



QUALITY, PATIENT SAFETY & COMPLIANCE COMMITTEE

MEETING AGENDA

December 10, 2025 at 10:00AM

1515 North Flagler Drive, Suite 101

West Palm Beach, FL 33401

Remote Participation Link:

<https://zoom.us/j/5507895592?pwd=REZ4TWtYUXowQWNpWTBaVXRzZlIdDQT09>

Telephone Dial-In Access: 646-558-8656 | Meeting ID: 550 789 5592 | Passcode: 946503

1. Call to Order

- A. Roll Call
- B. Affirmation of Mission: The mission of the Health Care District of Palm Beach County is to be the health care safety net for Palm Beach County. Our vision is meeting changes in health care to keep our community healthy.

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 of September 30, 2025 [Pages 1-4]

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

A. **ADMINISTRATION**

7A-1 **RECEIVE AND FILE:**

December 2025 Internet Posting of District Public Meeting.

<https://www.hcdpbc.org/EventViewTrainingDetails.aspx?Bck=Y&EventID=436&m=0|0&DisplayType=C>

7A-2 **RECEIVE AND FILE:**

Committee Attendance [Page 5]

7A-3 **RECEIVE AND FILE:**

2026 Meeting Schedule [Pages 6-7]

B. **PATIENT RELATIONS DASHBOARDS**

7B-1 **RECEIVE AND FILE:**

Patient Relations Dashboards

(Dr. Belma Andric) [Pages 8-10]

- Patient Relations Dashboard, School Health
(Alexa Goodwin/ Fe Pagtakhan) [Page 11]
- Patient Relations Dashboard, Community Health Centers
(Alexa Goodwin/ Laura Acosta) [Page 12]
- Patient Relations Dashboard, Skilled Nursing Facility
(Alexa Goodwin/ Laura Acosta) [Page 13]
- Patient Relations Dashboard, Lakeside Medical Center
(Alexa Goodwin/ Joe-Ann Reynolds) [Page 14]

C. **PRODUCTIVITY DASHBOARDS**

7C-1 **RECEIVE AND FILE:**

Productivity Dashboards

(Dr. Belma Andric) [Pages 15-18]

- Productivity Dashboard, School Health
(Fe Pagtakhan) [Page 19]

- Productivity Dashboard, Community Health Centers (Dr. Ana Ferwerda/ Ingrid Barlett) [Page 20]
- Productivity Dashboard, Skilled Nursing Facility (Sonja Susnjevic) [Page 21]
- Productivity Dashboard, Lakeside Medical Center (Jackie Drahos) [Pages 22-23]
- Productivity Dashboard, Ground Transportation (Jostein Lavoll) [Page 24]
- Productivity Dashboard, Pharmacy (Jose Rodriguez / Leamsi Borges) [Page 25]
- Productivity Dashboard, Human Resources (Brad Krietzberg) [Page 26]

D. **RISK MANAGEMENT**

7D-1 **MOTION TO APPROVE:**

Risk Management Plan 2026 for Lakeside Medical Center (Alyssa Tarter) [Pages 27-42]

8. Regular Agenda

A. **COMPLIANCE**

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

FY25 HCD Compliance Program Effectiveness Assessment: OIG General Compliance Program Guidance (Heather Bokor) [Pages 43-49]

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

HCD Compliance, Privacy and Ethics Quarterly Update Report (Heather Bokor) [Pages 50-64]

B. **CORPORATE QUALITY DASHBOARDS**

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

Quality & Patient Safety Dashboards (Steven Sadiku) [Pages 65-69]

- Quality & Patient Safety Report, School Health (Fe Pagtakhan) [Page 70]
- Quality & Patient Safety Report, Aeromedical (Jostein Lavoll) [Page 71]
- Quality & Patient Safety Report, Community Health Centers (Dr. Ana Ferwerda/Melanie Deeroop-Kangoo) [Page 72]
- Quality & Patient Safety Report, Skilled Nursing Facility (Sonja Susnjevic) [Pages 73-74]
- Quality & Patient Safety Report, Lakeside Medical Center (Jackie Drahos) [Page 75]
- Quality & Patient Safety Report, Ground Transportation (Jostein Lavoll) [Page 76]
- Quality & Patient Safety Report, Pharmacy (Jose Rodriguez / Leamsi Borges) [Page 77]
- Quality & Patient Safety Report, Corporate Quality Metrics: IT, Human Resources (Steven Sadiku) [Pages 78-79]

C. RISK MANAGEMENT DASHBOARDS

8C-1 RECEIVE AND FILE:

Risk Management Updates and Dashboards
(Alyssa Tarter) [Pages 80-87]

9. CEO Comments

10. Committee Member Comments

11. Upcoming Meetings

March 11, 2026

- 12:00PM, Quality, Patient Safety and Compliance Committee

June 10, 2026

- 12:00PM, Quality, Patient Safety and Compliance Committee

September Meeting (Date TBD)

- 2:00PM, Quality, Patient Safety and Compliance Committee

December 9, 2026

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

12. Motion to Adjourn



**QUALITY, PATIENT SAFETY & COMPLIANCE COMMITTEE
MEETING MINUTES
September 30, 2025 at 2:00PM
1515 North Flagler Drive, Suite 101
West Palm Beach, FL 33401**

1. Call to Order

Tracy Caruso called the meeting to order.

A. Roll Call

Committee Members present: Tracy Caruso, William Johnson, Kimberly Schulz, Dr. Alina Alonso, Dr. Jyothi Gunta, and Dr. Ishan Gunawardene (VIRTUAL). Tammy Jackson-Moore was absent.

Staff present: Darcy Davis, President & Chief Executive Officer; Dr. Belma Andric, EVP & Chief Medical Officer; Bernabe Icaza, SVP & General Counsel; Geoffrey Washburn, VP & Chief Human Resources Officer; Heather Bokor, VP & Chief Compliance & Privacy Officer; Jessica Cafarelli, VP & Chief Financial Officer; and Regina All, Chief Nursing Officer.

Transcribing Secretary: Bianca Badolati

B. Affirmation of Mission: The mission of the Health Care District of Palm Beach County is to be the health care safety net for Palm Beach County. Our vision is meeting changes in health care to keep our community healthy.

2. Agenda Approval

A. Additions/Deletions/Substitutions

B. Motion to Approve Agenda

CONCLUSION/ACTION: William Johnson made a motion to approve the agenda. The motion was duly seconded by Dr. Alina Alonso. There being no opposition, the motion passed unanimously.

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 of June 11, 2025.

CONCLUSION/ACTION: William Johnson made a motion to approve the Committee Meeting Minutes of June 11, 2025. The motion was duly seconded by Dr. Alina Alonso. There being no opposition, the motion passed unanimously.

7. Consent Agenda- Motion to Approve Consent Agenda Items

CONCLUSION/ACTION: Dr. Alina Alonso made a motion to approve the Consent Agenda. The motion was duly seconded by William Johnson. There being no opposition, the motion passed unanimously.

A. ADMINISTRATION

7A-1 RECEIVE AND FILE:

September 2025 Internet Posting of District Public Meeting.

<https://www.hcdpbc.org/EventViewTrainingDetails.aspx?Bck=Y&EventID=436&m=0|0&DisplayType=C>

7A-2 RECEIVE AND FILE:

Committee Attendance

B. PATIENT RELATIONS DASHBOARDS

7B-1 RECEIVE AND FILE:

Patient Relations Dashboards

- Patient Relations Dashboard, School Health
- Patient Relations Dashboard, Community Health Centers
- Patient Relations Dashboard, Skilled Nursing Facility
- Patient Relations Dashboard, Lakeside Medical Center

C. PRODUCTIVITY DASHBOARDS

7C-1 **RECEIVE AND FILE:**

Productivity Dashboards

- Productivity Dashboard, School Health
- Productivity Dashboard, Community Health Centers
- Productivity Dashboard, Skilled Nursing Facility
- Productivity Dashboard, Lakeside Medical Center
- Productivity Dashboard, Ground Transportation
- Productivity Dashboard, Pharmacy
- Productivity Dashboard Human Resources

D. **COMPLIANCE**

7D-1 **MOTION TO APPROVE:**

Modification to the District's Conflict of Interest Policy

7D-2 **MOTION TO APPROVE:**

Modification to the District's Standards of Conduct Policy and Booklet

8. Regular Agenda

A. **COMPLIANCE**

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

Compliance, Privacy and Ethics Program Activities and Updates

Ms. Bokor reviewed the Compliance, Privacy and Ethics Activities and provided updates to the committee.

CONCLUSION/ACTION: Received and filed.

B. **CORPORATE QUALITY DASHBOARDS**

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

Quality & Patient Safety Reports

- Quality & Patient Safety Report, School Health
- Quality & Patient Safety Report, Aeromedical
- Quality & Patient Safety Report, Community Health Centers
- Quality & Patient Safety Report, Skilled Nursing Facility
- Quality & Patient Safety Report, Lakeside Medical Center
- Quality & Patient Safety Report, Ground Transportation

- Quality & Patient Safety Report, Pharmacy
- Quality & Patient Safety Report, Corporate Quality Metrics

Mr. Sadiku reviewed and discussed all the Corporate Quality Dashboards to the committee.

CONCLUSION/ACTION: Received and filed.

C. **RISK MANAGEMENT DASHBOARDS**

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

Risk Management Updates and Dashboards

Tracey Archambo presented the Risk Management updates and dashboards.

CONCLUSION/ACTION: Received and filed.

9. CEO Comments

10. Committee Member Comments

11. Establishment of Upcoming Meetings

December 10, 2025

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

12. Motion to Adjourn

There being no further business, the meeting was adjourned.

Tracy Caruso, Chair

Date



QUALITY, PATIENT SAFETY & COMPLIANCE COMMITTEE

Attendance Tracking for 2025

	12/10/24	3/12/25	6/11/25	9/30/25	12/10/25
Dr. Jyothi Gunta	VIRTUAL	VIRTUAL	X	X	
Tracy Caruso	X	X	X	X	
Dr. Alina Alonso	ABSENT	X	X	X	
Tammy Jackson-Moore	VIRTUAL	VIRTUAL	VIRTUAL	ABSENT	
Kimberly Schulz	VIRTUAL	X	X	X	
Dr. LaTanya McNeal	VIRTUAL	X	-	-	-
William (Bill) Johnson	X	X	X	X	
Dr. Ishan Gunawardene	ABSENT	VIRTUAL	VIRTUAL	VIRTUAL	

QUALITY, PATIENT SAFETY & COMPLIANCE COMMITTEE

December 10, 2025

1. Description: Quality, Patient Safety and Compliance Committee Meeting Schedule for 2026

2. Summary:

This agenda item provides the Quality, Patient Safety and Compliance Committee with the meeting schedule for 2026.

3. Substantive Analysis:

In September, the Health Care District will convene two (2) Truth In Millage (TRIM) meetings. The actual September date will be determined once other taxing authorities establish their TRIM dates.

March 11, 2026

- 12:00PM, Quality, Patient Safety and Compliance Committee

June 10, 2026

- 12:00PM, Quality, Patient Safety and Compliance Committee

September Meeting (Date TBD)

- 2:00PM, Quality, Patient Safety and Compliance Committee

December 9, 2026

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



QUALITY, PATIENT SAFETY & COMPLIANCE COMMITTEE
December 10, 2025

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A	N/A	Yes <input type="checkbox"/> No <input type="checkbox"/>
Net Operating Impact	N/A	N/A	Yes <input type="checkbox"/> No <input type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

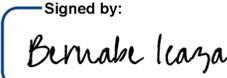
N/A

 Jessica Cafarelli
 VP & Chief Financial Officer

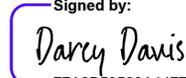
5. Recommendation:

Staff recommends the Quality, Patient Safety and Compliance Committee Receive and File the 2026 Committee Meeting Schedule.

Approved for Legal sufficiency:

Signed by:


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 Bernabe Icaza
 SVP & General Counsel

Signed by:


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 Darcy Davis
 President & Chief Executive Officer

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025

1. Description: Patient Relations Dashboards

2. Summary:

This agenda item provides the patient relations dashboard for the 3rd Quarter of 2025 for School Health, Community Health Centers, Skilled Nursing Center, and Lakeside Medical Center.

3. Substantive Analysis:

School Health

For Quarter 3 2025, School Health had a total of 5 Patient Relations events reported for 173 school locations. Of the 5 patient relation events, 2 were complaints, 3 were compliments, and there were no grievances. One of the 2 complaints was from a family member and the other one was from an employee. The complaints categories were nurse and communication related. The 3 compliments recognized the School Health Nurses, School Health HSTs and School Health aides received from School Health Staff.

Community Health Centers

For Quarter 3 2025 there were a total of 49 Patient Relations Occurrences that occurred between 8 Centers, Center Administration and Mobile Hero. This was an increase from the previous quarter where we had 33 Complaints and Grievances. Of the 49 occurrences, there were 5 Grievances and 45 Complaints. The top 5 categories were Nursing Related, Communication, Care & Treatment, Finance and Respect Related issues. The top subcategory was Nursing Related - Communication and Care & Treatment - Poor Communication with 7 occurrences from each.

There was also a total of 13 Compliments received across 4 Centers and Center Administration. All 13 Compliments were patient generated.

Skilled Nursing Center

For Quarter 3 2025, there were a total of 28 Patient Relations Occurrences that occurred between 5 resident units, Dietary, Laundry, Social Services and Nursing Administration. This was an increase from the previous quarter where we had 17 Complaints and Grievances. Of the 28 occurrences, there were 0 Grievances and 28

**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025**

Complaints. The top 5 categories were Personal Belongings, Nursing Related, Care & Treatment, Communication and Nutrition Related Issues. The top subcategory was Personal Belongings – Clothes with 4 occurrences.

There was also a total of 35 Compliments received across 8 departments. Of the 35 compliments, all were resident generated.

Lakeside Medical Center

For Quarter 3 2025, there were a total of 13 Patient Relations Occurrences that occurred between Emergency Services, Food Services, Intensive Care Unit, Clinical Laboratory, Dialysis and Med-Surg/Telemetry. There was no increase from the previous quarter where we had 13 Complaints and Grievances. Of the 13 occurrences, there were 2 Grievances and 11 Complaints. The top 5 categories were Nursing Related, Communication, Physician Related, Nutrition, and Care & Treatment Issues. The top subcategories were Nursing Related Communication, Poor Communication, Physician Related Communication and Nutrition Temperature with 2 occurrences in each.

There was also a total of 5 Compliments received across 4 departments. Of the compliments, all were patient generated.

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Net Operating Impact	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

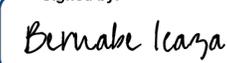
N/A
Jessica Cafarelli
VP & Chief Financial Officer

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025

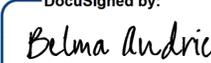
5. Recommendation:

Staff recommends the Committee Receive and File the Patient Relations Dashboards.

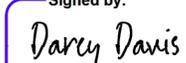
Approved for Legal sufficiency:

Signed by:

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Bernabe Icaza
SVP & General Counsel

DocuSigned by:

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Belma Andric, MD
EVP & Chief Medical Officer

Signed by:

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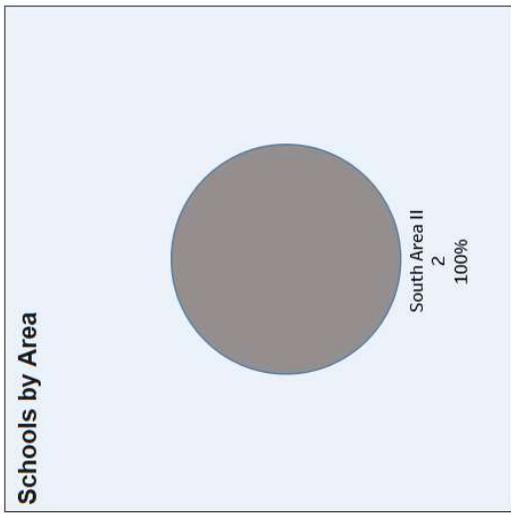
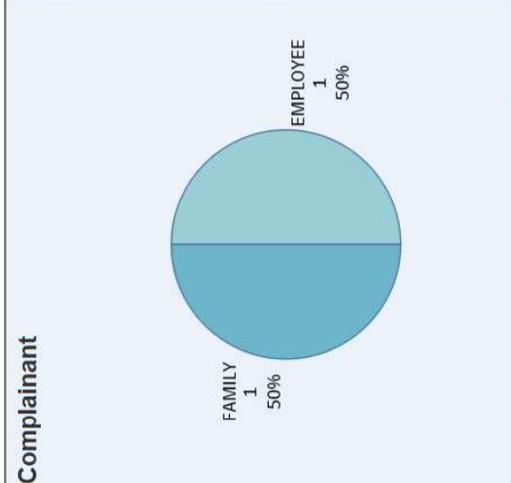
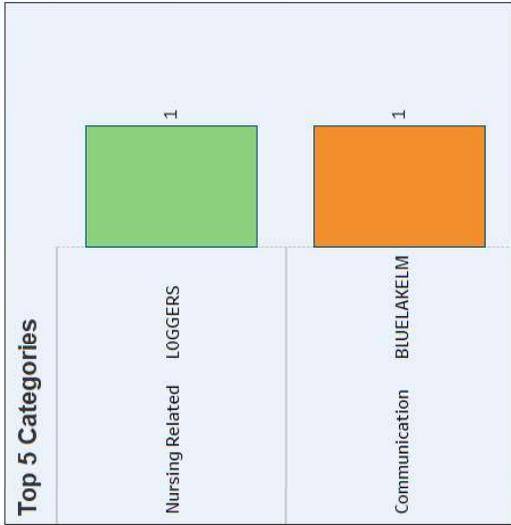
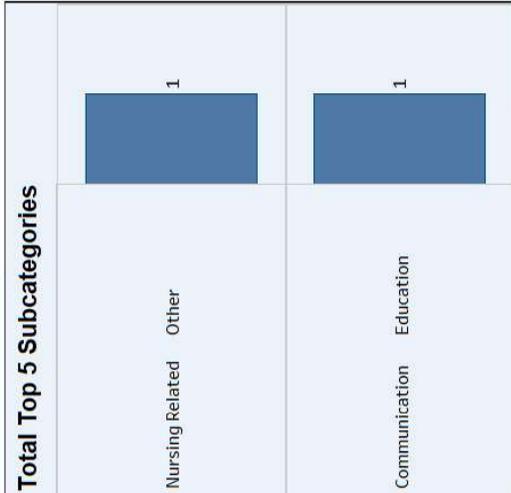
Darcy J. Davis
President & Chief Executive Officer

Patient Relations School Health (Grievances, Compliments & Compliments) - 7/1/2025 to 9/30/2025

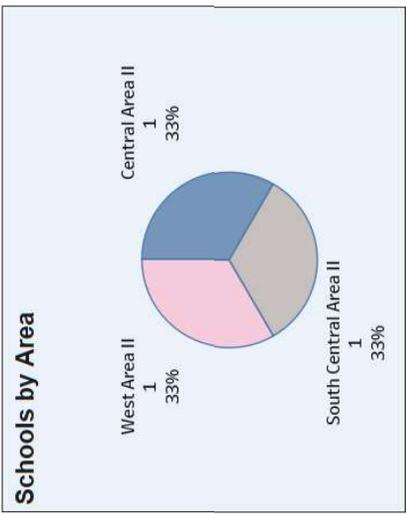
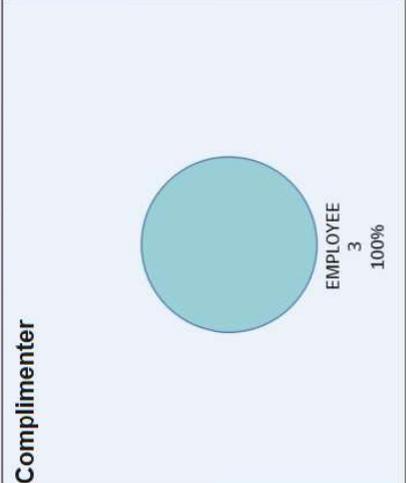
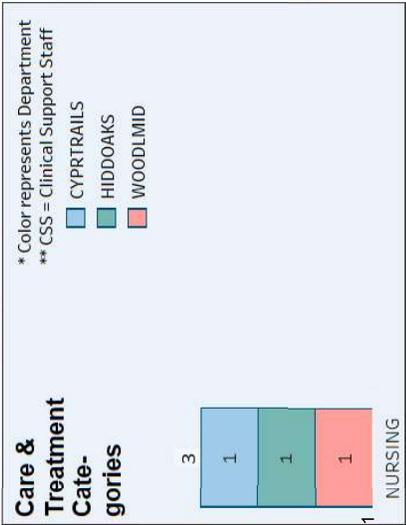
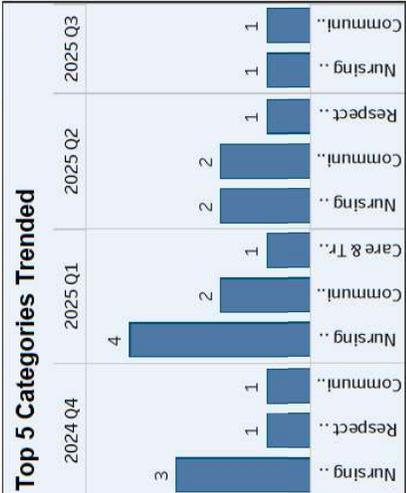


2025 Q3

Total Complaints and Grievances 2 Late Entries: 0



Total Compliments 3 Late Entries: 0

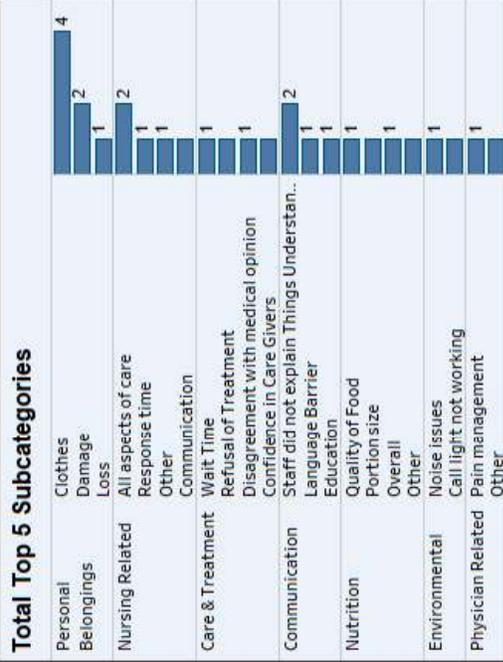
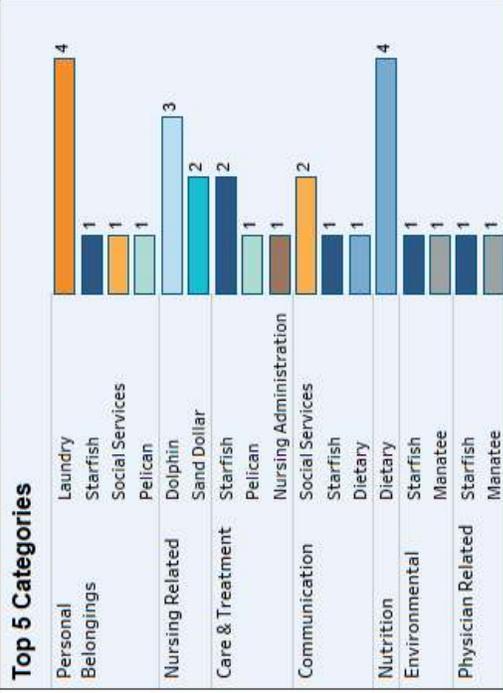
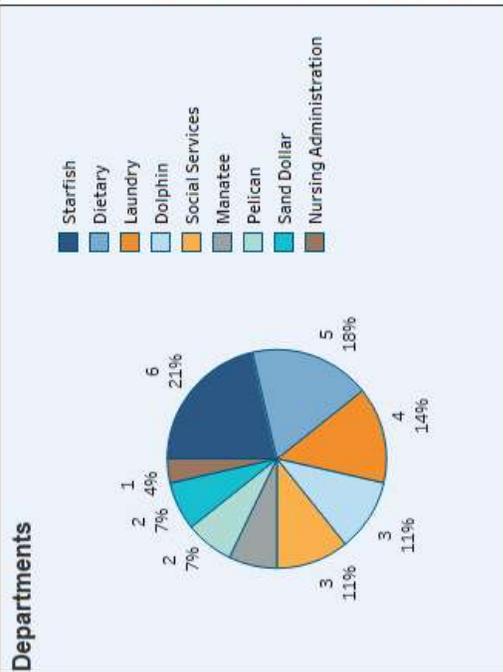


Comp/Griev Prev 4 Quarters 19

* Color represents Department
** CSS = Clinical Support Staff

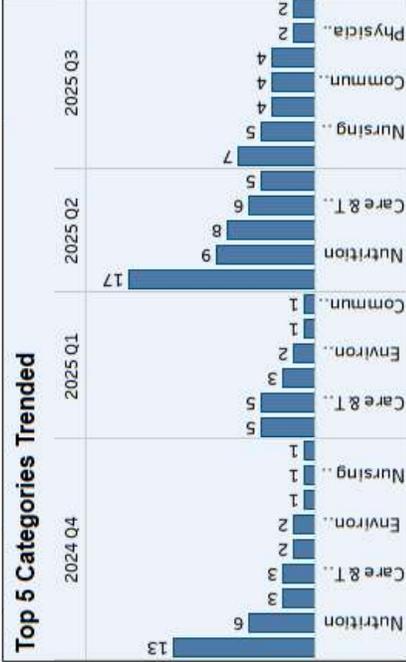
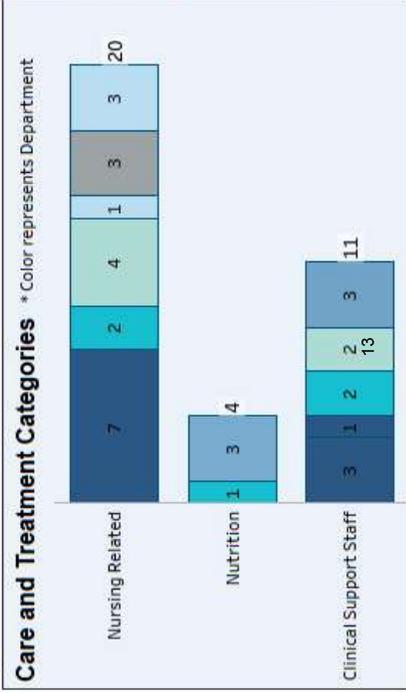
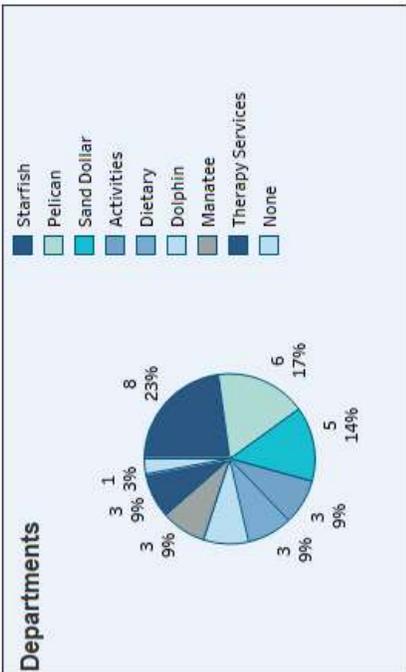
2025 Q3

Total Complaints and Grievances 28



Total Compliments 35

28



Complaints/Grievances Prev 4 Quarters

Patient Relations (Grievances, Complaints & Compliments)
Lakeside Medical Center - 7/1/2025 to 9/30/2025

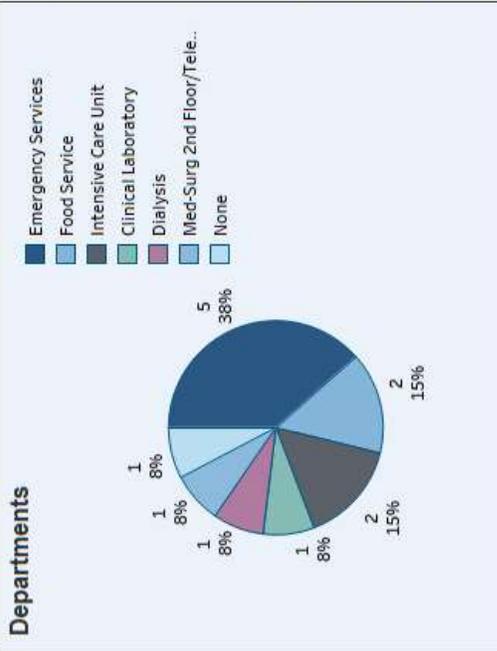
2025 Q3



Late Entries: 1

13

Total Complaints and Grievances



Top 5 Categories

Category	Count
Nursing Related	1
Intensive Care Unit	1
Emergency Services	1
Dialysis	1
None	1
Emergency Services	1
Clinical Laboratory	1
Physician Related	2
Emergency Services	2
Nutrition	2
Food Service	2
Care & Treatment	1
Med-Surg 2nd Floor/Telemet..	1
Emergency Services	1
Pain Management	1
Intensive Care Unit	1

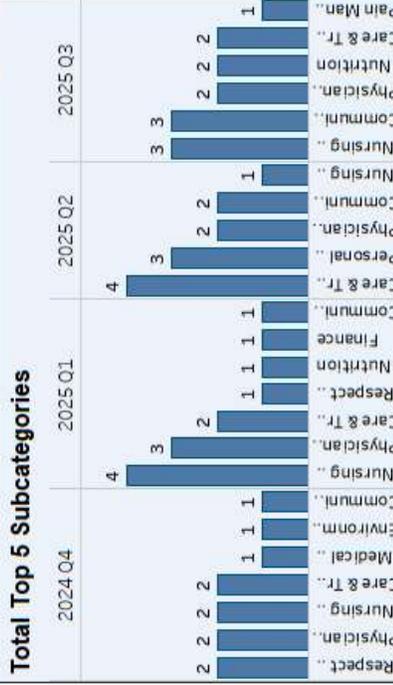
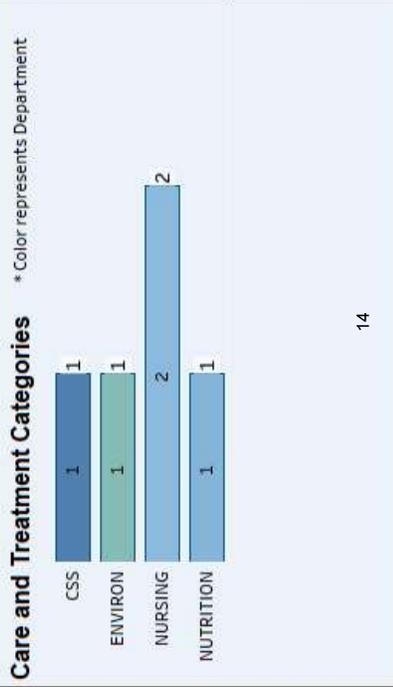
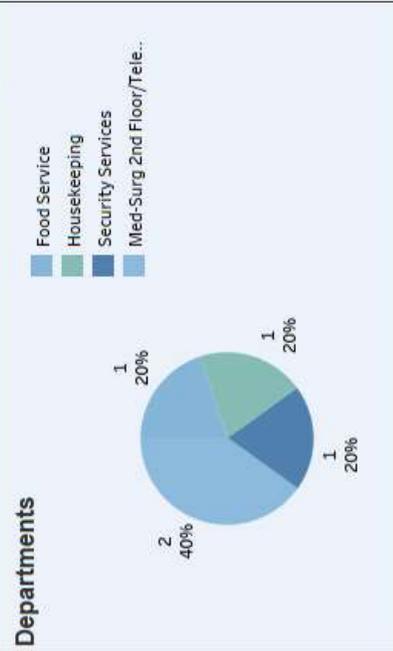
Total Top 5 Subcategories

Subcategory	Count
Nursing Related	2
Communication	1
All aspects of care	1
Poor Communication	2
Staff did not listen carefully	1
Physician Related	2
Communication	2
Temperature	2
Conflicting Information by Health Professionals	1
Confidence in Care Givers	1
Medication / pain management	1

Total Compliments 5

Late Entries: 0

Complaints/Grievances Prev 4 Quarters 49



QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE

DECEMBER 10, 2025

1. Description: Productivity Dashboards

2. Summary:

This agenda item provides the productivity reports for the 3rd Quarter of 2025 for School Health, Community Health Centers, Skilled Nursing Center, Lakeside Medical Center, Ground Transportation, Pharmacy and Human Resources.

3. Substantive Analysis:

School Health

In the 3rd Quarter of 2025, School Health completed a total of 159,365 events across 173 schools, providing care for a total of 85,804 students. These events were broken down into 56,605 consultation events, 48,298 office visits, 14,151 procedure visits, 20,218 medication visits, and 20,093 record reviews. The top three schools with the most events are Palm Beach Gardens High School, Emerald Cove Middle School, and Park Vista Community High School.

Community Health Centers

In Q3 of 2025, the Community Health Centers served 20,748 unique patients (a 4.27% increase from the previous quarter) and provided 43,535 patient visits (a 6.03% increase from the previous quarter). The top three departments with the highest patient visits were Atlantis Primary, West Palm Dental, and Mangonia BH.

Skilled Nursing Center

In Q3 of 2025, the average census for the Skilled Nursing Center was 98 residents. Nurses performed 41,852 treatments and administered 234,681 medications. There were 385 provider visits during the quarter. The CNA POC documentation compliance rate for the day shift averaged 99.07%, the evening shift averaged 98.89%, and the night shift averaged 99.57%. The therapy department completed 4,004 units for the quarter (PT-2,354, OT-1,409, and ST-241).

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE

DECEMBER 10, 2025

Lakeside Medical Center

The productivity data report for the 3rd Quarter 2025 represents the following detailed information:

- **Total Census Days by Level of Care** – There were a total of 1,572 patient days for Q3-2025 compared to 1,239 in the previous quarter, resulting in a 26.87% increase.
- **Emergency Services Visits**— There was a total of 4,969 visits for Q3-2025 compared to 4,910 in the previous quarter, resulting in a 1.2 % increase.
- **Physical Therapy Visits** (Evaluations and Treatments)—There were 247 evaluations and treatments in Q3-2025, compared to 172 in the previous quarter, a 43.6% increase.
- **Inpatient Admissions**—There were 182 Inpatient Admissions in Q3-2025, compared to 136 in the previous quarter, a 33.82% increase.
- **Surgical Cases**—A total of 87 surgical cases were performed in Q3-2025, compared to 51 in the previous quarter, a 70.59% increase.
- **Medication Administration**—A total of 40,579 medications was administered for Q3-2025, compared to 35,418 in the previous quarter, resulting in a 11.57% increase.
- **Radiology Exams Completed**—A total of 7,029 radiological exams was performed for Q3-2025, compared to 6,493 in the previous quarter, an 8.26% increase.
- **Laboratory Specimens Collected**—A total of 21,804 lab specimens was collected for Q3-2025 compared to 19,465 in the previous quarter, resulting in a 12.02% increase.

**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025**

Ground Transportation

In Quarter 3, 2025, the Ground Transportation department completed 412 patient transports, which was a 2.13% decrease from the previous quarter. 411 transports originated from Lakeside Medical Center. The top three (3) destinations were: 1) Palm West (183), 2) JFK Main (53) and 3) St. Mary’s Medical Center (50).

Of the 412 patients transported, 233 (57%) were male and 179 (43%) were female. The 71-80 age group had the highest transport need with 19% of overall transports, followed by the 31-40 age group (16%) and the 61-70 age group (15%). The top 5 Principal Diagnoses were: 1) Other specified pregnancy related conditions, 2) Unspecified Chest Pain 3) NSTEMI, 4) Unspecified Gastrointestinal hemorrhage, and 5) Unspecified convulsion. 1) Cardiology, 2) Gastroenterology, 3) OB/GYN, 4) Neurology, and 5) Hematology/Oncology.. Notably, the implementation of general tele-neurology services at LMC has significantly reduced the number of transports for “Neurology – Services Not Available”. This category, which had been the leading reason for ground transport since the program began, dropped to fourth place in the most recent quarter. There was a total of 23 canceled transports, 61% from the destination location, and there were 22 transports in which lights/sirens were used.

Pharmacy

HCD Pharmacies filled 34,527 prescriptions for 6,589 unique patients for Q3 of 2025, a 10.42% decrease compared to Q2. 78% of prescriptions were new, and 22% were refills. 19% of the patients served were new to the pharmacy, and 1,647 packages were mailed during the quarter, containing 3,684 prescriptions, which was 10% of the total prescriptions dispensed. Atlantis accounted for 32% of the total prescription volume with 11,145 prescriptions filled for the quarter. Additionally, 1,200 Narcan units were distributed to the community during this time frame.

Human Resources

- For Q3 2025, our employee headcount reached 1,240, a 1.04% decrease from the previous quarter (1253).
 - FT=1,155
 - PT regular=33
 - Per Diem=52
- Clinical job functions/positions are the leading with 47%, followed by technical at 13%, and specialist at 9%.



**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025**

- Through Q3 2025, the diversity headcount is 46% African American, 26% White, 18% Hispanic, and 10% Other; 79% of the workforce is female.
- Through Q3 2025, the average age of employees is 47 years old, with 216 employees projected to be within retirement age in the next 5 years

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Net Operating Impact	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Jessica Cafarelli
VP & Chief Financial Officer

5. Recommendation:

Staff recommends the Committee Receive and File the Productivity Dashboards.

Approved for Legal sufficiency:

Signed by:

Bernabe Icaza
SVP & General Counsel

DocuSigned by:

Belma Andric, MD
EVP & Chief Medical Officer

Signed by:

Darcy J. Davis
President & Chief Executive Officer

School Health Room Overview

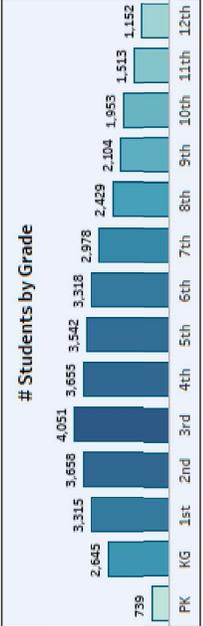
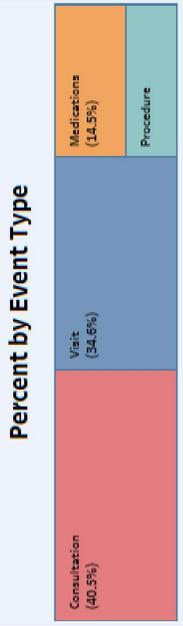
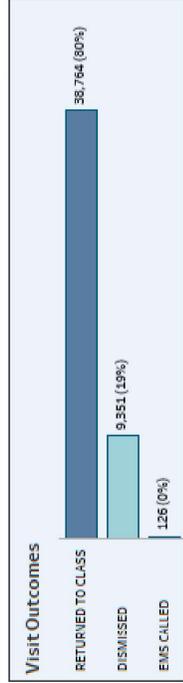
From 8/1/2025 to 9/30/2025

- Consultation
- Medications
- Procedure
- Visit
- Review



Activity Summary

Event Type	# Events	# Schools	# Students	# Providers	Avg Dur Min
Consultation	56,605	173	32,198	218	15.56
Visit	48,298	173	32,523	215	17.32
Medications	20,218	163	787	206	5.08
Procedure	14,151	104	203	158	10.38
Review	20,093	167	20,093	124	89.46

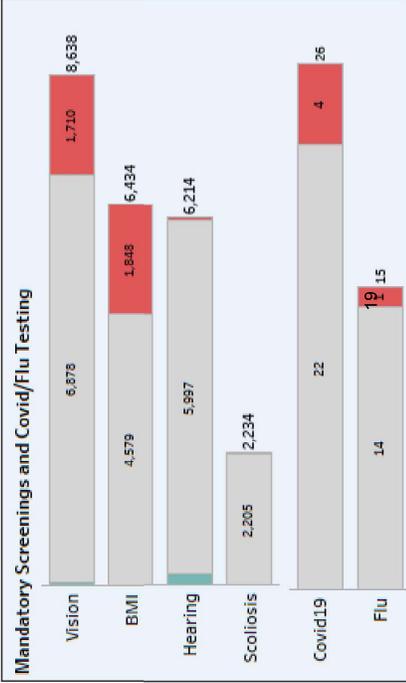
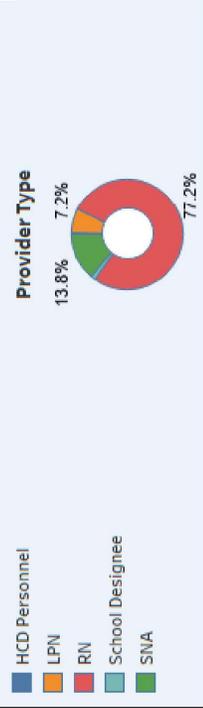
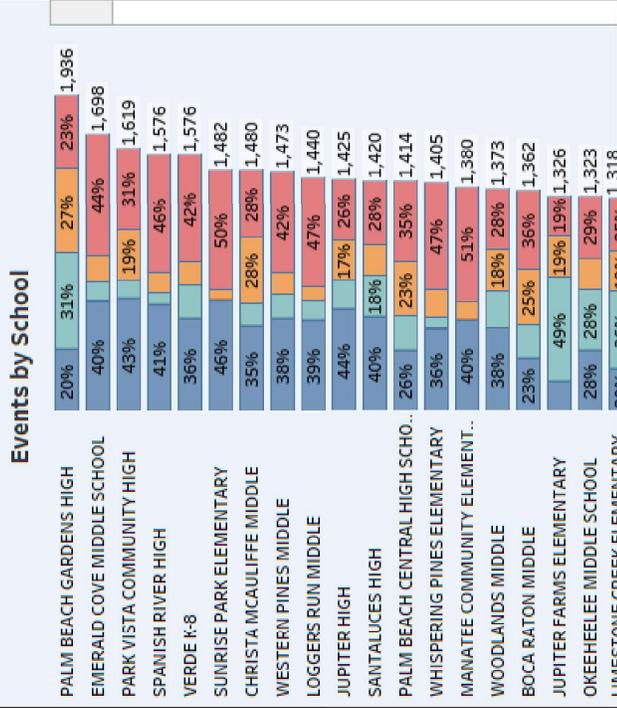


Flexible

Grade	SE I	SI	ME I	NE I	NI	EI	CWI	CNI	CE I	CI
W I	1,689	2,523	1,682	1,682	2,205	2,516	1,667	2,287	2,830	1,842
Standard	0.9%	1.8%	1.7%	1.2%	1.6%	1.8%	1.2%	1.6%	2.1%	1.3%

Standard

Grade	SC II	S II	NC II	N II	CI II
W II	17,775	18,510	22,764	17,898	20,478
Standard	12.7%	13.3%	16.3%	12.8%	14.7%



Clinic visit types, Trends & Different Service Utilization 7/1/2025 to 9/30/2025

Unique Patients
20,748

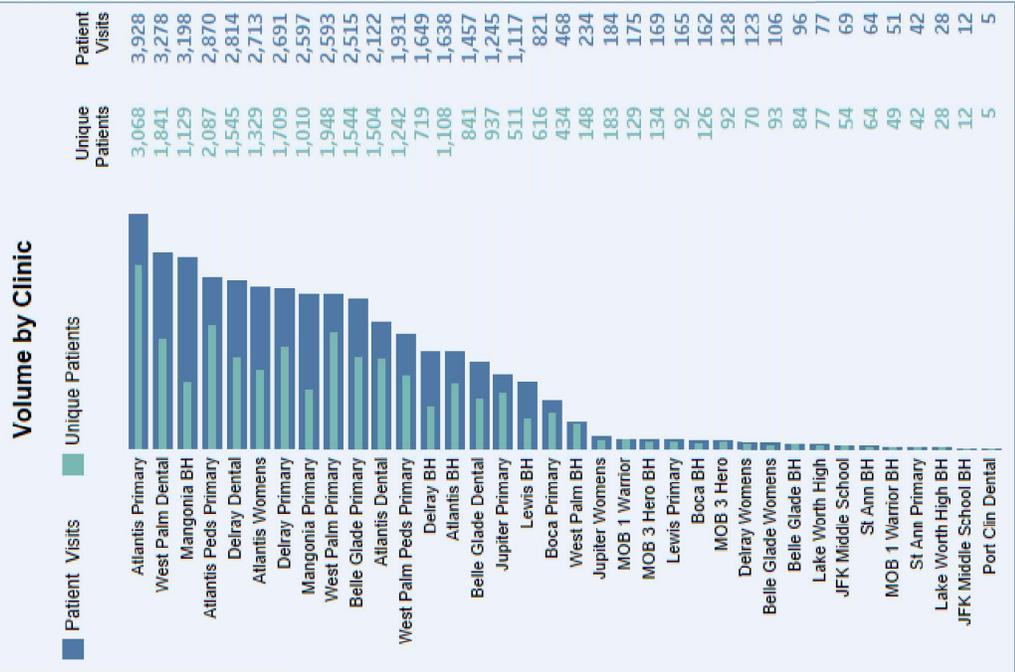
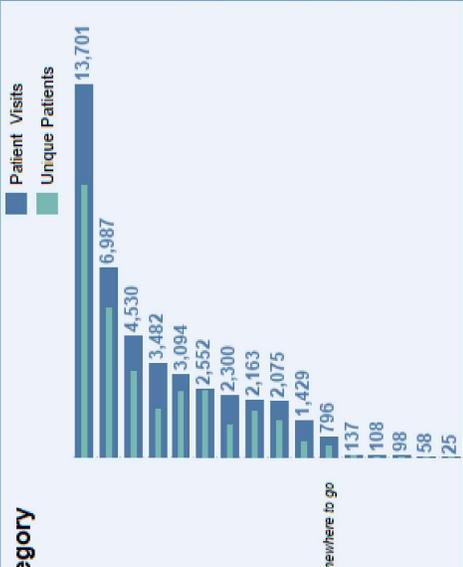
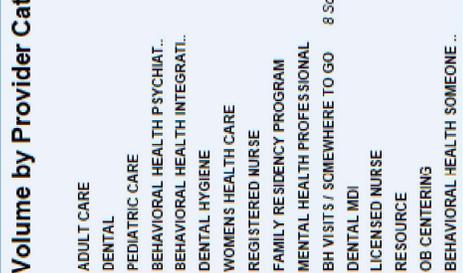
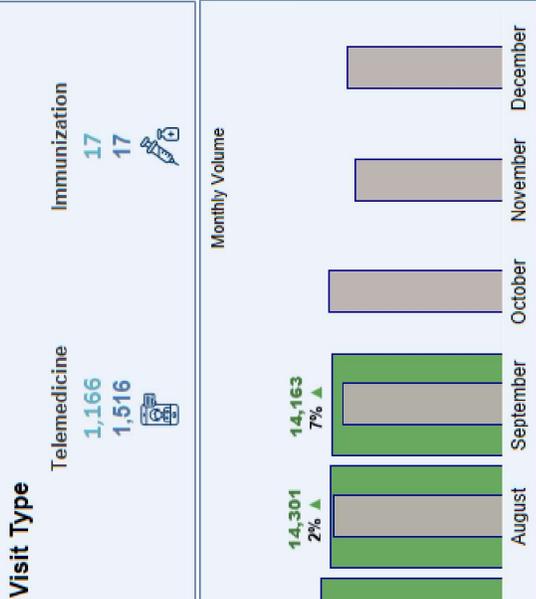
Patient Visits
43,535

Office Visit
20,393 Patients
40,004 Visits

Nurse Only
1,476 Patients
1,998 Visits

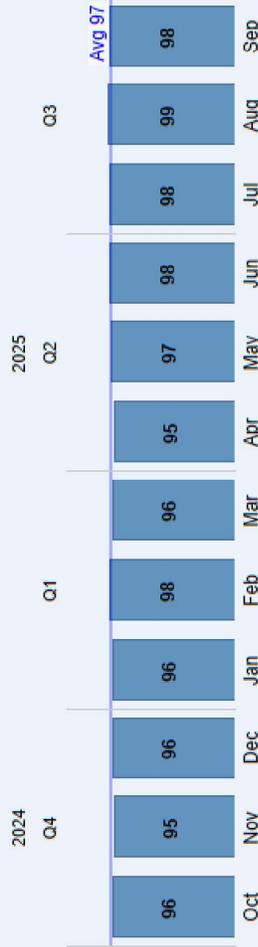
Telemedicine
1,166 Patients
1,516 Visits

Immunization
17 Patients
17 Visits

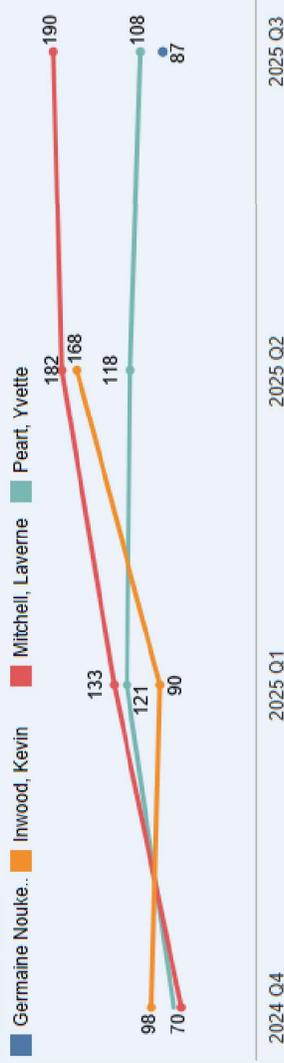


Healey Center Productivity Data Q3 2025

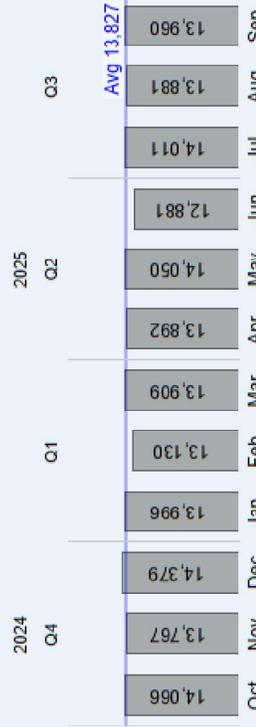
Avg Monthly Census



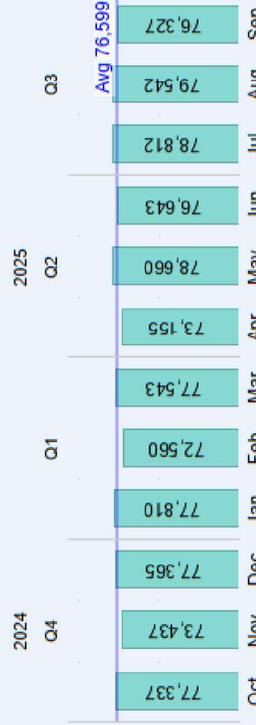
Provider Visits



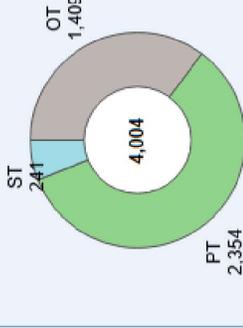
Treatments Performed



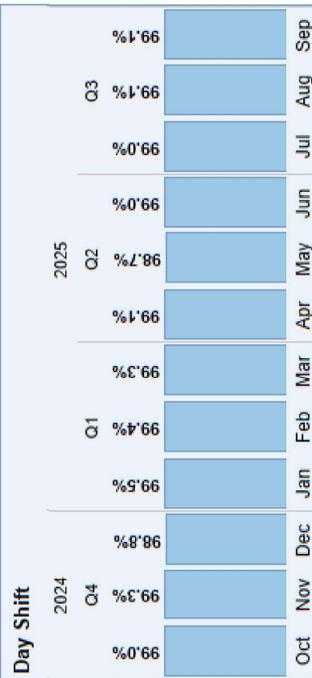
Medication Administrations



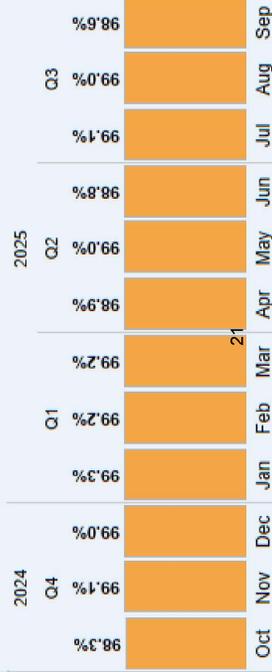
Therapy Productivity



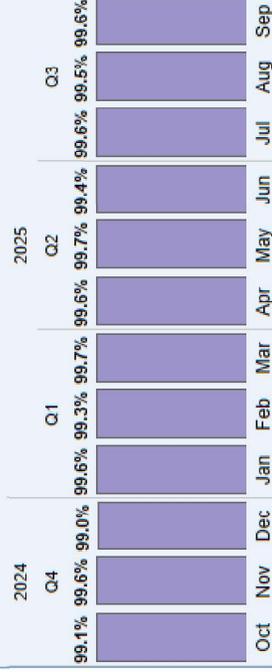
CNA Point of Care (POC) Compliance



Evening Shift



Night Shift



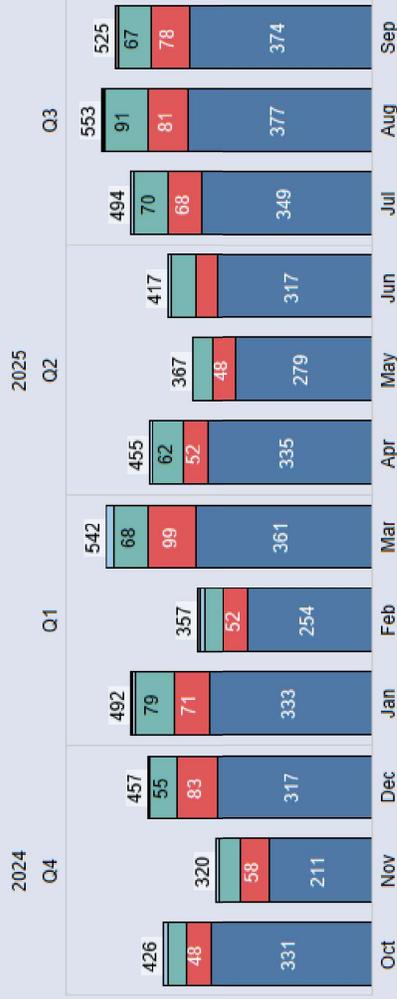
Lakeside Medical Center Patient Flow Productivity Data

10/1/2024 to 9/30/2025



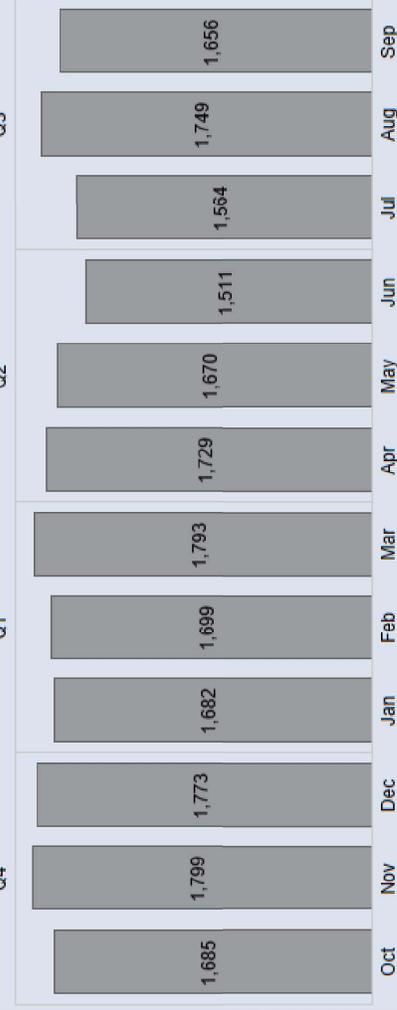
Total Census Days by Level of Care

- LOC Not Assigned
- Pediatrics
- Med/Surg
- Critical Care
- Telemetry



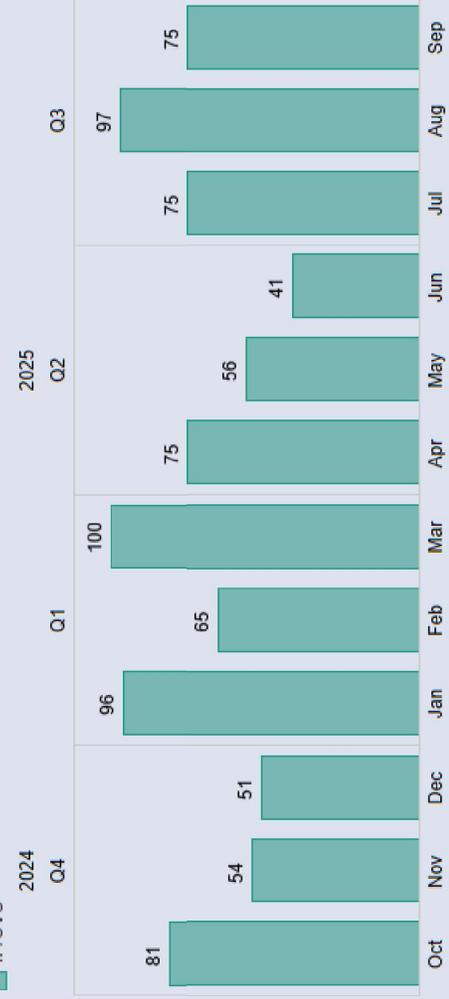
ED Visits

2024 Q4



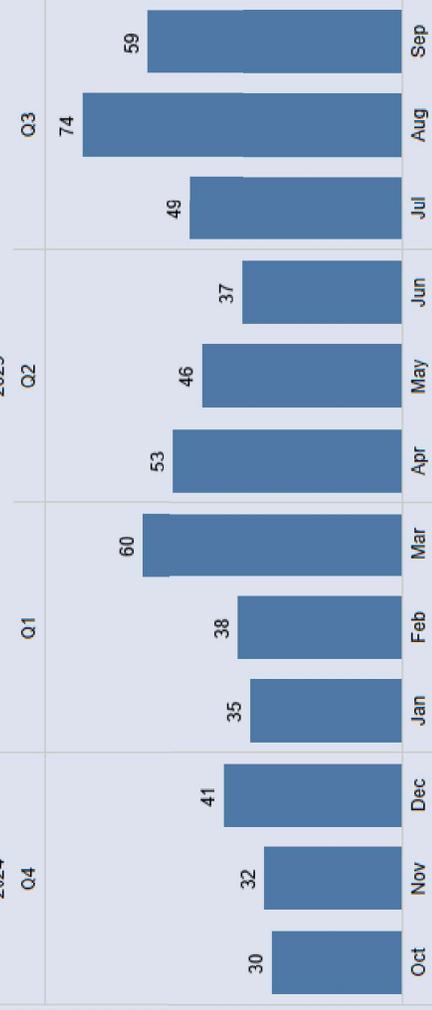
PT Visits (Evals and Treatments)

- IP/OVS



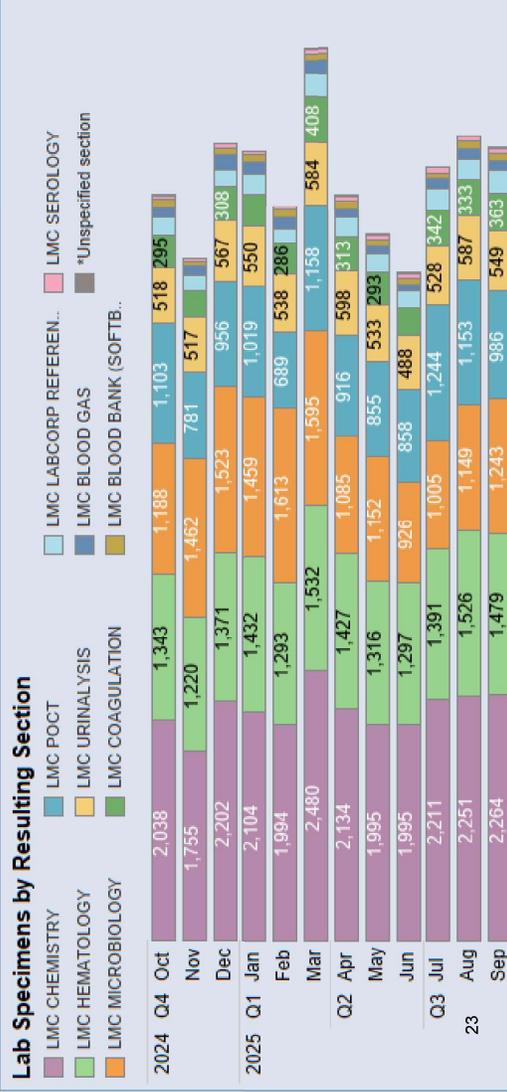
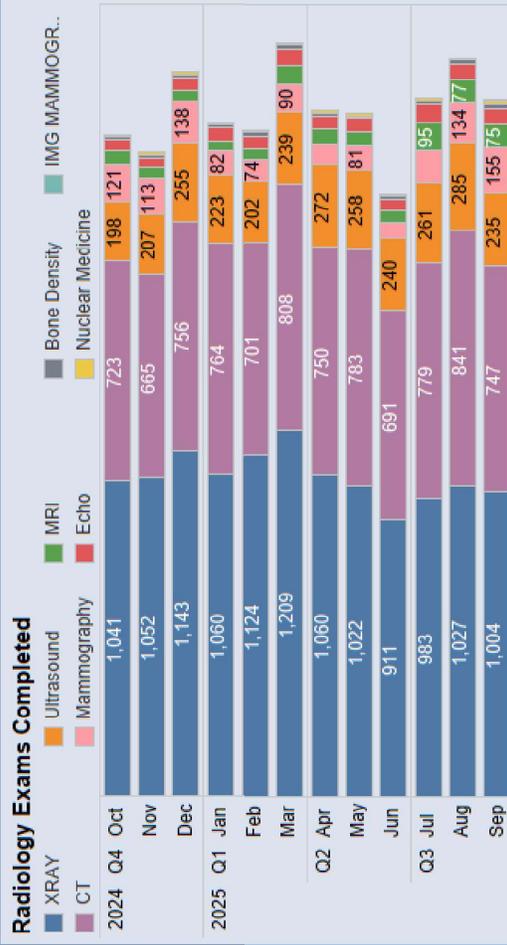
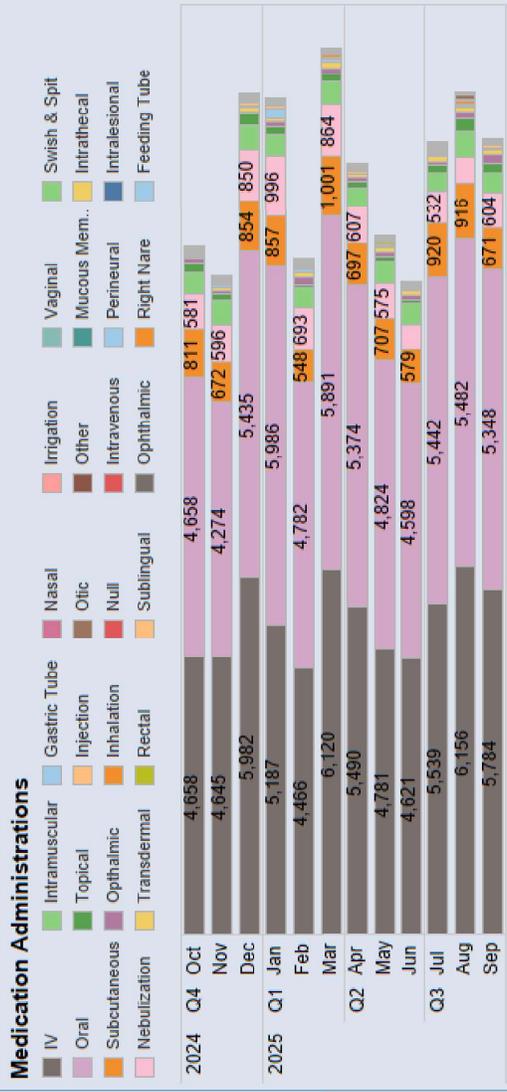
IP Admissions

2024 Q4



Lakeside Medical Center Clinical Productivity Data

10/1/2024 to 9/30/2025



Ground Transportation Services

7/1/2025 - 9/30/2025

filters

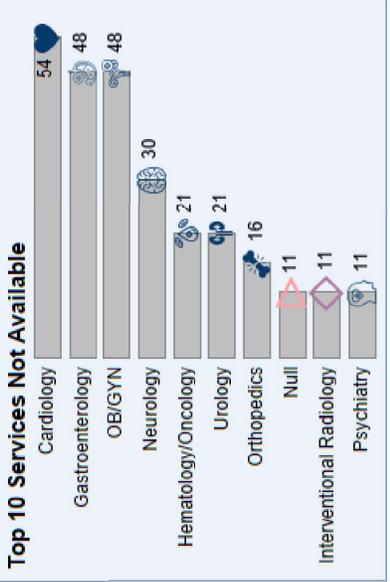
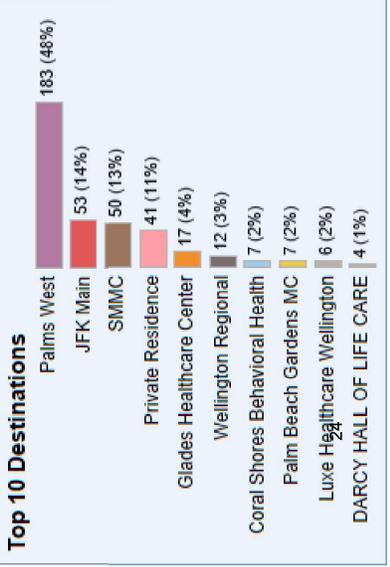
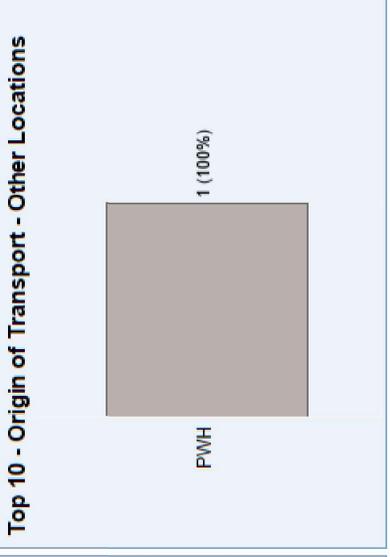
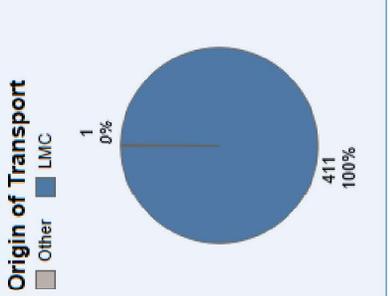
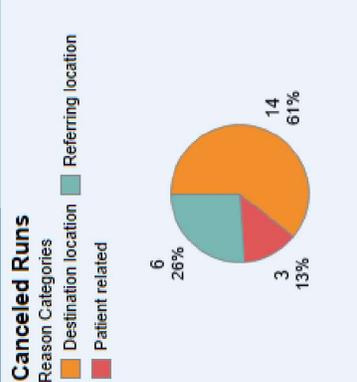
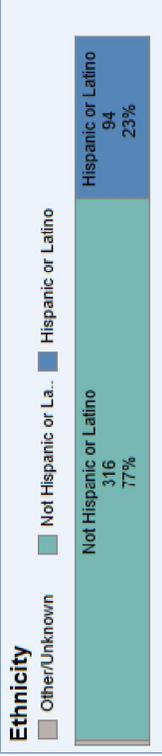
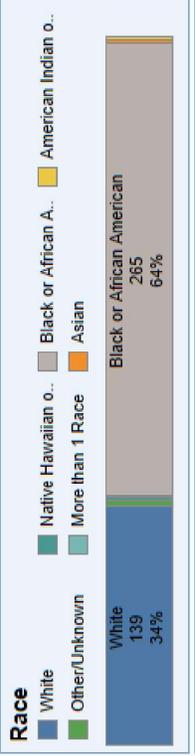
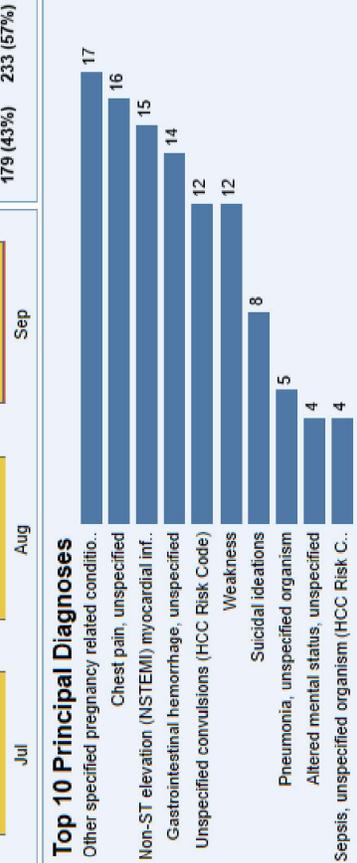
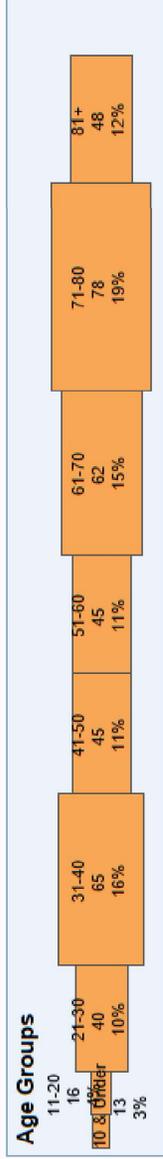
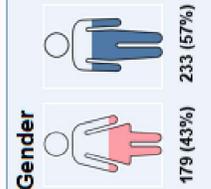
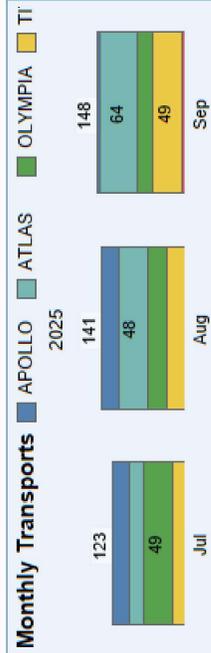
Completed Transports **412** Average Mileage **31 mi** Avg Pickup to Drop Off **62 min**

Delays **51** Canceled Transports **23** Avg Response Time **12 min** Lights/Sirens Used **22**

Patient Type - LMC Transports *Data Starting 12/2023

Emergency **333 (81%)**

IP & OBS **76 (19%)**



PHARMACY QUALITY DATA 7/1/2025 - 9/30/2025



Unique Pts
6,589

New Patients
1,282 (19%)

Rx Sold
34,527

Rx Return to Stock
2,576 (7.0%)

Out Of Stock
1,500 4.1%

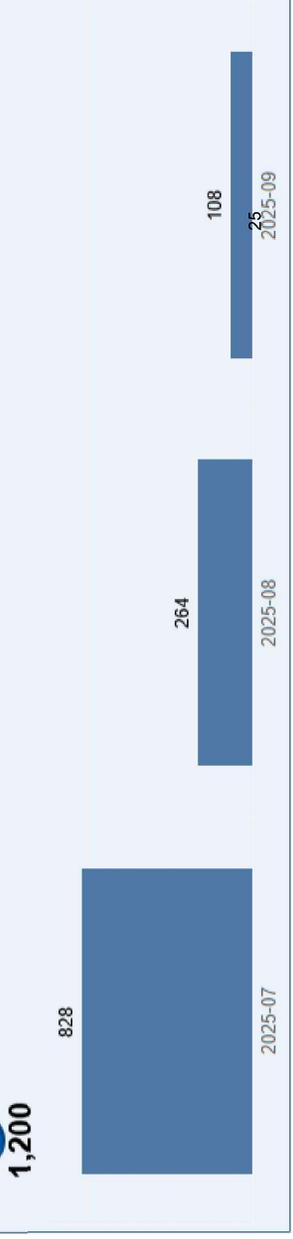
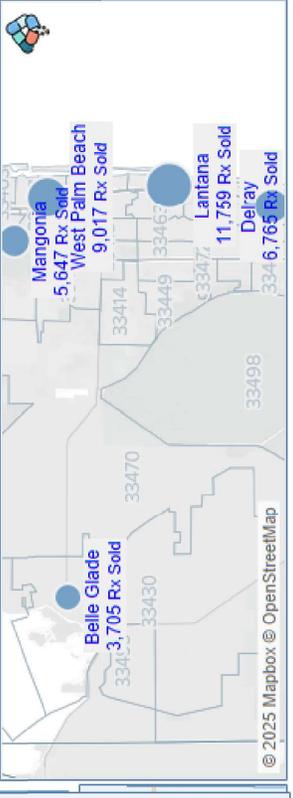
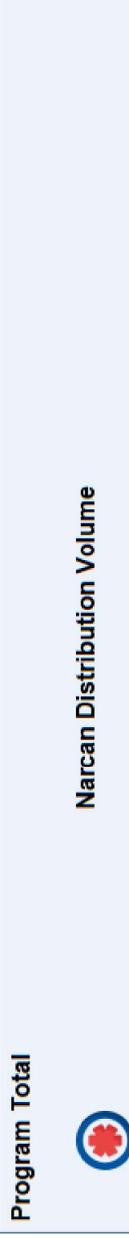
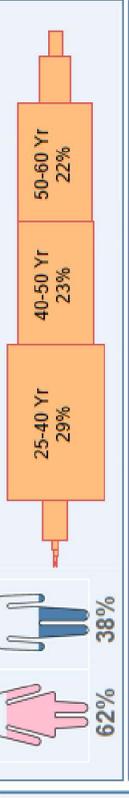
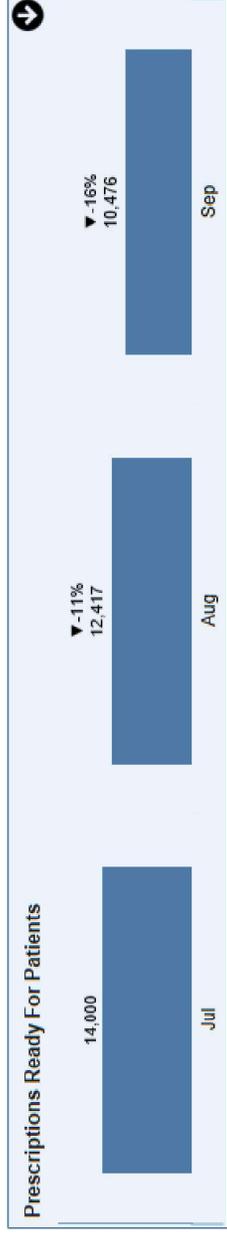
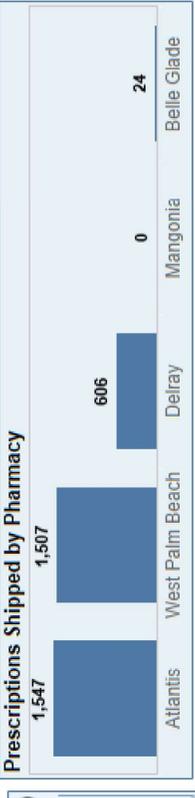
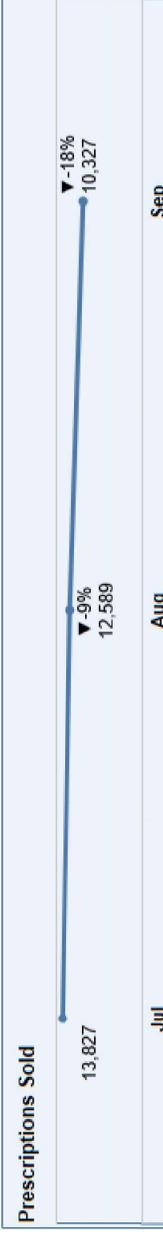
Pharmacy Visits
17,985

Avg Rx per patient
6

Rx Shipped to patient
3,684 (10%)
1,647 Pkgs

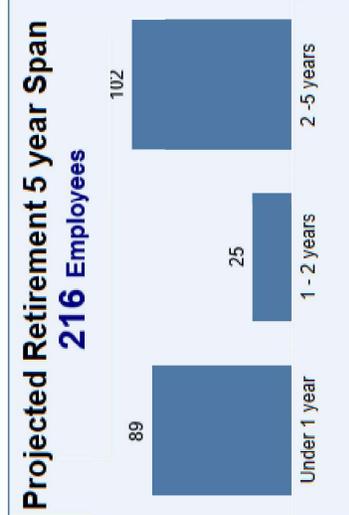
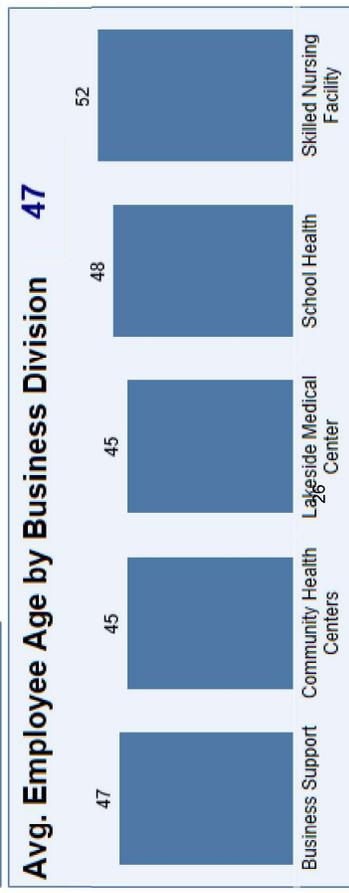
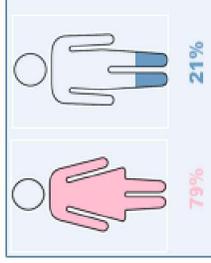
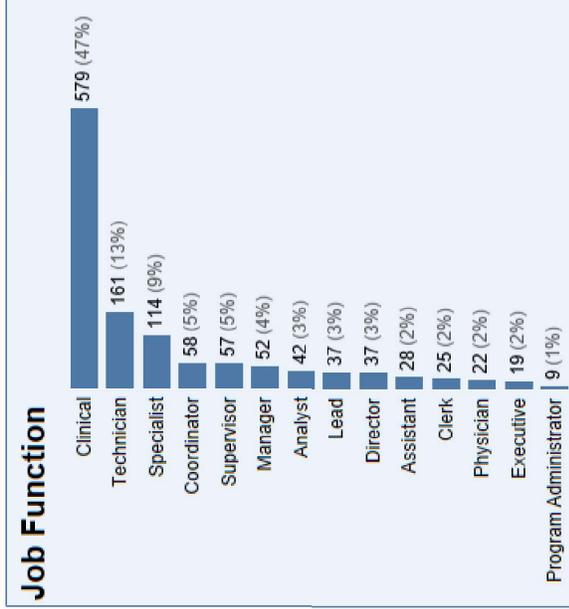
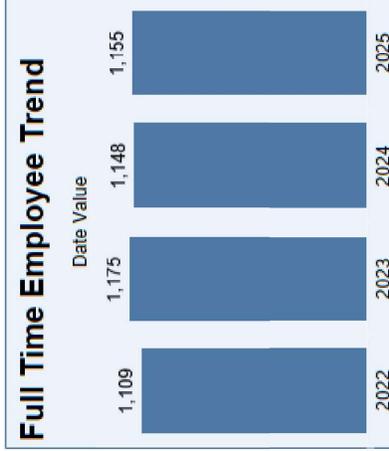
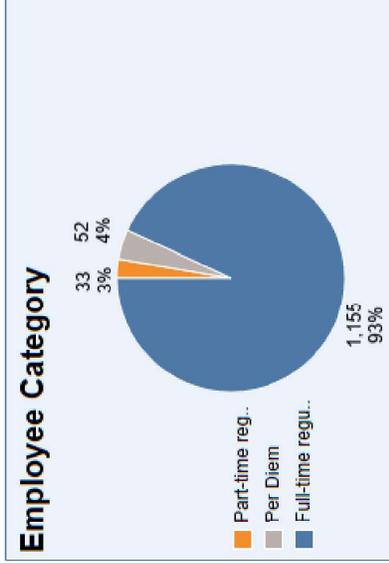
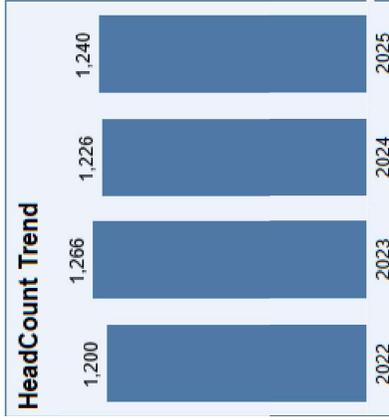
Prescriptions Filled by Pharmacy

Pharmacy	Percentage	Count
Atlantis	32%	11,145
West Palm Be...	24%	8,385
Delray	18%	6,301
Mangonia	15%	5,252
Belle Glade	10%	3,525



EMPLOYMENT STATUS AND EMPLOYEE DEMOGRAPHICS

End Date
9/30/2025





**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025**

1. Description: Risk Management Plan 2026 for Lakeside Medical Center.

2. Summary:

Lakeside Medical Center (LMC) maintains a comprehensive Enterprise Risk Management Program to ensure safe, high-quality care for patients, staff, and visitors while protecting organizational assets. The program supports ethical decision-making, minimizes business risks, and reinforces a just and accountable culture focused on safety, transparency, and continuous improvement.

3. Substantive Analysis:

LMC is committed to delivering healthcare services in alignment with the standards set by the Health Care District of Palm Beach County. The goal is to ensure the provision of safe, high-quality medical and professional care for patients, staff, visitors, and other stakeholders within a secure and supportive environment. Through the consistent application of ethical decision-making and actions, LMC seeks to minimize business risk and promote organizational integrity. The Risk Management Program is designed to safeguard the organization’s assets by mitigating the adverse effects of accidental losses, managing any losses that may occur effectively, and continuously improving patient care within a safe healthcare setting. LMC fosters a just and accountable culture—one that prioritizes evidence-based best practices, encourages learning from incident analysis, and emphasizes constructive feedback over blame or punishment. Proactive risk identification, occurrence reporting, and ongoing risk management education are integral to this culture, supporting our commitment to patient safety and organizational resilience.

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Net Operating Impact	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Jessica Cafarelli
VP & Chief Financial Officer

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025

5. Recommendation:

Staff recommends the Committee Approve the **Risk Management Plan 2026 for Lakeside Medical Center.**

Approved for Legal sufficiency:

Signed by:


0CF6F7DB6706434...
Bernabe Icaza
SVP & General Counsel

DocuSigned by:


12CE0504A1004C7...
Regina All
SVP & Chief Clinical Officer

Signed by:


77A3B53589A1477...
Darcy J. Davis
President & Chief Executive Officer



Risk Management Plan 2026 for Lakeside Medical Center

Plan #:	2026	Effective Date:	1/1/2026
Business Unit:	Lakeside Medical Center	Original Effective Date:	1/1/2026
Approval Group:	LMC Risk Policy and Procedure		

PURPOSE

Lakeside Medical Center (LMC) is committed to delivering healthcare services in alignment with the standards set by the Health Care District of Palm Beach County. Our goal is to ensure the provision of safe, high-quality medical and professional care for patients, staff, visitors, and other stakeholders within a secure and supportive environment.

Through the consistent application of ethical decision-making and actions, LMC seeks to minimize business risk and promote organizational integrity. The Enterprise Risk Management Program is designed to safeguard the organization’s assets by mitigating the adverse effects of accidental losses, managing any losses that may occur effectively, and continuously improving patient care within a safe healthcare setting.

LMC fosters a just and accountable culture—one that prioritizes evidence-based best practices, encourages learning from incident analysis, and emphasizes constructive feedback over blame or punishment. Proactive risk identification, occurrence reporting, and ongoing risk management education are integral to this culture, supporting our commitment to patient safety and organizational resilience.

AUTHORITY

Lakeside Medical Center (LMC) operates under the governance of the Health Care District (HCD) Board of Directors, which holds ultimate accountability for oversight of the organization’s healthcare delivery, including the Risk Management Program, in accordance with the standards of The Joint Commission (TJC), the Centers for Medicare & Medicaid Services (CMS), and other applicable regulatory bodies.

The Risk Management function is supported by a multidisciplinary team that may include the Risk Manager, Senior Leadership, a designated HCD Board representative, Unit Managers and Supervisors, Clinical Staff, Corporate Risk Management, and representatives from other departments, as appropriate. These individuals may serve as ad hoc members of risk-related committees or task forces, depending on the scope and nature of the issue under review.



This collaborative structure facilitates the integration of risk management principles with quality and patient safety initiatives, enabling the organization to proactively identify risks, analyze adverse events, and implement evidence-based improvements. The committee supports a culture of safety and continuous learning by promoting transparency, accountability, and adherence to best practices, in alignment with accreditation and regulatory requirements.

DEFINITIONS

- **Adverse Event or Incident:** An incident over which healthcare personnel have control, and which is associated – either wholly or in part – with medical intervention rather than the patient’s underlying condition.
- **Cause-and-Effect (Fishbone) Diagram:** A visual tool used to categorize potential causes or a specific problem, helping teams identify root causes for more effective problem-solving and prevention.
- **Claims Management:** A set of activities led by the Risk Manager to manage potential, actual, or filed claims against the organization or its providers. This includes early identification of potential claims, notifying liability insurers and legal counsel, assessing liability and costs, supporting legal defense, facilitating discovery, and employing strategies such as alternative dispute resolution.
- **Enterprise Risk Management (ERM):** A continuous, organization-wide decision-making process supported by leadership to identify, assess, and manage risks across all operational areas. ERM integrates clinical, financial, strategic, and regulatory risks to reduce uncertainty, promote safety, preserve assets, and recognize opportunities for improvement.
- **Failure Mode and Effects Analysis (FMEA):** A proactive, systematic method used to evaluate processes, identify where and how failures might occur, and assess the impact of those failures to prioritize improvements.
- **Just & Accountable Culture:** An organizational culture that supports open reporting, learning from mistakes, and system-based solutions. While recognizing that most errors result from systemic issues, the culture also emphasizes individual accountability in cases of gross negligence, misconduct, or willful violations.
- **Loss Control / Loss Reduction:** The proactive identification and reduction of potential risks through activities such as staff education, credentialing, policy development, quality improvement, and root cause analysis.



- **Good Catch / Near Miss:** An unplanned event that did not result in harm but had the potential to do so. These incidents are valuable learning opportunities used to strengthen processes and prevent future errors.
- **Plan-Do-Check-Act (PDCA) / Plan-Do-Study-Act (PDSA):** An iterative, four-step management methodology used to control and continuously improve processes and outcomes. It emphasizes planning changes, implementing them, studying the results, and acting on what is learned.
- **Potentially Compensable Event (PCE):** An unexpected event resulting in, or with the potential to result in, patient harm—often accompanied by a complaint or dissatisfaction—that may lead to a legal claim.
- **Risk Analysis:** A structured process to identify risks, evaluate their potential impact, compare them against standards or benchmarks, and determine acceptable risk levels. The process supports the implementation of preventative measures.
- **Risk Avoidance:** A strategy used to eliminate exposure to risk, often by discontinuing a service, procedure, or activity deemed to have excessive risk.
- **Risk Containment / Response Plan:** The strategic management of known risks to limit their impact, ensure they remain within acceptable thresholds, and support achievement of organizational goals.
- **Risk Financing:** The assessment and allocation of financial resources to cover risk-related losses. Methods include commercial insurance (risk transfer), self-insurance (funded retention), risk pooling, and alternative financing such as captive insurance or catastrophe bonds.
- **Risk Identification:** The process of detecting and documenting existing and potential risks that could cause patient harm or organizational loss. Sources include incident reports, audits, claims data, patient complaints, accreditation results, and direct staff communication.
- **Risk Management (Traditional):** The clinical and administrative activities designed to identify, evaluate, prevent, and control risks to patients, staff, visitors, and the organization. Traditional risk management seeks to minimize harm and organizational loss through informed decision-making and strategic interventions.

GOALS AND OBJECTIVES

The Enterprise Risk Management (ERM) Program at Lakeside Medical Center (LMC) is designed to promote a culture of safety, minimize organizational risk, and ensure compliance with regulatory and accreditation standards. The key goals and objectives of the program are to:



Patient, Staff, and Visitor Safety

- Reduce or prevent errors, adverse events, and system failures that may result in harm to patients, staff, visitors, or others within the healthcare environment.
- Promote proactive risk identification and mitigation strategies to enhance overall patient safety and staff well-being.

Risk Identification, Mitigation, and Prevention

- Identify, assess, and mitigate potential clinical, operational, and business risks before they result in adverse outcomes.
- Monitor and manage critical risks related to scope, schedule, budget, business performance, and change management by ensuring timely communication, escalation, and resolution.
- Minimize potential losses by implementing effective control measures to reduce exposure to liability, property loss, and financial risk.
- Protect individual staff, clinicians, officers, and directors from personal liability by promoting adherence to risk reduction strategies and legal protections.

Compliance and Regulatory Alignment

- Ensure compliance with applicable laws, regulations, and accreditation standards, including those set by The Joint Commission (TJC), Centers for Medicare & Medicaid Services (CMS), and other regulatory bodies.
- Support enterprise-wide regulatory readiness through routine documentation, internal audits, and performance improvement initiatives.

Education and Awareness

- Provide risk management and safety training to all staff at the time of hire and on an annual basis to reinforce a culture of safety and accountability.
- Promote ongoing staff engagement in identifying and reporting potential risks.

Risk Monitoring and Reporting

- Conduct annual risk assessment and perform an annual Failure Mode and Effects Analysis (FMEA) to proactively identify and address vulnerabilities in processes or systems.



- Submit quarterly risk management activity reports to the Board of Directors to maintain oversight and transparency.
- Conduct a comprehensive Patient Safety Culture Survey annually to evaluate organizational safety practices and perceptions.

Program Review and Accountability

- Review and update the Risk Management Program annually to reflect organizational changes, regulatory updates, and performance improvement findings.
- Ensure relevant stakeholders are informed, engaged, and involved in the risk mitigation process, as appropriate to their roles.
- Maintain a detailed audit trail of risk discussions, mitigation strategies, and outcomes to support accountability, learning, and regulatory compliance.

SCOPE

The Risk Management Program at Lakeside Medical Center (LMC) encompasses a comprehensive, organization-wide approach to identifying, assessing, and mitigating clinical, operational, and environmental risks. The program is closely integrated with Quality and Patient Safety functions to ensure a coordinated and proactive risk management strategy.

As part of its scope, LMC participates in an annual risk assessment, with focused attention on designated high-risk areas and activities, including but not limited to:

- Prenatal and obstetric care
- Pediatric services
- Behavioral health and crisis intervention
- Infection prevention and control
- Environmental and physical safety hazards

Risk Management and Quality departments collaborate to develop and monitor key performance indicators (KPIs) for high-risk and high-volume processes. These indicators are tracked monthly and benchmarked against internal and external standards to ensure continuous improvement. Performance metrics are reported to the Continuous Quality and Patient Safety Committee monthly and presented to the Board of Directors on a quarterly basis to ensure oversight and accountability.



In addition, Risk Management and Quality jointly conduct periodic audits to:

- Verify compliance with established clinical protocols and safety procedures
- Assess the completeness and accuracy of documentation within the patient’s medical record
- Identify opportunities for improvement in clinical and operational workflows

All findings and trends related to risk, quality, and safety are reviewed by the Lakeside Medical Center Quality and Patient Safety Committee, supporting data-driven decision-making and fostering a culture of continuous learning and improvement.

PROGRAM ELEMENTS

The LMC Enterprise Risk Management Program follows a structured four-step process to ensure consistent identification, evaluation, and mitigation of risks across the organization:

1. **Risk Identification:** Risk identification is the initial step in which potential risks are recognized and documented with sufficient detail to enable further analysis. This process involves identifying any threats or uncertainties that could impact project or organizational outcomes. All identified risks are recorded in the Risk Register Log for ongoing monitoring and management.
2. **Risk Assessment and Analysis:** Each identified risk undergoes a qualitative assessment to estimate both the likelihood of occurrence and the potential impact on LMC operations, patient safety, or strategic objectives. Risks are scored using a standardized Risk Scoring Matrix (also referred to as a Probability and Impact Matrix). This scoring enables prioritization by evaluating risks in terms of:
 - Probability (how likely the event is to occur), and
 - Impact (the severity of consequences if the event occurs).
3. **Risk Containment and Response Planning:** Risk containment involves proactively managing identified risks by assigning responsible parties to implement appropriate mitigation strategies. Effective risk management aims to balance the level of containment with the probability and potential impact of each risk. The Risk Owner is responsible for analyzing each identified risk and determining an appropriate response plan – even in cases where no immediate action is required.
4. **Risk Control and Monitoring:** Once a risk and its response plan are established, the Risk Manager will conduct monthly reviews in collaboration with the Risk Owner or assigned responsible party. These reviews are designed to reassess the risk considering evolving circumstances and to



update the risk response strategy accordingly. The control process continues until the risk has been mitigated to an acceptable level and formally closed.

Risk Control Activities include:

- Validating risk mitigation strategies and alternative options.
- Initiating corrective actions when risk events occur.
- Assessing the impact of mitigation efforts on cost, timeline, and resource allocation.
- Identifying new risks that may emerge from mitigation efforts.
- Maintaining the Risk Management Plan with up-to-date information.
- Ensuring that change control processes incorporate risk considerations.
- Updating risk management documentation to reflect outcomes of risk responses.
- Keeping the Risk Register current.
- Communicating risk status and follow-up actions to relevant stakeholders.
- Establishing and maintaining appropriate communication channels.

Risk Monitoring Activities include:

- Verifying implementation of the Risk Management Plan through periodic reviews.
- Assess existing risks as documented in the Risk Register.
- Evaluating the effectiveness of risk response actions and tracking their progress.
- Validate prior risk assessments (likelihood and impact), identify emerging risks, and track risk response.
- Report on the status of risk management efforts and ensuring appropriate follow-through.

ADMINISTRATIVE AND COMMITTEE STRUCTURE

The Health Care District (HCD) Board and physician leadership, in collaboration with the Risk Management Department, hold overall responsibility for the Risk Management Program. They are accountable to ensure that the Risk Management Plan is implemented effectively and remains operational.

Risk-related matters are reviewed quarterly as a dedicated agenda item during the Quality, Patient Safety & Compliance Committee (QPSCC). The Director of Corporate Risk or designee presents all identified risk



issues, which are addressed through appropriate action plans or reporting mechanisms, in full compliance with applicable municipal, state, and federal laws and regulations.

COMMUNICATIONS AND REPORTING MECHANISMS

Guided by Administration and the Medical Staff performance improvement processes, the event reporting system is maintained to ensure that unusual or unanticipated events are communicated promptly to the appropriate individuals, departments, and medical staff committees.

Issues or trends identified through the Risk Management Program are escalated to the relevant stakeholders or committees for review, consideration, and appropriate action. Aggregated and trended Risk Management data are routinely shared with departments and committees to support their ongoing Performance Improvement activities and to inform data-driven decision-making.

PATIENT SAFETY AND ADVERSE EVENTS

The National Coordinating Council (NCC) for Medication Error Reporting and Prevention (MERP) index will be utilized for Adverse Event and/or Medication Error Severity Rating; it classifies an error according to the severity of the outcome. The categories are as follows:

- Category A: NEAR MISS – Circumstance or events that have the capacity to cause error, but no error occurred.
- Category B: NEAR MISS – An error occurred but did not reach the patient.
- Category C: No Harm – An error reached the patient but did not cause harm.
- Category D: MINOR – An error reached the patient, required monitoring or intervention to confirm it resulted in no harm.
- Category E: MODERATE – An error occurred that may have contributed to or resulted in temporary harm and required intervention.
- Category F: MAJOR – An error occurred that may have contributed to or resulted in temporary harm and required initial or prolonged hospitalization.
- Category G: SEVERE – An error occurred that may have contributed to or resulted in permanent patient harm.
- Category H: CATASTROPHIC – An error occurred that required intervention necessary to sustain life.
- Category I: DEATH – An event occurred that might have contributed to or resulted in the patient's death.



The Risk Manager will classify each event based on the outcome. Detailed processes for identifying, reporting, tracking, and investigating incidents—including tools such as cause-and-effect diagrams, the 5 Whys method, timelines, and structured improvement processes—are outlined in the Incident Reporting Policy. An adverse event is defined as “an untoward, undesirable, and typically unanticipated event that results in death, serious injury, or poses a significant risk thereof.” Reporting of both adverse events and near misses is actively encouraged and supported across LMC. To foster a culture of safety, all staff receive annual education on recognizing and reporting incidents. Just Culture principles are promoted to enhance transparency and accountability, thereby encouraging increased reporting. Near miss or “good catch” reports are recognized and rewarded on a quarterly basis. Improvement initiatives—whether identified through trend analysis, Failure Mode and Effects Analysis (FMEA), risk scoring, or isolated high-impact events—utilize evidence-based quality tools such as Plan-Do-Study-Act (PDSA) cycles and Lean/Six Sigma methodologies to drive continuous improvement. Reportable events are communicated to appropriate external agencies as required, including the Agency for Health Care Administration (AHCA), the Joint Commission, the Food and Drug Administration (FDA), the Department of Health (DOH), and others. Events with litigation potential are referred to the Legal/Claims Department and flagged as Potential Compensable Events (PCEs). A Root Cause Analysis (RCA) or Comprehensive System Analysis (CSA) is conducted for all AHCA Code 15 events and Catastrophic Adverse Events, followed by the implementation of a corrective action plan with defined measures of success.

To guide hospital-wide risk mitigation efforts, LMC applies the eight domains of Enterprise Risk Management (ERM):

1. Operational
2. Clinical and Patient Safety
3. Strategic
4. Financial
5. Human Capital
6. Legal and Regulatory
7. Technology
8. Hazard



EVALUATION OF THE RISK MANAGEMENT PROGRAM

The progress of the Enterprise Risk Management Program in achieving its established goals and objectives is evaluated annually and presented to the management team and Governing Body of Lakeside Medical Center for review and oversight.

CONFIDENTIALITY

The Enterprise Risk Management Program at Lakeside Medical Center (LMC) involves the collection and maintenance of sensitive information related to patient care, provider performance, and organizational processes. In accordance with applicable state and federal laws, including legal privilege protections for risk management activities, all records, documentation, and proceedings are handled with the highest level of confidentiality.

It is the intent of this program to ensure that all documents, reports, and committee proceedings related to internal risk management activities are safeguarded under relevant legal and regulatory standards. These protections extend to individuals participating in risk management processes and to the integrity of the information collected.

All records and materials generated through the Risk Management Program, including but not limited to incident reports, investigations, committee minutes, and quality reviews, shall be maintained in a secure and confidential manner. Disclosure of such information in judicial or administrative proceedings will occur only under a valid court order, subpoena, or legal mandate.

Information related to specific events or investigations will not be released to any individual or entity not directly involved in the organization's quality improvement, patient safety, or risk mitigation efforts. This confidentiality is essential to maintaining a just culture, promoting open reporting, and fostering continuous improvement in care delivery.



LAKESIDE MEDICAL CENTER RISK ASSESSMENT

(Data 10/1/2024 – 9/30/2025)

Probability (Likelihood)	Impact (Seriousness)					
		Very Low	Low	Medium	High	Very High
	Very High	AMA	IV Infiltrations	N/A	N/A	N/A
	High	Behavior Aggressive	Patient Care Delay Diagnostic Results	N/A	N/A	N/A
	Medium	Security Access Control	Safety Code Red / Lockdown	ADT Discharge/Transfer Issues	N/A	N/A
	Low	Equipment Related	Falls	Behavior Attempted / Threatened Assault	N/A	N/A
	Very Low	ADT LWBS	Security Unauthorized / Breach	Medication Variance	Patient Care Protocol Deviation	Patient Care Patient Monitoring Related

Score	Definition
High Risk (3)	An event that is highly probable or almost certain to occur and is expected to have a severe impact on the facility, potentially resulting in catastrophic outcomes or substantial financial loss. This level of risk warrants escalation (when applicable) and requires frequent review and close monitoring.
Medium Risk (2)	An event with a moderate likelihood of occurrence (approximately a 50% chance) that, if realized, could result in measurable cost increases or adverse outcomes. This risk level should be monitored and reviewed on a regular basis to ensure timely mitigation.
Low Risk (1)	An event that is unlikely or highly unlikely to occur and, if it does, is expected to have minimal or no impact, with negligible cost implications or adverse outcomes. In most cases, such risks can be effectively managed or absorbed through existing preventive measures and system controls.



LAKESIDE MEDICAL CENTER SWOT ANALYSIS

Strengths	Weaknesses	Opportunities	Threats
<p>Hands-On Clinical Experience for Trainees: Residents often get more direct care responsibility and procedural experience than in large academic centers.</p> <p>Mission-Driven Culture: Staff often share a deep commitment to service.</p> <p>Broader Scope of Practice for Providers: Physicians, NPs, PAs may manage more diverse cases, enhancing skill sets and engagement.</p> <p>Flexibility and Innovation: Smaller organizations can implement new processes, technologies, or protocols more quickly than large systems.</p>	<p>Limited Resources: Lack of access to advanced technology, specialty services, or updated infrastructure.</p> <p>Staffing Challenges: Harder to recruit and retain specialists and experienced staff.</p> <p>Financial Constraints: Lower patient volume and payer mix (more Medicare/Medicaid) can strain finances.</p> <p>Narrow Referral Base: Smaller population limits revenue growth and case diversity.</p>	<p>Telemedicine Expansion: Technology allows better access to specialists and training.</p> <p>Government grants: Rural health and academic funding opportunities.</p> <p>Community Partnerships: Collaborate with public health organizations, schools, or local businesses.</p> <p>Population Health Initiatives: Can pilot or lead efforts in chronic disease management and social determinants of health.</p> <p>Residency Program Growth: Rural-focused training tracks to build future workforce.</p> <p>Medical Tourism: Attract patients seeking quality care with less urban hassle.</p>	<p>Policy/Regulatory Changes: Shifting reimbursement models may disproportionately affect small/rural hospitals.</p> <p>Healthcare Worker Shortage: National shortage of nurses, primary care, and specialty providers impacts hiring.</p> <p>Aging population: Increases demand, but with higher costs and lower reimbursement.</p> <p>Competition from Urban Centers: Patients may bypass local care for perceived better care in city.</p> <p>Technology Gap: Falling behind EMR, AI tools, or advanced diagnostics.</p>



NATIONAL PERFORMANCE GOALS



Hospital National Performance Goals (NPGs)

- Goal 1** **The hospital ensures that the correct patient receives the correct care at the correct time.**

- Goal 2** **The governing body and leadership team foster a culture of safety.**

- Goal 3** **The hospital has an emergency management program.**

- Goal 4** **The hospital prioritizes excellent health outcomes for all.**

- Goal 5** **The hospital prioritizes infection prevention and control.**

- Goal 6** **The hospital prioritizes pain management and safe prescribing practices.**

- Goal 7** **The hospital respects the patient's right to safe, informed care.**

- Goal 8** **The hospital reduces the risk for suicide.**

- Goal 9** **The hospital develops and implements safe transplant practices.**

- Goal 10** **The hospital performs waived testing in a safe and consistent manner.**
*Note: Waived tests are categorized by CLIA as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." The Food and Drug Administration (FDA) determines which tests meet these criteria when it reviews a manufacturer's application for test system waiver. The list of FDA-approved waived tests can be accessed at the following link:
<https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm>.*

- Goal 11** **The hospital maintains workplace and patient safety.**

- Goal 12** **The hospital is staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care.**

- Goal 13** **The hospital safely performs imaging services.**

- Goal 14** **The hospital has a medication management program that focuses on safety.**

EXCEPTIONS

N/A



RELATED DOCUMENTS	
Related Policy Document(s)	
Related Forms	
Reference(s)	The Joint Commission. (2025). <i>National Performance goals</i> . https://www.jointcommission.org/en-us/standards/national-performance-goals
Dynamic Health/EBSCO link:	

APPROVALS	
Final approver	(Enter Final Approver)
Final approval date	(Enter Final Approval Date)

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QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025

1. Description: Compliance, Privacy & Ethics – Compliance Program Analysis and Effectiveness Assessment

2. Summary:

The U.S. Department of Health and Human Services’ (“HHS”) Office of Inspector General (“OIG”) recommends that organizations evaluate their compliance programs against the General Compliance Program Guidance (“GCPG”) and report findings to their boards. This process helps prevent and detect fraud, waste, and abuse, mitigate legal and operational risks, and demonstrate a strong commitment to compliance.

While adherence to the guidance is voluntary, it reflects a clear *tone from the top*—a critical factor in how both the OIG and the Department of Justice (“DOJ”) assess an organization in the event of an investigation.

The OIG further emphasizes that board members have a fiduciary duty of care to ensure effective information and reporting systems are in place to monitor compliance with applicable laws. Regular reporting ensures the board remains informed, engaged, and accountable for the program’s operation and effectiveness.

In FY25, HCD Compliance, Privacy & Ethics (“CPE”) prioritized a Comprehensive Gap Analysis and Program Effectiveness Review of its Program against the OIG’s newly issued GCPG. Accordingly, HCD’s Vice President & Chief Compliance and Privacy Officer provides this report and accompanying reference document, which detail the FY25 review and its application to HCD’s CPE Program.

Background on the GCPG

As part of its modernization initiative, the OIG released its first comprehensive guidance (GCPG) in over 15 years. Designed for all healthcare industry stakeholders, the GCPG consolidates and updates previously fragmented guidance dating back to 1998 (updated in 2008). It serves as a central reference for compliance risks, program infrastructure, enforcement standards, and federal laws.

The GCPG also integrates related publications from agencies such as the DOJ and establishes a new “hub and spoke” model, with the GCPG as the core resource. Beginning in 2024, the OIG began issuing Industry-Specific Compliance Program Guidance (“ICPGs”) tailored to fraud and abuse risks in individual healthcare sectors

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(e.g., Skilled Nursing Facilities). These will be updated periodically to reflect emerging issues and best practices, marking a significant shift toward a unified and dynamic approach to healthcare compliance oversight.

Application of the GCPG and ICPGs

OIG's existing CPGs, the new GCPG, and forthcoming ICPGs do not constitute a model compliance program. Instead, they serve as resources for the healthcare community. They are not intended to be one-size-fits-all, comprehensive, or all-inclusive of compliance considerations and fraud and abuse risks for every organization.

The goal of these documents is to set forth voluntary compliance guidelines, identify risk areas, and provide practical tips for organizations developing new compliance programs or evaluating and updating existing ones. Existing CPGs and supplemental CPGs will remain available as ongoing resources to help identify risk areas in particular industry subsectors, even as ICPGs are issued.

1. Substantial Analysis: Gap Analysis and Program Effectiveness Review and Results Summary

In FY25, HCD's Vice President & Chief Compliance and Privacy Officer, together with the Compliance, Privacy & Ethics (CPE) Department, completed a comprehensive gap analysis and program effectiveness review of the OIG's General Compliance Program Guidance (GCPG), benchmarking it against HCD's existing Program. A formal report was prepared and shared with the Quality, Patient Safety, and Compliance Committee of the Board, confirming substantial compliance.

While the FY25 review was conducted as an internal assessment, it represented a significantly expanded effort compared to the prior external assessment completed in 2021. The scope and depth of this internal review were more comprehensive, incorporating enhanced benchmarking against OIG's new and existing updated General Compliance Program Guidance. The results confirmed both the effectiveness of HCD's Compliance, Privacy & Ethics Program and substantial compliance with regulatory expectations, demonstrating measurable progress and program improvement since the 2021 external evaluation.

In summary, HCD's CPE Program integrates the OIG's seven elements of an effective compliance program, aligning with federal, state, and local laws, industry standards,

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and healthcare fraud enforcement practices. The Program is designed to prevent, detect, and respond to risks, supporting HCD's mission to eliminate fraud, waste, and abuse while promoting ethics and reinforcing integrity across all operations.

The Standards of Conduct serve as the foundation, communicating HCD's mission, values, and ethical expectations for all workforce members and affiliates. Policies and procedures provide structure for compliance operations and risk mitigation. Oversight is led by the Vice President & Chief Compliance and Privacy Officer, who reports directly to the President & CEO and regularly to the Board and Quality, Patient Safety, and Compliance Committee. The Committee meets quarterly to review program activities, including auditing, monitoring, hotline reports, investigations, and updates to the Work Plan.

CPE ensures effectiveness through comprehensive training, open and confidential reporting channels, and consistent enforcement of standards. Risk assessments, auditing, and monitoring are integrated into a coordinated strategy that informs the Work Plan and allows for targeted reviews in response to emerging risks. Investigations of credible concerns—such as privacy violations or audit findings—are conducted promptly and thoroughly.

These measures demonstrate HCD's proactive approach, strong adherence to OIG guidance, and commitment to ethical, lawful operations across all federal healthcare programs. The FY25 reviews confirm alignment with OIG objectives and affirm the effectiveness of the CPE Program under both current and updated guidelines. Supporting references and compliance documents provide concrete examples of compliance and reflect a robust, proactive framework aligned with regulatory expectations and continuous improvement.

CPE regularly evaluates HCD's operations and adjusts the Program to address areas requiring attention or improvement. Through the Work Plan and related activities, the goal is to consistently meet or exceed OIG's Effective Compliance Program Elements while assessing the effectiveness of both new and existing guidance. The FY25 review demonstrates substantial compliance and outlines recommendations for future work.

Recommendations and Next Steps

Beginning in FY26, the Compliance, Privacy & Ethics (CPE) Department will conduct a multidisciplinary assessment of the OIG's new ICPG focused on HCD's Skilled Nursing

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Facility. Additionally, proposed additions to the FY26–27 Work Plan will be presented for approval at the next meeting. These recommendations are informed by the FY25 completion of the OIG GCPG assessment, which evaluated all seven elements of an effective compliance program (e.g., policies and procedures, training and education, and auditing and monitoring). The number of recommendations reflects proactive planning and a commitment to continuous enhancement, rather than deficiencies in any area. Collectively, these initiatives provide strong evidence of program effectiveness and demonstrate HCD’s readiness for future external reviews.

Supporting Materials and References:

Link to HHS–OIG GCPG: [General Compliance Program Guidance | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services](#)

About the GCPG: A User’s Guide

The GCPG is a reference guide for the healthcare compliance community and other stakeholders. It provides information about relevant federal laws, compliance program infrastructure, OIG resources, and other useful materials for understanding healthcare compliance. The GCPG is voluntary and nonbinding. OIG uses the word “should” throughout the document to indicate recommendations rather than requirements.

OIG GCPG – Overview and Key Sections (Table of Contents)

The GCPG contains a structured overview of the General Compliance Program Guidance issued by the HHS Office of Inspector General.

I. Introduction

Provides background on the Office of Inspector General (OIG), its history of issuing compliance guidance, and the modernization of its approach to compliance program guidance.

II. Health Care Fraud Enforcement and Other Standards

Summarizes key federal laws relevant to healthcare compliance, including the:

- A. Anti-Kickback Statute and Stark Law
- B. False Claims Act (FCA)
- C. Civil Monetary Penalty Law (Beneficiary Inducements, Information Blocking, HHS Grants and Contracts)
- D. Exclusions

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- E. Criminal Health Care Fraud Statute
- F. HIPAA Privacy & Security Rules.

III. Compliance Program Infrastructure (“7 elements”)

Outlines the seven elements of an effective compliance program, including:

- A. Written Policies and Procedures (e.g., Code of Conduct and Policy Maintenance)
- B. Compliance Leadership and Oversight (e.g., Compliance Officer, Boards, and Committees)
- C. Training and Education
- D. Effective Lines of Communication with the Compliance Officer and Disclosure Programs
- E. Enforcing Standards (Consequences and Incentives)
- F. Risk Assessment, Auditing and Monitoring
- G. Responding to Detected Offenses and Developing Corrective Action Initiatives (Investigations of violations, Reporting to the Government, and Implementing Corrective Action Initiatives)

IV. Compliance Program Adaptations for Small and Large Entities

Discusses how compliance programs can be tailored for small and large healthcare entities, with specific roles and responsibilities. This section is further broken down into:

- A. Compliance Programs for Small Entities (Compliance Contact, Policies, Procedures, and Training, Open Lines of Communication, Risk Assessment, Auditing, and Monitoring, Enforcing Standards, and Responding to Detected Offenses and Developing Corrective Action Initiatives)
- B. Compliance Leadership for Large Entities (Compliance Officer, Compliance Committee, and Board Compliance Oversight)

V. Other Compliance Considerations

Covers additional topics such as quality and patient safety, new entrants in healthcare, and financial incentives. This section is further broken down into:

- A. Quality and Patient Safety
- B. New Entrants in the Health Care Industry
- C. Financial Incentives: Ownership and Payment (Ownership, including Private Equity and Others, and Payment Incentives)
- D. Financial Arrangements Tracking

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VI. OIG Resources and Processes

Details resources provided by OIG. This section is further broken down into:

- A. Compliance Toolkits; Compliance Resources for Health Care Boards; Provider Compliance Training; A Roadmap for New Physicians; and RAT-STATS Statistical Software
- B. OIG Reports and Publications
- C. Advisory Opinions; Special Fraud Alerts, Bulletins, and Other Guidance; Safe Harbor Regulations
- D. Frequently Asked Questions (FAQs)
- E. Corporate Integrity Agreements (CIA)
- F. Enforcement Action Summaries
- G. OIG Self-Disclosure Information
- H. OIG Hotline

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Net Operating Impact	N/A	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Jessica Cafarelli
VP & Chief Financial Officer

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
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5. Recommendation:

Staff recommends the Committee Receive and File the effectiveness review report.

Approved for Legal sufficiency:

Signed by:

Bernabe Icaza

Bernabe Icaza
196FF57326706434...

SVP & General Counsel

Signed by:

Heather Bokor

Heather Bokor
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VP & Chief Compliance & Privacy Officer

Signed by:

Darcy Davis

Darcy J. Davis
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Darcy J. Davis

President & Chief Executive Officer

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025

1. Description: Compliance, Privacy & Ethics – Quarterly Program Update

2. Summary:

The Office of Inspector General (“OIG”) recommends reporting on a regular basis to the governing body, CEO, and compliance committee(s) regarding the planning, implementation, and monitoring of the Compliance Program. This report is designed to offer a transparent view of measures and initiatives such as auditing and monitoring, responding to issues and inquiries, and other department activities, to maintain and enhance compliance, privacy, and ethics within the Health Care District (“HCD”).

HCD’s Chief Compliance and Privacy Officer, provides the following report regarding HCD’s Compliance, Privacy, and Ethics (“CPE”, “Compliance”, “Privacy”, or “Program”). This report includes data for fiscal year 2025 and 2026 during the period from August 1 – October 31, 2025 (“Current Period”), including routine FY25–27 Work Plan reports and notable departmental activities.

3. Substantive Analysis: Compliance, Privacy, and Ethics Report

HCD undertakes comprehensive efforts to maintain high standards of compliance. These efforts during the reporting period include measures outlined in the Work Plan to meet or exceed the OIG’s Compliance Program Guidance and program elements for an effective program. This involves addressing potential risks, continuously assessing and improving processes, and responding to staff needs and emerging issues.

CPE regularly evaluates HCD and adjusts its Program to address areas needing attention or improvement. Through the Work Plan and other activities, the goal is to meet or exceed existing OIG Effective Compliance Program Elements, while assessing new and existing published guidelines for effectiveness. Highlights of these activities are summarized in the report below. Additionally, CPE has placed significant focus on its internal comprehensive gap analysis and program effectiveness review related to the HHS-OIG’s new General Compliance Program Guidance (GCPG). A report is being provided at this meeting, demonstrating significant compliance and assigning recommendations for future work. Beginning in FY26, CPE will conduct a multidisciplinary assessment of OIG’s new industry-specific guidance (ICPG) which

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focuses on Nursing Facilities.

At our next meeting, we will present for your approval proposed additions to the FY26–27 Work Plan. These recommendations are informed by our comprehensive FY25 completion of the OIG GCPG assessment and analysis, which evaluated all seven elements of an effective compliance program (e.g., Policies and Procedures, Training and Education, Auditing and Monitoring). *Note: The volume of recommendations reflects proactive planning and a commitment to continuous enhancement—not a deficiency overall or in any area. These materials collectively serve as valuable evidence of program effectiveness and readiness for future external reviews.* In addition, we will introduce new work plan items addressing key areas of focus for HCD and CPE, including but not limited to, Pharmacy/340B program compliance, IT Security and Data Privacy, Coding, Billing, Documentation compliance, and HCD strategic initiatives and changes.

A. Auditing and Monitoring Activity (FY25–27 Work Plan)

HCD's commitment to compliance is furthered through robust auditing and monitoring activities. These ongoing efforts are designed to assess organizational risks, identify areas for process improvement, and ensure compliance with regulatory requirements and internal policies and standards through routine and unique audits.

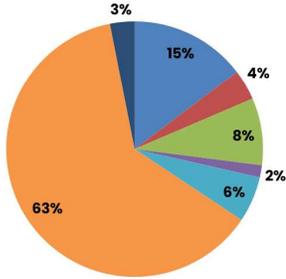
In FY25 and FY26 YTD, CPE initiated 150 audits, data risk assessments, research analyses, risk assessments, and comprehensive reviews per its Work Plan. This includes 39 unique and 111 routine reviews. As per OIG's Guidance, CPE addressed additional items.

Of the 150 reviews initiated, 132 have been completed, including 21 unique and 111 routine reviews. Among the 132 complete reviews, 32 have been finalized since the last report, comprising 4 unique and 28 routine reviews. The remaining 17 reviews are at various stages of preparation, in progress, or awaiting final reports, consisting of 17 unique reviews. Details are included in the tables below.

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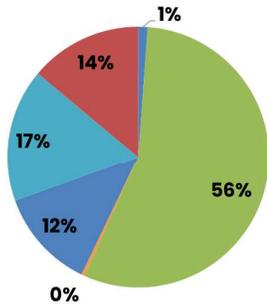
HCD Compliance, Privacy, and Ethics FY25-27 YTD Work Plan Status / Updates

Work Plan % by Element



- 1 - WRITTEN POLICIES AND PROCEDURES
- 2 - COMPLIANCE LEADERSHIP AND OVERSIGHT
- 3 - TRAINING AND EDUCATION
- 4 - EFFECTIVE LINES OF COMMUNICATIONS WITH THE COMPLIANCE OFFICER AND DISCLOSURE PROGRAM
- 5 - ENFORCING STANDARDS; CONSEQUENCES AND INCENTIVES
- 6 - RISK ASSESSMENT, AUDITING, AND MONITORING
- 7 - RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

Work Plan Status



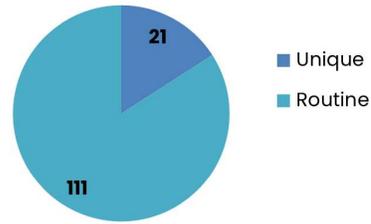
- Closed
- Completed
- Completed w/ Action Items
- In Process
- Ongoing/Continuous
- Work Plan Item Not Yet Started

FY25-27 YTD and Current Period Audit Activity Summary

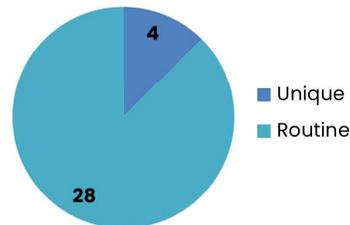
Initiated Audit Completion Status YTD



Initiated Audits YTD (Unique Vs. Routine)



Completed Audits (Current Period)



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Auditing and Monitoring: Summary of Unique Work Plan Items Completed During the Current Period	
<p>Authorization for Marketing/Patient Stories (HCD) Audit</p> <p>Audit of compliance with privacy rules for 45 CFR 164.501, 164.508(a)(3) – Marketing. This audit follows our departments previously issued guidance and staff training testing HCD's compliance with the privacy rules.</p>	<p>Review Complete, Report issued. Results: Unfavorable, Action items and recommendations made.</p> <p>Overall, the audit identified various areas for improvement, including enhanced staff training and education, revisions to existing processes for collecting required documentation, improved review and approval workflows for content, and strengthened controls for public postings on websites, social media, and other platforms. In response, Privacy requested action items to be completed within 30 days.</p>
<p>Privacy and Security Compliance Follow-up Walkthrough(s) for Atlantis Community Health Center (“CHC”)</p> <p>Follow-up on-site review(s) of HCD site to ensure compliance with the privacy and security rules, regulations, and internal policies to ensure proper safeguards are in place to protect privacy. Privacy/IT Security is currently pending the finalized HIPAA Risk Analysis and Compliance Assessment Report from external auditor RSM. Details are provided below.</p>	<p>Review(s) Complete, Report findings to be addressed through follow-up/external audit action plan. Results: Unfavorable, Action items and recommendations made.</p> <p>All observations and findings identified in the walkthrough are scheduled to be addressed internally through a post-audit action plan. While Atlantis CHC has implemented actions and recommendations from the prior internal audit, the follow-up review revealed opportunities for improvement, including physical safeguards and workflows resulting from unattended or sensitive PHI in shared or unsecured areas (fax/printing machines, desktop/workstations, and materials), and technical safeguards resulting from unattended and unsecured workstations.</p>
<p>Credentialing Risk Assessment (Lakeside Medical Center (“LMC”))</p> <p>Work Plan risk assessment to assess existing practices and controls for compliance with regulatory and accreditation requirements for credentialing and privileging at LMC.</p>	<p>Review Complete, Final report issued. Results: Favorable, recommendations made.</p> <p>While LMC complies with regulatory requirements, we identified opportunities to enhance LMC policies and procedures and documentation and accessibility of the medical staff bylaws. These enhancements will help ensure the consistent application of credentialing standards, improve documentation practices, and reinforce accountability across departments. We recommend the following:</p>

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	<ul style="list-style-type: none"> • Revise the Medical Staff bylaws to reflect a 3-year reappointment cycle; • Publish the Medical Staff bylaws on the hospital intranet to improve accessibility and add bylaws to MCN (HCD Policy Manual). Consider also posting on LMC’s public facing website; • Develop or update a formal hospital admitting policy and procedure; and • Develop a comprehensive hospital credentialing policy that aligns with the Medical Staff Bylaws.
<p>High Dollar / High Volume / High Reimbursement Services Data Risk Assessment and Analysis: Hospital Services (LMC)</p> <p>Annual review to determine future work plan items that may require review or pose external audit risk to the organization based on volume and activity.</p>	<p>Review Complete, Final report issued as Memorandum to File. Results Favorable, Recommendations made.</p> <p>Findings: Various outpatient services provided at LMC were identified as targeted areas of potential concerns for various government agencies. These included:</p> <ul style="list-style-type: none"> • 4 target areas of the Recovery Audit Contractor (RAC) including Therapeutic, Prophylactic, and Diagnostic Injections and Infusions – Medical Necessity and Documentation Requirements, Radiologic Examination of the Chest – Medical Necessity and Documentation Requirements, Magnetic Resonance Imaging (MRI) Procedures – Excessive Units, and Use of Modifier 59. • 2 target areas of the OIG’s Work Plan: Use of Modifier 25, and Use of Modifier 59. • Laboratory Services: Eleven (11) of the top 25 Laboratory Tests by Expenditure. • Actions taken/planned: Proactive measures were implemented by Compliance to monitor the RAC, OIG Monthly Work Plan, National and Local Coverage Determinations activities. Additionally, some of the services identified in the assessment are present in the CPE Work Plan. Compliance continues to monitor, update the work plan as needed.
<p>Auditing and Monitoring: Summary of Routine Work Plan Items Completed During the Current Period</p>	

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Note: These are continuous/ongoing, however, captured monthly for reporting purposes.

Security Risk Assessments: Status: Complete. Results: Favorable, actions required/completed.
Privacy/IT Security Reviews of HCD’s Third-Party Vendors conducted on an ongoing / continuous basis.

Epic User Access/Activity Monitoring through FairWarning System for Potential Privacy violations. Status: Complete. Results: Unfavorable, actions required (Complete). 13 weekly user-access reviews were completed for the period, with 4 resulting in disciplinary actions, including training, education, and attestation of HCD’s Confidentiality and Data Security Agreement. Status: Actions complete.

HCD Leadership/Board VIP EHR Monitoring through FairWarning system for potential Privacy violations. Status: Complete. Results: Favorable, no recommendations. 13 weekly user access audit reviews were completed for the period. No inappropriate/unauthorized user access findings identified.

Expanded Access/Activity Monitoring through FairWarning system for potential Privacy violations. Status: Complete. Results: Favorable, no recommendations. 13 weekly reviews were completed for the period, indicating 100% compliance. This also included: SlicerDicer, Clarity, Caboodle, etc.

21st Century Cures Act Information Blocking Rule Monitoring for potential rule violations. Status: Complete. Results: Favorable, no recommendations. 13 weekly reviews were completed for the period. No issues were found regarding information blocking or access to records.

Referral Source/Physician Payment Audits/Ongoing Reviews. Status: Complete. Results: Partially favorable, actions required (in process). All physician and referral source payments routed for approval are audited by Compliance, and any issues are corrected prior to payment. Note: Prior recommendations made which require follow-up for process improvements. Item added to FY25-27 Work Plan to audit payments made to independent contracted physicians. The reported physician group guarantee payment reconciliation issue has been resolved for the closed period. For the review period, the following issues were found and have been for past, in process of applying payments for future for invoices for expired contracts were processed, however, not paid due to pre-audit process.

Exclusion Screening Compliance Reviews. Status: Complete. Results: Favorable, recommendations made. Continuous reviews completed for the period. All potential matches were reviewed and resolved. 100% compliance with applicable rules/policy and no exclusions.

Credentialing Committee (CCP) Clearance/Monitoring for Exclusion, Background/Licensure. Status: Complete. Results: Favorable, Actions recommended (in process). 44 providers were reviewed for these months. 100% compliance with applicable rules and policy, with no exclusions. Case review details for background information were provided to the Committee before approving or renewing credentialing applications. CCP to provide files for exclusion screenings to avoid duplication.

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<p>Nursing Student Clearance Reviews. Status: Complete. Results: Favorable, Actions recommended for process improvement (in process). CPE reviewed 72 students from 3 higher education institutions to ensure compliance with privacy for the period.</p>
<p>OIG Work Plan Reviews: Completed monthly. Results: Favorable. Actions recommended. The OIG added 11 new items since the last report. The following two may apply to HCD: 1) Identifying 340B Units to Recoup Inflation Rebates for Part B Drugs in Medicare Advantage; 2) Using Targeted Reviews to Reduce Fraud, Waste, and Abuse in Medicaid Nonemergency Medical transportation. Compliance has notified applicable staff of items #1 and 2 via email.</p>

Note: The table above omits detailed background and rationale details for routine reporting of completed auditing and monitoring items as these were provided previously. These items are reported monthly for volume purposes; however, they may be completed more frequently.

<p>External RSM Annual HIPAA Risk Assessment (Status: Complete, pending final report):</p>
<p>HCD is pending receipt of the final audit report from this year’s external HIPAA risk analysis and compliance assessment, conducted by RSM. This annual required review conforms to the methodology found within the National Institute of Standards and Technology (NIST) Special Publication (SP) 800–30 Guide for Conducting Risk Assessments and the Office for Civil Rights (OCR’s) Guidance on Risk Analysis Requirements under the HIPAA Security Rule for potential risks and vulnerabilities to confidentiality, integrity, and availability of electronic protected health information.</p> <p>Other assessments for Privacy and Security are planned or in process, with our external auditor, RSM, including PCI External Pentest, PCI Internal Pentest, Purple Team Exercise & Assessment, Firewall & Network Architecture Review, Wireless Pentest, and PCI Gap Assessment.</p>

<p>Auditing and Monitoring Status: Complete, Pending Issuance of Final Report (during this reporting period)</p>
<p>Signage Review (LMC: hospital-wide). Status: Complete, Pending issuance final report. The audit of hospital-wide signage as part of the Work Plan has been completed, after the completion of the Emergency Department (ED) signage review for LMC. Action items are due following the report.</p>
<p>Telehealth Compliance Mini-Risk Assessment (HCD). Status: Complete, Pending issuance final report. The assessment of telehealth services provided at HCD locations and to gain a better understanding of telehealth provided and to evaluate the current telehealth framework is complete.</p>
<p>Medicare Outpatient Observation Notice (MOON) Follow-Up Audit: Status: Complete, Pending final</p>

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report. Follow-up audit to verify that the action items and recommendations identified in the prior audit (FY25) have been effectively implemented and resolved has been completed.

Auditing and Monitoring

Status: In process or in preparation (during this reporting period)

Blood Bank Risk Assessment (LMC). Status: In preparation. Risk assessment to review and understand processes surrounding HCD’s implementation of its new system for blood bank.

Monitoring Nursing Homes Engagement of Medical Directors Risk Assessment (Skilled Nursing Center (SNF)). Status: On Hold. Added due to a new OIG approved work plan audit. Audit focus is on employment and engagement of, and the accuracy of Payroll-Based Journal (PBJ) data, reported to CMS. Refer to prior report for additional information. This item is on hold due to transition of HCD’s SNF Administrator and will resume in early 2026.

Monitoring of Skilled Nursing Facility Financial Responsibilities for Medicare D Enrollee's Drugs in Part A Stays. Status: On Hold. Added because of the OIG approved work plan. This item is on hold due to transition of HCD’s SNF Administrator and will resume in early 2026.

Routine Auditing and Monitoring Items. Status: Ongoing/In Process.

- Exclusion Screening; Nursing Student Clearance; Credentialing Committee Clearance
- 21st Century Cures Act Information Blocking Rule Monitoring for Privacy Rule Compliance
- FairWarning User Access/Activity Monitoring for Potential Privacy/Rule Violations: Epic, VIPs, Expanded user access reviews
- Referral Source/Contracted Physician Payment Compliance Audits
- Privacy and Security Compliance Surveys for HCD Departments (HCD system-wide)
- OIG Work Plan
- Censinet Third Party Vendor Security Risk Assessments
- ROI (Release of Information) Audits

B. Department Activity and Statistics:

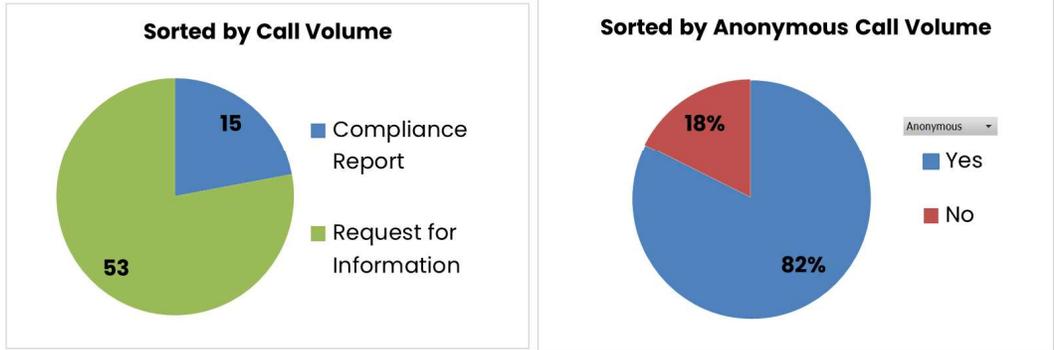
1. Non-Auditing and Monitoring Activity

Issuing Guidance and Enforcing Standards; Responding to Inquiries, Issues, and Investigations

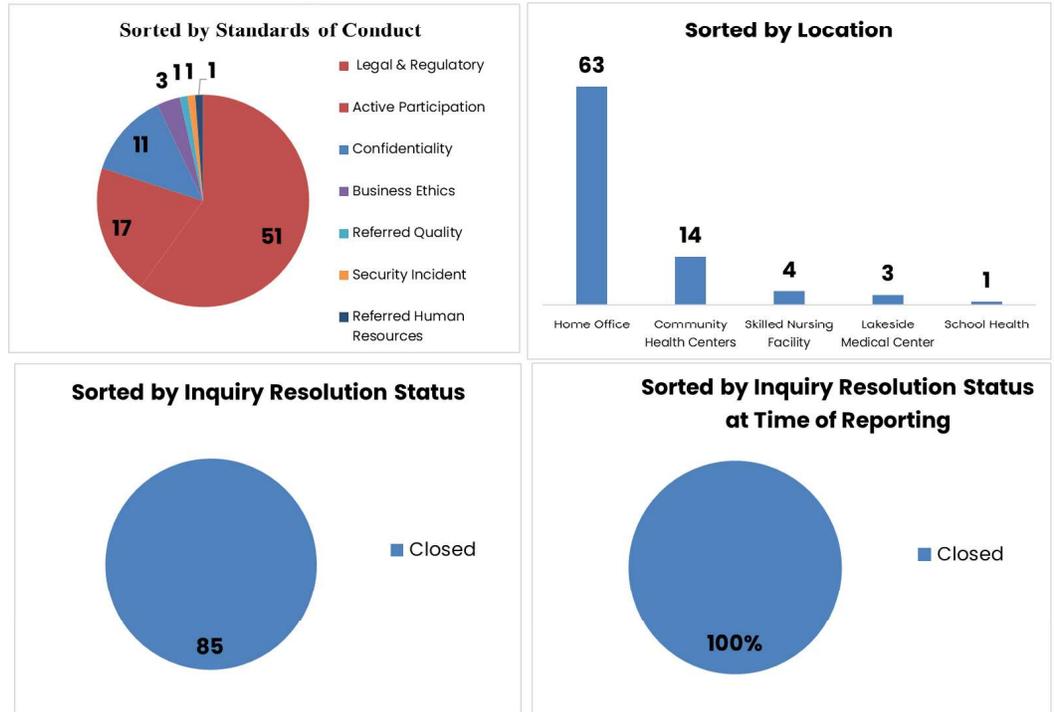
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Summary of HCD Compliance, Privacy, and Ethics Program Department Activity and Statistics

Hotline Activity Quarter + Current Period; YTD = 276



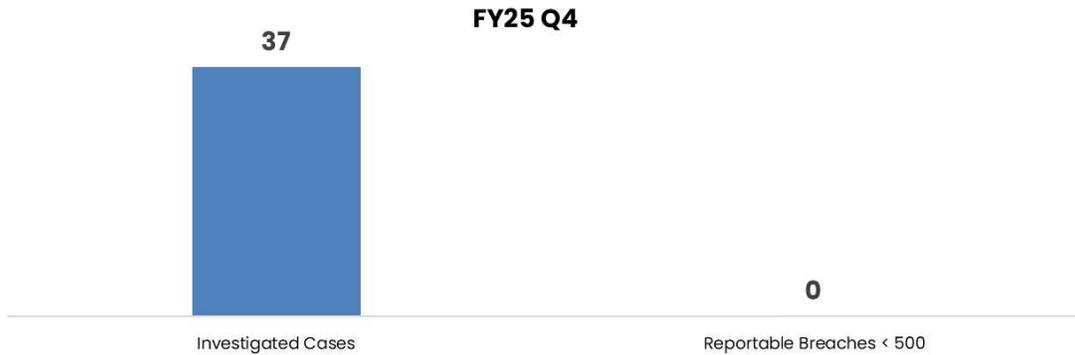
Inquiries Quarter + Current Period; YTD = 492



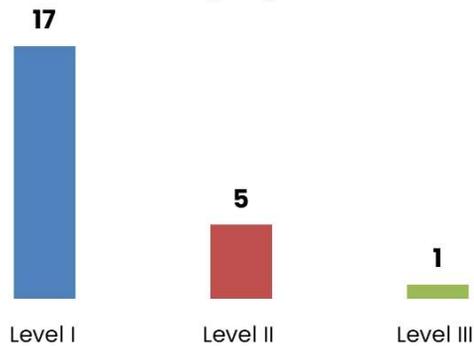
3. Privacy Department Investigations

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Privacy Incident Activities Quarter + Current Period; YTD = 161, 5 < 500 Breaches



Substantiated Violations by Severity (YTD)



The most common types of Substantiated Violations during FY25 YTD included:

- Improper Use or Disclosure of PHI (Written, Electronic, Verbal)
- Improper Disposal of PHI
- Access Violation (Viewed Record Without Authorization, Password)
- Minimum Necessary Violation

Internal/External Incidents, Complaints, & Investigations:

- **External: (Closed)** MHS OnBase Document Collision Breach Incident: On August 22, 2025, Memorial Healthcare System (MHS) experienced a significant and unplanned downtime event that disrupted multiple core systems, including EPIC’s MyChart, Care Everywhere, and the OnBase document repository. This incident occurred during a routine backup and recovery process and resulted in a collision of document identifiers created by restoration of the OnBase system. The collision led to the misclassification of numerous scanned documents that affected incorrect patient records in EPIC. A total of 4,330 documents were affected, impacting 2,200 patients

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across MHS and HCD populations. Of these, 322 patients were identified as part of the HCD population, with 224 being HCD-only and 98 shared between MHS and HCD. Notifications were sent to 38 HCD patients via certified mail, and EPIC records were corrected to remove erroneous document links. The incident was contained within the scope of the affected documents and did not result in the exposure of sensitive information such as social security numbers or financial data. Preventative measures are now underway to enhance system safeguards and avoid similar issues in future recovery scenarios (Pending: MHS HHS’ notification via OCR’s Breach Reporting Portal).

- **Internal (Closed):** Anonymous complaint made to HCD Board of Commissioners. Completed investigation, response issued. Note: As a matter of policy and due to the anonymous emailed nature of the complaint, no additional information is disclosed.

Training and Education; Compliance Awareness Survey and Activities

CPE delivers training to HCD employees through a blend of online and in-person events, formal sessions, and the distribution of publications and educational materials. The annual training cycle is scheduled for completion in November 2025.

To mark November, the month in which the national awareness week is held, we hosted **Compliance, Privacy, and Ethics Awareness Month**, featuring site visits and awareness activities across HCD to strengthen recognition and reinforce core compliance, privacy, and ethics principles. During this initiative, we also introduced a **new incentives program**.

Additionally, we launched the **Annual Compliance, Privacy, and Ethics Awareness Survey** to collect feedback, measure engagement, and further educate HCD staff.

C. Conflict of Interest (COI)

The Health Care District’s Conflict of Interest (“COI”) Annual Disclosure form along with our Policy and Procedure regarding COI was sent to all staff and contractors for completion by July 31, 2025. As per HCD’s Policy, it is mandatory for all employees to complete and return the initial and new annual COI Disclosure to help identify, document, and follow-up on any potential or known conflicts.

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Approximately 70% of HCD’s staff and contractors have completed the requirement as of the time of this report. The deadline has been extended and communicated to staff and leaders to complete by December 31, 2025, to continue working, following the policy revision approved at the September meeting.

D. Recent Regulatory Updates and Industry Enforcement Activity

HCD Compliance, Privacy, and Ethics (“CPE”) consistently reviews regulatory updates and industry enforcement activity to keep abreast of the changes and potential impacts to HCD, communicate information to necessary parties, and help shape CPE’s Work Plan. Information is searched, tracked, reviewed, analyzed, monitored, and posted to our regulatory dashboard. CPE determines the information necessary to communicate to HCD staff, physicians, and leadership, as well as if additional action (e.g., audit, policy, training) is necessary.

Recent health care regulatory updates and industry enforcement activity which may impact the Health Care District of Palm Beach County (“HCD”) are provided by title and accessible link below. An overall summary and supplemental details are provided quarterly to the Board and to HCD leadership *as informational* since the last meeting held (the propr report covered June – September 2025). Should you wish to review CPE’s review of these items in full, please notify Heather Bokor.

Recent trends include, but are not limited to: The government shutdown ending, issuance of 2026 final rules for hospitals and physicians, changes to telehealth waivers and a new extension through January 2026, enforcement actions for information blocking, an increased focus on cybersecurity—with several sectors facing ransomware attacks and malicious actors, EMTALA violations, numerous cases of Civil Monetary Penalties Law violations for employment of excluded or unlicensed individuals, and continued enforcement of the Stark Law and Anti-Kickback Statute.

Regulatory Updates

1. [CISA, FBI, DOD, & DHS Release Update on Akira Ransomware Advisory \(11/2025\)](#)
2. [CMS Issues FY2026 Hospital Outpatient Prospective Payment System Final Rule \(11/2025\)](#)
3. [New Spending Bill Extends Telehealth Flexibilities Through January 2026 \(11/2025\)](#)
4. [CMS Updates CY2026 Telehealth FAQ \(11/2025\)](#)
5. [DEA Posts Upcoming Rule on Extension of Telehealth Flexibilities for Controlled Substances \(11/2025\)](#)
6. [CMS Announces it Will Lower Prices on 15 Drugs for Seniors \(11/2025\)](#)
7. [CMS Issues FY2026 Medicare Physician Fee Schedule Final Rule \(10/2025\)](#)

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8. [CDC Approves Changes to COVID-19 Vaccine Recommendations and MMR \(10/2025\)](#)
9. [United States Government Fails to Pass Funding Resolution, Leads to Shutdown \(10/2025\)](#)
10. [Telehealth Waivers Expire October 1, 2025 \(10/2025\)](#)
11. [Department of Justice Creates New Civil Division Enforcement and Affirmative Litigation Branch \(10/2025\)](#)
12. [The Joint Commission Issues First Guidance on Responsible Use of Artificial Intelligence \(10/2025\)](#)
13. [AHCA Proposes New Rule to Improve Healthcare Data Breach Transparency and Preparedness for Security related Incidents \(09/2025\)](#)
14. [OCR, ASTP release updated version of Security Risk Assessment Tool \(09/2025\)](#)
15. [Florida Hospitals Challenge Organ Transplant Program Changes in Florida \(09/2025\)](#)
16. [FTC Files to Dismiss Non-Compete Clause Rule \(09/2025\)](#)

Industry Enforcement Activity

1. [South Carolina Hospital to Pay \\$100,000 to Resolve EMTALA Allegations \(11/2025\)](#)
2. [Vohra Wound Physicians to Pay \\$45 Million to Resolve False Claims Act Allegations \(11/2025\)](#)
3. [CVS Pharmacy to Pay \\$18.2 Million to Resolve False Claims Act Allegations \(11/2025\)](#)
4. [Medical Device Company to Pay \\$38.5 Million Following False Claims Allegations \(11/2025\)](#)
5. [Urgent Care Clinic Pays Over \\$2.8 Million to Resolve Fraud Allegations \(11/2025\)](#)
6. [Lab Company Pays Over \\$9 Million to Resolve Kickback Allegations \(11/2025\)](#)
7. [Swedish Health Services Self-Discloses Research Errors \(10/2025\)](#)
8. [Lee Health Agrees to Pay \\$18.8 Million for Employing Excluded Individual and Other Misconduct \(10/2025\)](#)
9. [HHS' OCR Settles HIPAA Investigation of Cadia Healthcare for PHI Disclosure \(09/2025\)](#)
10. [Chicago System Agrees to Settlement After Employing Excluded Individual \(09/2025\)](#)
11. [Texas Hospital Self-Discloses Upcoding Issues \(09/2025\)](#)
12. [Pharmacy Agrees to be Excluded After Paying Inducements \(09/2025\)](#)
13. [Chiropractor and Medical Center Agree to Resolve Claims Related to Unnecessary Services \(09/2025\)](#)
14. [Ideal Health and Related Party Reach Settlement to Resolve Improper Remuneration Allegations \(09/2025\)](#)
15. [Baptist Hospital Agrees to Pay \\$200,000 to Resolve EMTALA Allegations \(09/2025\)](#)
16. [Bristol Regional Medical Center Agrees to Pay \\$150,000 to Resolve EMTALA Violation \(09/2025\)](#)

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- 17. [Swedish American Hospital Agrees to Resolve EMTALA Allegation \(09/2025\)](#)
- 18. [Semler Scientific, Bard Peripheral Vascular Inc. to Pay Approximately \\$37 Million to Resolve False Claims Act Allegations \(09/2025\)](#)
- 19. [Fraud Charges Made Against 12 More Individuals Involved in Operation Nightingale \(09/2025\)](#)

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Net Operating Impact	N/A	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Jessica Cafarelli
VP & Chief Financial Officer

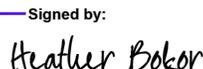
5. Recommendation:

Staff recommends the Committee Receive and File the CPE Program Quarterly Report.

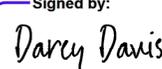
Approved for Legal sufficiency:



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 Bernabe Icaza
 SVP & General Counsel

Signed by:


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 Heather Bokor
 VP & Chief Compliance & Privacy Officer

Signed by:


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 Darcy J. Davis
 President & Chief Executive Officer

**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
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1. Description: Quality & Patient Safety Dashboards

2. Summary:

This agenda item provides the quality and patient safety reports for the 3rd Quarter of 2025 for School Health, Aeromedical, Community Health Centers, Skilled Nursing Center, Lakeside Medical Center, Ground Transportation, Pharmacy, and Corporate Quality Metrics.

3. Substantive Analysis:

School Health

Florida-Mandated Student Screenings

- During quarter 3, a new school year started on August 11th 2025. There were no screening goals for the quarter.
 - BMI screening: Through the 3rd quarter of 2025, we screened 6,427 (20.2%) of eligible students in the 1st, 3rd, and 6th grades. Out of 6,427 students, 1,849 (29%) students required referral.
 - Hearing screening: Through the 3rd quarter of 2025, we screened 6,032 (19.2%) of eligible students in kindergarten, 1st, and 6th grades. Out of 6,032 students, 35 (0.6%) students required referral.
 - Vision screening: Through the 3rd quarter of 2025, we screened 8,588 (19.5%) of eligible students in kindergarten, 1st, 3rd, and 6th grades. Out of 8,588 students, 1,710 (20%) students required referral.
 - Scoliosis screening: Through the 3rd quarter of 2025, we screened 2,229 (21.9%) of eligible students in 6th grade. Out of 2,229 students, 24 (1.1%) students required referral.
 -

Aeromedical

Trauma Hawk completed a total of 105 flights, transporting 107 patients. Of the 107 patients transported, 83 were transported from the scene, and 24 patients were flown interfacility, with 2 dual patient flights. This was 8 fewer transports (7%) than the previous quarter and 11 fewer transports (9%) compared to Q3 of 2024. For scene flights, Trauma Hawk averaged 5 min 46 sec response time from dispatch to airborne and an average of 18 min 30 sec from dispatch to arrival on scene for the quarter. For interfacility flights, the average dispatch to en route for the quarter was 22 min 29 sec, and the average dispatch to the hospital was 33 min.

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77% were scene calls, and 23% were Interfacility transports.

The top dispatch reason for interfacility flights was Stroke-related, with the top origin location being Lakeside Medical Center and the top destination being St. Mary's Medical Center. The top dispatch reason for scene flights was trauma-related, with the top destination being St. Mary's Hospital. During the quarter, 78 requests were cancelled by the referring agency—68% of these occurred before the aircraft was airborne, primarily due to being in standby status. Additionally, 22 requests were turned down, with weather conditions being the primary reason, accounting for 13%.

Community Health Centers

The following measures were not meeting goal at the end of Quarter 3 2025: Hypertension (74%), goal is 80%, Ischemic Vascular Disease/Antiplatelet Therapy (69%), goal is 86%, Adult Weight Screening and Follow Up (85%), goal is 90%, Childhood immunization (56%), goal is 60%, Weight Screening and Counseling for children and adolescents (85%), goal is 90%, Breast Cancer Screening (58%), goal is 60%, Colorectal Cancer Screening (42%) with goal of 82%.

All other goals were achieved for the quarter.

Skilled Nursing Center

For Q3 2025, the following quality measures did not meet goal:

- % of Residents who have/had a catheter inserted and left in their bladder (long stay) was 2.7% which was above the national benchmark of 1.3%.
- Discharge Function Score was 28.6% which was below the national benchmark of 54.1%.

All other CMS quality measures met goal for the quarter and were within the national benchmark.

Lakeside Medical Center

During Q3 of 2025, Lakeside Medical Center continued to monitor performance across the CMS Inpatient and Outpatient Quality Measures. The majority of measures met target; however, two Emergency Department (ED) throughput measures fell short of goal and continue to represent an opportunity for improvement.

Inpatient Quality Measures

Of the four inpatient measures evaluated, two did not meet performance targets—ED-1a (ED arrival to admission) and VTE-1 (VTE prophylaxis).

- **ED-1a:** A total of 81 cases were included in the Q3 sample. The median ED-to-

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admission time was 320 minutes, exceeding the goal of <313 minutes.

- **VTE-1:** A total of 76 cases fell into the sample population for Q3, with 83% compliance, which did not meet our internal goal of > 90% for the quarter (variance attributed to mapping and technical alignment)
- **IMM-2:** Immunization data was not collected this quarter due to seasonal CMS requirements.

- **SEP-1:** The measure exceeded the established SEP-1 compliance goal with a compliance of 89% for the quarter.

Outpatient Quality Measures

Of the two outpatient measures evaluated, one did not meet the goal OP-18a (ED arrival to discharged home/transferred).

- **OP-18** A total of 45 cases were sampled. The median time was 141 minutes, above the target of <134 minutes.
- **OP-23:** The measure met goal for the quarter.

Ground Transportation

Response Time (PBC Ordinance)

Ground Transportation completed 412 transports for Q3 2025. Of the 412, 17 were considered Alerts and 310 were Emergent as defined by PBC COPCN criteria. For Alerts transports, the crews are expected to respond to the patient within 10 minutes of being dispatched in accordance with the PBC County COPCN criteria. The 17 transports were responded to with an average response time of 3 min 18 sec, meeting a 100% compliance with the COPCN requirements. 310 transports were Emergent in nature, where the crews are expected to respond to the patient within 30 min of being dispatched. The average response time for the 310 transports were 9 min 36 sec with 94.2% meeting the goal, fulfilling the 90% target set by the County.

Pharmacy

For the 3rd Quarter of 2025, Pharmacy has met all goals. We serviced a total of 6,589 unique patients, dispensed a total of 34,527 prescriptions, with each patient averaging and receiving approximately 6 prescriptions per quarter. The out-of-stock percentage for the quarter was 4.1% which exceeded the goal of <5%. The return to stock percentage was 7% exceeding our goal of <9%. The promised time goal was met for over 91% of orders, which exceeded our goal of >90%. The average

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE

DECEMBER 10 2025

prescription wait-time was approximately 30 minutes, in line with our goal of less than 30 minutes, and 25% of our total prescriptions were filled while patients waited.

****Note:** On September 8th, 2025, our HCD pharmacies successfully implemented the sliding fee scale for each prescription. Patients, providers, and HCD staff worked diligently and collaboratively to accomplish this initiative with minimum disruption of services.

Corporate Quality Metrics

Information Technology

In Q3, our IT department opened a total of 6,521 new support tickets and successfully closed 6,393 tickets, including those carried over from the previous month (50.63% increase from the previous quarter). On average, we received 72 new tickets each day. Additionally, the IT Service Desk handled 4,003 calls. The average wait time for these calls was 31 seconds, and the rate of calls abandoned was 5.0%, which is above our target rate of 4.5%.

Human Resources

Turnover and Recruitment:

- Through Q3 2025, the average turnover was 19.5% which is below the industry standard of 26%.
- Through Q3 2025, the top 3 highest turnover rates by division were Community Health Centers, followed by School Health, and Business Support.
- Through Q3 2025, the highest turnover rate (11%) was among employees under one year of service.
- Recruitment: At the end of Q3 2025, there were 33 open requisitions.
 - 35.3 days = Average time to fill, which is within the 63-day industry standard.
 - 16.7 days = Average time to start, which is within the industry standard of 27 days.

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE DECEMBER 10 2025

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Net Operating Impact	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

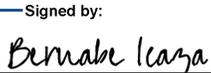
N/A

Jessica Cafarelli
VP & Chief Financial Officer

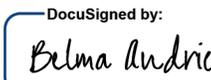
5. Recommendation:

Staff recommends the Committee Receive and File the Quality & Patient Safety Dashboards

Approved for Legal sufficiency:

Signed by:


Bernabe Ceza
SVP & General Counsel

DocuSigned by:


Belma Andric, MD
EVP & Chief Medical Officer

Signed by:


Darcy J. Davis
President & Chief Executive Officer

DocuSign Envelope ID: C2326EF6-E1BE-4D2C-B7AF-7D61A0C61D79



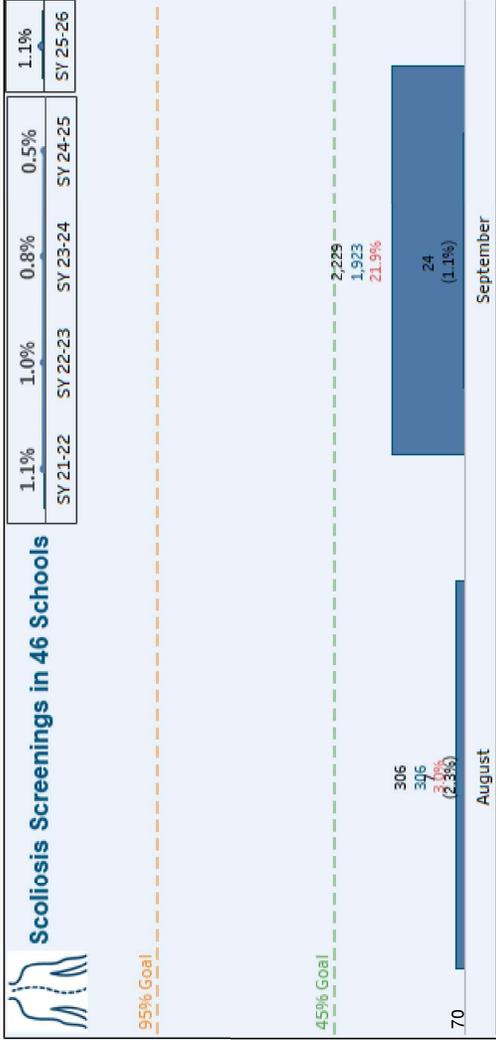
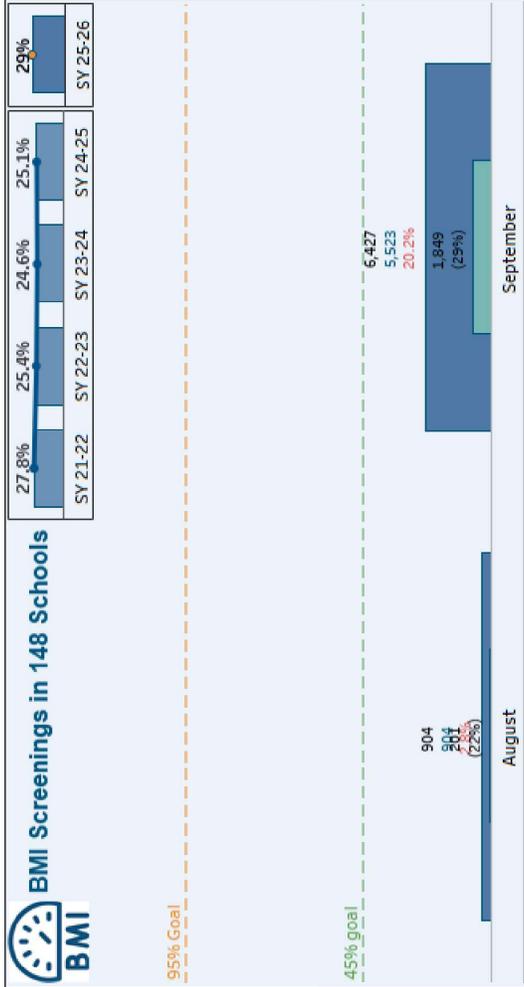
Florida Mandated Student Screening Summary

Goal 45% of Students to Have Completed Vision and Hearing Screenings by December 2025
 Goal 45% of Students to Have Completed BMI and Scoliosis Screenings by March 2026

- #Abnormal
- #Normal

Color Legend:

- # Total Distinct Students
- # Distinct Students Screened this month
- Percent of Goal Reached



AEROMEDICAL DATA Q3 2025



Flights 105

IFT 24 (23%)

Scene 81 (77%)

Monthly Volume

Month	IFT	Scene
Jul	9	29
Aug	9	31
Sep	9	27

RunTime Dispatches

Avg. Dispatch To Arrival At Scene: 35m 33s (Jul), 38m 18s (Aug), 39m 18s (Sep)

Avg. Dispatched To Enroute: 18m 41s (Jul), 19m 29s (Aug), 17m 22s (Sep)

Scene: Dispatch to Enroute & Scene: 4m 57s (Jul), 6m 17s (Aug), 6m 5s (Sep)

Dispatch Type

Stroke	5 (21%)
Cardiac-Non ST..	4 (17%)
Trauma- Penetr..	3 (13%)
Trauma- Burn	3 (13%)
Trauma-Blunt	2 (8%)
Pediatric	2 (8%)
Neurology	2 (8%)
Cardiac-STEMI	2 (8%)
Organ/Transplant	1 (4%)

Origin

Lakeside Medical C..	13
Palms West Hospital	3
Hendry Medical Ce..	3
St Mary's Hospital	2
Jupiter Medical Ce..	1
JFK Medical Center	1
Delray Medical Cen..	1

Destination

St Mary's Hospital	8
JFK Medical Center	6
Palms West Hospital	4
Jackson Memorial	4
Ryder Miami Joe Dimaggio Memorial Regional	1
70FL	1

Interfacility Dispatches

Interfacility: Dispatch to Enroute & Scene: 20m 53s (Jul), 20m 30s (Aug), 20m 30s (Sep)

Dispatch Type

Trauma-Blunt	40 (49%)
Trauma- Penetrating	16 (20%)
Stroke	13 (16%)
Neurology	5 (6%)
Cardiac-STEMI	3 (4%)
Trauma- Burn	2 (2%)
Cardiac-Non STEMI	2 (2%)

Destination from Scene

St Mary's Hospital	70
Delray Medical Center	6
Palm Beach Gardens Medical Center	3
JFK Medical Center	1
Broward Health Medical Center	1

Cancelled/Turned Down Flights

Reasons For Cancelled/Turned Down

By Referring Agency	68 (68%)
Weather	13 (13%)
Patient Expired	6 (6%)
Maintenance	3 (3%)
Out of County	2 (2%)
2nd AC not Scheduled	2 (2%)
Medical No-Go	2 (2%)
Other	2 (2%)
Duty Time	1 (1%)

Flights by Patient Type

TRAUMA	33%
CARDIAC	25%
NEUROLOGY	29%
OTHER	8%

Monthly Volume

Month	Turned Down (By HCD)	Cancelled (By referring)
Jul	8 (12%)	9 (15%)
Aug	5 (7%)	27 (44%)
Sep	5 (7%)	27 (44%)

Utilization % by Hour

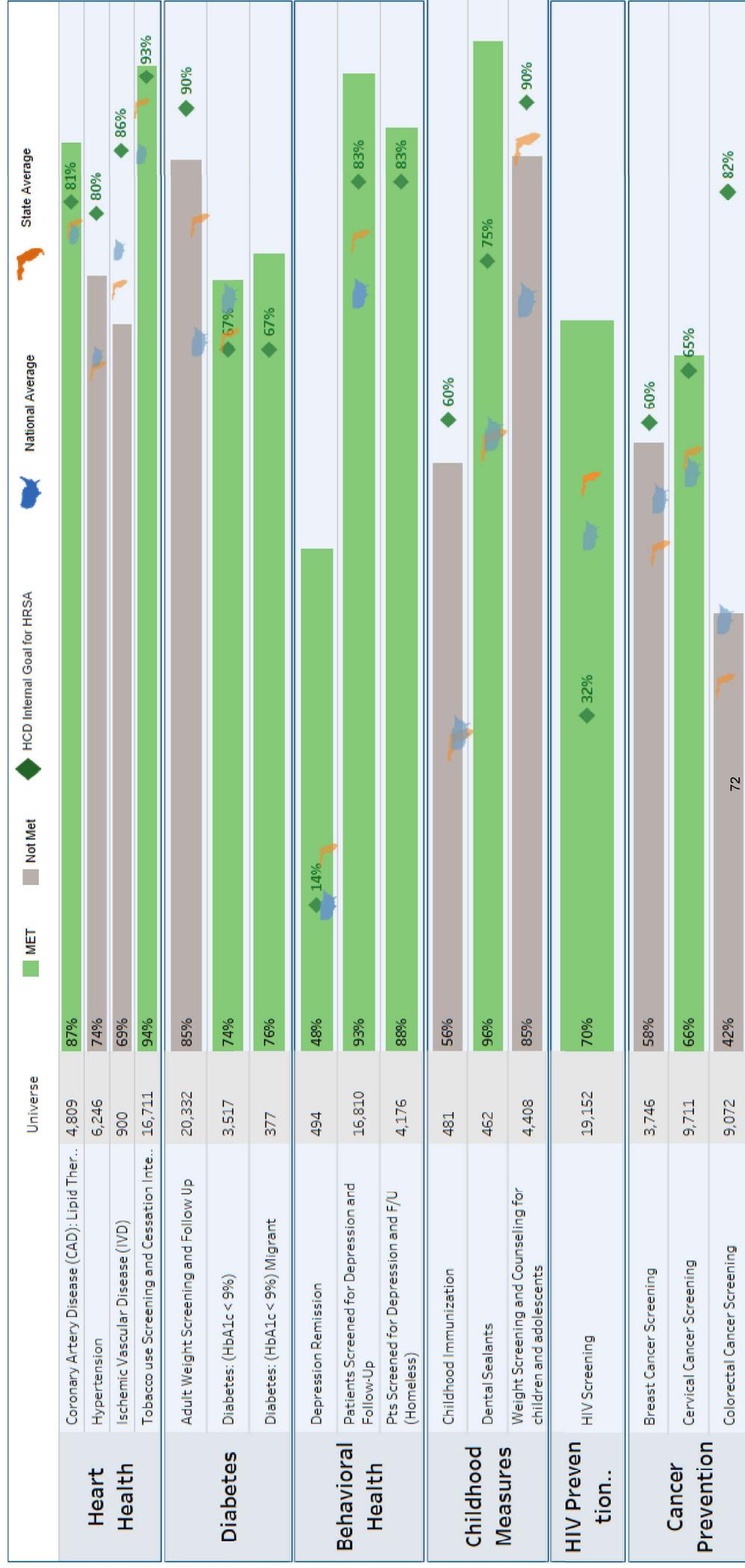
Hour	2025 Q3
00:00	1.0% [1]
01:00	2.9% [3]
02:00	3.8% [4]
03:00	2.9% [3]
04:00	1.9% [2]
05:00	2.9% [3]
06:00	1.0% [1]
07:00	5.7% [6]
08:00	2.9% [3]
09:00	1.9% [2]
10:00	5.7% [6]
11:00	7.6% [8]
12:00	9.5% [10]
13:00	5.7% [6]
14:00	3.8% [4]
15:00	6.7% [7]
16:00	2.9% [3]
17:00	8.6% [9]
18:00	2.9% [3]
19:00	7.6% [8]
20:00	4.8% [5]
21:00	2.9% [3]
22:00	1.0% [1]
23:00	3.8% [4]
Total	100% [105]

UDS PROVIDER LEVEL QUALITY MEASURES 2025

NATIONAL QUALITY LEADER METRICS

Load Date
10/6/2025

Filters



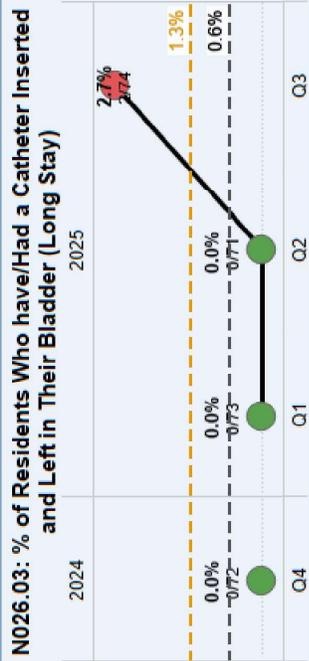
Quality Measures

Q3 2025

Comparisons Groups: State National

Meeting Goal? Yes No

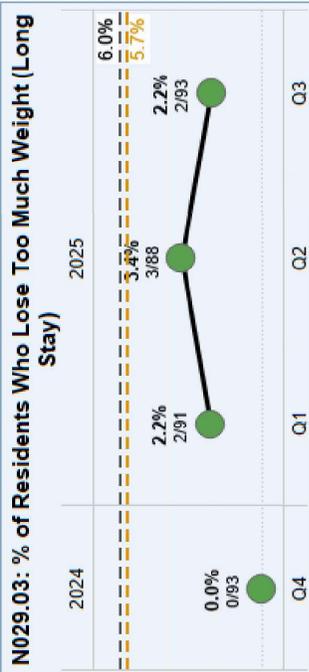
Infection Control



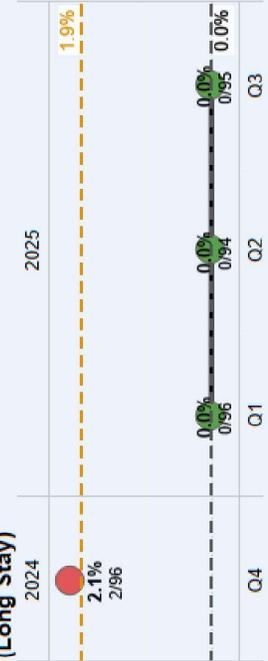
Functional Status



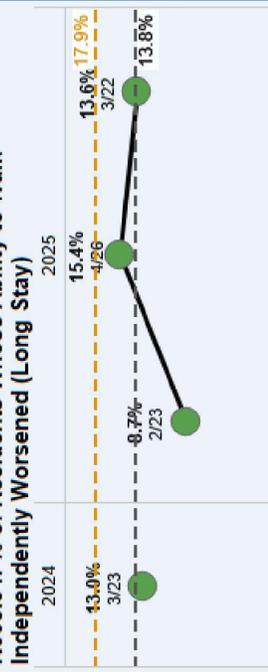
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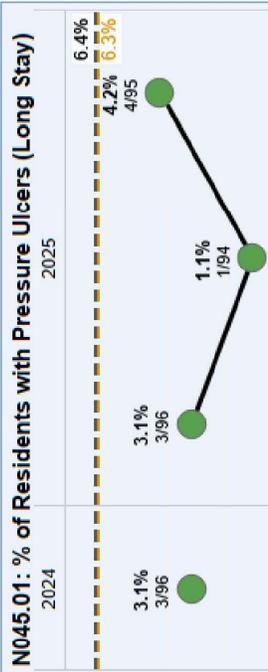
Functional Status



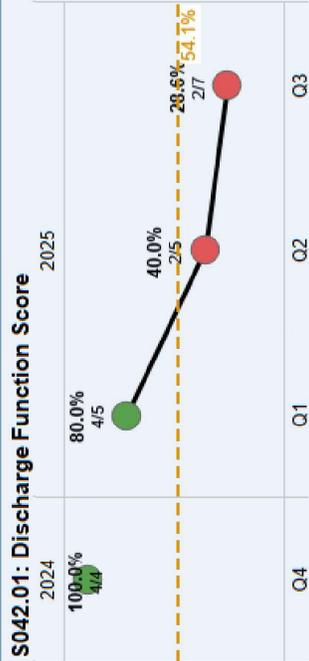
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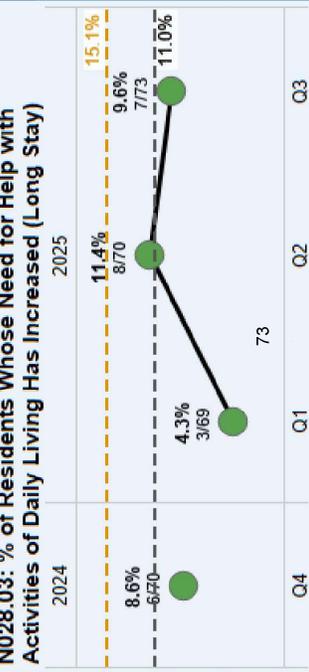
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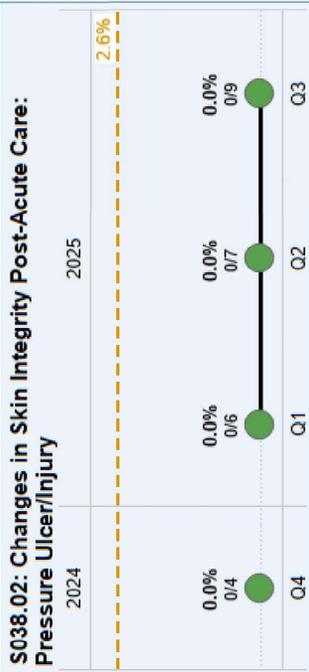
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Functional Status



Functional Status



Quality Measures

Q3 2025

Comparisons Groups:

State

National

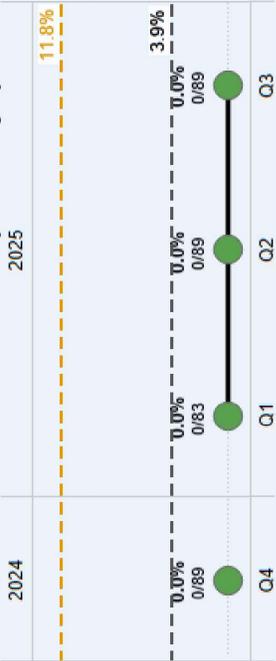
Meeting Goal?

Yes

No

Behavioral Health

N030.03: % of Residents Who Have Depressive Symptoms

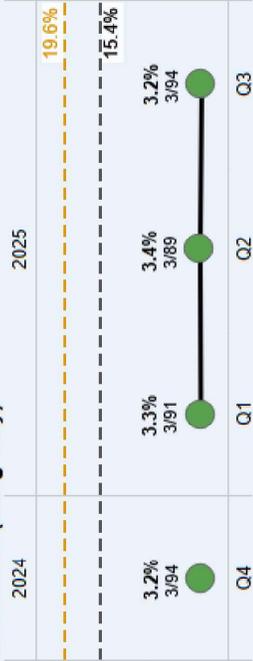


N034.02: Prevalence of Behavior Symptoms Affecting Others (Long Stay)



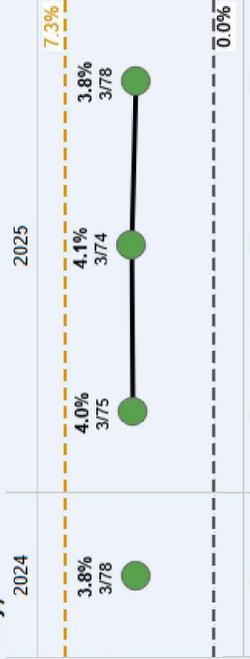
Medications

N036.03: % of Residents Who Used Antianxiety or Hypnotic Medication (Long Stay)

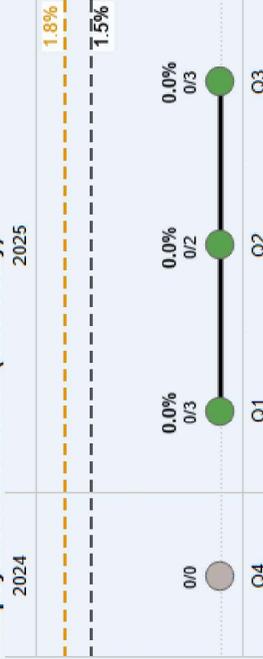


Medications

N033.03: Prevalence of Antianxiety/Hypnotic Use (Long Stay)



N011.03: % of Residents Who Newly Received an Antipsychotic Medication (Short Stay)

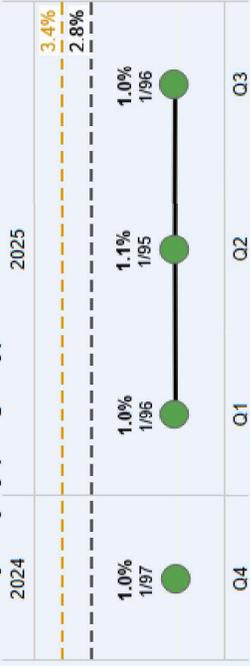


N031.04: % of Residents Who Received an Antipsychotic Medication (Long Stay)

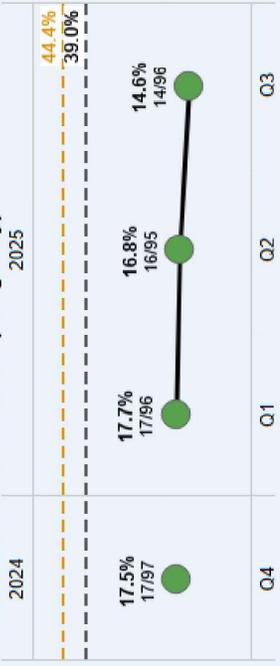


Falls

N013.02: % of Residents Experiencing One or More Falls with Major Injury (Long Stay)

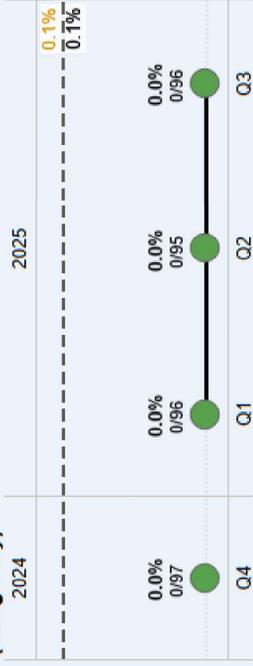


N032.02: Prevalence of Falls (Long Stay)



Restraints

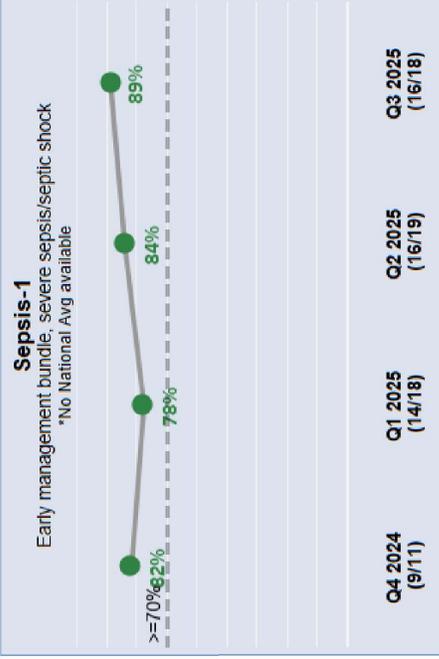
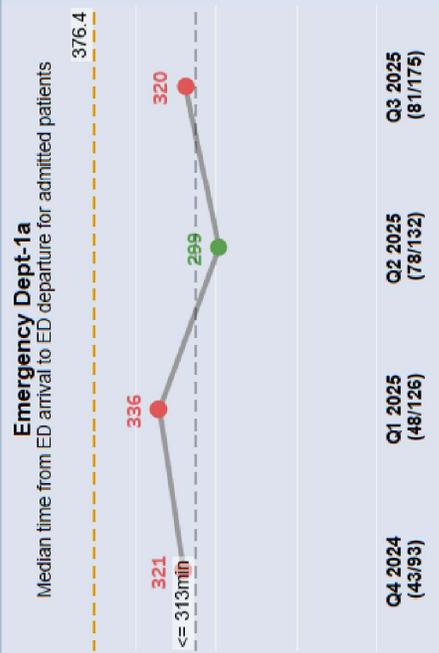
N027.02: % of Residents Who Were Physically Restrained (Long Stay)



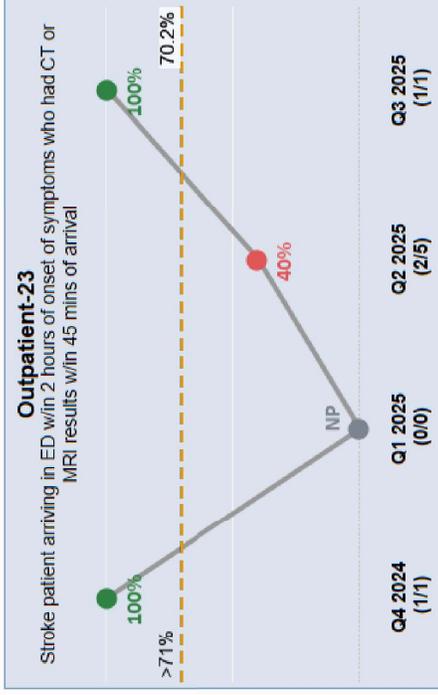
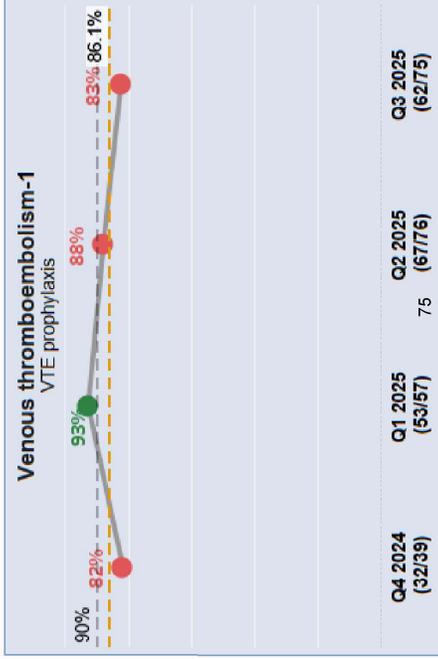
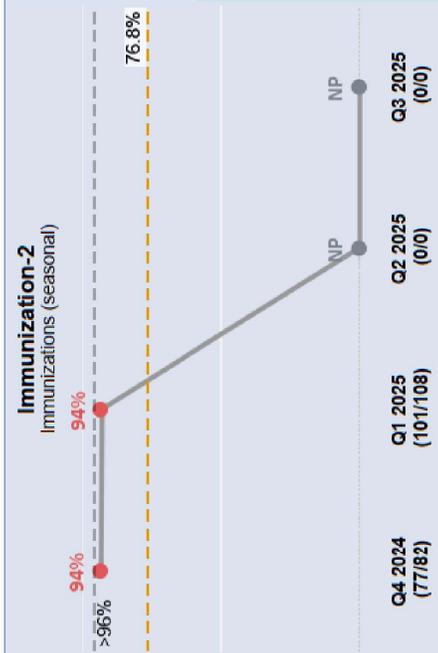
LMC Quality Core Measures Q3 2025

Inpatient Measures

Meeting Goal? ■ Yes ■ No ■ No Population ■ LMC Internal Goal Line ■ National Avg Line ■



Outpatient Measures



Ground Transportation Response Times

7/1/2025 to 9/30/2025

Alerts

Definition (6.1 Priority 1): Interfacility Transports to higher level of care - Stroke, trauma, etc

Completed Transport Requests

✓ 17

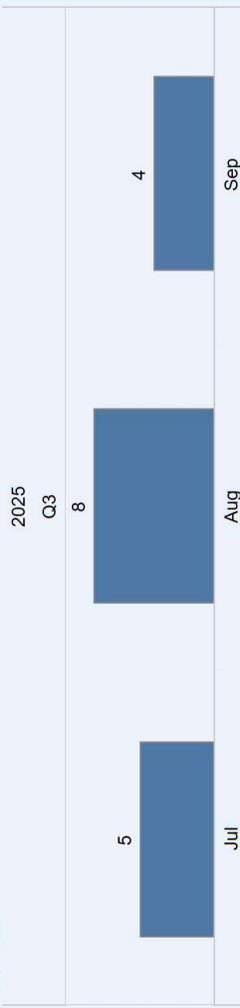
Avg Response Time

🕒 3.3min

Percent Meeting Goal

🎯 94.1%

Volume



Mean Response Time



Emergency Transports

Definition (6.2): Requests for transports of urgent nature, but are not an emergency medical classification and not prescheduled.

Completed Transport Requests

✓ 310

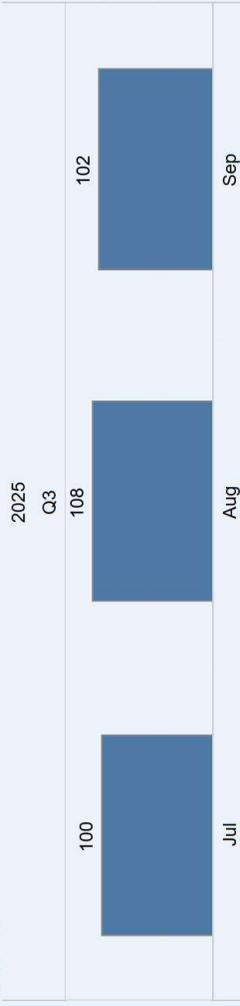
Avg Response Time

🕒 9.6min

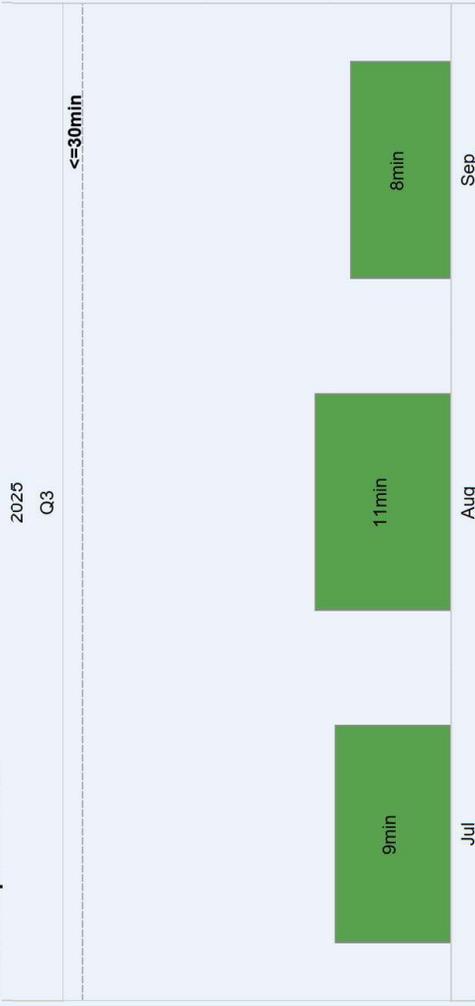
Percent Meeting Goal

🎯 94.2%

Volume



Mean Response Time



PHARMACY QUALITY DATA 7/1/2025 - 9/30/2025



Unique Pts
6,589

New Patients
1,282 (19%)

Rx Sold
34,527

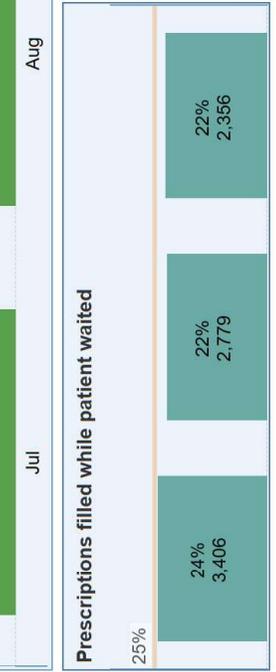
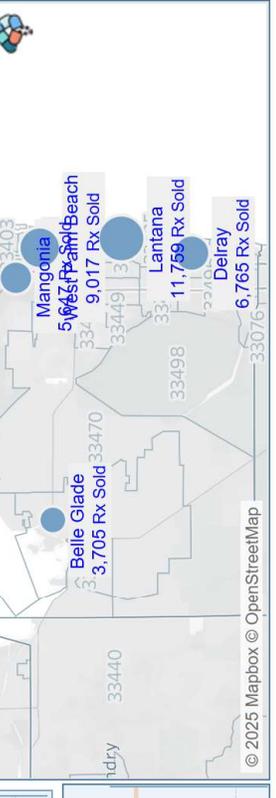
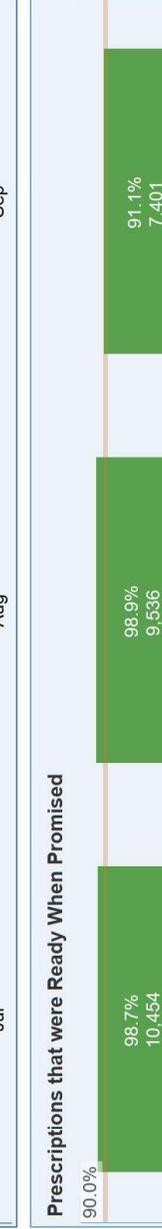
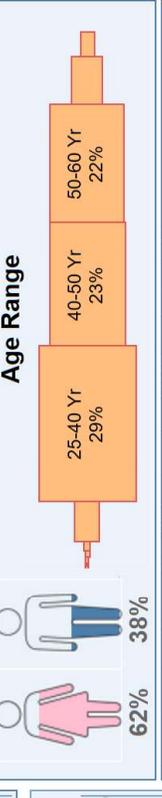
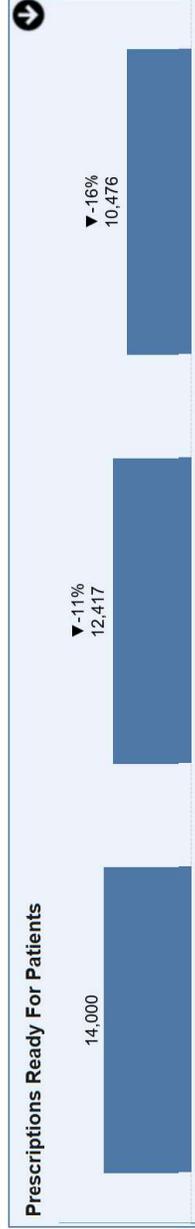
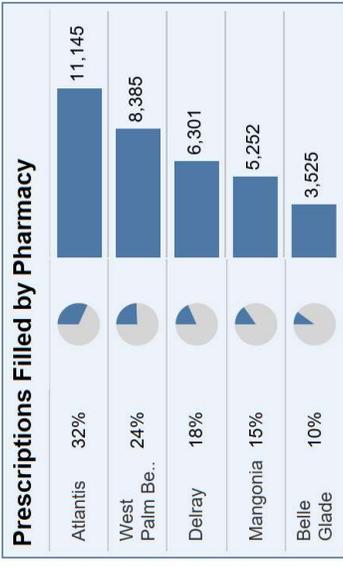
Rx Return to Stock
2,576 (7.0%)

Out Of Stock
1,500 4.1%

Pharmacy Visits
17,985

Avg Rx per patient
6

Rx Shipped to patient
3,684 (10%)
1,647 Pkgs

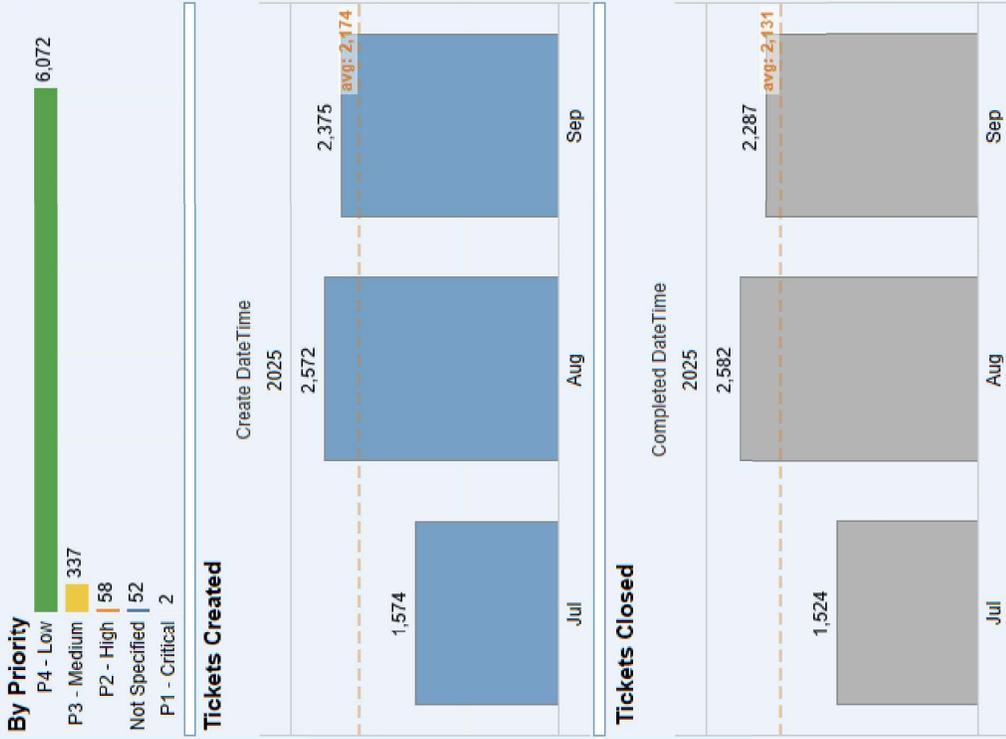
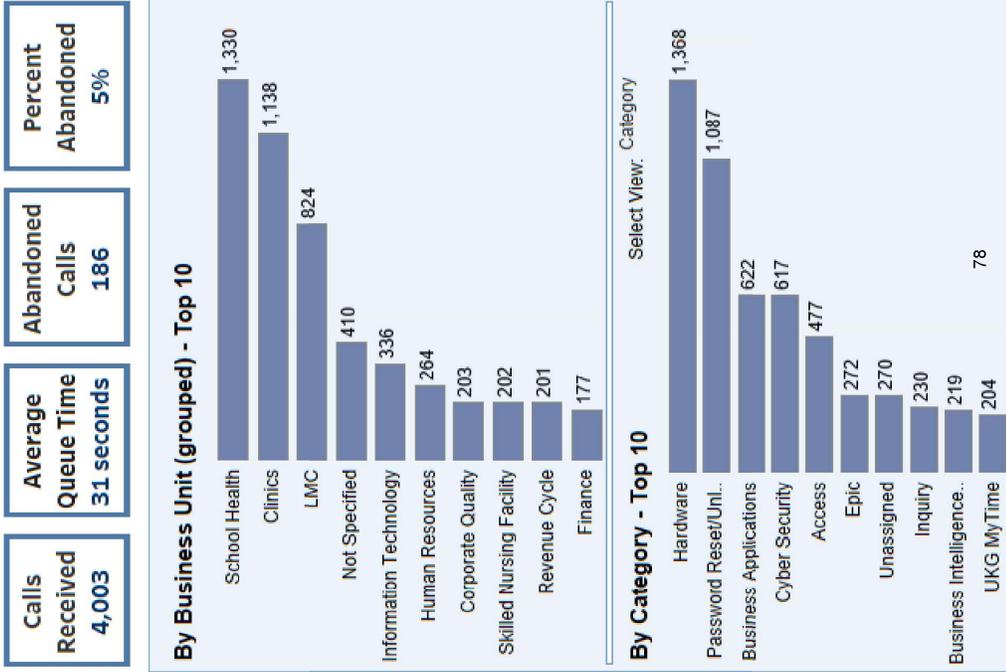


Summary View - Tickets Created/Closed

from 7/1/2025 to 9/30/2025 - All Service Lines

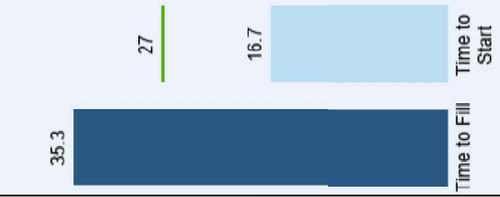
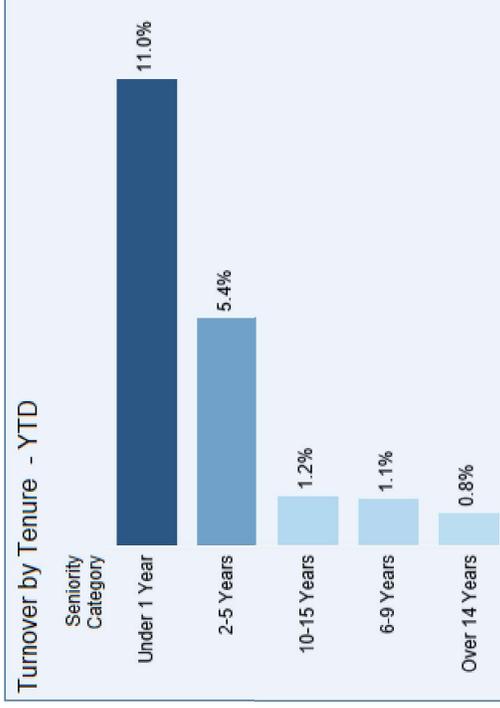
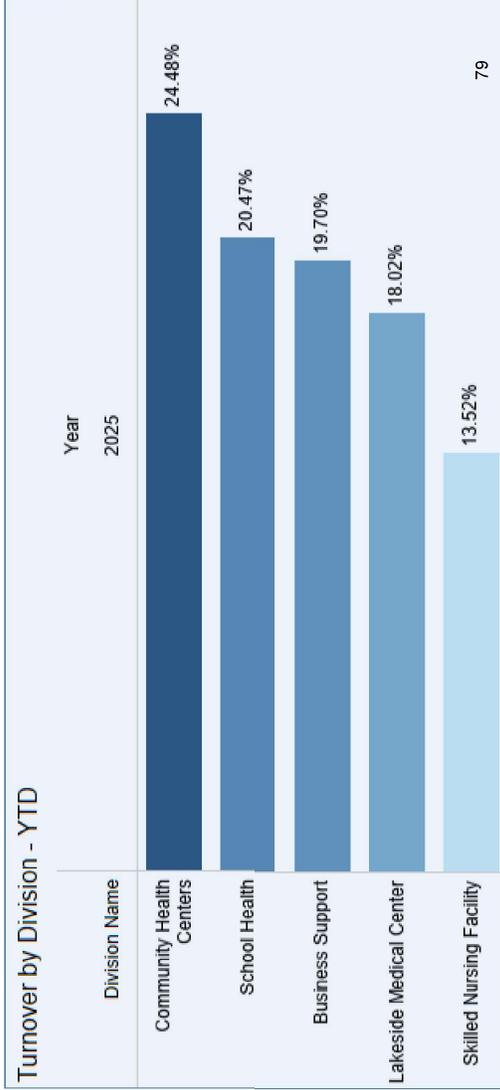
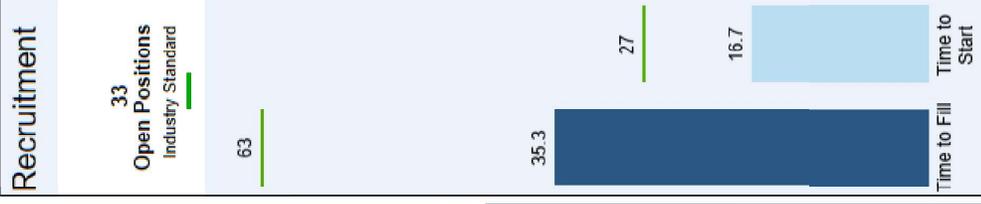
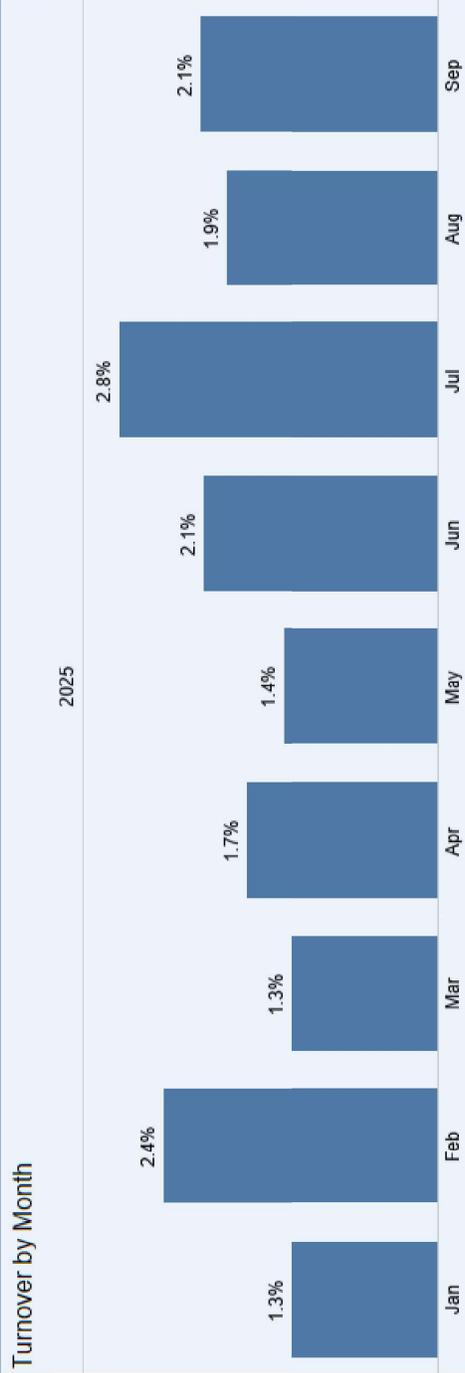
Last Updated: 12/4/2025 3:00:00 AM

Tickets Created		Tickets Closed						
6,521		6,393						
By Day of Week and Hour								
Created Hour	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
0	5	1	5	6	1	3	2	
1			6	5	3	3	1	
2	4		2	1	6			
3	4	2	5		2	2	2	
4	2		3	4	3	2		
5		3	3	2	5			
6	5	7	7	8	5	8	4	
7	6	65	100	82	50	36	3	
8	13	163	215	164	154	117	7	
9	4	158	179	184	132	133	5	
10	8	146	148	155	121	108	3	
11	8	162	128	149	132	100	12	
12	3	125	105	89	151	97	5	
13	2	196	105	81	137	111	4	
14	2	151	102	110	120	117	19	
15	4	118	116	82	80	58	9	
16	10	66	70	69	70	48	2	
17	3	22	27	23	33	30	3	
18		8	10	14	22	10	3	
19	4	10	6	11	14	6	2	
20	7	8	5	8	14	7	14	
21	3	8	5	4	4	10	6	
22		5	3	1	6	2	4	
23	2	2	5		3		7	



Turnover and Recruitment

3rd Quarter 2025



**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
DECEMBER 10, 2025**

1. Description: HCD Enterprise Risk Management Quarterly Report and Dashboard (Q3 2025).

2. Summary:

A summary report of the Enterprise Risk Management (“ERM”, “Risk”, or “Risk Management”) dashboard covering the top five trending events. This report covers the Third Quarter of 2025 (“Q3 2025”) for the following Health Care District of Palm Beach County (“HCD”, “HCDPBC”, or “District”) business units: Lakeside Medical Center (“LMC”), Edward J. Healey Nursing and Rehabilitation Center (“Healey”, “Skilled Nursing Center”, or “SNF”), Community Health Centers (“CHC” or “Clinics”, formerly known as C.L. Brumback Primary Care Clinics), Pharmacy, School Health, Aeromedical/TraumaHawk (“Aeromedical”), Ground Transportation Services (“Ambulance” or “GTS”), District Administration/Home Office, and Managed Care.

3. Substantive Analysis:

In Q3 2025, HCD had a total of 619 reports entered in its Safety Event Reporting System (“SERS” or “RiskQual/HAS”). The dashboard represents the Top five (5) trending event categories reported along with the risk severity levels and near misses for each HCD Business Unit. A detailed summary is provided below.

Risk Severity Volumes/Types:

Of the 619 entries reported in RiskQual/HAS, 595 were events/occurrences and 24 were near misses.

- 3.9% (24) of the events reported were “Near-Misses” or “Near Miss Events”. A *Near Miss is an event that was prevented from actually occurring and did not result in any harm to an individual.*
- 78.0% (483) of the events reported were “No Harm Events”. A *No Harm Event is an event that occurred but resulted in no harm to an individual.*
- 17.8% (110) were “Minor Events”. A *Minor Event is an event that occurred, but had no harm to the patient, however, required monitoring.*
- 0.3% (2) were “Moderate Events”. A *Moderate Event is an event that occurred, temporary harm, no required treatment.*

Events/Near Misses by Business Unit, Category, and Volume.

Includes all reported events and any required regulatory reported events and PCE’s:

Hospital (LMC):

LMC reported a total of 223 entries in HAS.

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE

DECEMBER 10, 2025

This included 211 events (185 patient events, 26 non-patient events), and 12 Near Misses).

The 211 Events were reported under the following categories, sorted by volume: The 211 Events were reported under the following categories, sorted by volume: AMA (68), IV/Blood Issues (29), Telemedicine (15), Patient Care (15), Admission process/discharge/transfer (9), Skin Issues (8), Fall/Slips (8), Security (8), Behavior (6), Facility & Administrative Services (6), EHR & HIT (6), Medication Variance (5), Equipment Related (5), Medication Safety (4), Lab (3), Clinical Event for Review (3), Treatment & Therapies (2), Safety (2), Respiratory Therapy (2), Radiology (2), Property (2), Nutrition & Dietary (1), Medical Documentation and Patient Records (1), and Infection Control (1). The Near Misses included Security (4), Medication Variance (4), Treatment & Therapies (1), Surgery (1), Medication Safety (1), and Behavior (1). Reported regulatory events: N/A, (0) cases were reported to the Agency for Healthcare Administration (“AHCA”) as an Adverse Incident/Code 15.

Skilled Nursing Center (Healey):

Healey reported a total of 93 entries in HAS.

This included 89 events (87 resident events, 6 non-resident events), and 4 Near Misses.

The 89 Events were reported under the following categories, sorted by volume: Skin Issues* (55), Falls/Slips (12), EMS/911 Referral (10), Medication Variance (3), Safety (2), Property (2), Patient Care (2), HIPAA/Privacy (1), Nutrition & Dietary (1), and Behavior (1). (*) These are included for facility-requested reporting purposes only due to a resident condition, however, were non-incident related events. The Near Misses included Medication Variance (1), Safety (1), HIPAA/Privacy (1), and Medication Safety (1). Reported regulatory events: One (1) case was reported to the Agency for Healthcare Administration (“AHCA”) as an Immediate (1-day) and 5- Day Report.

42 CFR s. 483.13(c) - Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

Community Health Centers (Clinics):

CHC’s reported a total of 126 entries in HAS.

This included 126 events (103 patient events, 23 non-patient events), and 0 Near Misses.

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE

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The 126 Events were reported under the following categories, sorted by volume: Behavior (51), EMS/911 Referral (17), Safety (12), Treatment & Therapies (8), Equipment Related (8), Medical Documentation and Patient Records (5), Lab (4), Property (3), Patient Care (3), HIPAA/Privacy (3), Falls/Slips (3), Medication Variance (2), Infection Control (2), EHR & HIT (2), Supplies (1), Facility & Administrative Services (1), and Clinical Event for Review (1).

Pharmacy:

Pharmacy reported a total of 10 entries in HAS.

This included 9 events (9 patient events, 1 non-patient event) and 1 Near Miss.

The 9 events were reported under the following categories, sorted by volume:

Medication Variance (8) and Behavior (1). The Near Miss included: Medication Variance (1).

School Health:

School Health reported a total of 154 entries in HAS.

This included 148 events (142 student events, 6 non-student events) and 6 Near Misses.

The 148 events were reported under the following categories, sorted by volume:

Safety (50, including 22 DCF Referrals*), Medication Variance (47), Medical Documentation/Patient Records (17), Behavior (11), Treatment/Therapies (11), Patient Care (9), Facility & Administrative Services (2), and Lab (1). The 6 Near Misses included: Medication Variance (5) and Equipment Related (1). Reported regulatory events: (*) 22 DCF referrals were mandatory reporting purposes only, however, were non-incident related events.

Ground Ambulance (GTS):

GTS reported a total of 10 entries in HAS.

This included 9 events (8 patient events, 1 non-patient event), and 1 Near Miss.

The 9 Events were reported under the following categories: Safety (8) and Admission Process / Discharge / Transfer (1). The Near Miss included: Patient Care (1).

Aeromedical / TraumaHawk:

Aeromedical / TraumaHawk reported 0 entries in HAS and 12 entries in the Baldwin System. This included 6 events (6 non patient events) and 6 Near Misses.

The 6 Baldwin events were reported under the following categories: Flight



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Operations (5) and Aircraft Maintenance (1). The 6 Near Misses were reported under the following categories: Flight Operations (4), Ground Operations (1), and Facility Maintenance (1).

District Administration / Home Office:

Home Office/District Administration reported a total of 3 entries in HAS. This included 3 events and 0 Near Misses. The 3 events were reported under the following categories: Equipment Related (1), HIPAA/Privacy (1), and Security (1).

4. Fiscal Analysis & Economic Impact Statement:

	Current FY Amounts	Total Amounts (Current + Future)	Budget
Capital Requirements	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Net Operating Impact	N/A		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

*Non-budgeted expenditures in excess of \$250,000 require Finance and Audit Committee review and Board approval. Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Jessica Cafarelli
VP & Chief Financial Officer

5. Recommendation:

Staff recommends the Committee Receive and File the **HCD Enterprise Risk Management Quarterly Report and Dashboard (Q3 2025)**.

Approved for Legal sufficiency:

Signed by:

Bernabe Icaza
SVP & General Counsel

DocuSigned by:

Regina All
SVP & Chief Clinical Officer

Signed by:

Darcy J. Davis
President & Chief Executive Officer



Health Care District
OF PALM BEACH COUNTY
WE CARE FOR ALL

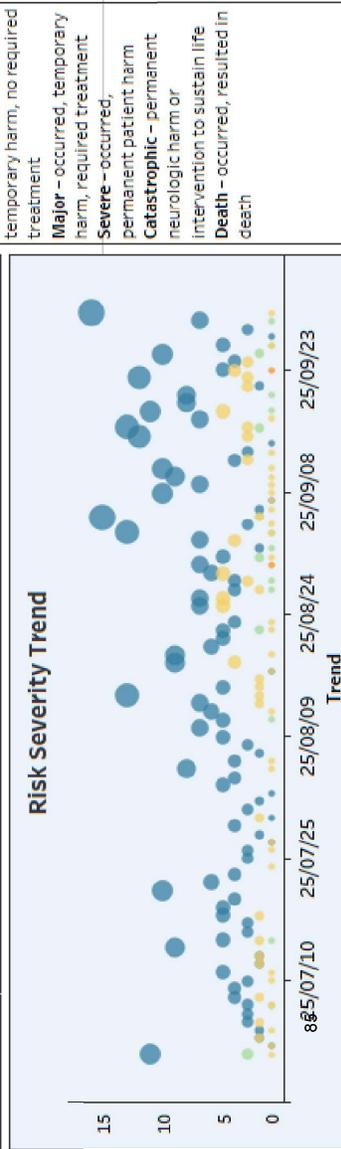
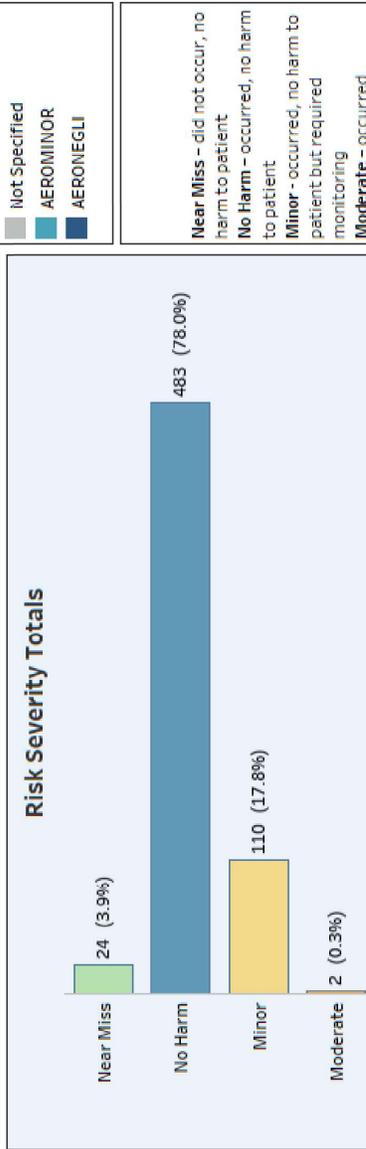
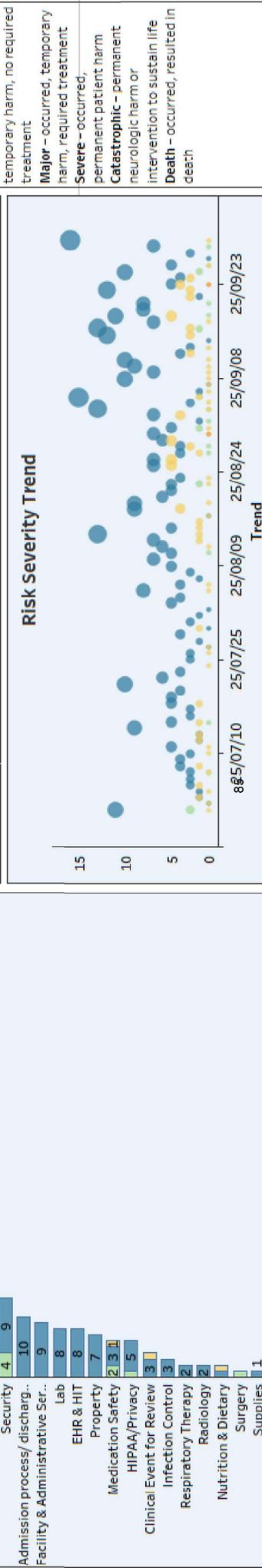
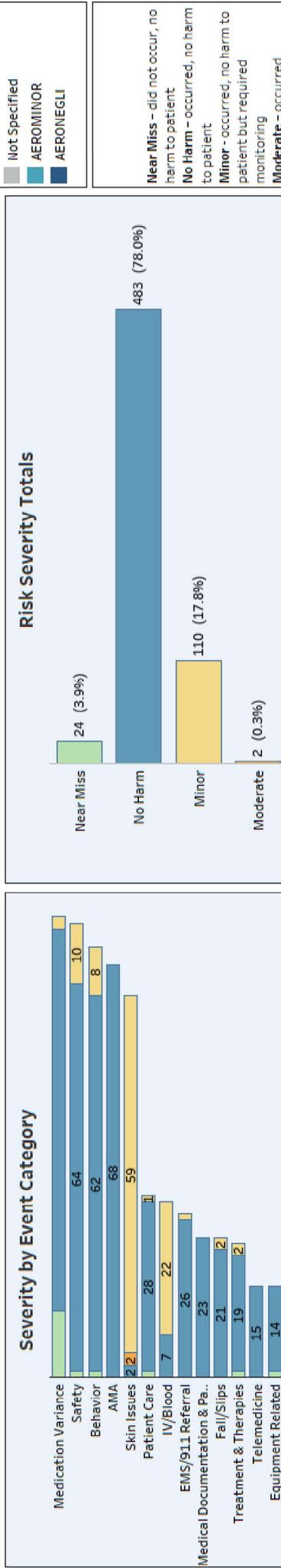
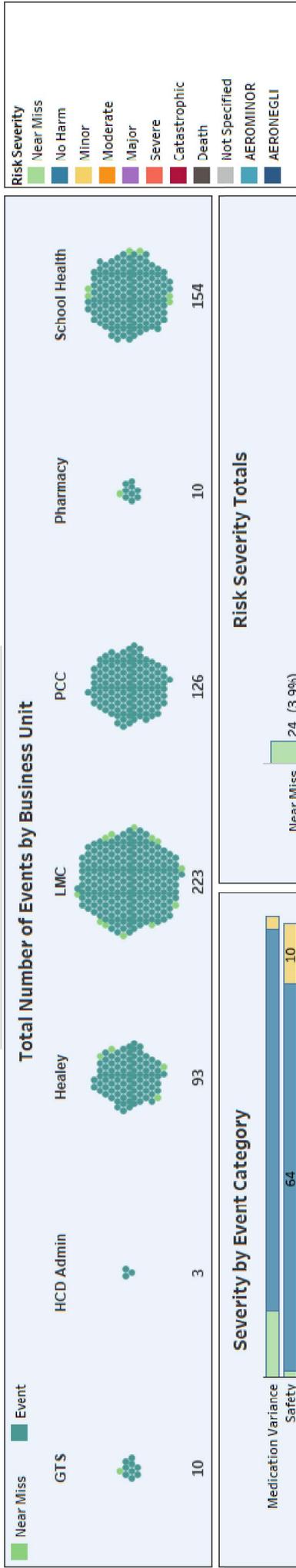
HCD Enterprise Risk Management Dashboards

Q3 2025 (July-September)

Risk Severity

Total Events **619** Near Misses **24** Near Miss % **3.9%**

Event Date
7/1/2025 to 9/30/2025



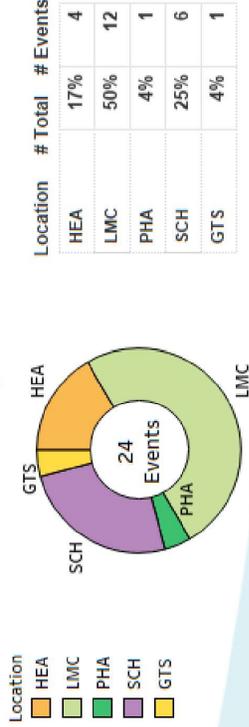
Near Miss - did not occur, no harm to patient
No Harm - occurred, no harm to patient
Minor - occurred, no harm to patient but required monitoring
Moderate - occurred, temporary harm, no required treatment
Major - occurred, temporary harm, required treatment
Severe - occurred, permanent patient harm
Catastrophic - permanent neurologic harm or intervention to sustain life
Death - occurred, resulted in death



NEAR MISS REPORTING PROGRAM

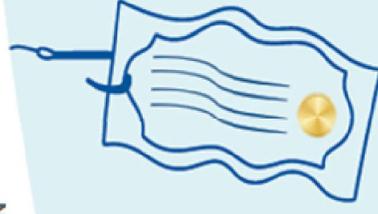
Reporting period from 7/1/2025 to 9/30/2025

Good Catch Events by Location

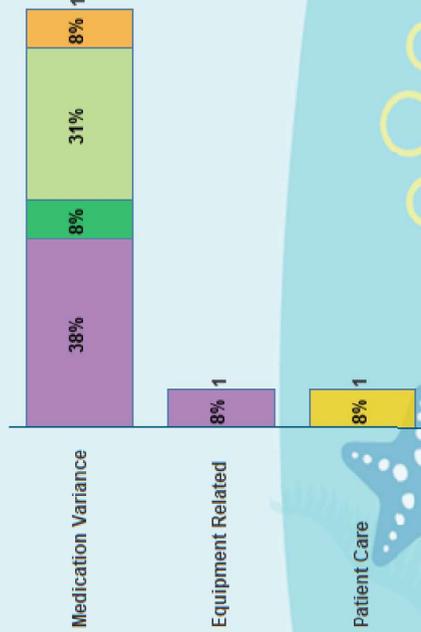


WHAT IS A GOOD CATCH?

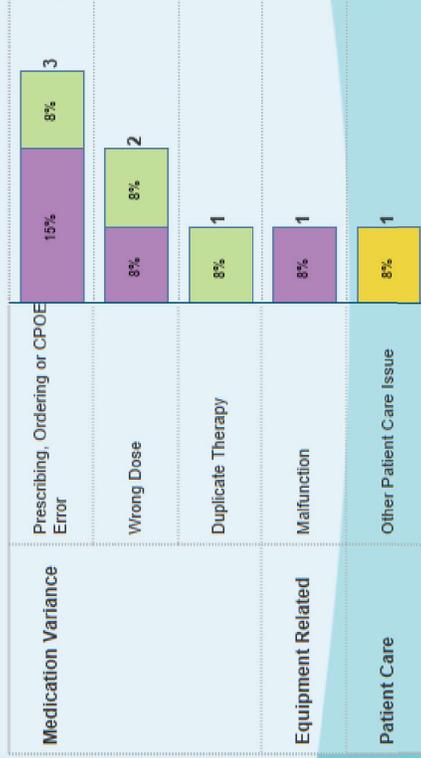
RECOGNITION BY AN EMPLOYEE OF A CONDITION OR SITUATION THAT HAD THE POTENTIAL TO CAUSE AN INCIDENT BUT DID NOT OCCUR DUE TO THE CORRECTIVE ACTION/INTERVENTION OF THAT EMPLOYEE.



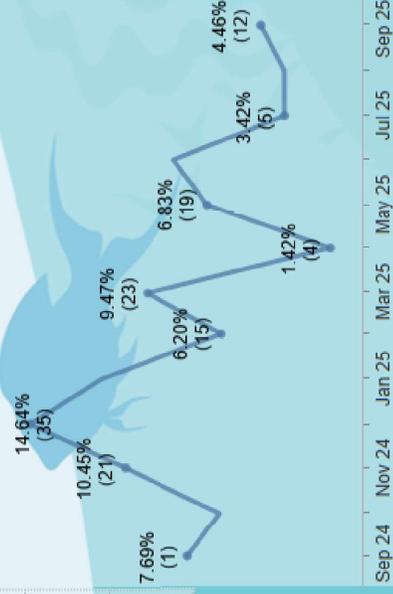
Top 5 Event Categories



Top 3 Event Sub-Categories



Near Misses Last 12 Months



CULTURE OF SAFETY

We practice a Just Culture that optimally supports a system of safety through transparency and accountability. Our major focus is on understanding what happened, how it happened, and how we can prevent it from happening again. We do this by looking at system processes, and human behavior, not through blaming or focusing solely on the individual.

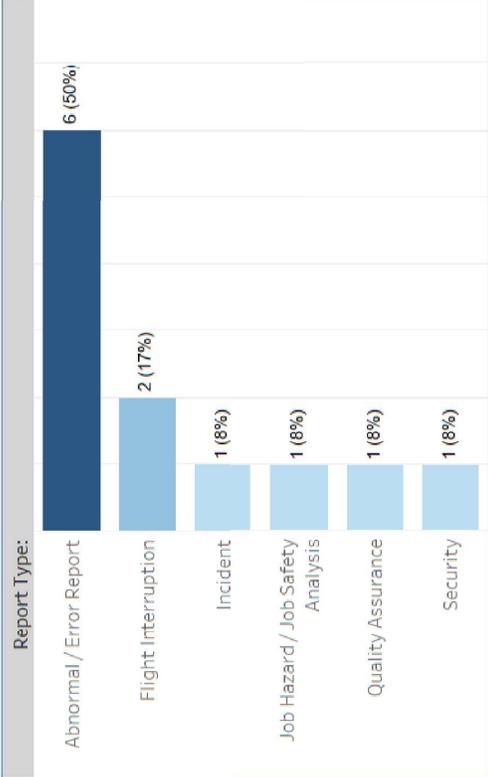
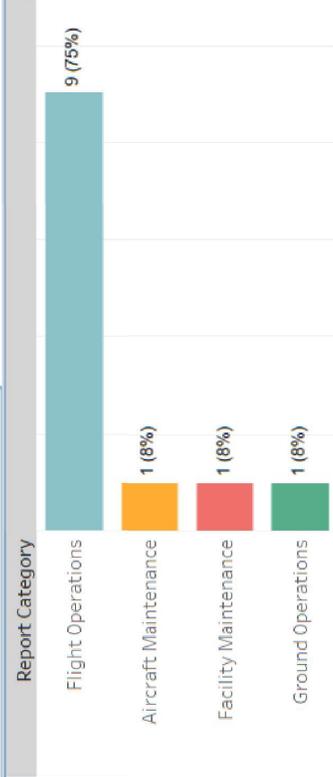
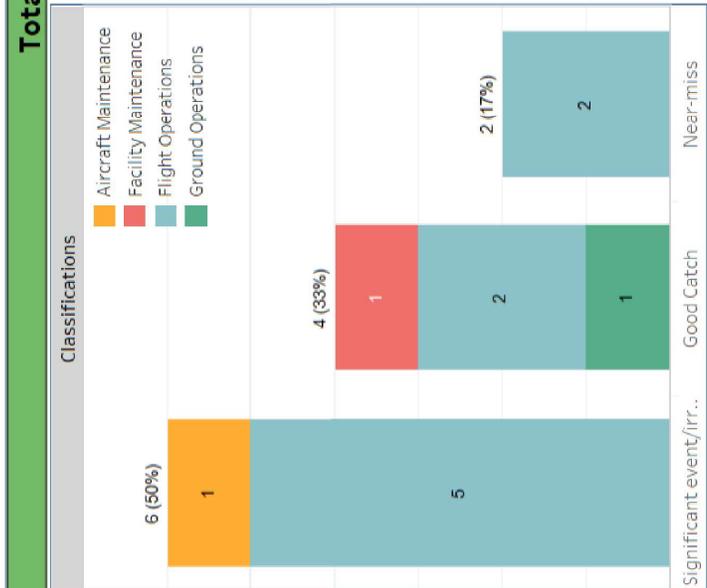
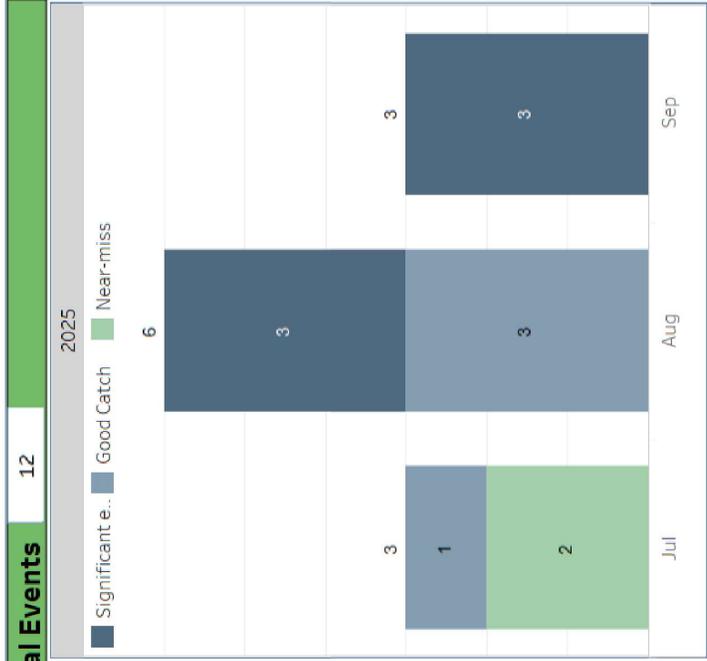


Risk Management Aeromedical



Start Date
7/1/2025

End Date
9/30/2025



Regulatory Reportable

Agency	Count
FAA	0
NASA ASR	0
NTSB	87

Agency	Count
UAS	0
TCAS	0
NASA ASR	87
NTSB	0