accept or continue the flight request

OTHER DEFINITIONS

Call to Scene (minutes) for Scene Flights – This statistical group does <u>not</u> include scene flights where the patient was transported by ground to the airport for further transfer by helicopter.

Green <20 is a response where the time between the request for transport until the aircraft's arrival at the pickup location is less than 20 minutes

Blue >20 is a response where the time between the request for transport until the aircraft's arrival at the pickup location is greater than 20 minutes and the pickup location was West of 20 mile bend.

Red >20 is a response where the time between the request for transport until the aircraft's arrival at the pickup location is greater than 20 minutes and the pickup location was East of 20 mile bend.

Why do we reference 20 minutes? This is one of the metrics that is referenced in the EMS Ordinance as a measureable response time. Another metric referenced in the EMS Ordinance is Average Response time which is also presented on the Quality report.

Hours of Operation – Operating 1 aircraft 24 hours per day and a 2nd aircraft 12 hours per day provides 36 hours of service time per day. When an aircraft is not available during the 12 hours normally scheduled for any reason this time is recorded. Reducing the availability thereby reduces the normal 36 service hours per day. When both aircraft are not available that time is also recorded.

Available Hours – 36 hours per day times days per month are normal available hours. Months with 31 days = 1,116 hours, 30 days = 1,080, etc. Example: if 4 days occur during the month with 31 days when the 2nd aircraft is not available for the mid shift the available hours for that month would be 1,068.

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

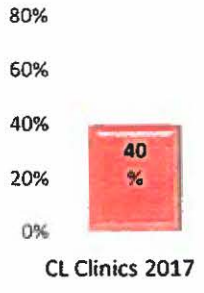
C. L. BRUMBACK PRIMARY CARE CLINICS

YTD SEPTEMBER 2018

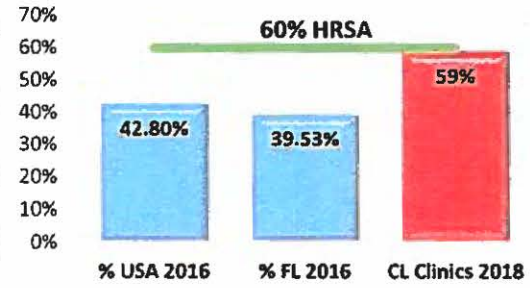
CHILDHOOD IMMUNIZATION

Findings: 1. Florida shots is till not crossing over. 2. Staff is only documenting last vaccine administration instead of all administrations.

Interventions: 1. IT is working with Florida Shots to get updates and improve interface. 2. Train staff on reconciling vaccines and historically documenting.

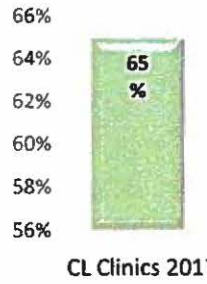


CERVICAL CANCER SCREENING

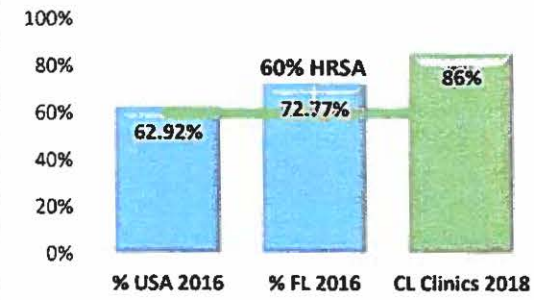


Findings: 1. Providers are not performing PAP on all visits regardless of reason for visit. 2. Records of previous screening are missing. 3. Providers failing to document pap smear results and due date for next screening.

Interventions: 1. Retrain staff on performing PAP whenever due, regardless of reason for visit. 2. Retrain staff on using medical record request order and check follow up "bucket" when records have not be receieved. 3. Investigate best method for documenting due date for next screening (history section vs QM tab section)



WEIGHT SCREENING AND COUNSELING FOR CHILDREN AND ADOLESCENTS



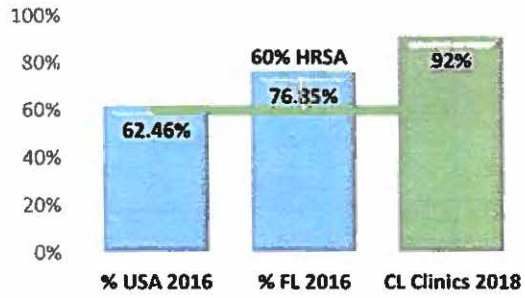
Not Available

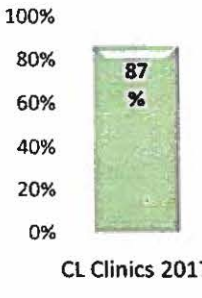
C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

C. L. BRUMBACK PRIMARY CARE CLINICS

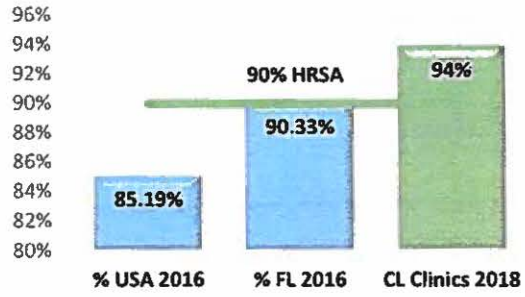
YTD SEPTEMBER 2018

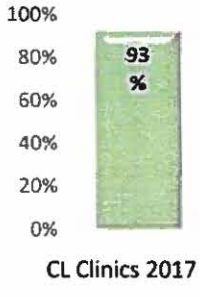
ADULT WEIGHT SCREENING AND FOLLOW UP



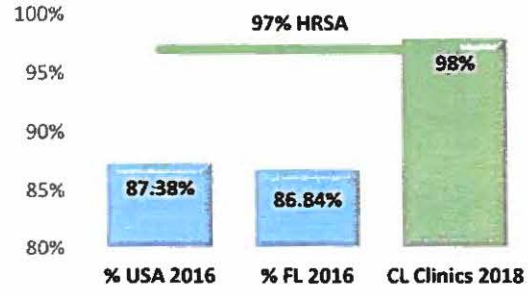


TOBACCO USE SCREENING AND CESATION INTERVENTION



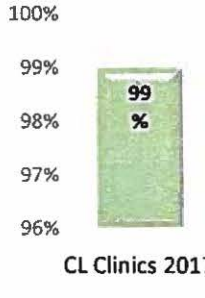


ASTHMA PHARMACOLOGIC THERAPY



Findings: 1.

Interventions: 1.

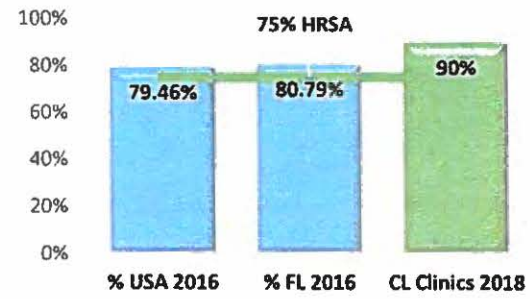


C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

C. L. BRUMBACK PRIMARY CARE CLINICS

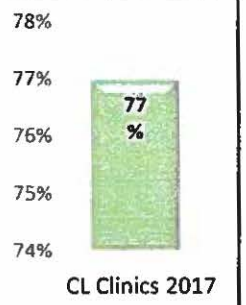
YTD SEPTEMBER 2018

CORONARY ARTERY DISEASE (CAD): LIPID THERAPY

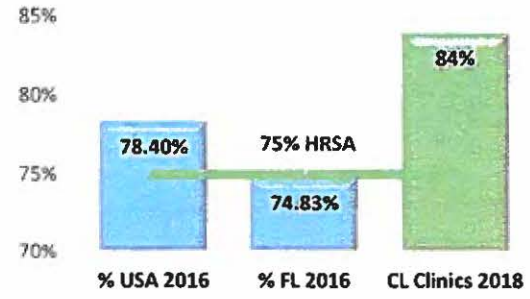


Findings: 1.

Interventions: 1.

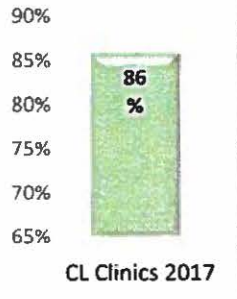


ISCHEMIC VASCULAR DISEASE (IVD): Antiplatelet Therapy



Findings: 1.

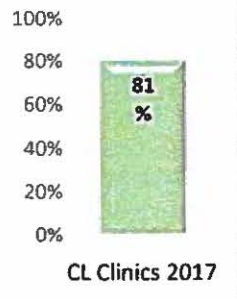
Interventions: 1.



COLORECTAL CANCER SCREENING

Findings: 1. Low specimen return rate. 2. Low rates for POD

Interventions: 1. Reducate staff on importance of colon cancer screening and patient education. Remind staff of screening script. 2. Incentivise staff with highest POD rates.

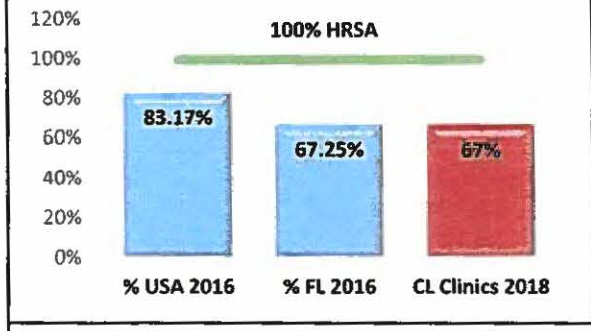


C. L. Brumback Primary Care Clinics
Health Care District Palm Beach County

C. L. BRUMBACK PRIMARY CARE CLINICS

YTD SEPTEMBER 2018

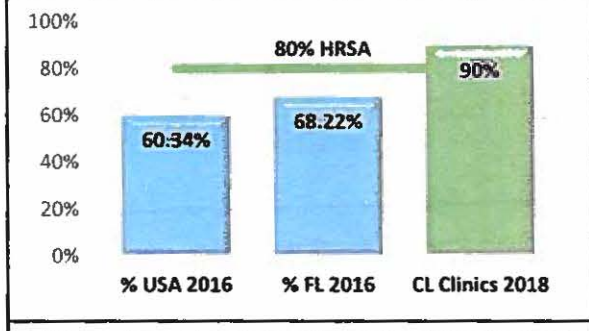
HIV LINKAGE TO CARE



Findings: 1. Patients are lost to follow up

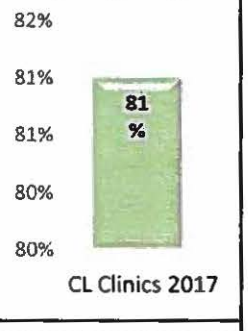
Interventions: 1. Partner with DOH's HIV Disease Intervention Service to join provider during follow up visit to discuss positive test results. This will ensure that patient is linked to care as soon as results are shared.

PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP

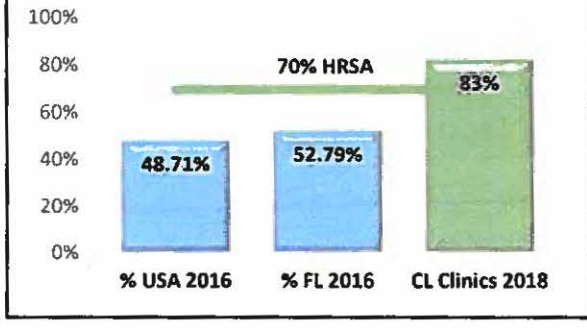


Findings: 1.

Interventions: 1.

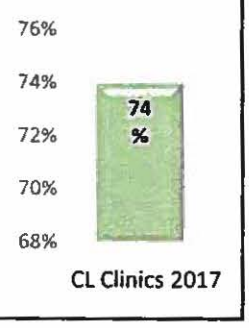


DENTAL SEALANTS



Findings: 1.

Interventions: 1.



C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

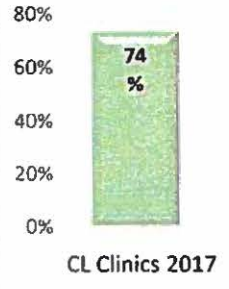
C. L. BRUMBACK PRIMARY CARE CLINICS

YTD SEPTEMBER 2018

HYPERTENSION

Findings: 1.

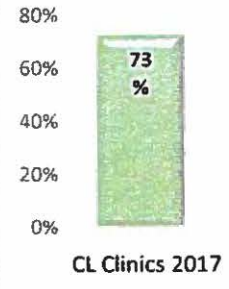
Interventions: 1.



DIABETES

Findings: 1. Patient A1c result is not in the chart. 2. Evidence of clinical inertia and failure to advance medical therapy in patients with high A1c

Interventions: 1. Retrained all staff on how to document A1c that are not reported through lab interface (i.e specialist report or result in ALLSCRIPTS). 2. Develop Diabetes Plan to be in line with HRSA diabetes initiative.



Healey Center

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
3rd Quarter 2018
Percentages

Total average patients served per month: 119

Measure Set: Casper Report	Comparison Group		ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL	Previous Quarters									
MDS 3.0 Facility Level Quality Measure Report Note: Comparison Group National Percentile Cuts that cross the threshold equal to or greater than 75 percentile is emphasized on the survey or any internal quality improvement initiative	2018 Q3		2018 Q3	2018 Q2		2018 Q1				2017 Q4			
	Goal	EJH Percentile		Goal	EJH Percentile	% USA	% FL	GOAL	% EJH	% USA	% FL	GOAL	% EJH
High Risk Long Stay Residents With **Pressure Ulcer**	< 75	78	**Findings:** Of the 87 residents included in the sample set, only 8 were identified with a pressure ulcer. 4 admitted (1 since resolved) and 4 acquired (1 since resolved). 3 residents have been non-compliant with care and treatment. Ongoing education provided to residents on risks of wound (s) worsening and other negative outcomes as a result of refusing care. **Interventions:** 1. Risk assessment is completed on admission, weekly X 4weeks and as needed. 2. Skin checks weekly & as needed. 3. Use of Interact Stop & Watch upon identification of any change in condition. 4. Review of preventative measures and revision of care plans as needed. 5. Nutritional assessment and Therapy evaluation if indicated. 6. Consult Wound Care MD 7. Weekly review at the IDT Focus meeting.	< 75	83	6.2	6.6	0>st2	8.4	6.1	6.6		8.3
Newlworse Pres Ulcer (S)	< 75	0		< 75	0	1.0	0.5	0.0	0.0	0.8	0.4		0.0
Experiencing One or More **Falls with Major Injury**	< 75	0		< 75	0	3.5	2.8	0.0	0.0	3.5	2.9		0.0
Falls (L)	< 75	6		< 75	5	45.6	41.1	12.0	22.2	45.5	40.9		15.5
Who Have **Depressive Symptoms**	< 75	0		< 75	0	4.8	1.2	1.0	0.0	4.8	1.1		0.0
Who **Lose Too Much Weight**	<75	33		<75	7	7.9	7.9	6.0	6.0	7.4	7.9		10.3
Who Received an **Antipsychotic Medication (L)**	< 75	75	**Findings:** Of the 111 residents, only 21 residents were included in the sample set. **Interventions:** 1. Residents who are admitted on antipsychotic medications are referred to Psych. 2. Medical records review conducted by Consultant Pharmacist to ensure medications have appropriate diagnoses. 3. Monitoring of behaviors every shift and review at Psych meeting for gradual dosage reduction attempts. 4. Non-pharmacological interventions prior to medicating the resident.	< 75	75	15.1	14.4	15.0	17.8	15.4	14.8		16.8
Who Received an **Antipsychotic Medication (S)**	<75	0		<75	0	2.1	2.2	2.0	0.0	2.2	2.2		0.0
Who Received **Anti-anxiety or Hypnotic Medication**	<75	44		<75	45	7.7	7.5	9.0	6.8	7.9	8.2		8.4
Who Self Report Moderate to Severe **Pain (L)**	<75	45		<75	51	6.3	4.0	5.0	9.6	5.4	3.4		6.8
Who Self Report Moderate to Severe **Pain (S)**	< 75	94	**Findings:** Of the 3 residents, only 1 resident was identified in the sample set & was admitted with a Dx: Chronic Pain Syndrome, Multiple Pressure Ulcers, and Neuropathy. **Interventions:** 1. Pain assessment upon admission, quarterly, and as needed. 2. Medication management by the Medical Practitioner. 3. Pain monitoring every shift by Licensed Nurse. 4. Non-pharmacological interventions. 5. Pain Management Consult as needed	< 75	81	13.1	9.0	2.0	33.3	9.6	13.5		0.0
Who Were **Physically Restrained**	<75	0		<75	0	0.4	0.3	0.0	0.0	0.4	0.3		0.0
Whose **Behavioural Symptoms** Affect Others	<75	46		<75	57	21.1	15.3	12.0	8.3	21.3	15.7		4.5
Increase **ADL Help (L)**	<75	17		<75	33	16.0	14.1	10.0	8.8	15.2	13.7		9.3
with a **Catheter** Inserted and Left in Their Bladder	<75	47		<75	56	2.5	1.9	1.9	3.8	2.1	1.6		5.8
With a **Urinary Tract Infection**	<75	57		<75	59	3.1	3.0	3.0	5.1	3.5	3.5		2.6
Low Risk LSRs Who Lose Control of Their **Bowel or Bladder**	<75	42		<75	48	48.2	54.4	47.0	42.3	47.8	54.4		50.0
Move Independent Worsens (L)	<75	29		<75	19								
Improvement in Function (S) Higher % Better	<75	0		<75	99								

Lakeside Medical Center

QUALITY CORE MEASURES REPORT
3rd Quarter July - September 2018
PRELIMINARY REPORT

Inpatient Quality Measures	AVG FL*	AVG LMC 2017	LMC GOAL	Sampled Population (defined by Press Ganey**)	Patient Encounters: 7,460 3Q '18	Actions Taken When Indicator not Meeting Goal	Patient Encounters: 8,014 2 Q '18	Patient Encounters: 8,443 1Q '18	Patient Encounters: 8,356 4Q '17	Patient Encounters: 7,835 3Q '17
Emergency Department: ED-1a **Median time from ED arrival to ED departure for admitted patients.** Numerator: Departed ED in less than 267 minutes. Denominator: Measure sampled population for any ED Patient from the facility's emergency department. TJC	269 mins	264 mins	<267 mins	45/96	282 mins 47 %	**Findings:** Based on review of 4 cases found that the median time from ED arrival to ED departure ranged from 7-7.5 hours. Consideration given to the complexity of cases, stabilization and treatment. **Interventions:** Collaborative efforts continue with AMR and the District Team. The ED Manager and the Elite Team continue to analyze the ED data for improvement opportunities.	264 mins 50%	286 mins 36%	283 mins 49%	283 mins
Emergency Department: ED-2a **Median time from decision to admit time to ED departure for admitted patients.** Numerator: Admitted and departed ED in less than 79 mins. Denominator: Measure sampled population or any ED Patient from the facility's emergency department. CMS/TJC	89 mins	94 mins	<79 mins	36/96	98 mins 38 %	**Finding:** Based on review of 4 cases found that the median time from decision to admit to ED departure range was 4-4.5 hours. Consideration given to findings of the patients condition, stabilization and treatment. **Interventions:** Collaborative efforts continue with Internal Medicine team to improve transition process for ED admissions and inpatient discharges.	94 mins 37%	103 mins 33%	89 mins 39%	118 mins
Immunizations (seasonal): IMM-2 **Influenza Immunization** Numerator: Number hospitalized inpatients 6 months or older screened for seasonal Influenza immunization status and vaccinated if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March. TJC	97%	90%	>98%	NA	NA	**Findings:** NA **Interventions:** No actions required.	NA	94%	82%	N/A
Perinatal Care: PC-01 **Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed.** **(Lower percentage is better, for cases that fall into measure).** Numerator: Patients with elective deliveries. Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed. TJC	2%	0%	0%	0/14	0%	**Findings:** Goals were met. **Interventions:** No actions required.	0%	0%	0%	0%
Perinatal Care: PC-02 **Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth** **(Lower percentage is better).** Numerator: Patients with cesarean births. Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation. TJC		31%	<20%	2/21	10%	**Findings:** The two records were reviewed. C-Sections were performed due to findings but not limited to Prolonged second stage of Labor, Macrosomia, Non-Reassuring FHR(Late Deceleration) Oligohydramnios. The C-Sections were required based on ACOG standards. **Interventions:** No further actions required.	21%	18%	31%	17%
Perinatal Care: PC-03 **Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns** **(Higher percentage is better).** Numerator: Patients with antenatal steroids initiated prior to delivering preterm newborns, Denominator: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed TJC		100%	100%	1/1	100%	**Findings:** The patient presented to unit 28 weeks gestation with no Prenatal Care in active labor. **Interventions:** No actions required.	NP ****	NP ****	N/A	100%

Lakeside Medical Center

QUALITY CORE MEASURES REPORT
3rd Quarter July - September 2018
PRELIMINARY REPORT

Inpatient Quality Measures	AVG FL*	AVG LMC 2017	LMC GOAL	Sampled Population (defined by Press Ganey**)	Patient Encounters: 7,460 3Q'18	Actions Taken When Indicator not Meeting Goal	Patient Encounters: 8,014 2Q'18	Patient Encounters: 8,443 1Q '18	Patient Encounters: 8,356 4Q '17	Patient Encounters: 7,835 3Q '17
Perinatal Care: PC-04 **Health Care-Associated Bloodstream Infections in newborns (Lower percentage is better).** **Numerator:** Newborns with septicemia or bacteremia. **Denominator:** Live born newborns TJC		0	0	0	NP ****	**Findings:** No population **Interventions:** No actions required.	NP ****	NP ****	N/A	0
Perinatal Care: PC-05 **Exclusive breast milk feeding during the newborn's entire hospitalization.** **(Higher percentage is better)** **Numerator:** Number of moms Exclusively Breast Feeding. **Denominator:** Single term newborns discharged alive from the hospital. TJC		14%	>13%	1/25	4%	**Findings:** Based on review of all cases (60%) of the sampled population both breast and bottled fed. (36%) bottle fed only and (4%) strictly breast fed. **Interventions:** The LMC OB Nurse continues to study for her IBCLC and attend the monthly Breastfeeding Coalition Meetings.	7%	4%	16%	3%
***Sepsis: SEP-1** **Early management bundle, severe sepsis/septic shock** **Special Note: Measure is not publicly reported by Hospital Compare.** **Numerator:** Patients who received ALL of the following within three hours of presentation of severe sepsis; Specific Labs, Hydration, Examination (i.e. B/P Antibiotics, Perfusion assessment). **Denominator:** Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis or Septic Shock. CMS/TJC	57%	76%	>60%	12/19	63%	**Findings:** Based on the review 7 cases failed. The reasons for the failed cases were (2) blood cultures (1) crystalloid fluids (1) vasopressor administration (2) presistent hypotension (1) assessment. **Interventions:** With on-going focus on moving the hospital towards zero harm and transforming processes Sepsis has been selected for a closer review as an Performance Improvement Project for the Continuous Quality and Patient Safety Committee.	79%	72%	74%	74%
VTE-6 Hospital Acquired Preventable VTE **Numerator:** Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date. **Denominator:** Patients who developed confirmed VTE during hospitalization. CMS/TJC	1%	0%	0%	0/0	NP ****	**Findings:** No population **Interventions:** No actions required	NP ****	NP ****	0%	0%

*The October 2018 Hospital Compare Preview Report for reporting period July 27th through August 25,2018 has been used to update the current Florida Averages for the following Core Measures noted in column 2: ED-1a, ED-2a, IMM-2 and Sep-1.

**Press Ganey

***Sepsis benchmark goal was amended on August 31st at the Sepsis Committee Meeting. After reviewing the Quality Net CMS Hospital Inpatient Sepsis Quality report, were able to determine that the benchmark established for Lakeside Medical Center was significantly higher than that of the National and State average. A review of the previous 3 quarters were used as a reference to determined the newly established goal of 60% versus the previous goal of 90%.

**** NP= No Patients

***** Correction made to 2nd Quarter 2017 ED 1a previous documentation 227 mins.

****** CMS is retiring ED-1, IMM-2, and VTE-6 for CY2019; TJC is NOT retiring ED-1, IMM-2, and VTE-6 for CY2019.

Lakeside Medical Center

QUALITY CORE MEASURES REPORT
3rd Quarter July - September 2018
PRELIMINARY REPORT

Outpatient Quality Measures	AVG FL *	AVG LMC 2017	LMC GOAL	Sampled Population (defined by Press Ganey**)	Patient Encounters: 7,460 3Q '18	Actions Taken When Indicator not Meeting Goal	Patient Encounters: 8014 2Q '18	Patient Encounters: 8,443 1Q '18	Patient Encounters: 8,356 4Q '17	Patient Encounters: 7,835 3Q '17
Acute Myocardial Infarction: OP-3a **Median time to transfer to another facility for acute coronary interventions** **Numerator:** Number of patients transferred to another facility with less than 90 minutes **Denominator:** Patients with Transfer for Acute Coronary Intervention. CMS/TJC		102 mins	<90 mins	1/1	129 mins 100%	**Findings:** Based on review of the only case, the median time for transfer to another facility for acute coronary intervention range was 2 hours. Initial pateint transport was arranged with AMR (turn round time was 2 hours). The final decision was made to transport the patient via Trauma Hawk service. **Interventions:** Planning with Healthcare District and AMR continues for contract implementation.	94 mins 67%	100 mins 0%	100 mins 0%	94 mins
Chest Pain: OP-5 **Median time to EKG (Goal 10 mins)** **Numerator:** Number of patients received EKG within 10min upon arrival to ED. **Denominator:** Emergency Department AMI or Chest Pain patients (with Probable Cardiac Emergency Department AMI or Chest Pain patients (with Probable Cardiac Chest Pain). CMS/TJC		7 mins	<10 mins	13/19	7 mins 68%	**Findings:** The goal was met for Median time to EKG completion. **Interventions:** Records are audited by the Respiratory Manager monthly. Records not meeting time frame for Critical Values are reported and entered into Risk Qual for follow up with CMO/Nurse Manager. Performance will be reported at the monthly Continuous Quality and Patient Safety Meeting.	9 mins 63%	6 mins 56%	7 mins	2 mins
Emergency Department Throughput: OP-18 **Median time from ED arrival to discharge home or transferred** **Numerator:** Number of patients discharged in less than 120 minutes. **Denominator:** Any ED patient from the facility's emergency department. CMS/TJC		124 mins	<120 mins	50/102	125 mins 49%	**Findings:** Based on the review of 5 cases, the median time from ED arrival to discharge ranged was from 6.5-10.5 hours - relative to the complexity of the patient condition, treatment plan and need for specialized care. Conditions ranged from end-of -life care transition to Hospice, patient was unstable with a change of condition (transferred), need for Orthopedic Hand Surgeon and Dialysis. **Interventions:** Discuss chart review findings with the Chief Medical Officer and ED Director for review with ED physicians and staff for establishment of improvement opportunities. Future goals include discussion to add additional service lines.	147 mins 51%	122 mins 49%	139 mins 45%	137 mins *****
Stroke: OP-23 **Stroke patient arriving in ED w/in 2 hours of onset of symptoms who had CT or MRI results w/in 45 mins of arrival (Higher percentage is better).** **Numerator:** Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients. **Denominator:** Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well with an order for a head CT or MRI scan. CMS/TJC		100%	100%	1/4	75%	**Findings:** No population. **Interventions:** No actions required.	N/A	N/A	N/A	N/A

Health Care District
PALM BEACH COUNTY

Pharmacy Services
Quality Report
3rd Quarter 2018

Measure Set:				ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL	Previous Quarters								
Pharmacy Quality Measures	**2018 Q3**				**2018 Q2**			**2018 Q1**			**2017 Q4**		
	Goal	Total			Goal	Total		Goal	Total		Goal	Total	
340B utilization		#	%			#	%		#	%		#	%
Total HCD prescriptions sold (excludes RW)		63,875				72,679			70,737			74,511	
340B prescription fills sold		62,907	98.5			72,250	99.4		70,238	99.3		73,560	98.7
Central Fill		22,003	34.5	Only at WPB, Lantana, Lake Worth, Delray locations		17,990	24.9		4,648				
Ready when promised (non-waiters)												52,657	97.9
Belle Glade		5,992	99.9			5,904	99.8		5,482	99.9		5,360	99.9
Boca Raton									1,659	99.0		230	97.5
Delray	>90%	10,854	99.0		>90%	13,107	99.0	>90%	9,182	98.2	>90%	10,877	96.8
Jupiter		3,033	99.8			2,693	99.9		2,261	100.0		801	99.8
Lake Worth		8,503	96.5			11,006	96.3		10,474	92.4		10,420	95.2
Lantana		12,338	97.3			11,073	97.9		10,463	99.3		9,857	97.8
West Palm		12,137	96.8			12,888	93.3		13,999	97.8		15,112	98.3
Prescriptions designated as waiters												16,078	
Belle Glade		833	12.2			1,446	19.7		2,233	28.9		2,247	29.5
Boca Raton									463	21.8		201	46.6
Delray	<25% per site	2,101	16.2		<25% per site	1,723	11.6	<25% per site	2,880	23.9	<25% per site	2,942	21.3
Jupiter		173	5.4			339	11.2		806	26.3		1,217	60.3
Lake Worth		644	7.0			653	5.6		1,588	13.2		1,939	15.7
Lantana		3,119	20.2			2,731	19.8		4,450	28.8		4,357	30.7
West Palm		4,113	25.3			3,756	22.6		3,967	22.1		3,175	17.4
Prescriptions returned to stock				Outbound notification system being assessed; budgeted for fiscal year 2019								5,571	
Belle Glade		523	7.7			533	7.3		453	5.9		464	6.1
Boca Raton									77	3.6		18	4.2
Delray	<5% per site	1,408	10.9		<5% per site	947	6.8	<5% per site	906	7.5	<5% per site	1,160	8.4
Jupiter		176	5.5			94	3.1		120	3.9		38	1.9
Lake Worth		787	8.5			754	6.5		751	6.2		892	7.2
Lantana		1,199	7.6			948	6.9		775	5.2		946	6.7
West Palm		2,154	13.3			1,989	12.0		1,720	9.6		2,053	11.2
Total wait time in minutes (waiters)		23.1 Minutes				21.72 Minutes			19.62 minutes			20.71 minutes	
Belle Glade		19.8 mins				17.8 mins			16.57 mins			16.74 minutes	
Boca Raton									11.19 mins			10.23 minutes	
Delray	<30 mins	21.2 mins			<30 mins	19.3 mins		<30 mins	25.93 mins		<30 mins	29.81 minutes	
Jupiter		7.2 mins				6.8 mins			7.86 mins			10.8 minutes	
Lake Worth		23.6 mins				25.6 mins			31.11 mins			26.87 minutes	
Lantana		26.8 mins				23.2 mins			18.39 mins			21.72 minutes	
West Palm		38.1 mins				37.6 mins			26.32 mins			28.79 minutes	
Total out of stock fills												3,050	
Belle Glade		140	2.1			151	2.1		113	1.5		162	2.1
Boca Raton									68	3.2		28	6.4
Delray	<5% per site	152	1.2		<5% per site	132	1.1	<5% per site	256	2.1	<5% per site	532	3.8
Jupiter		155	4.8			157	5.2		85	2.8		179	5.4
Lake Worth		73	0.8			308	2.6		882	6.8		958	7.4
Lantana		416	2.6			292	2.1		357	2.4		421	2.9
West Palm		262	1.6			310	1.8		408	2.2		770	4.2

Health Care District

Trauma
Quality Report
3rd Quarter 2018
Percentages

Measure Set:	ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL				Previous Quarters								
Eligibility	**2018 Q3**				**2018 Q2**			**2018 Q1**			**2017 Q4**		
	Num/Den	%	Goal		Num/Den	%	Goal	Num/Den	%	Goal	Num/Den	%	Goal
Total Number of Records Entered Beyond Three Business Days	38	3.8%	<5%		76	[illegible]	<5%	52	4.6%	<5%	41	3.6	<5%
Total Number of Trauma Patients Seen	1004				1321			1116			1117		
Referral Hospital Length of Stay													
Referral Hospital Length of Stay > 6 Hours	7	2.7%	<5%		16	4.0%	<5%	5	1.5	<5%	5	1.5	<5%
Total Number of Interfacility Transfers	263				409			337			337		

Trauma Agency TQIC Case Review

Type of Review	Total	% of Total Cases Reviewed
Total DOA Cases Reviewed	20	14%
Total Hospice Cases Reviewed	34	43%
Total Non-Viable Cases Reviewed	21	33%
Total Non-Trauma Related Determinations Reviewed	3	1%
Total Cases Presented for Further Quality Analysis and Review	9	6%
Total Pre-Hospital Issues Identified, Discussed, and Presented for Educational Opportunities	1	3%
Total Cases Reviewed for Delray Medical Center	54	53%
Total Cases Reviewed for St. Mary's Medical Center	34	47%

Trauma Agency Quality Metrics Review

Type of Review	Occurance	Result
Total ME Cases Reviewed for Fallout	387	0 Case Resulted in Fallout
Total Interfacility Cases Reviewed for Appropriate Transfer, Missed Opportunities, and Timeliness	295	263 Appropriate Transfers 32 Consulted Appropriately 0 Missed Opportunities
St. Mary's Site Visit Data Reviews, Trainings and Meetings Held	0	0 PI Recommendations Made
Delray Site Visit Data Reviews, Trainings and Meetings Held	3	3 PI Recommendations Made
Trauma Agency Educational Outreaches Completed *(EMS, PBC Schools, Acute Care Facilities, Trauma Centers, FHP, and General Public)*	17	3 Topics

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
November 27, 2018

1. Description: Annual Report on Compliance and Privacy

2. Summary:

This agenda item contains the annual report of compliance and privacy activities for FY2018.

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3. Substantive Analysis:

The purpose of this annual report is to provide an overview of compliance activities and actions. The OIG recommends reporting on a regular basis to the governing body, CEO, and compliance committee with regard to planning and implementing the compliance program. Reporting the compliance and privacy activities helps to establish methods to improve the District's efficiency and quality of services, and to reduce the District's vulnerability to fraud, waste, and abuse.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

Dawn L Richards

Dawn Richards
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Quality, Patient Safety and Compliance Committee receive and file the Annual Report for Compliance and Privacy FY2018.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Ellen Pentland
Chief Compliance Officer

Darcy J Davis
Chief Executive Officer

Annual Compliance Summary

Acknowledgements

The Chief Compliance and Privacy Officer would like to acknowledge the following groups and individuals for their contributions toward sustaining a successful enterprise-wide Compliance Program:

- The Quality, Patient Safety, and Compliance Committee and Chief Executive Officer for their support of the Compliance and Privacy Department and its mission and activities.
- The Legal Department and the Finance Department for their valuable ongoing partnership and support of the Compliance and Privacy Department and assisting with the efforts to sustain an effective Compliance Program.
- The Executive Team and Senior Management, for their support and leadership in successfully developing and maintaining the enterprise-wide Compliance Program.
- All of the entities and departments for their ongoing compliance efforts throughout the year.

Introduction

The District is committed to maintaining an accountability structure to assure compliance with governmental laws, rules and regulations, organizational policy and procedures. The Compliance Program supports the District's ethical standards, Standards of Conduct and a zero tolerance for fraud, waste and abuse.

The Compliance Program demonstrates the commitment of the District staff and the Board of Commissioners to meet the highest standards of compliance.

The Chief Compliance and Privacy Officer has access to the Chief Executive Officer and Board of Commissioners and reports to the Quality, Patient Safety and Compliance Committee of the Board of Commissioners.

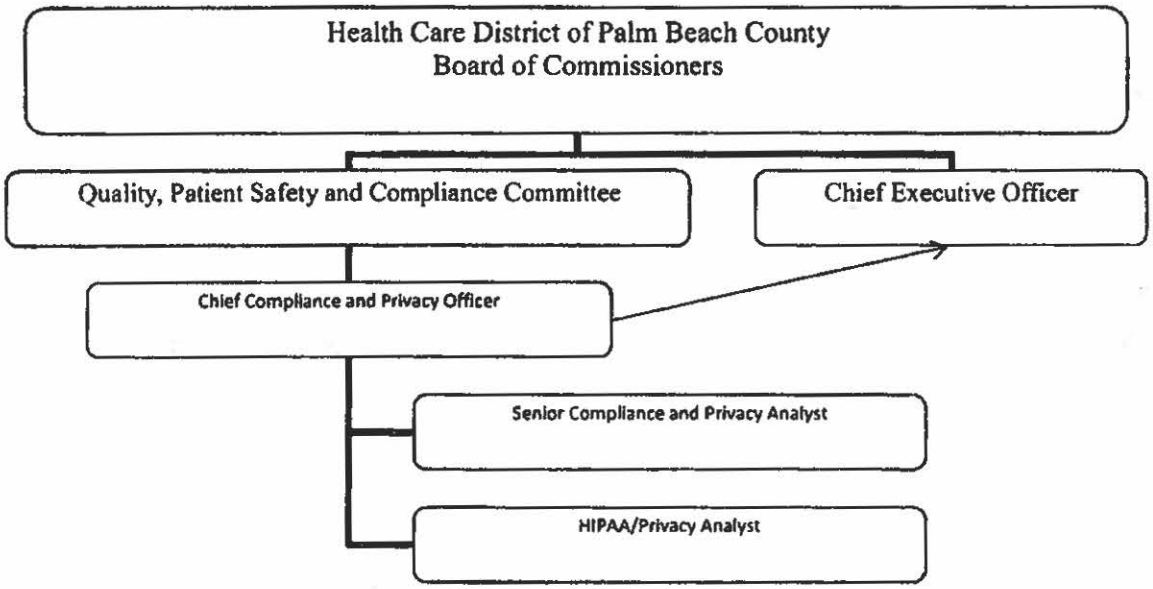
Appointed by the Quality, Patient Safety, and Compliance Committee, the Chief Compliance and Privacy Officer serves as head of the Compliance and Privacy Department and as a resource to the District's multiple entities, Officers and Boards.

Lead by the Office of Inspector General's ("OIG") Compliance Program Guidance's, the Compliance and Privacy Department aspires to serve our employees in the timeliest, most cost-effective and responsive manner possible.

Audit and Compliance Timeline

- On November 9, 2005, the Health Care District Board of Commissioners approved the formation of an audit committee separate from the finance committee. The decision to split the two committees came from the desire to isolate the audit and oversight function of the Health Care District.
- The Audit Committee Charter was approved by the Audit Committee on May 3, 2006.
- District leadership brought to the Board a request for a "comprehensive compliance function" on January 9, 2008 and the Board approved the creation of the Compliance Department.
- The first Chief Compliance Officer was hired in September 2008 with the first formal Compliance Plan approved by the District Board on November 12, 2008.
- The Audit and Compliance Committee Charter was established in January 2009.
- The Audit and Compliance Committee structure changed on February 28, 2017, to the Quality, Patient Safety and Compliance Committee and the Audit and Finance Committee.
- The Quality, Patient Safety, and Compliance Committee Charter was amended September 25, 2018.

Structure



Skills and Certifications held by Compliance and Privacy Staff:

- Certified Health Care Auditor
- Certified in Health Care Privacy Compliance
- Masters of Science in Nursing and Masters in Health Law with a concentration in Regulatory Compliance
- Master of Business Administration with a concentration in Management
- Master in Public Health – Health Services Administration

Seven Elements of an Effective Compliance Program

Compliance programs have traditionally been structured around the requirements established by the United States Sentencing Commission's "Organizational Sentencing Guidelines," which are widely recognized as hallmarks of an effective compliance and ethics program. Under these guidelines, an effective program is maintained to exercise due diligence to prevent and detect fraud, waste, or abuse and promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

The Compliance and Privacy Department's role includes:

- Developing compliance and privacy policies and procedures according to best practices
- The maintenance of a process, such as the hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.
- Auditing, monitoring and reporting on compliance-related activities for the various business lines.
- Conducting employee compliance and privacy training.
- Conducting internal investigations.
- Functioning as part of the business structure and decision-making process.

Policies and Procedures

Policies and procedures are an integral part to an effective Compliance Program. All Compliance Policies and Procedures have been made available on the District's Intranet. Employees have the ability to review and print a copy of the policies and procedures. The following policies and procedures were developed, reviewed or revised during the past fiscal year:

- Access to Protected Health Information
- Accounting of Disclosures
- Amendment of Protected Health Information
- Authorization for Use and Disclosure of Protected Health Information
- Breach Notification for Protected Health Information
- Conflict of Interest Procedure
- Deidentification of Protected Health Information
- Designated Record Set
- Designation of Privacy Officer

- Disclosure of Protected Health Information for the Facility Directory
- Individuals Right to Confidential Communication
- Internal Reporting of Potential Compliance Issues Policy, Procedure, and Attestation.
- Limited Data Sets/Data Use Agreements
- Marketing and Fundraising
- Minimum Necessary Uses, Disclosures and Requests
- Notice of Privacy Practices
- Privacy Complaints
- Privacy Incident Notification Form
- Professional Services Contract
- Release of PHI in the Event of a Natural Disaster or Mass Casualty
- Reporting of Information Privacy and Security Breaches
- Restrictions on Uses and Disclosure of Protected Health Information
- Safeguarding Protected Health Information Offsite
- Standards of Conduct Booklet 10/2018
- Sanctions for Non-Compliance with Information Privacy and Security
- Use of Personal Camera-Equipped Devices
- Use and Disclosure of Protected Health Information for Deceased Individuals
- Use and Disclosure of Protected Health Information for Research Purposes
- Verification of Identity and Authority of Persons Requesting Protected Health Information
- Whistleblower Policy

Effective Lines of Communication

The District maintains a Compliance Hotline which is available for employees, physicians and contractors, to report any suspected wrongdoing. The hotline serves as a mechanism for reporting compliance concerns without fear of retaliation. Callers are given the option of providing their name and contact information or remaining anonymous. The hotline number is currently posted on SharePoint, listed available in our Standards of Conduct, on hotline posters, on the Compliance Connection Newsletter and the District Website. Our Compliance Hotline is outsourced to Compliance Concepts Inc. Calls are sent to the Chief Compliance Officer via e-mail for investigation and follow up. All calls are documented into the compliance database, ComplyTrack, for tracking and trending.

To promote Compliance Awareness, posters were developed and placed throughout the District. The posters contain reporting and hotline information. Compliance and Privacy education and introduction to the Standard of Conduct is provided for all new employees.

Hotline Calls

Since Inception	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
309	12	18	25	33	32	27	23	41	43	55

Compliance and Privacy Activity by Category

During 2018, the Compliance and Privacy Department handled more than 433 matters that came in to the office through walk-ins, the hotline, letters, calls, or the Work Plan.

Audit	7.9%
Communication	26.1%
Compliance	8.3%
Compliance line	12.7%
Corporate Audit	1.2%
Education	9.5%
Investigation	14.3%
Privacy	18.2%
Regulatory	1.2%
Request to Amend	0.2%
Security	0.5%

Auditing and Monitoring

One of the seven critical elements of a compliance program is ongoing auditing and monitoring. The OIG calls for auditing and monitoring as "an ongoing evaluation process (that) is critical to a successful compliance program." The OIG Compliance Program Guidance states that auditing and monitoring should be an ongoing process whereby regular, periodic audits are performed. These audits should focus on programs with substantive exposure to government enforcement actions and help to ensure compliance with federal and state law and internal policies and procedures.

As part of our commitment to compliance, the following audits were performed during 2018:

- Privacy Walk Thru Quarterly
- Business Associate Agreement Audit
- Payment Adjustments at C. L. Brumback
- Uses and Disclosure of Facility Patient Directory
- Permitted Use of Disclosure of PHI other than for Treatment, Payment and Operations
- Asset Inventory of Laptops and iPads
- Medicare Outpatient Observation Notice

- Limited Data Sets and Data Use Agreements
- Skilled Nursing National Background Screening
- Discharge Disposition
- EHR Consents for Clinic
- Controls over Opioid Treatment Programs
- EHR Clinic Record Audit for Discrepancy
- Volunteer, Student and Resident On-boarding Process
- External OCR Desk Audit
- External Hospital and Clinic Audit
- Mock TJC Survey

Training and Education

Training and education are key components of an effective Compliance Program. Throughout the past fiscal year training and education was provided to new hires, current employees, physicians, and students participating in programs at our facilities.

The Compliance and Privacy Department disseminates a quarterly newsletter, Compliance Connection, to keep employees up-to-date on current compliance issues and education.

Two online training courses were developed for annual staff training and new hire staff, which provided an easier way to track completion and generate reports. In addition to the annual online training, there were a total of forty one (41) live training sessions provided to employees by the Compliance and Privacy Department. Mini Modules were developed and implemented monthly.

Training topics included:

- General Compliance and Privacy for New Hire Orientation
- HIPAA Information Privacy and Security with G4 Staff
- Clinic Notice of Privacy Practice Training and Patient Bill of Rights
- Fraud, Waste and Abuse Compliance Training
- Physician Stark and AntiKickback Training
- HIPAA/FERPA Privacy Rules for School Nurses
- Clinic Orientation
- MAT Training
- Compliance Training Finance Department Staff
- Evaluation and Management Education by Acevedo Consulting
- Evaluation and Management Education by ATOS
- Healey annual Compliance and Privacy Training with in person sessions
- HIPAA Privacy and Data Security
- How to Report
- Gifts and Entertainment
- Standard of Conduct

Responding to Detected Offenses and Corrective Action Initiatives

The Chief Compliance and Privacy Officer established processes to investigate and respond to detected offenses. A web-based database, ComplyTrack, was upgraded in 2018 to track reported or identified issues. Prior to the implementation of ComplyTrack, all incidents were tracked on paper. A summary of each incident and supporting documentation is included in the database. Summaries for reporting are prepared using the new software. Corrective actions are reported to the Patient Safety, Quality and Compliance Committee and the Board of Commissioners through the Patient Safety, Quality and Compliance Dashboard.

Other Initiatives

Workgroups

As part of our ongoing initiative to breakdown silos and encourage quick action and productive decision making between facilities and departments, the Compliance and Privacy team holds quarterly workgroups on varying topics. Compliance facilitates a Non-Discrimination Workgroup with an interdisciplinary task-force and membership from each entity. The Non-Discrimination Workgroup examines policies and procedures, notification requirements, and services offered for the District's patients with Limited English Proficiency and/or disabilities.

Compliance also holds quarterly billing and HIPAA/privacy workgroups where discussions consist of current topics, regulatory changes, policies and procedures, and transitioning to ICD-10. In addition, the workgroups act to identify methods that will enhance communication and efficiency between departments.

Sanction Screening

Annually, the District screens all employees, providers, and vendors against the OIG's List of Excluded Individuals/Entities; the System for Award Management Exclusions which also includes the U.S. Department of the Treasury Specially Designated Nationals List; and the State of Florida Agency for Health Care Administration's Medicaid Sanctioned Provider list. This year's screening by our vendor, John Sterling, included 1,310 employees, 123 providers, and 937 vendors. In addition to the annual screening, we also screen all employees, providers, and vendors at on boarding. All new employees, providers, and vendors are submitted to John Sterling on a monthly basis for inclusion in our monthly screening. We did not have any matches that required further review.

Serving as a Resource

In the Compliance and Privacy Department a large portion of time is spent serving as a resource for our different lines of businesses and departments. This responsibility includes reviewing policies and procedures and providing feedback related to compliance with Federal and State laws. Additionally, the Compliance and Privacy Department researches

and identifies applicable laws, rules, and regulations and disseminates them accordingly. The Department consults on matters concerning contracts, physician arrangements, Business Associate Agreements, regulatory billing changes, coding changes, and researches any issues brought to the attention of the Compliance and Privacy Officer.

Compliance and Privacy Program Goals 2018

- Enhance outreach efforts to provide employees with improved compliance-related tools, resources and assistance.
- Work with the Quality, Patient Safety and Compliance Committee, Internal Audit, and Executive Leadership to identify and prioritize processes that require compliance auditing or monitoring.
- Continue to identify applicable laws, rules, regulations, and policies that apply to the each entity and/or business unit.
- Continue to provide education and outreach through compliance and ethics training.
- Strengthen the working relationship with Internal Audit.
- Review all Compliance and Privacy policies and procedure for best practices in the industry and update accordingly.
- Ensure responses to all compliance inquiries, complaints, and questions are completed in a timely manner.
- Explore the use of technology to collect data for more effective analysis of revenue cycle areas or risk and/or opportunities at the District.
- Manage and allocate the Compliance Department's financial resources to ensure the District is provided with a high quality, efficient Compliance Program that is sustainable from year to year.