



**Quality, Patient Safety &  
Compliance Committee Meeting  
June 29, 2021  
12:00 P.M.**

**Meeting Location  
1515 N Flagler Drive, Suite 101  
West Palm Beach, FL 33401**



**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
AGENDA**

**June 29, 2021 at 12:00 P.M.  
1515 North Flagler Drive, Suite 101  
West Palm Beach, FL 33409  
Zoom Webinar Meeting**

**Remote Participation Link:**

**<https://zoom.us/j/5507895592?pwd=REZ4TWtYUXowQWNpWTBaVXRzZ1dDQT09>**

**Via Telephone dial-in access: (646) 558-8656 / Meeting ID: 550 789 5592 /  
Password: 946503**

- 1. Call to Order – Dr. Alina Alonso, Chair**
  - A. Roll Call
- 2. Agenda Approval**
  - A. Additions/Deletions/Substitutions
  - B. Motion to Approve Agenda
- 3. Awards, Introductions and Presentations**
  - A. Trauma Update – David Summers
- 4. Disclosure of Voting Conflict**
- 5. \*Public Comment**
- 6. Meeting Minutes**
  - A. **Staff recommends a MOTION TO APPROVE:**  
Committee Meeting Minutes from March 10, 2021. [Pages 1-4]
- 7. Consent Agenda- Motion to Approve Consent Agenda Items**
  - A. **ADMINISTRATION**
    - 7A-1 **RECEIVE AND FILE:**  
Internet Posting of District Public Meeting.  
<http://www.hcdpbc.org-Resources-Public Meetings>
    - 7A-2 **RECEIVE AND FILE:**  
Committee Attendance. [Page 5]

## 8. Regular Agenda

### A. COMPLIANCE

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

Summary of Compliance and Privacy Activities  
(Sonia Johnson) [Pages 6-14]

### B. ADMINISTRATION

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

Edward J. Healey Rehabilitation & Nursing Center  
(Karen Harris) [Pages 15-24]

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

Lakeside Medical Center Joint Commission Lab Accreditation Survey  
Results  
(Karen Harris) [Pages 25-34]

### C. CORPORATE QUALITY & PATIENT SAFETY DASHBOARDS

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

Patient Relations Dashboards  
(Belma Andric) [Pages 35-42]

- Patient Relations Dashboard, School Health.  
(Andrea Steele/ Steven Sadiku) [Page 38]
- Patient Relations Dashboard, C.L. Brumback Care Clinics.  
(Andrea Steele/David Speciale) [Page 39]
- Patient Relations Dashboard, E.J. Healey Center.  
(Andrea Steele/Tracy Ann Reid) [Page 40]
- Patient Relations Dashboard, Lakeside Medical Center.  
(Andrea Steele/Regina Stolpman) [Page 41]
- Patient Relations Dashboard, Pharmacy.  
(Andrea Steele/Luis Rodriguez) [Page 42]

#### 8C-2 RECEIVE AND FILE:

Quality & Patient Safety Reports  
(Belma Andric) [Pages 43-82]

- Patient Relations Dashboard, School Health.  
(Andrea Steele/Steven Sadiku) [Pages 49-51]

- Quality & Patient Safety Report, Aeromedical.  
(Andrea Steele/Gerry Pagano) [Pages 52-56]
- Quality & Patient Safety Report, C.L. Brumback Care Clinics.  
(Andrea Steele/Dr. Charmaine Chibar) [Pages 57-61]
- Quality & Patient Safety Report, Corporate Quality Metrics  
(Andrea Steele) [Pages 68-73]
- Quality & Patient Safety Report, E.J. Healey Center.  
(Andrea Steele/Tracy Ann Redi) [Page 68-73]
- Quality & Patient Safety Report, Lakeside Medical Center.  
(Andrea Steele/Sylvia Hall) [Pages 74-79]
- Quality and Patient Safety Report, Pharmacy.  
(Andrea Steele/Luis Rodriguez) [Page 80]
- Quality & Patient Safety Report, Trauma Program.  
(Andrea Steele/Amelia Stewart) [Pages 81-82]

**9. CEO Comments**

**10. Committee Member Comments**

**11. Closed Risk and Peer Review Meeting [Under Separate Cover]**

Pursuant to Florida Statute Ch. 768.28, 395.0197, 766.101 and 400.119, 400.147 and 395.0193.

**12. Establishment of Upcoming Meetings**

**September 28, 2021**

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

**December 15, 2021**

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

**13. Motion to Adjourn**

\* Public comments should be emailed to [nwhite@hcdpbc.org](mailto:nwhite@hcdpbc.org) or submitted via telephone to 561-804-5870 by 12:00 P.M. on Tuesday, June 28, 2021. All comments received during this timeframe will be read aloud and included in the official meeting record.



**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
SUMMARY MEETING MINUTES  
March 10, 2021 at 10:00 A.M.  
1515 North Flagler Drive, Suite 101  
West Palm Beach, FL 33409  
Zoom Webinar Meeting**

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

A. Roll Call

**2. Agenda Approval**

A. Additions/Deletions/Substitutions

B. Motion to Approve Agenda

**Conclusion/Action: Ms. Larson made a motion to approve the agenda as presented. The motion was duly seconded by Mr. O’Bannon. There being no opposition, the motion was passed unanimously.**

**3. Awards, Introductions and Presentations**

A. Press Ganey Population and Sampling – Sylvia Hall  
Ms. Hall presented on the Press Ganey reports that are provided to LMC.

**4. Disclosure of Voting Conflict**

**5. \*Public Comment**

**6. Meeting Minutes**

A. **Staff recommends a MOTION TO APPROVE:**  
Committee Meeting Minutes from September 24<sup>th</sup>, 2020.

Committee Meeting Minutes from December 8<sup>th</sup>, 2020

**Conclusion/Action: Ms. Larson made a motion to approve the agenda as presented. The motion was duly seconded by Mr. O’Bannon. There being no opposition, the motion was passed unanimously.**

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

**Conclusion/Action: Mr. O'Bannon made a motion to approve the agenda as presented. The motion was duly seconded by Ms. Larson. There being no opposition, the motion was passed unanimously.**

**A. ADMINISTRATION**

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

Internet Posting of District Public Meeting.  
<http://www.hcdpbc.org-Resources-Public Meetings>

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

Committee Attendance

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

Proposed Schedule for 2021 Quality, Patient Safety and Compliance Committee.  
(Darcy Davis)

**7A-4 RECEIVE AND FILE:**

Amendment to the Quality, Patient Safety and Compliance Committee Charter  
(Darcy Davis)

**8. Regular Agenda**

**A. COMPLIANCE**

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

Summary of Compliance and Privacy Activities  
(Sonia Johnson)

**CONCLUSION: Received and Filed**

**B. CORPORATE QUALITY & PATIENT SAFETY DASHBOARDS**

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

Patient Relations Dashboards  
(Belma Andric)

**CONCLUSION: Received and Filed**

- Patient Relations Dashboard, School Health.  
(Andrea Steele/ Steven Sadiku)

- Patient Relations Dashboard, C.L. Brumback Care Clinics.  
(Andrea Steele/David Speciale)
- Patient Relations Dashboard, E.J. Healey Center.  
(Andrea Steele/Terretha Smith)
- Patient Relations Dashboard, Lakeside Medical Center.  
(Andrea Steele/Regina Stolpman)
- Patient Relations Dashboard, Pharmacy.  
(Andrea Steele/ Luis Rodriguez)

8B-2 **RECEIVE AND FILE:**  
Quality & Patient Safety Reports  
(Belma Andric)

**CONCLUSION: Received and Filed**

- Patient Relations Dashboard, School Health.  
(Andrea Steele/Steven Sadiku)
- Quality & Patient Safety Report, Aeromedical.  
(Andrea Steele/Gerry Pagano)
- Quality & Patient Safety Report, C.L. Brumback Care Clinics.  
(Andrea Steele/Dr. Charmaine Chibar)
- Quality & Patient Safety Report, Corporate Quality Metrics  
(Andrea Steele)
- Quality & Patient Safety Report, E.J. Healey Center.  
(Andrea Steele/Terretha Smith)
- Quality & Patient Safety Report, Lakeside Medical Center.  
(Andrea Steele/Sylvia Hall)
- Quality and Patient Safety Report, Pharmacy.  
(Andrea Steele/Luis Rodriguez)
- Quality & Patient Safety Report, Trauma Program.  
(Andrea Steele/Sandra Smith)

**9. CEO Comments**

**Ms. Davis commented on the HRSA survey that was conducted with the clinics. This was originally scheduled last year, but was rescheduled due to COVID and done virtually this year. There were 93 elements of the survey and there were only 9 findings. The findings were not quality, care or patient treatment but were admiring findings such as number of scheduled board meetings, updated policy and procedures, etc.**

**Ms. Davis commented on this being Valerie Shariari's last meeting as she will be retiring.**

**10. Committee Member Comments**

**Dr. Alonso wished Valerie a happy retirement.**

**11. Closed Risk and Peer Review Meeting [Under Separate Cover]**

Pursuant to Florida Statute Ch. 768.28, 395.0197, 766.101 and 400.119, 400.147 and 395.0193.

**12. Establishment of Upcoming Meetings**

**June 9, 2021**

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

**September Meeting (Date TBD)**

**December 15, 2021**

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

**13. Motion to Adjourn**

**There being not further business, the meeting was adjourned at 11:51AM.**



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

**12 Month Attendance Tracking**

	<b>6/09/20</b>	<b>9/24/20</b>	<b>12/08/20</b>	<b>3/10/21</b>
Alina Alonso	X	X		X
Cory Neering	X		X	
Dr. Daniel Padron	X	X	X	X
James Elder	X			X
Kimberly Shultz	X	X	X	X
Mary Weeks	X	X	X	X
Sean O'Bannon	X	X	X	X
Sharon Larson	X	X		X
Dr. Ishan Gunawardene	X	X	X	X

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

**1. Description: Summary of Compliance and Privacy Activities**

**2. Summary:**

This item presents a summary of the District's compliance and privacy activities for the first quarter of 2021.

**3. Substantive Analysis:**

The Office of Inspector General (OIG) recommends reporting on a regular basis to the governing body, CEO, and compliance committee regarding planning, implementing, and monitoring the compliance and privacy program. Reporting the compliance and privacy activities helps to establish methods for improving the District's efficiency and quality of service, and to reduce vulnerability to fraud, waste, and abuse.

Compliance and Privacy highlights and ongoing initiatives:

- Completion of the Compliance Program Effectiveness (CPE) Assessment;
- Compliance and Privacy P&P review;
- Continued development and implementation of Compliance and Privacy Program;
- Participation in the Clinic Compliance Task Force, Internal Control Committee, and Patient Relation Committee for ongoing management initiatives;
- Ongoing implementation of the Compliance Workplan;
- Ongoing compliance support for COVID-19 operations; and
- Review of effective lines of communication.

Reported Compliance and Privacy incidents for the 1<sup>st</sup> Quarter of 2021:

- Five (5) privacy concerns, including one (1) reportable breach where a notice to the patient was sent timely.
- Fifteen (15) compliance inquiries.


The ComplianceLine (the District's Compliance Hotline) received three-hundred thirty-seven (337) calls mostly related to the COVID-19 vaccine.

## HEALTH CARE DISTRICT QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE June 29, 2021

**4. Fiscal Analysis & Economic Impact Statement:**

	Amount	Budget
Capital Requirements		Yes <input type="checkbox"/> No <input type="checkbox"/>
Annual Net Revenue		Yes <input type="checkbox"/> No <input type="checkbox"/>
Annual Expenditures		Yes <input type="checkbox"/> No <input type="checkbox"/>

Reviewed for financial accuracy and compliance with purchasing procedure:

DocuSigned by:  
  
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 Darcy J. Davis  
 Interim VP & Chief Financial Officer

**5. Reviewed/Approved by Committee:**

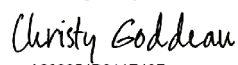
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 Committee Name

\_\_\_\_\_  
 Date

**6. Recommendation:**

Staff recommends the Board receive and file the District’s Summary of Compliance and Privacy Activities.

Approved for Legal sufficiency:

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 Christy Goddeau, Esq.  
 Interim General Counsel

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 Sonia Johnson  
 Manager, Compliance & Privacy

DocuSigned by:  
  
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 Darcy J. Davis  
 Chief Executive Officer



# Health Care District of Palm Beach County

*Dedicated to the health of our community*

**QUALITY, PATIENT SAFETY AND  
COMPLIANCE COMMITTEE**

**June 29, 2021**



# Highlights and Ongoing Initiatives

- Prompt response to potential non-compliance and review of communication lines
- Compliance Program Effectiveness (CPE) Assessment
- Compliance and Privacy P&P review
- Compliance and Privacy Program development
  - Training and education
  - Compliance Workplan
  - Software and vendor assessment
- Participation in ongoing management initiatives:
  - Clinic Compliance Task Force
  - Internal Control Committee
  - Patient Relations Committee
  - IT Steering Committee
  - Vendor Risk/Management Steering Committee
- Support for COVID-19 operations and regulatory inquiries



# Compliance & Privacy Reporting

January 1, 2021 – March 31, 2021

Reported Privacy Concerns				
Entity	January	February	March	Total
Home Office	-	2	-	2
Lakeside Medical Center	-	-	-	-
C.L. Brumback Clinics	-	-	1	1
E.J. Healey Center	-	-	-	-
Aeromedical	-	-	-	-
Pharmacy	-	-	-	-
School Health	1	1	-	2
<b>Total</b>				<b>5</b>

Compliance Inquiries				
Entity	January	February	March	Total
Home Office	-	2	2	4
Lakeside Medical Center	1	-	1	2
C.L. Brumback Clinics	-	1	3	4
E.J. Healey Center	-	-	-	-
Aeromedical	-	-	1	1
Pharmacy	-	-	-	-
School Health	-	1	-	1
<b>Total</b>				<b>10</b>

Privacy Category Reported	
Disclosure to an Unauthorized Person	2
Proper Safeguards	-
Misdirected Fax/Email	2
Medication Error	-
Misfile of PHI	-
Consent for Treatment	-
Unauthorized Access	1

Breach Notifications Mailed	
Home Office	-
Lakeside Medical Center	-
C.L. Brumback Clinics	1
E.J. Healey Center	-
Aeromedical	-
Pharmacy	-
School Health	-

Compliance Hotline Calls			
Jan.	Feb.	Mar.	Total
1	149	187	337

Record Amendment Requests			
Jan.	Feb.	Mar.	Total
-	-	1	1

# Compliance Program Effectiveness Assessment

**Audit Objective:** To assess HCDPBC's compliance program and outline enhancement opportunities that can be used as the basis for the development of the HCDPBC's compliance program work plan to improve the effectiveness of its compliance program.

**Audit Scope:** ACG requested documentation for the current compliance program for all lines of business.

**Audit Methodology:** To conduct our assessment, ACG based its assessment on the OIG compliance program guidance and the CMS audit standards (Prevention, Detection & Correction). This guidance was designed to provide specific compliance program objectives to ensure an effective compliance program. Our approach to conducting this assessment included:

- Reviewing documentation submitted by HCDPBC prior to and after the webinar sessions;
- Reviewing the Compliance program data systems, operations, and documentation by conducting webinar reviews; and
- Interviewing HCDPBC's compliance staff and the Chief Executive Officer (CEO) as part of the compliance reporting structure.

# Summary of Assessment Results

Audit Element	# of Observations	# of Conditions
Element I: Written Policies, Procedures and Standards of Conduct	2	1
Element II: Compliance Officer, Compliance Committee and High Level Oversight	2	1
Element III: Effective Training and Education	2	0
Element IV: Effective Lines of Communications	1	1
Element V: Well-publicized Disciplinary Actions	1	0
Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risk	1	3
Element VII: Procedures and Systems for Promptly Responding to Compliance Issues	1	1
<b>Total:</b>	<b>10</b>	<b>7</b>

## “Conditions”

A condition is the result of a material non-compliance with specific requirements.

## “Observations”

Observations are either immaterial events of non-compliance with specific requirements or other items that may be useful to management in preventing non-compliance in the future.





# Assessment Area Ranking

## Low Priority

- Standards of Conduct
- Lines of Communication
- Disciplinary Standards

## Medium Priority

- Compliance Committee
- Governing Body
- Board of Commissioners Training
- Compliance Staff Training
- Exclusion Lists Check/Sanction Screening
- Root Cause Analysis

## High Priority

- Compliance Policies & Procedures
- Compliance Officer
- Regulatory Guidance
- Risk Assessment
- Fraud, Waste & Abuse Program
- Internal Auditing & Monitoring
- Corrective Actions



# Questions?

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE MEETING  
June 29, 2021**

**1. Description: Edward J. Healey Rehabilitation & Nursing Center**







**2. Summary:**

This agenda item is to provide an overview of the Agency for HealthCare Administration (AHCA) Survey results and Plan of Correction.

**Substantive Analysis:**

The AHCA survey commenced on 5/17/21 and ended on 5/20/21. The Center received four (4) citations for the re-certification and re-licensure portion of the survey and one (1) citation for the life safety portion of the survey.

The graph below outlines where the citations fell on the Deficiencies Matrix:

	<b>Isolated</b>	<b>Pattern</b>	<b>Widespread</b>
Immediate jeopardy to resident health or safety	<b>J</b> PoC Required 	<b>K</b> PoC Required 	<b>L</b> PoC Required 
Actual harm that is not immediate	<b>G</b> PoC Required	<b>H</b> PoC Required 	<b>I</b> PoC Required 
No actual harm with potential for more than minimal harm that is not immediate jeopardy	<b>D</b> PoC Required <i>F689 F805</i> <i>F803 F808</i> <i>K1150 – Life Safety</i>	<b>E</b> PoC Required	<b>F</b> PoC Required 
No actual harm with potential for minimal harm	<b>A</b> No PoC required	<b>B</b> PoC Required	<b>C</b> PoC Required

## HEALTH CARE DISTRICT QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE MEETING June 29, 2021

Table Key:



Refers to:

*Substandard quality of care means one or deficiencies related to participation requirements. Resident rights, freedom from abuse, neglect and exploitation, behavioral health, quality of life, pharmacy services, administration, Infection control*

**PoC** refers to Plan of Correction

All citations were assigned a severity level of “D”. The following is a breakdown of the citations:

ID Tag	Scope & Severity	Findings	Date for compliance
F689	D	Failure to secure syringes and lancets	6/20/21
F803	D	Failure to follow approved menu for pureed diet	6/20/21
F805	D	Failure to prepare pureed food in a form that meets the needs of the residents	6/20/21
F808	D	Failure to follow physician’s order for fluid restrictions	6/20/21
K1150	D	Failure to have a complete Security Management plan	6/19/21

### 3. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Net Revenue		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Expenditures		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Reviewed for financial accuracy and compliance with purchasing procedure:

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Darcy J. Davis  
Interim VP & Chief Financial Officer

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE MEETING  
June 29, 2021**

**4. Reviewed/Approved by Committee:**

\_\_\_\_\_  
N/A  
Committee Name

\_\_\_\_\_  
N/A  
Date Approved

**5. Recommendation:**

Staff recommends the Committee receive and file the information regarding the Healey Center's survey.

Approved for Legal sufficiency:

DocuSigned by:  
*Christy Goddeau*  
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Christy Goddeau, Esq.  
Interim General Counsel

DocuSigned by:  
*Karen Harris*  
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Karen A. Harris  
VP of Field Operations

DocuSigned by:  
*Darcy Davis*  
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Darcy J. Davis  
Chief Executive Officer



***Health Care District of Palm Beach County  
Edward J. Healey Rehabilitation and Nursing Center  
Agency for Healthcare Administration Survey Results***

**Karen A. Harris**

**VP of Field Operations**



# Executive Summary

- **Program**
  - Recertification, re-licensure, complaint and Fire & Life Safety Survey
- **Survey dates**
  - 5/17/2021 to 5/20/2021
- **Outcome**
  - Facility found not in substantial compliance
- **Follow-up Activity**
  - Complaint survey was unsubstantiated. No further action warranted
  - Statement of deficiencies received within ten(10) days of survey exit
  - Plan of correction needs to be uploaded within ten (10) days of receipt from AHCA
- **Follow up timeframe**
  - Deficiencies correction date:
    - Recertification & re-licensure 6/20/2021
    - Life Safety 6/19/2021
- **Re-survey**
  - The surveyors will be making an unannounced onsite visit anytime after 6/20/2021. The re-survey can occur over a weekend.

# Summary of survey results







	<b>Isolated</b>	<b>Pattern</b>	<b>Widespread</b>
<b>Immediate jeopardy to resident health or safety</b>	<b>J</b> PoC Required 	<b>K</b> PoC Required 	<b>L</b> PoC Required 
<b>Actual harm that is not immediate</b>	<b>G</b> PoC Required	<b>H</b> PoC Required 	<b>I</b> PoC Required 
<b>No actual harm with potential for more than minimal harm that is not immediate jeopardy</b>	<b>D</b> PoC Required <i>F689 F805</i> <i>F803 F808</i> <i>K1150 - Life Safety</i>	<b>E</b> PoC Required	<b>F</b> PoC Required 
<b>No actual harm with potential for minimal harm</b>	<b>A</b> No PoC required	<b>B</b> PoC Required	<b>C</b> PoC Required

Table Key:



Refers to:

*Substandard quality of care means one or deficiencies related to participation requirements. Resident rights, freedom from abuse, neglect and exploitation, behavioral health, quality of life, pharmacy services, administration, Infection control*

**PoC** refers to Plan of Correction



# Corrective Actions

- ***F689 Scope and Severity – D***
  - Facility failed to secure insulin syringes and lancets on 1 (Pelican wing) of 5 residential wings.
    - Central Supply team was in-serviced to hand off insulin syringes and lancets to the nursing team and not leave them on the medication cart. Audits/Observation will be done weekly for four (4) weeks and randomly thereafter. DON and/or designee will bring findings to QAPI for three (3) months and randomly thereafter.
  
- ***F803 Scope and Severity – D***
  - Facility failed to ensure that pureed diets were followed for eight (8) sampled resident's who were reviewed for Nutrition.
    - Dietary team was in-serviced. Menus were revised. Like resident's will be reviewed. Audits/Observations will be done five (5) days a week for six (6) weeks, then weekly for three (3) months and randomly thereafter. Consultant Dietician and/or designee will bring findings to QAPI for six (6) months and randomly thereafter.

# Corrective Actions

- ***F805 Scope and Severity – D***

- Facility failed to ensure that pureed food is prepared in a form that meets the needs of the resident's for eight (8) resident's sampled.
  - Dietary team was in-serviced. Like residents were reviewed. Audits will be conducted on pureed food preparation and taste five (5) days a week for six (6) weeks, then weekly for three (3) months and randomly thereafter. Consultant Dietician and/or designee will bring findings to QAPI for six (6) months and randomly thereafter.

- ***F808 Scope and Severity – D***

- Facility failed to follow doctor's orders for fluid restriction for 1 out of the 5 sampled residents.
  - Dietary team will be in-serviced on ensuring that the meal tickets are compliant with the physician order. The nursing team will be in-serviced on ensuring that correct amount of fluids are given with medication administration. Audits/Observations will be done three (3) days a week for four (4) weeks, then weekly for three (3) months and randomly thereafter. Consultant Dietician and/or designee will bring findings to QAPI for three (3) months and randomly thereafter.

# Corrective Actions – Life Safety

- ***K1150 Scope and Severity – D***
  - Facility failed to comply with NFPA 99 chapter 13 Security Management.
    - Security Management Plan was developed. The Plan was added to the QAPI calendar to ensure annual review. AVP/Administrator and/or designee will bring plan to QAPI in June 2021, annually or when a change is warranted.

# Summary

- The Plan of Correction was due on 6/5/2021.
- Submission was uploaded and approved by AHCA.
- The re-survey window opens on 6/19/21 and 6/20/21 respectively.
- Next survey:
  - Certification is in effect for up to fifteen (15) months.

## HEALTH CARE DISTRICT QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE MEETING June 29, 2021

**1. Description: Lakeside Medical Center Joint Commission Lab Accreditation Survey Results**

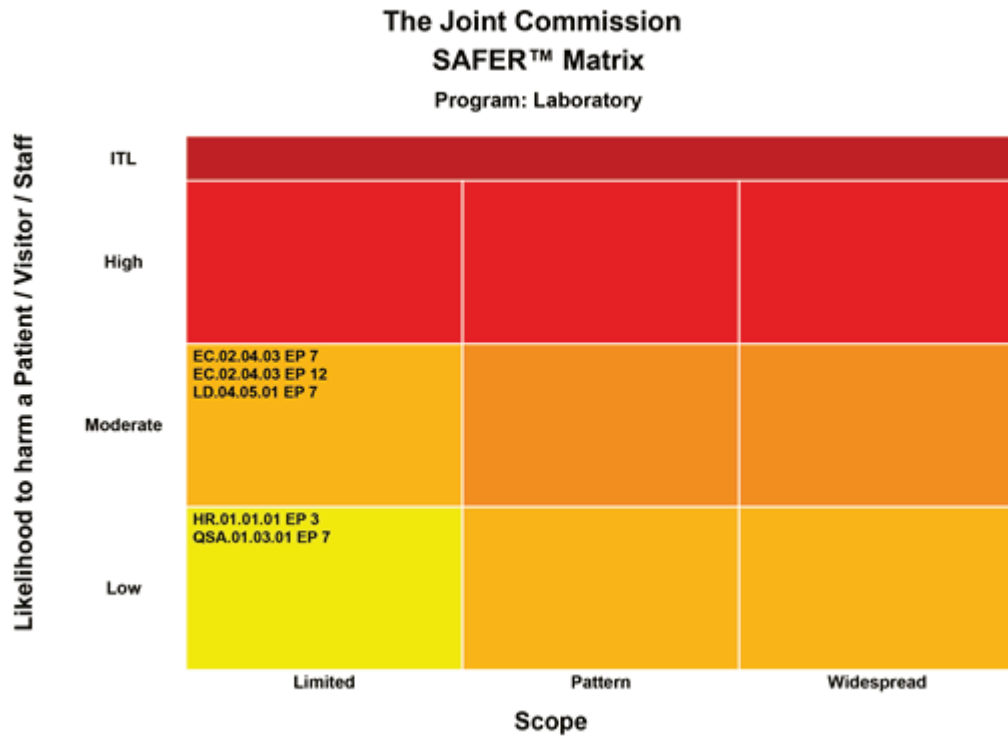
**2. Summary:**

This agenda item is to provide an overview of the Joint Commission Lab Survey results and Evidence of Standards (plan of correction).

**3. Substantive Analysis:**

The Joint Commission Lab survey commenced on 3/16/21 and ended on 3/18/21. Due to COVID 19 the survey was conducted virtually. The Lab received five (5) areas of concern with the Evidence of Standards for compliance being due on 5/18/2021.

The graph below outlines where the citations fell on the Safer Matrix:



## HEALTH CARE DISTRICT QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE MEETING June 29, 2021

The citations carried a severity level of Low and Moderate with a limited scope. The following is a breakdown of the citations:

Standard	Safer Placement	EP Text	Current Level of compliance
EC.02.04.03	Moderate Limited	The lab performs preventive maintenance inspection	Compliant
EC.02.04.03	Moderate Limited	The lab monitors temperature in controlled spaces	Compliant
HR.01.01.01	Low Limited	Verify documents relevant to job descriptions	Compliant
LD.04.05.01	Moderate Limited	Lab director is responsible for performing all her job duties	Compliant
QSA.01.03.01	Low Limited	Lab director signs attestations for proficiency testing	Compliant

#### 4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Net Revenue		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Expenditures		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Reviewed for financial accuracy and compliance with purchasing procedure:

DocuSigned by:  
  
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 Darcy J. Davis  
 Interim VP & Chief Financial Officer

#### 5. Reviewed/Approved by Committee:

N/A  
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 Committee Name

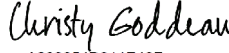
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 \_\_\_\_\_  
 Date Approved


**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE MEETING  
June 29, 2021**

**6. Recommendation:**

Staff recommends the Committee receive and file the update on the Lab survey.

Approved for Legal sufficiency:

DocuSigned by:  
  
A209254D911E48F...  
Christy Goddeau, Esq.  
Interim General Counsel

DocuSigned by:  
  
0AB213918F93424...  
Karen A. Harris  
Vice President of Field Operations

DocuSigned by:  
  
77A3B53589A1477...  
Darcy J. Davis  
Chief Executive Officer



***Health Care District of Palm Beach County  
Lakeside Medical Center  
Joint Commission Lab Accreditation Survey Results***

**Karen A. Harris**

**VP of Field Operations**

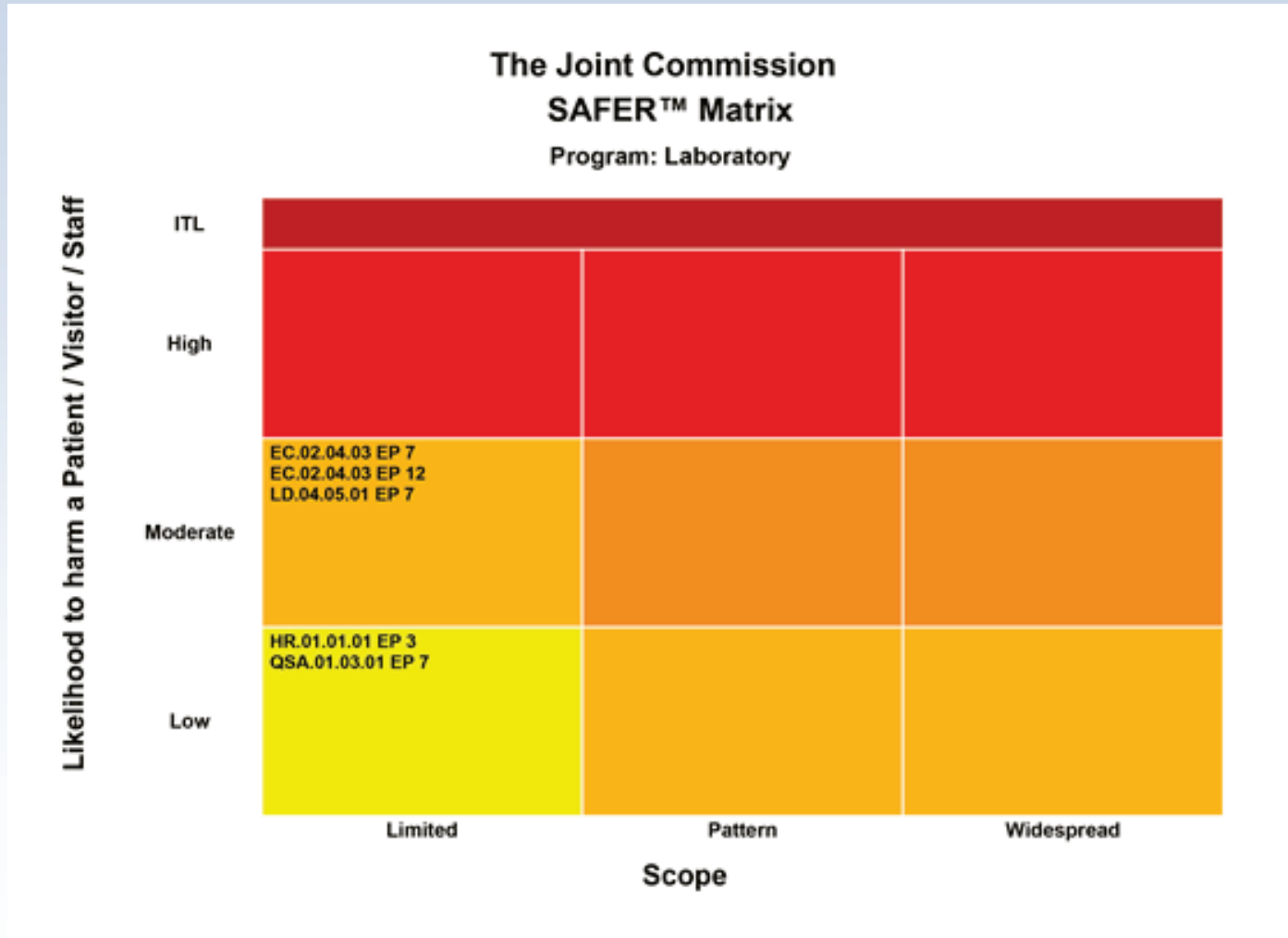




# Executive Summary

- **Program**
  - Laboratory
- **Survey dates**
  - 03/16/2021 to 03/18/2021
- **Event Outcome**
  - Requirements for Improvement
- **Follow-up Activity**
  - Clarification (Optional)
  - Evidence of Standards Compliance (ESC)
- **Follow-up timeframe**
  - Clarification – submit within 10 business days from the final posted report date
  - ESC – submit within 60 calendar days from the final posted report date

# Summary of survey results



# Requirements for Improvement

- **EC.02.04.03** – Moderate/Limited
  - The O-ring seals had not been lubricated every thirty (30) days.
    - Biomedical department has established a recurring work order to ensure compliance. Monthly reports will be brought to Continuous Quality for six (6) months to monitor compliance with the standard.
  
- **EC.02.04.03** - Moderate/Limited
  - The temperature log was not in place to monitor the temperature in the supply room where the testing kits were stored.
    - The medical technologist will ensure that the temperature is checked and recorded daily. Monthly reports will be brought to Continuous Quality for six (6) months to monitor compliance with the standard.

# Requirements for Improvement

- **HR.01.01.01** – Low/Limited
  - High school diploma was not present in employees file.
    - Job descriptions were updated to reflect high school diploma or GED preferred but not required. Monthly reports will be brought to Continuous Quality for six (6) months to monitor compliance with the standard.
- **LD.04.05.01** – Moderate/Limited
  - There was no documentation of duties that had been delegated to the technical consultant for moderately complex testing.
    - Standard Operating Procedure (SOP) # Lab82 was updated to reflect the required delegation. Form 209 was updated. Monthly reports will be brought to Continuous Quality for six (6) months to monitor compliance with the standard.

# Requirements for Improvement

- **QSA.01.03.01** – Low/Limited
  - The immunohematology proficiency test attestations were signed by the lab manager who does not meet the qualifications of a technical supervisor.
    - The Laboratory Medical Director will review and sign the attestations going forward. Monthly reports will be brought to Continuous Quality for six (6) months to monitor compliance with the standard.

# Summary

- The Evidence of Standards was due on 5/18/2021.
- All were submitted and accepted by Joint Commission.
- The Lab is currently in compliance.
- Next survey:
  - Certification is good for twenty-four (24) months

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

**1. Description: Patient Relations Dashboards**

**2. Summary:**

This agenda item provides the patient relations dashboard for the 2<sup>nd</sup> Trimester of the 2020/2021 school year for School Health and the 1<sup>st</sup> Quarter of 2021 for C. L. Brumback Primary Care Clinics, Edward J. Healey Nursing and Rehabilitation Center, Lakeside Medical Center and Pharmacy.

**3. Substantive Analysis:**

**School Health**

For Trimester 2 of School Year 2020/2021, School Health had a total of 23 Patient Relations events that occurred between 167 school locations. Of the 23 events, 5 were complaints and 18 were compliments. The 2 complaints were related to medication being clarified by the nurse, one complaint was from a parent upset that the student was classified as an exposure, and two complaints came from 2 different principals. One principal that wanted the COVID report at the end of the day and the other principal requesting a second nurse for his school. 17 of the compliments recognized the School Health Nurses and 1 was for the School Health Educator.

**C. L. Brumback Primary Care Clinics**

For Quarter 1, there were a total of 64 Patient Relations Occurrences that occurred between 9 clinics, Clinic Administration, South County Civic Center and Fairgrounds. Of the 64 occurrences, there were 20 Grievances and 44 Complaints. The top 5 categories were Care & Treatment, Communication, Finance, Respect Related, and Physician Related. The top subcategory with 18 Complaints and Grievances was Poor Communication followed by Finance with 15 Complaints and Grievances.

There was also a total of 65 compliments received across 5 clinics, Clinic Administration, South County Civic Center and Fairgrounds. Of the 65 compliments, 50 were towards the Clinic Support Staff.

**E. J. Healey Nursing & Rehabilitation Center**

There were a total of 34 grievances submitted by 15 out of 116 residents during the 1st quarter. The top 5 categories were Personal Belongings, Communication, Activities, Environmental, and Nutrition. Some of the concerns included: room temperature being too warm, request for longer banking hours and to be able to withdraw more money, missing watch (resident found the watch), request for personal shower chair, and not being able to sit and touch family members. 28 were resolved timely and 6 were beyond 72 hours due to missing clothing, missing watch, and timing clothing returned from laundry.

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

A total of 82 compliments submitted this quarter by residents and resident representatives. The compliments surrounded the staff being respectful and providing outstanding care.

**Lakeside Medical Center**

For the first quarter, Lakeside served 5,506 patients. There were 17 complaints. The top 5 categories were Care & Treatment, Respect Related and Communication. The top 5 subcategories were Care & Treatment with 6 complaints, Communication with 1 complaint, Discharge with 2 complaints, Finance with 2 complaints and Respect Related with 4.

There were 27 compliments related to care and treatment 14 for nursing, 10 other for ancillary departments, 2 for housekeeping and 1 for lab.

**Pharmacy**

For Q1, there were two entries as patient complaints, but upon further review, it should be changed to bad patient behavior. One patient was angry and vulgar because they had to wait their turn while a pharmacy staff member attended another patient. Another patient was rude to staff because a DOH staff told them that they could sit and wait for a prescription. HCD staff wasn't aware and because of the newly opening rules of our lobby.

**4. Fiscal Analysis & Economic Impact Statement:**

	<b>Amount</b>	<b>Budget</b>
Capital Requirements	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Net Revenue	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Expenditures	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

\_\_\_\_\_  
Darcy J. Davis  
Interim VP & Chief Financial Officer

**5. Reviewed/Approved by Committee:**

\_\_\_\_\_  
N/A  
Quality, Patient Safety, and Compliance  
Committee

\_\_\_\_\_  
N/A  
Date Approved

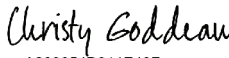



**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

**6. Recommendation:**

Staff recommends the Committee receive and file this information.

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DocuSigned by:  
  
1F272D34C8B04A5...  
Belma Andric, MD  
CMO, VP & Executive Director of Clinical  
Services

DocuSigned by:  
  
77A3B53589A1477...  
Darcy J. Davis  
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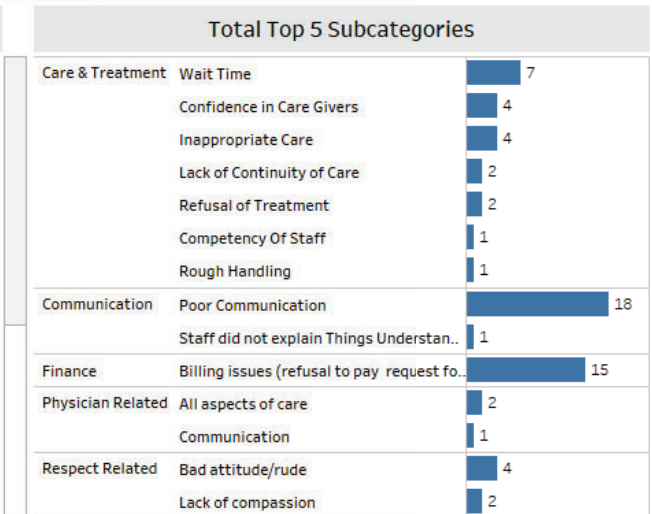
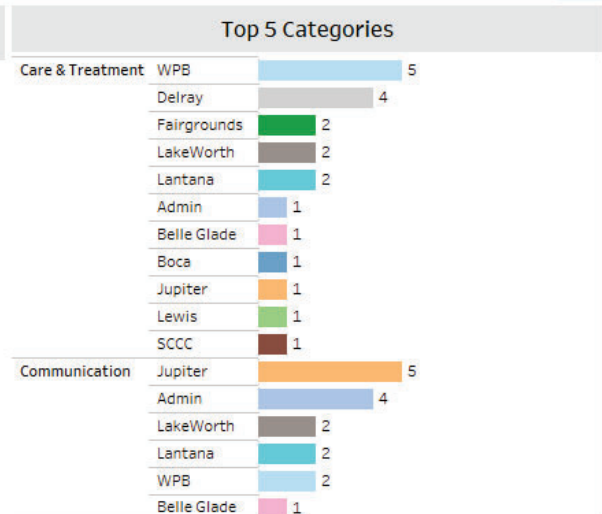
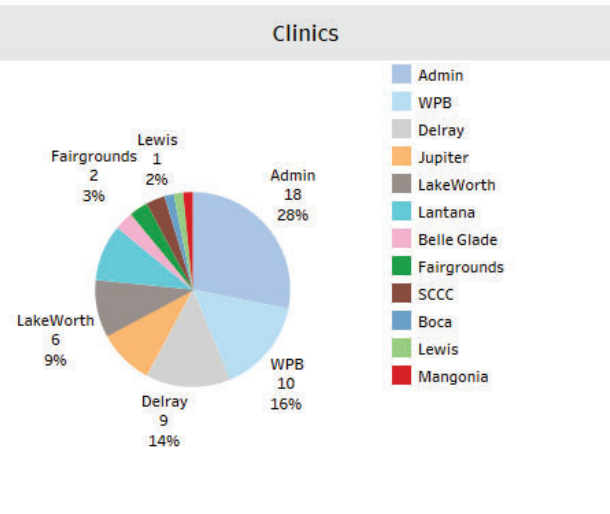
**Patient Relations (Grievances, Complaints & Compliments)**  
C.L. Brumback Primary Care Clinics



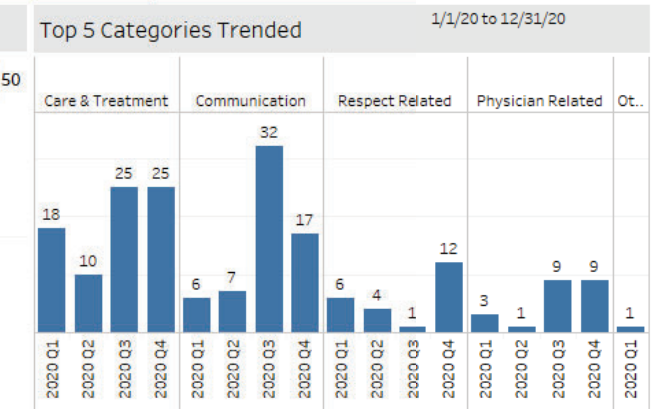
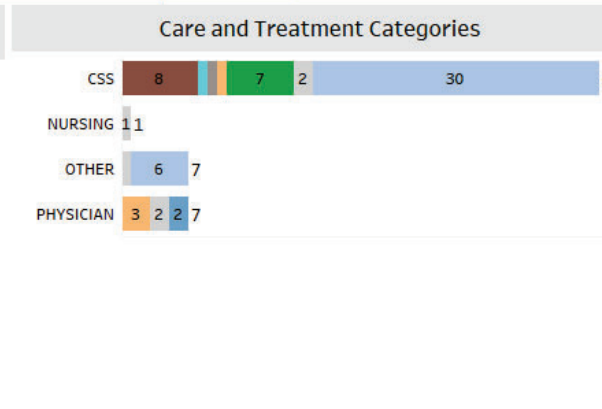
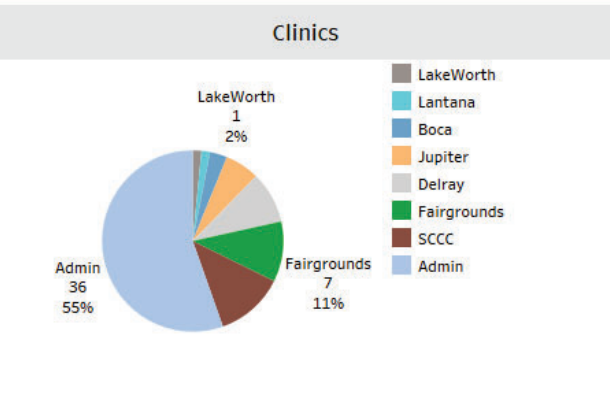
Top Categories  
5

Provider: All | 2021 Q1 | 1/1/21 to 3/31/21

Total Complaints and Grievances: 64 | Clinic: All



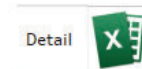
Total Compliments: 65 | Complaints/Grievances Prev 4 Quarters: 218



\* Color represents Department



## Patient Relations (Grievances, Complaints & Compliments) Healey Center



Top Categories  
5

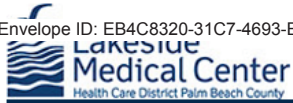
Provider: All 2021 Q1 1/1/21 to 3/31/21

**Total Complaints and Grievances** 35

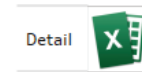
Departments	Top 5 Categories	Total Top 5 Subcategories																																																																											
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**Total Compliments** 82 Complaints/Grievances Prev 4 Quarters 165

Departments	Care and Treatment Categories	Top 5 Categories Trended																																																																																																																																							
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## Patient Relations (Grievances, Complaints & Compliments) Lakeside Medical Center



Top Categories  
5

Provider: All 2021 Q1 1/1/21 to 3/31/21

**Total Complaints and Grievances** **17**

Departments	Top 5 Categories	Total Top 5 Subcategories																																																			
<ul style="list-style-type: none"> <li><span style="color: red;">■</span> PROGRESSIVE CARE UNIT</li> <li><span style="color: blue;">■</span> EMERGENCY SERVICES</li> <li><span style="color: grey;">■</span> MED SURGERY 3RD FLOOR</li> <li><span style="color: lightblue;">■</span> NONE</li> <li><span style="color: cyan;">■</span> OBSTETRICS</li> <li><span style="color: yellow;">■</span> PLANT OPERATIONS/BIO..</li> </ul>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Care &amp; Treatment</td> <td>PROGRESSIVE CARE UNIT</td> <td style="text-align: right;">5</td> </tr> <tr> <td>Respect Related</td> <td>EMERGENCY SERVICES</td> <td style="text-align: right;">2</td> </tr> <tr> <td></td> <td>PLANT OPERATIONS/BIO..</td> <td style="text-align: right;">1</td> </tr> <tr> <td></td> <td>PROGRESSIVE CARE UNIT</td> <td style="text-align: right;">1</td> </tr> <tr> <td>Communication</td> <td>OBSTETRICS</td> <td style="text-align: right;">1</td> </tr> </table>	Care & Treatment	PROGRESSIVE CARE UNIT	5	Respect Related	EMERGENCY SERVICES	2		PLANT OPERATIONS/BIO..	1		PROGRESSIVE CARE UNIT	1	Communication	OBSTETRICS	1	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Care &amp; Treatment</td> <td>Confidence in Care Givers</td> <td style="text-align: right;">2</td> </tr> <tr> <td></td> <td>Anger, Threats, Physical Abuse</td> <td style="text-align: right;">1</td> </tr> <tr> <td></td> <td>Inappropriate Care</td> <td style="text-align: right;">1</td> </tr> <tr> <td></td> <td>Order Issues</td> <td style="text-align: right;">1</td> </tr> <tr> <td></td> <td>Wait Time</td> <td style="text-align: right;">1</td> </tr> <tr> <td>Communication</td> <td>Poor Communication</td> <td style="text-align: right;">1</td> </tr> <tr> <td>Discharge</td> <td>Discharge instructions incomplete</td> <td style="text-align: right;">1</td> </tr> <tr> <td></td> <td>Inappropriate / early discharge</td> <td style="text-align: right;">1</td> </tr> <tr> <td>Finance</td> <td>Billing issues (refusal to pay request fo..</td> <td style="text-align: right;">2</td> </tr> <tr> <td>Respect Related</td> <td>Discrimination or perception</td> <td style="text-align: right;">2</td> </tr> <tr> <td></td> <td>Bad attitude/rude</td> <td style="text-align: right;">1</td> </tr> <tr> <td></td> <td>Inappropriate comments / conversations</td> <td style="text-align: right;">1</td> </tr> </table>	Care & Treatment	Confidence in Care Givers	2		Anger, Threats, Physical Abuse	1		Inappropriate Care	1		Order Issues	1		Wait Time	1	Communication	Poor Communication	1	Discharge	Discharge instructions incomplete	1		Inappropriate / early discharge	1	Finance	Billing issues (refusal to pay request fo..	2	Respect Related	Discrimination or perception	2		Bad attitude/rude	1		Inappropriate comments / conversations	1
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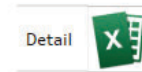
**Total Compliments** **27** **Complaints/Grievances Prev 4 Quarters** **65**

Departments	Care and Treatment Categories	Top 5 Categories Trended <span style="float: right;">1/1/20 to 12/31/20</span>																																																			
<ul style="list-style-type: none"> <li><span style="color: blue;">■</span> ADMISSIONS</li> <li><span style="color: teal;">■</span> CLINICAL LABORATORY</li> <li><span style="color: yellow;">■</span> PHARMACY</li> <li><span style="color: lightblue;">■</span> PLANT OPERATIONS/BIO..</li> <li><span style="color: red;">■</span> RADIOLOGY</li> <li><span style="color: lightgreen;">■</span> HOUSEKEEPING</li> <li><span style="color: pink;">■</span> PROGRESSIVE CARE UNIT</li> <li><span style="color: grey;">■</span> INTENSIVE CARE UNIT</li> <li><span style="color: lightblue;">■</span> NONE</li> <li><span style="color: darkblue;">■</span> UTILIZATION REVIEW</li> <li><span style="color: blue;">■</span> EMERGENCY SERVICES</li> </ul>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>CSS</td> <td>1</td> <td>1</td> </tr> <tr> <td>ENVIRON</td> <td>2</td> <td>2</td> </tr> <tr> <td>NURSING</td> <td>2</td> <td>1</td> <td>3</td> <td>8</td> <td>14</td> </tr> <tr> <td>OTHER</td> <td>3</td> <td>1</td> <td>1</td> <td>1</td> <td>2</td> <td>1</td> <td>1</td> <td>10</td> </tr> </table>	CSS	1	1	ENVIRON	2	2	NURSING	2	1	3	8	14	OTHER	3	1	1	1	2	1	1	10	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Category</th> <th>2020 Q1</th> <th>2020 Q2</th> <th>2020 Q3</th> <th>2020 Q4</th> </tr> </thead> <tbody> <tr> <td>Care &amp; Treatment</td> <td>6</td> <td>5</td> <td>9</td> <td>2</td> </tr> <tr> <td>Communication</td> <td>3</td> <td>4</td> <td>1</td> <td>5</td> </tr> <tr> <td>Nursing Related</td> <td>2</td> <td>3</td> <td>2</td> <td>2</td> </tr> <tr> <td>Other</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td>Physician Related</td> <td>2</td> <td>1</td> <td></td> <td></td> </tr> </tbody> </table>	Category	2020 Q1	2020 Q2	2020 Q3	2020 Q4	Care & Treatment	6	5	9	2	Communication	3	4	1	5	Nursing Related	2	3	2	2	Other	2	2	2	2	Physician Related	2	1		
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Physician Related	2	1																																																			

\* Color represents Department



### Patient Relations (Grievances, Complaints & Compliments) Pharmacy

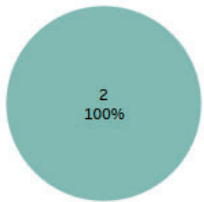


Top Categories  
5

Provider: All | 2021 Q1 | 1/1/21 to 3/31/21

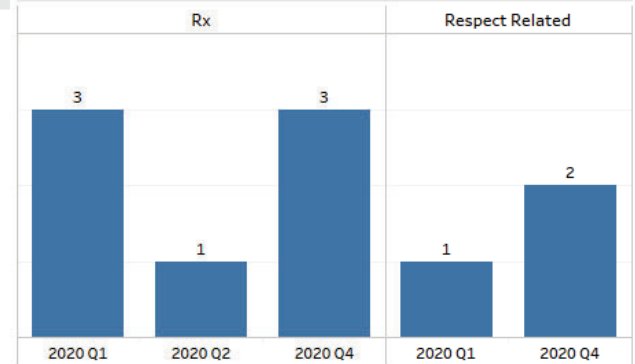
**Total Complaints and Grievances** 2

Departments	Top 5 Categories		Total Top 5 Subcategories			
WEST PALM BEACH PHAR...	Rx	WEST PALM BEACH PHARMACY	1	Respect Related	Bad attitude/rude	1
	Respect Related	WEST PALM BEACH PHARMACY	1	Rx	Other	1



**Total Compliments** | **Complaints/Grievances Prev 4 Quarters** 10

Departments | Care and Treatment Categories | **Top 5 Categories Trended** 1/1/20 to 12/31/20



\* Color represents Department

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

**1. Description: Quality & Patient Safety Reports**

**2. Summary:**

This agenda item provides quality and patient safety reports for the 2<sup>nd</sup> Trimester of the 2020/2021 school year and the 1<sup>st</sup> Quarter of 2021 for Aeromedical, C. L. Brumback Primary Care Clinics, Corporate Quality Metrics, Edward J. Healey Nursing and Rehabilitation Center, Lakeside Medical Center, Pharmacy, and Trauma.

**3. Substantive Analysis:**

**School Health**

In the second trimester of the 2020/2021 school year (Jan 1 – Mar 31), we completed a total of 40,706 office visits, with a total of 82,764 completed events. The office visits included 28,338 COVID-19 screenings. The 32% increase in office visits, 38% increase in COVID-19 screenings, 51% increase in medications and 82% increase in procedures in the school health room can be attributed to the increase in return of students on campus from virtual learning. There was significant decrease in record review (76%) and consultations (68%) because it's a group of activities that is predominantly done at the beginning of the school year and on as needed basis throughout the school year. We are meeting goal in the school's return rate from office visits, with 84.6% of students remained in school versus 15.4% who were excused (non-COVID -19 related). We have four pregnancies who were all identified and referred to Healthy Mothers/Healthy Babies. We are currently meeting the goal for all our mandated screenings (vision, hearing, scoliosis, & BMI for total enrolled students.

The following measures were not meeting their goal at the end of T2:

- Total # of Schools with completed screenings (Target >95%) 82.9% for scoliosis. Due to the COVID-19 pandemic, school started late this year on 9/21. Scoliosis screening began after vision and hearing screenings started.

**COVID dashboard:** In the second trimester we completed a total of 28,338 COVID-19 student screenings. The elementary schools completed the most screenings at 74%, followed by middle schools at 15% and high schools at 10%. As a result of the COVID-19 screenings, 40% were recommended for testing and 60% remained in school. The leading primary symptom is constant cough and the leading secondary symptom is headache. We performed a total of 2,131 in-house point of care COVID tests for both staff and students. 95% resulted in a negative test, and 5% resulted in a positive test. 76% of the tests were performed on students and 24% on staff members.

# HEALTH CARE DISTRICT QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE June 29, 2021

## **Aeromedical**

For Q1, there were 127 flights with 130 unique patients. The Aeromedical Quality Report shows a total of 13 out of 54 flights were missed, cancelled or aborted due to weather between January and March.

All Dispatch To Enroute and Dispatch to Hospital Average times met the goal for the quarter despite TH2 being out of service: August 25, 2020 – April 14, 2021.

GAMUT stands for Ground and Air Medical qUality Transports. Trauma Hawk has been benchmarking data to this national file repository site since 2018 for quality purposes. For Q1, 2021 Trauma Hawk transported 129 patients. 61% of transports were trauma related and the remaining 29% accounted for medical emergencies. 70% of patient transports by Trauma Hawk were dispatched as a 911 response to the scene and 30% were dispatched as an interfacility transfer. Injuries to the head account for 29% of Trauma Hawk flights.

4 patients required intubation by Trauma Hawk crew members. 2 patients were intubated on the first attempt and 2 patients were intubated on the second attempt. 2 patients suffered a hypoxic event during transport. All intubations were carried out through rapid sequence intubation protocols with an ETT confirmation rate of 100%.

## **C. L. Brumback Primary Care Clinics**

In the first quarter of 2021, the clinics served 14,507 unique patients and provided 26,375 clinic visits.

The following measures were not meeting goal at the end of March: Cervical Cancer Screening (61%), Colorectal Cancer Screening (42%), Hypertension (65%) and Diabetes (63%).

All other goals achieved for the quarter.

## **Corporate Quality Metrics**

- **Clinic Service Center Stats**
  - For Quarter 1 2021, there were 262,513 calls received by the Clinic Service Center. Of these calls there were 88,205 unique numbers.
  - Most calls were received between 9am and 12pm.
  - All voicemails for the quarter month were responded to.
  
- **Human Resources**
  - Quarter 1 headcount ended at 1,281 team-members after 123 new hires and 87 separations.
  - Turnover rate for Q1 was 6.93%, while New Hire turnover rate was 4.56%.



**HEALTH CARE DISTRICT**  
**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE**  
**June 29, 2021**

- The current diversity headcount is 68.76%, average age of employees is about 47 years old and 80.41% of the workforce is female.
- **Information Technology**
  - **Operations:** Information Technology has established a service level of 99.90% of mission critical application availability. The chart includes the top 8 mission critical applications for the organization. We met our service level for all applications in in the 1<sup>st</sup> quarter except Phreesia. Phreesia is the software we use for the mass vaccination site. This software is a result of a collaboration between Phreesia and the Health Care District. The outages are a result of Phreesia's platform having technical issues managing the vaccine volume. The Phreesia vaccine self-scheduler was discontinued in early May.
  - **Customer Service:** For Q1, we saw an overall slight reduction in tickets opened and a reduction at a greater rate of tickets closed causing us to fall behind in responding to support requests. Receiving 1,903 in January, 1,664 in February and 1,851 in March. Our close rate started the quarter at a high of 99.5% in January dropping to 89.3% by March due to the resources redirected to support the vaccine operations. The IT Help Desk saw an increase in the abandon call rate from 4<sup>th</sup> quarter ending at 2.43% to 4.5% in January, 3.25% in February and 3.85% in March. The abandon call rate tracks with the overall number of phone calls. Our target is 4.5% average abandon call rate.
  - **Cybersecurity:** For Q1 we investigated 191 security incidents. Of the total incidents, all are closed and 0 were reportable. The incidents included phishing and spam emails, responding to malware alerts and requested security investigations. Comparing 2020 to the Q12021, we are experiencing another significant increase that could lead to doubling the number of incidents in 2021. The increase is due to our Security Program maturing and adding additional tools for monitoring as well as an overall increase in email phishing and malware activity.
- **Legal**
  - For Quarter 1 there were 166 new contract requests, 51 of which were expedited requests, mostly related to the EPIC implementation and the HRSA audit.
  - There were 97 contracts fully executed and closed for the quarter.
  - Of the 97 contracts closed, 13 of those fell outside our 45-day timeframe for completion due to turnover in Legal Contracting staff, absence of General Counsel, use of outside counsel for review, absence of Compliance Officer to approve compliance related contracts and BAAs, and a delay in the internal approvals.

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

**E. J. Healey Rehabilitation Center**

For Q1, 17 of 17 quality measures were met.

**Lakeside Medical Center**

For Q1 2021, **Inpatient Quality Measures** there were 3 of 8 measures (ED-1a, PC-02, PC-06) that did not meet goal.

- **ED Measure:** For ED-1a, there were (134) cases sampled with a median time of (296) minutes, which is higher than the set goal of (280) minutes. The top (5) cases were reviewed monthly, care and treatment rendered was appropriate and an increase in patient census and bed availability was noted to be a contributing factor.
- **Perinatal Measures:** For PC-02, there was (1) case of the sample population (2), that fell into the numerator for a rate of 50% which is higher than the set goal of less than 20%. The (1) case was reviewed and care was deemed appropriate.

For PC-06, there was (1) case of the sample population (13), that fell into the numerator for a rate of 8% which is higher than the set goal of less than 7%. The (1) case was reviewed, care was deemed appropriate and the newborn was discharged home with the parents after care and treatment.

For Q1 2021, **Outpatient Quality Measures** there were 2 of 3 measures (OP-3a, OP-18) that did not meet goal.

For OP-3a there were (3) cases that fell into the sample population with a median time of 105 minutes, which is higher than the goal of a median time of less than 58 minutes. All (3) cases were reviewed and it was determined that care and treatment was rendered appropriately based on the patient condition.

For the final measure OP-18, there were (101) cases sampled with a median time of (146) minutes, which is higher than the set goal of (137) minutes. The top (5) cases were reviewed monthly, care and treatment rendered was appropriate and patient transport was noted to be a contributing factor.

**Pharmacy**

For Q1 2021, the total HCD prescriptions filled were 43,615. Mailed over 8,437 prescriptions (3,256 packages). Decrease from the previous quarter because lobbies opened mid-March, allowing foot traffic and patient pick up.

**Trauma**

For Q1 2021, 1,316 patients were seen at a trauma center (an increase of 98 patients compared to Q1 2020). Rolling year comparison (April 2020 - March 2021) showed St. Mary's treating 2,544 traumatically injured patients and Delray treated 2,201

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

traumatically injured patients for a total of 4,745 patients treated at a PBC Trauma Center. Pediatrics (Age  $\leq 15$ ) accounted for 9% of total volume, Adults (Ages 16 – 64) accounted for 51% of total volume and Geriatrics (Age  $>65$ ) accounted for 39% of total volume. Age distribution of the trauma centers highlight the difference in populations between the two centers. Delray’s largest supplier of trauma patients come from those in their 8th decade of life. 18% of trauma patients seen at Delray Medical Center are  $\geq 80$  years of age. St. Mary’s however receives their largest supplier of trauma patients from those in their 2nd decade of life. 15% of St. Mary’s total volume are between the ages of 20 and 30. 93% of trauma volume originates in Palm Beach County with the remaining 7% originating from Martin, Hendry and St. Lucie counties. Trauma Alerts accounted for 56% of total volume with Transfers from Acute Care Hospitals representing 26% of total volume. Emergency Department upgrades at the Trauma Centers account for the remaining 18%. The leading and dominating mechanism of injury for all patients is Falls [(44% of total volume) seen primarily in Geriatrics and Pediatrics]. Vehicular crashes including MVC, motor vehicle vs pedestrian and motorcycle crashes account for 33% of total volume. Combined, these two categories account for over 75% of total trauma volume.

**4. Fiscal Analysis & Economic Impact Statement:**

	<b>Amount</b>	<b>Budget</b>
Capital Requirements	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Net Revenue	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Annual Expenditures	N/A	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A  
\_\_\_\_\_  
Darcy J. Davis  
Interim VP & Chief Financial Officer

**5. Reviewed/Approved by Committee:**

N/A  
\_\_\_\_\_  
Quality, Patient Safety, and Compliance  
Committee

N/A  
\_\_\_\_\_  
Date Approved

**HEALTH CARE DISTRICT  
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE  
June 29, 2021**

**6. Recommendation:**

Staff recommends the Committee receive and file this information.

Approved for Legal sufficiency:

DocuSigned by:  
*Christy Goddeau*  
A209254D911E48F...  
Christy Goddeau, Esq.  
Interim General Counsel

DocuSigned by:  
*Belma Andric*  
1F272D34C8B04A5...  
Belma Andric, MD  
CMO, VP & Executive Director of Clinical  
Services

DocuSigned by:  
*Darcy Davis*  
77A3B53589A1477...  
Darcy J. Davis  
Chief Executive Officer

**School Health**  
**Quality Report (School Year 2020-2021)**  
**2nd Trimester**

MEASURE SET:										ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL
Demographics	T1 2020/2021 (Aug - Dec)			T2 2020/2021 (Jan - March)			T3 2020/2021 (Apr - June)			
Total Completed Events	95,885			82,764			0			
Office Visits	30,862			40,706						
Medications	13,762			20,830						
Procedures	4,694			8,565						
Record Review - Immunizations/Physical Exams/School Registrations	30,112			7,322						
Consultations	16,455			5,341						
Return Rate	T1 2020/2021 (Aug - Dec)			T2 2020/2021 (Jan - March)			T3 2020/2021 (Apr - June)			
	Num/Den	%	Goal	Num/Den	%	Goal	Num/Den	%	Goal	
Total Number of Students Remained in School	8,326	79.8%	>80%	10,454	84.6%	>80%		#DIV/0!	>80%	
Total Number of Students Excused from School	2,113	20.2%	<20%	1,910	15.4%	<20%		#DIV/0!	<20%	
Continuum of Care	T1 2020/2021 (YTD Aug - Dec)			T2 2020/2021 (YTD Aug - March)			T3 2020/2021 (YTD Aug - June)			
	Num/Den	%	Goal	Num/Den	%	Goal	Num/Den	%	Goal	
Total Number of Student Pregnancies Identified	6			4						
Number of Student Pregnancies who have been referred to Healthy Mothers / Healthy Babies	4	66.7%	>95%	4	100.0%	>95%		#DIV/0!	>95%	
Mandated Screenings	T1 2020/2021 (YTD Aug - Dec)			T2 2020/2021 (YTD Aug - March)			T3 2020/2021 (YTD Aug - June)			
	Num/Den	%	Goal	Num/Den	%	Goal	Num/Den	%	Goal	
Vision - Number of Schools (county-wide) with Mandated Grades	144			144						
Vision - Total # of Schools (w/ Mandated Grades) with Completed Screenings	58	40.3%	>45%	140	97.2%	>95%		#DIV/0!	>95%	
Vision - Total # of Students	30716			30716						
Vision - Total # of Students Screened	8811	28.7%	>10%	26502	86.3%	>10%		#DIV/0!	>10%	
Vision - Total # of Students Requiring Referral for Further Evaluation	1416			3724						
Vision - Completed Outcomes		0.0%	See 3rd Tri for Goal		0.0%	See 3rd Tri for Goal		#DIV/0!	>65%	
Hearing - Number of Schools (county-wide) with Mandated Grades	144			144						
Hearing - Total # of Schools (w/ Mandated Grades) with Completed Screenings	58	40.3%	>45%	137	95.1%	>95%		#DIV/0!	>95%	
Hearing - Total # of Students	22813			22813						
Hearing - Total # of Students Screened	6833	30.0%	>10%	18873	82.7%	>10%		#DIV/0!	>10%	
Hearing - Total # Students Requiring Referral for Further Evaluation	97			243						
Hearing - Completed Outcomes		0.0%	See 3rd Tri for Goal		0.0%	See 3rd Tri for Goal		#DIV/0!	>75%	
Scoliosis - Number of Schools (county-wide) with Mandated Grades	41			41						
Scoliosis - Total # of Schools (w/ Mandated Grades) with Completed Screenings	7	17.1%	>45%	34	82.9%	>95%		#DIV/0!	>95%	
Scoliosis - Total # of Students	7336			7336						
Scoliosis - Total # of Students Screened	564	7.7%	>10%	4806	65.5%	>10%		#DIV/0!	>10%	
Scoliosis - Total # of Students Requiring Referral for Further Evaluation	7			50						
Scoliosis - Completed Outcomes		0.0%	See 3rd Tri for Goal		0.0%	See 3rd Tri for Goal		#DIV/0!	>60%	
BMI - Number of Schools (county-wide) with Mandated Grades	144			144						
BMI - Total # of Schools (w/ Mandated Grades) with Completed Screenings	33	22.9%	>45%	138	95.8%	>95%		#DIV/0!	>95%	
BMI - Total # of Students	23205			23205						

Due to the COVID-19 pandemic, school started late this year on 9/21. Scoliosis screening began after vision and hearing screenings started.



# Palm Beach County Schools Covid-19 Student Screenings

Elementary 21,020  
Middle 4,356  
High 2,961

Start Date 1/1/2021  
End Date 3/31/2021

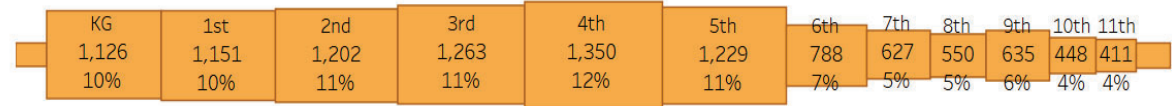
School Name All  
Area All

Number of Screenings **28,338**

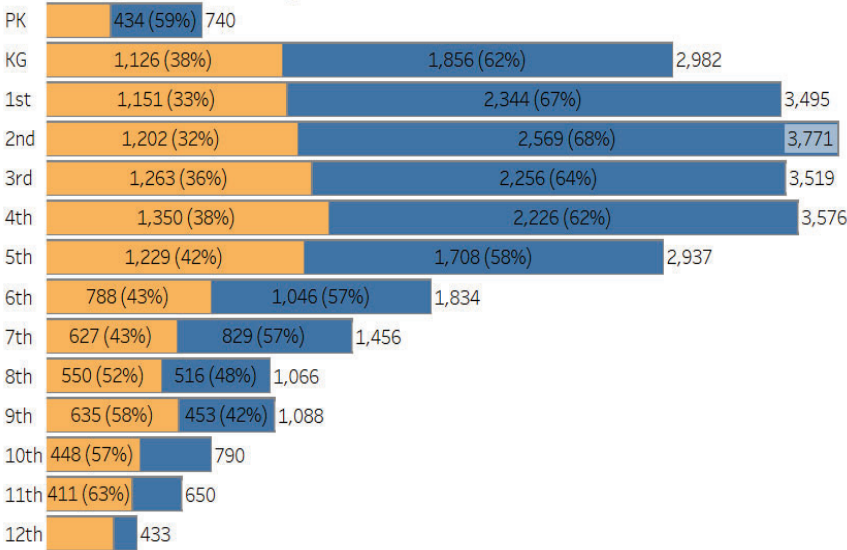
Detail

Recommend Testing **11,411 (40%)**  
Remain in School **16,927 (60%)**

## Grade Distribution for Screenings Recommended for Testing



## Screenings Performed by Grade



## Exposure

To Diagnosed/Infected



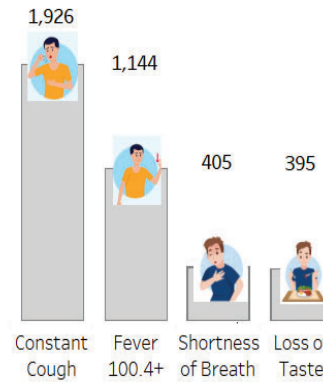
**4,789**

To Resp/GI Symptoms

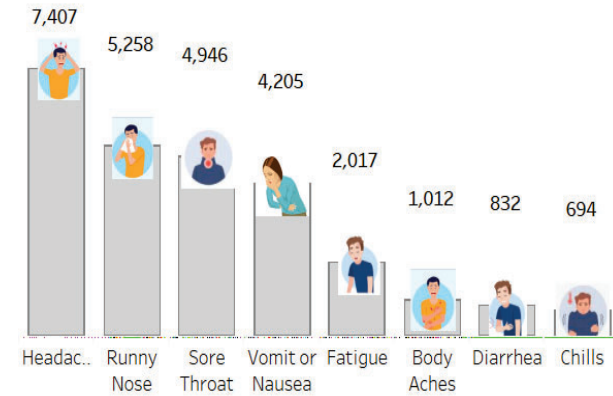


**2,247**

## Primary Symptoms

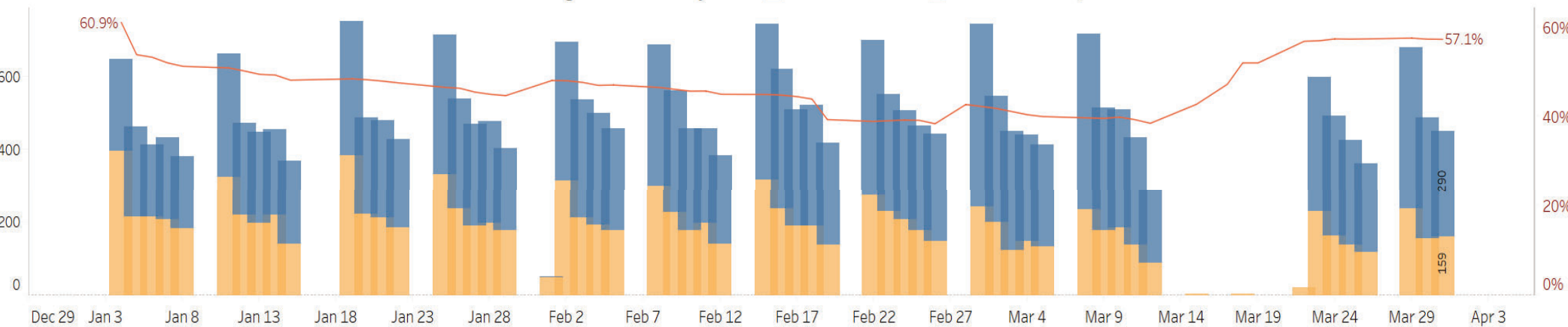


## Secondary Symptoms (Chills Added 10/15/20)



## Screenings Performed by Date

Remain in School (Blue) Recommend Testing (Orange) Red line is the rolling average of % Recommended for testing (14 day)

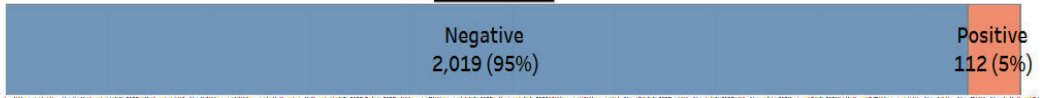




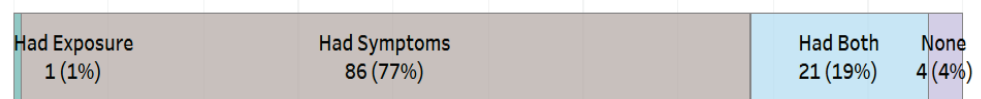
# Palm Beach County Schools In-House Rapid AG Covid-19 Student and Staff Test Results

Elementary	1,150	Start	1/1/2021
Staff	510	End Date	3/31/2021
Middle	273	Area	All
High	198	School Na..	All

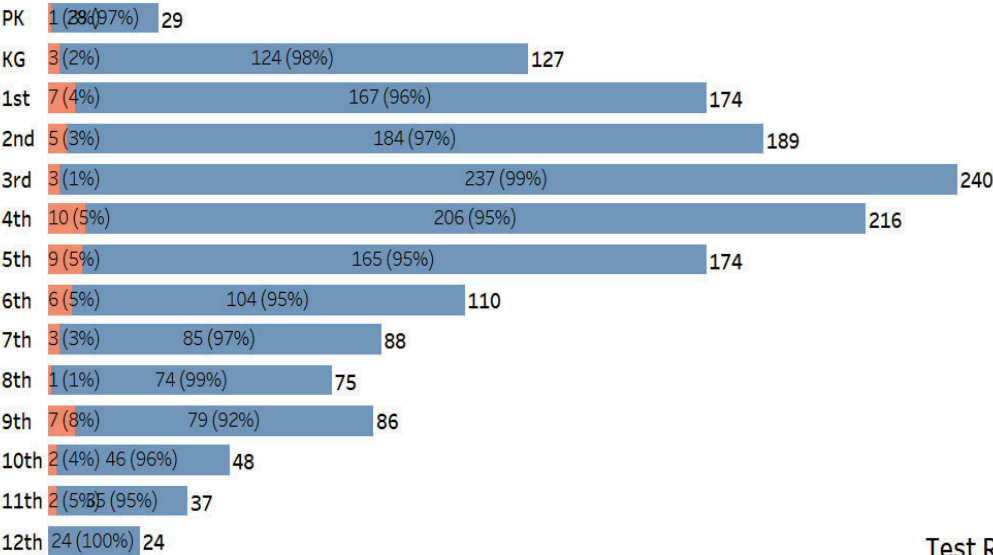
In-House Rapid AG tests performed **2,131**



## Symptom Breakdown for Positive Results



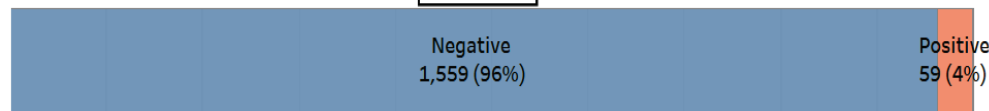
## Students Test Results by Grade



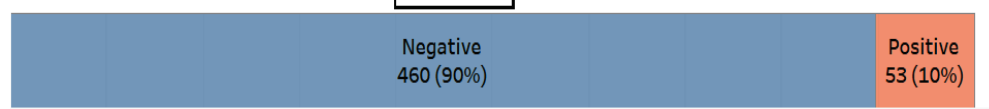
## Grade Distribution for Students Tested Positive



## Students Test Results Breakdown

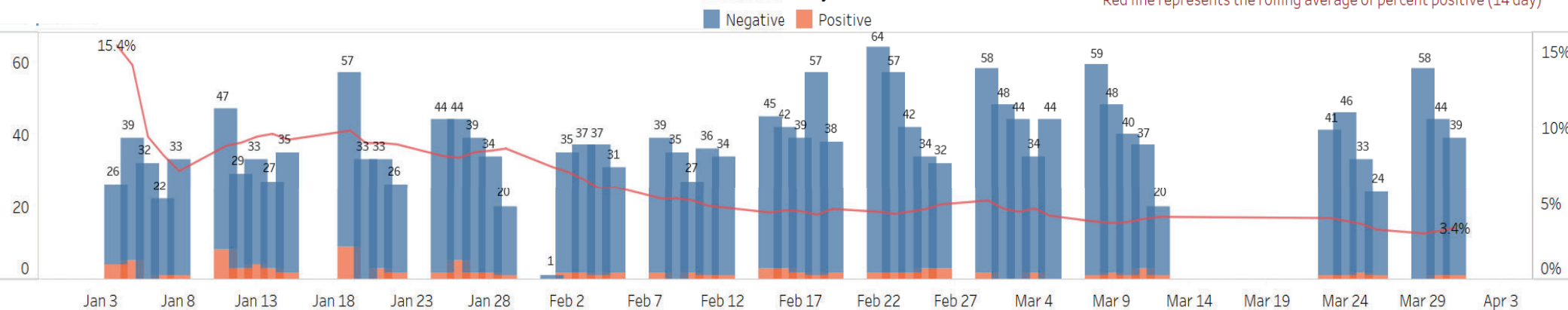


## Staff Test Results Breakdown



## Test Results by Date

Red line represents the rolling average of percent positive (14 day)





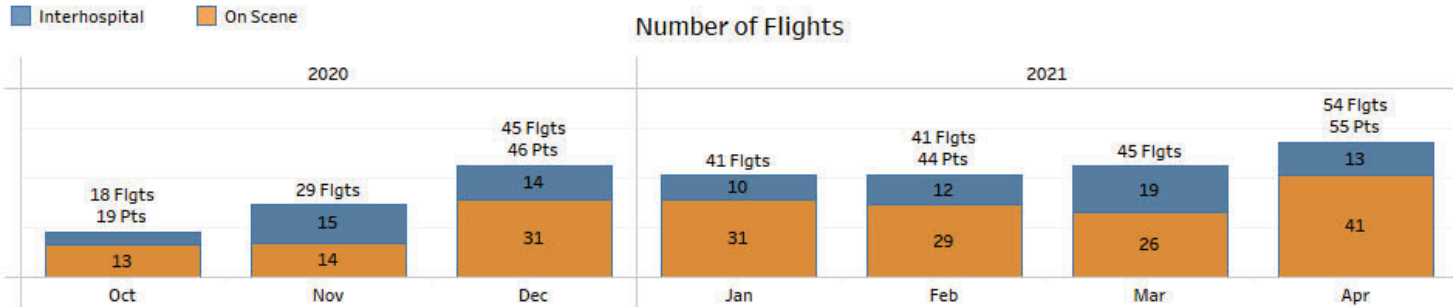
# Aeromedical Quality Report

Start Date  
10/1/2020

End Date  
5/13/2021

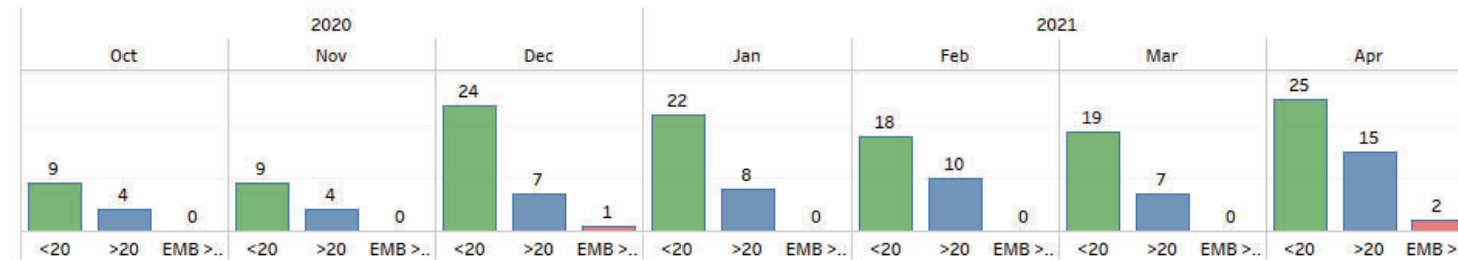
Flights **273**

Patients **279**



\*EMB - East of 20 Mile Bend

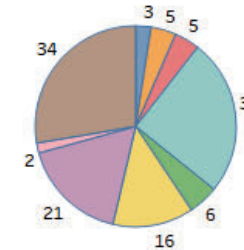
## Call to Scene (Minutes) for Scene Flights with 3 Legs or More



## Utilization

	2020			2021			
	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Hours Utilized	25	47	69	58	66	67	85
% Hours Utilized	5.8%	6.6%	9.5%	7.8%	10.2%	9.3%	9.1%
Available Hours	432	718	729	741	645	722	930
% Available Hours	39%	66%	65%	66%	60%	65%	86%

## Missed, Cancelled or Aborted Flights



**123**

Miss Start  
10/1/2020

Miss End  
5/13/2021

### Missed Reason

- Admin
- County Coverage
- Expired
- Maintenance
- Medical No Go
- No Backup
- Referring Agency
- Simultaneous Flight
- Weather

[Go to Detail](#)

## Average Times for Scene Flights

Year of Flight D..	Month of Flight Da..	On Scene	Disp To Enroute	Disp To OnScene
2020	Oct	10m 20s	4m 35s	15m 24s
	Nov	8m 41s	5m 30s	17m 0s
	Dec	9m 31s	5m 8s	16m 12s
2021	Jan	8m 2s	5m 7s	15m 51s
	Feb	7m 47s	5m 32s	17m 20s
	Mar	7m 47s	5m 2s	15m 46s
	Apr	11m 4s	5m 8s	16m 55s





# Detailed RunTime Report TH135

273

Start Date  
10/1/2020

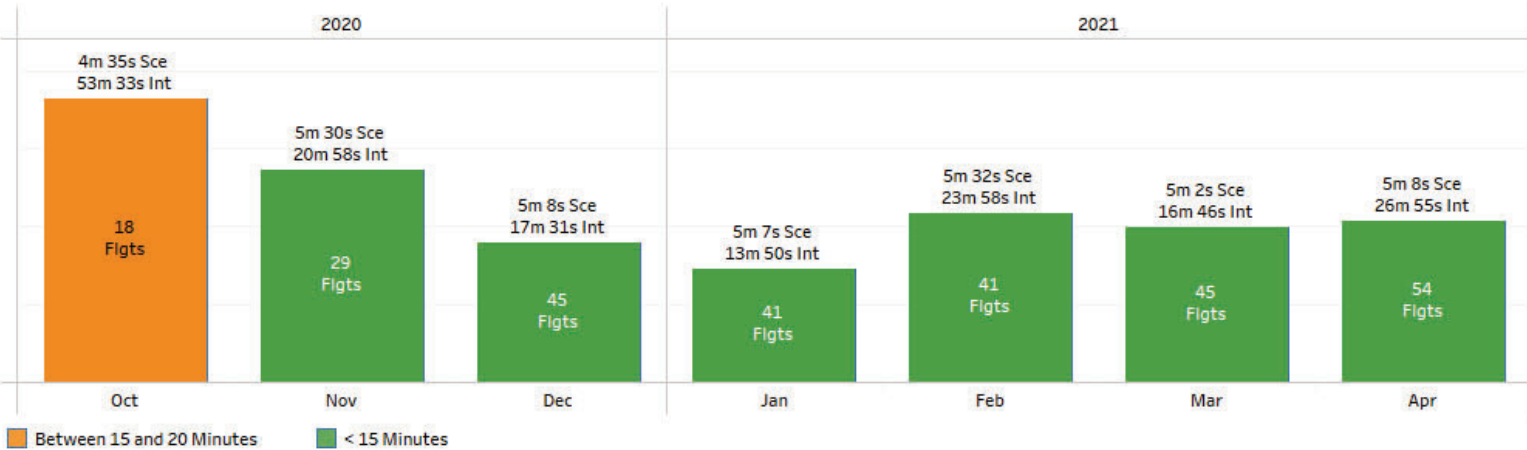
End Date  
5/13/2021

Flight Type  
All

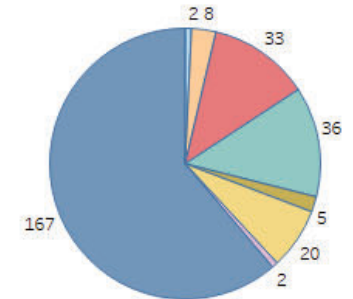
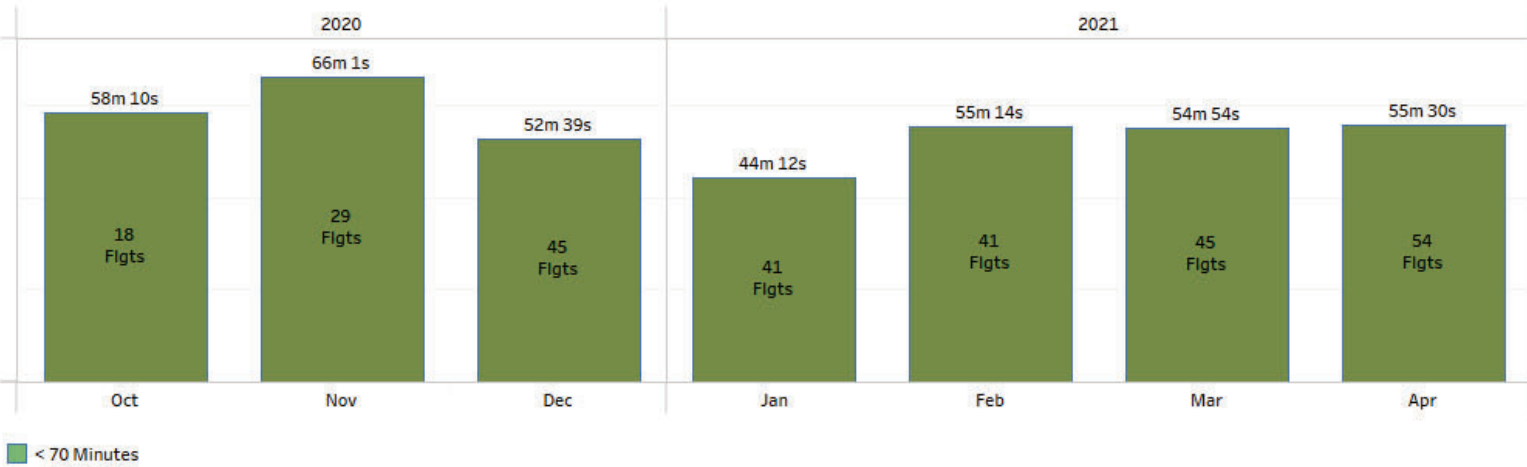
Patient Type  
All

20 Mile Bend  
All

Dispatch To Enroute Average



Dispatch To Hospital Average



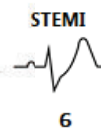
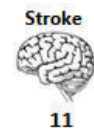
Patient Type

- ANEURYSM - THOR OR A...
- BURN
- CARDIAC
- NEUROLOGY
- OBSTETRIC
- OTHER
- PEDIATRIC NON TRAUMA
- TRAUMA



# AEROMEDICAL UTILIZATION

Q1 2021



**PATIENT TRANSPORTS BY TRAUMA HAWK (Q1 2021): 129**  
**Rolling Year (May 2020 - April 2021): 784**

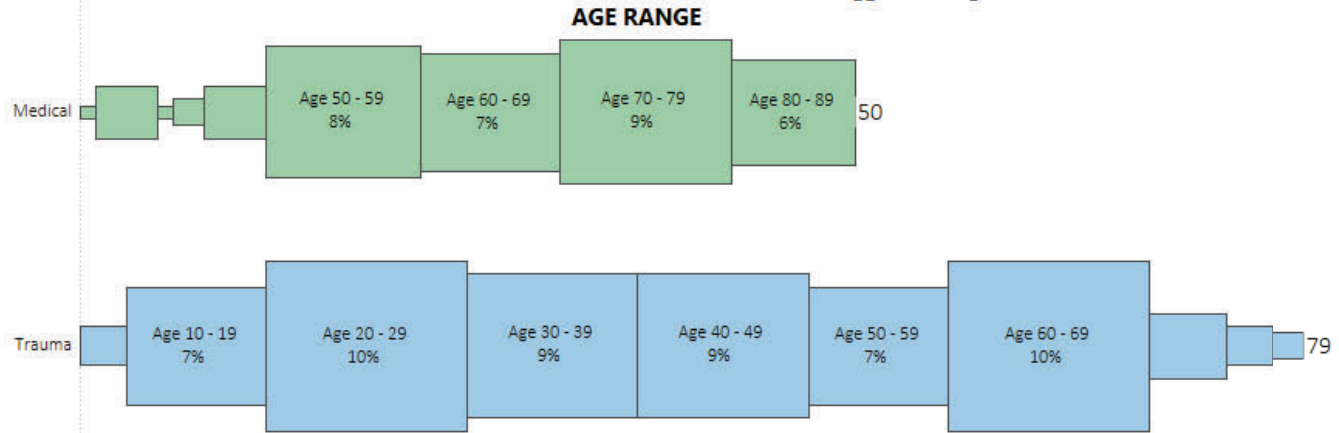
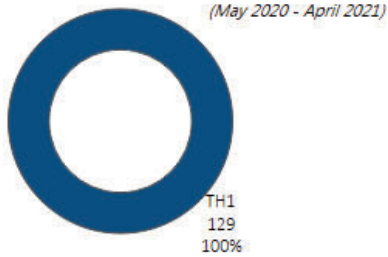
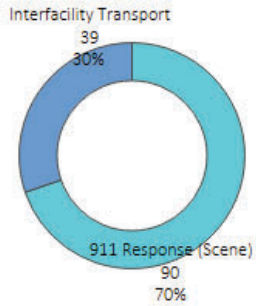
*\*Aeromedical Assist Flights are omitted from total flight numbers*

TH2 out of service: **September, 2020 - March, 2021**

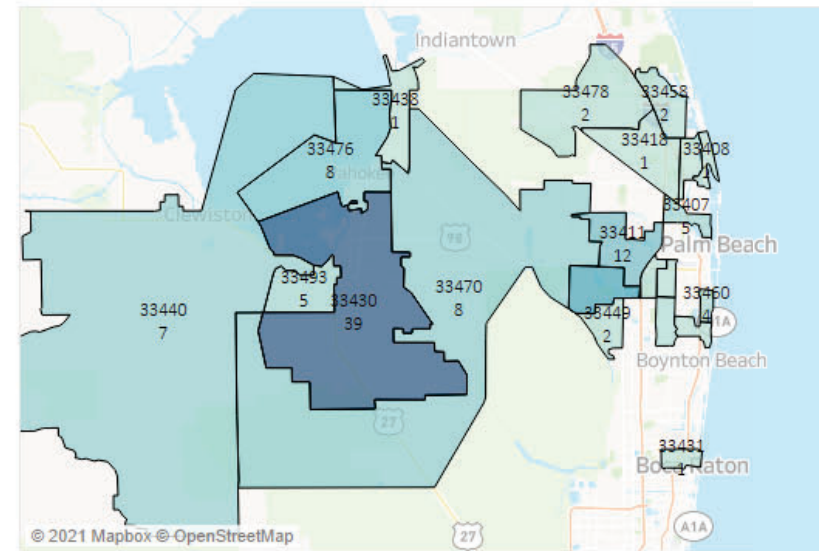
TH1 and TH2 out of service: **October 2020**

## SCENE / INTERFACILITY RESPONSE

## AIRCRAFT RESPONSE

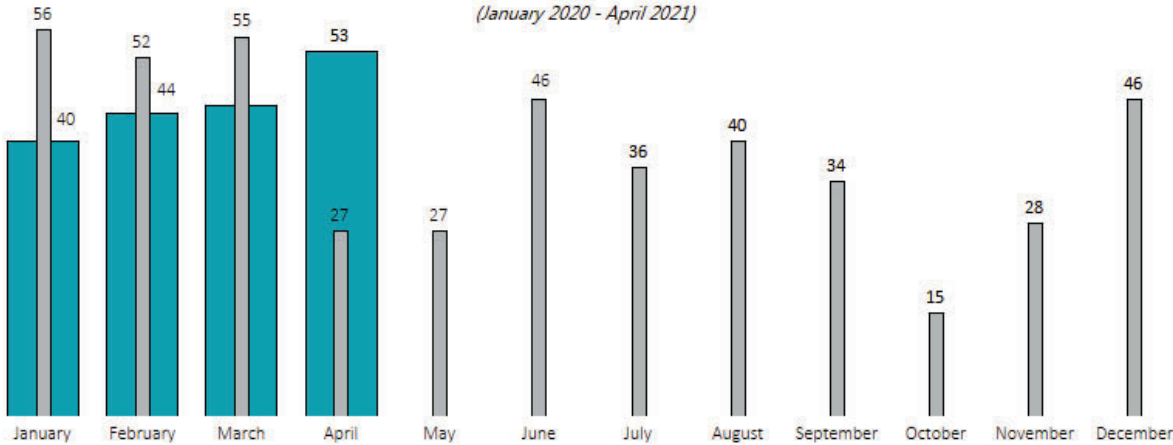


## ZIPCODE DISPATCH



## TOTAL FLIGHTS BY MONTH

2020 2021  
(January 2020 - April 2021)





# GAMUT ADVANCED AIRWAY BENCHMARK ANALYSIS

(Ground & Air Medical Quality Transport)

Q1 2021



**TOTAL PATIENTS TRANSPORTED BY TRAUMA HAWK: 129**

*\*Aeromedical Assist Flights are omitted from total flight numbers*



MEAN MOBILIZATION TIME (All Patient Transports): **6:14**

MEAN ON-SCENE TIME (STEMI Cases Only): **8:10**

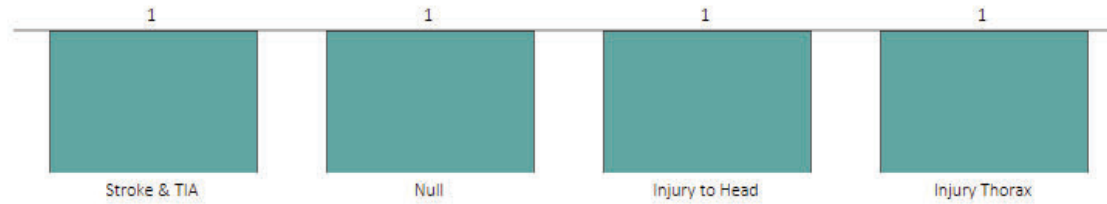
*\*Time format = mm:ss*

ENDOTRACHEAL TUBES **PLACED** BY TH CREW: **4**

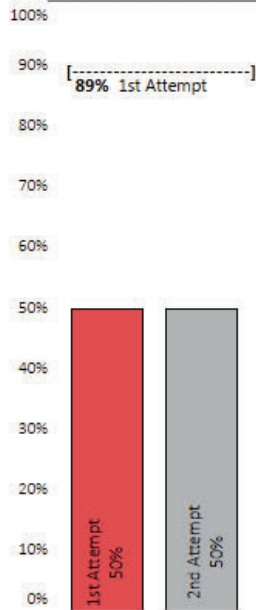
ENDOTRACHEAL TUBES **MANAGED** BY TH CREW: **11**

*\*Black dotted line represents GAMUT National Average [-----]*

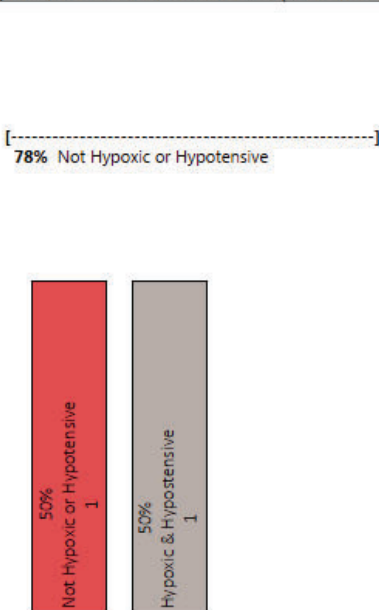
## INJURIES & MEDICAL EMERGENCIES REQUIRING INTUBATION BY TH CREW



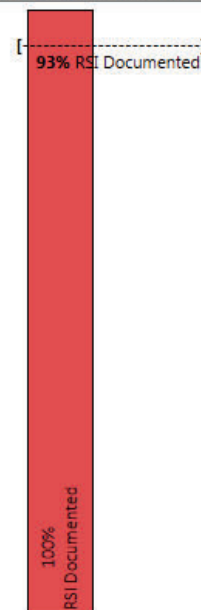
### 1ST ATTEMPT INTUBATION



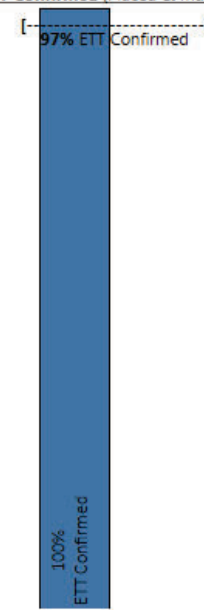
### W/OUT HYPOXIA OR HYPOTENSION (1ST ATTEMPT)



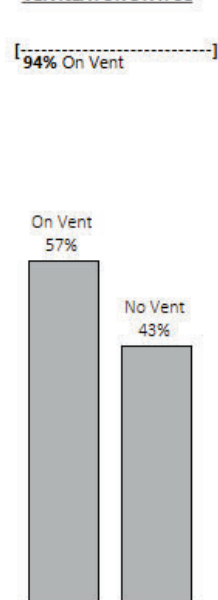
### RSI Protocol Documentation (ETT Placed)



### ETT Confirmed (Placed & Managed)



### VENTILATOR STATUS

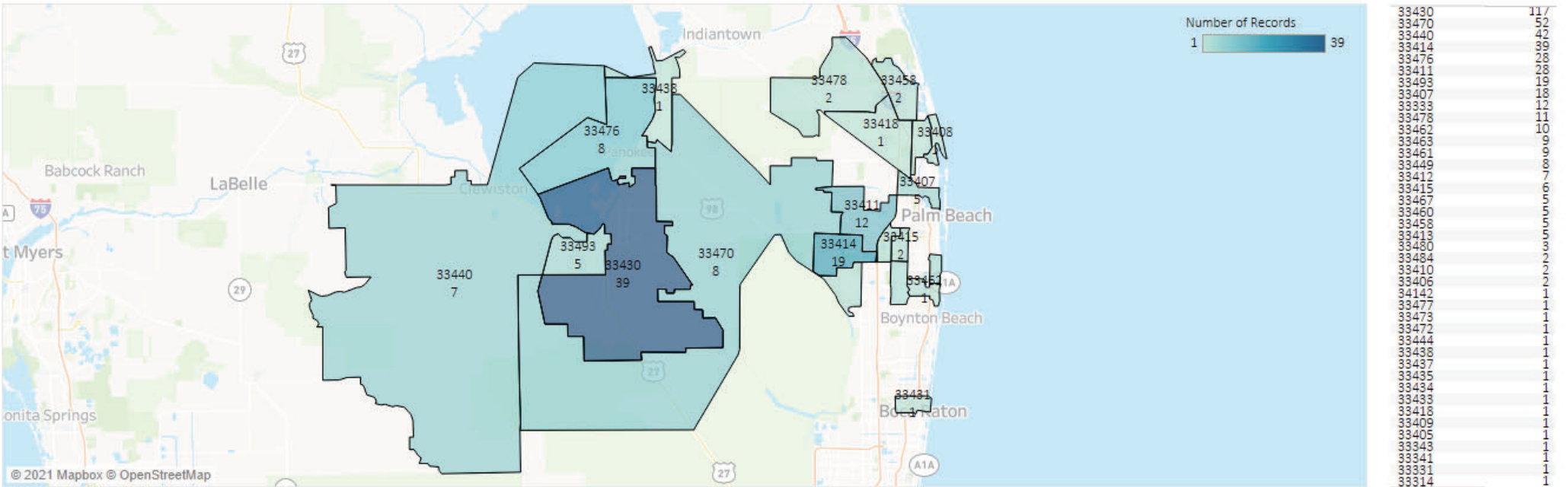
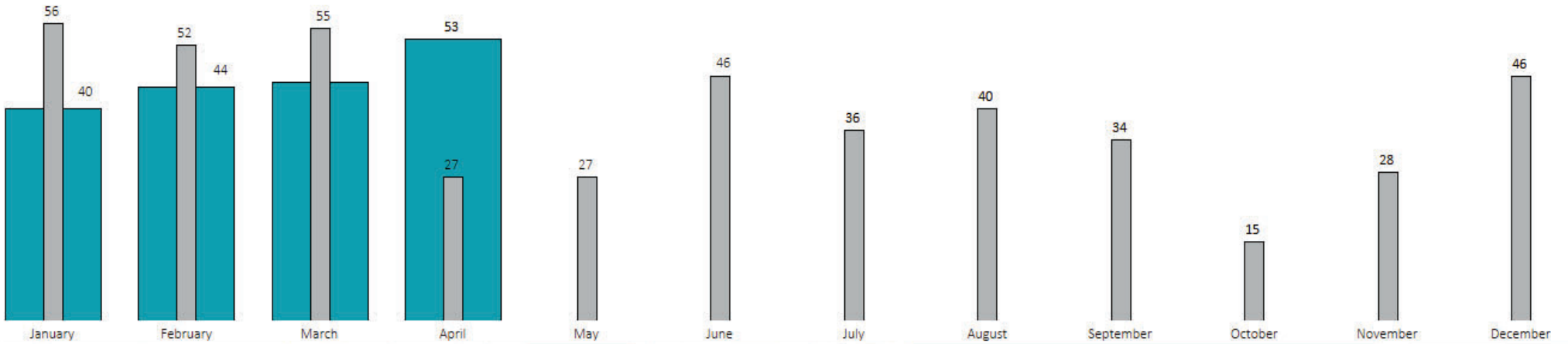


*\*A low ventilator status benchmark does not necessarily reflect the quality of patient care delivered.*

### TOTAL FLIGHTS BY MONTH

(January 2020 - April 2021)

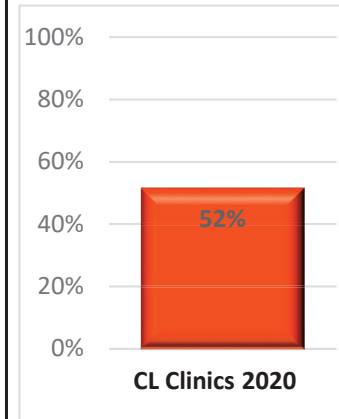
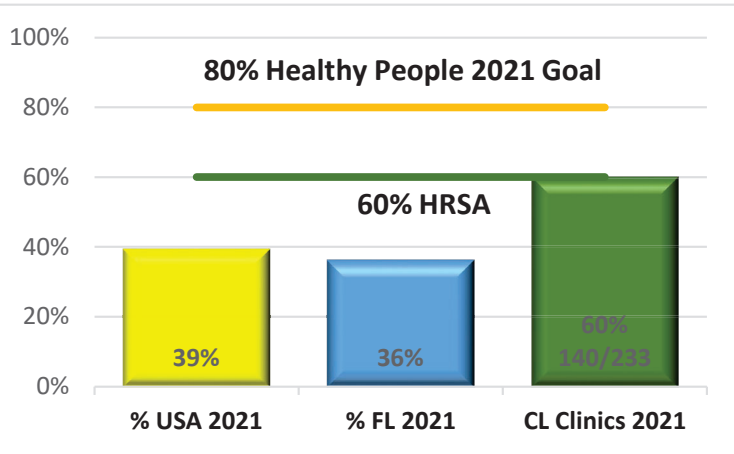
2020 2021



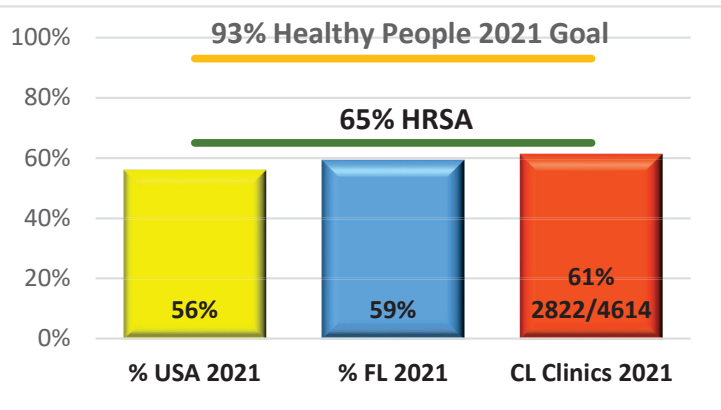


## C. L. BRUMBACK PRIMARY CARE CLINICS YTD March 2021

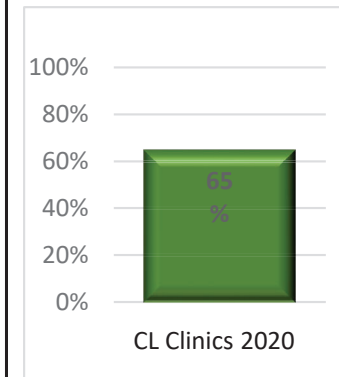
### CHILDHOOD IMMUNIZATION



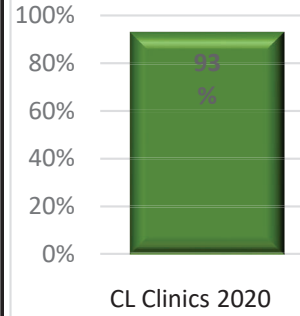
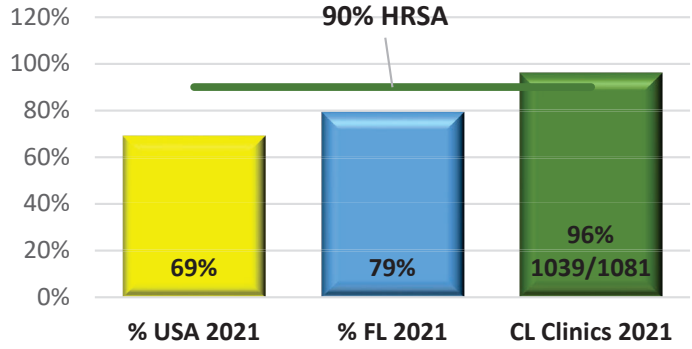
### CERVICAL CANCER SCREENING



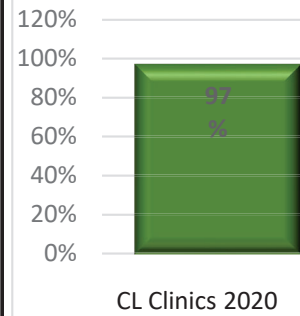
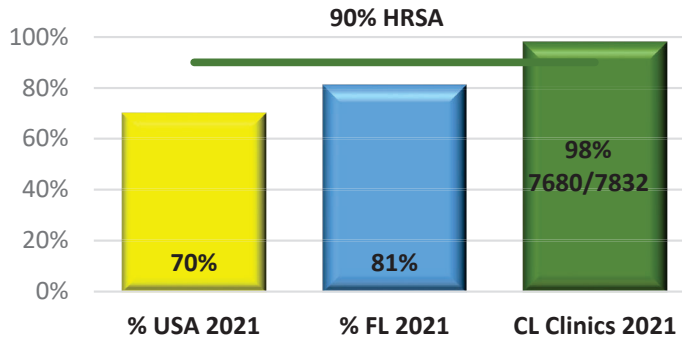
**Findings:** 1. Compared to February the score increased by 5%. 2. The QMR report is not capturing PAP smears done with HPV co-testing.  
**Interventions:** 1. List of patients with missing cervical cancer screenings will be stratified by clinic and the list will be provided to clinic supervisors to follow with MAs and providers on the day of patient's appointment to close the gap.  
 2. Providers will be reminded of proper documentation as per peer review findings related to cervical cancer screening.  
 3. Patient's with no schedule appointments and missing the metric will be scheduled by the call center.



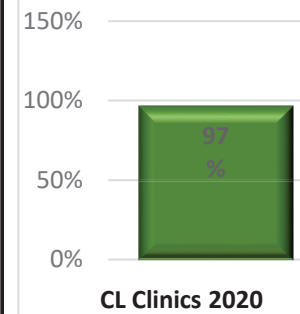
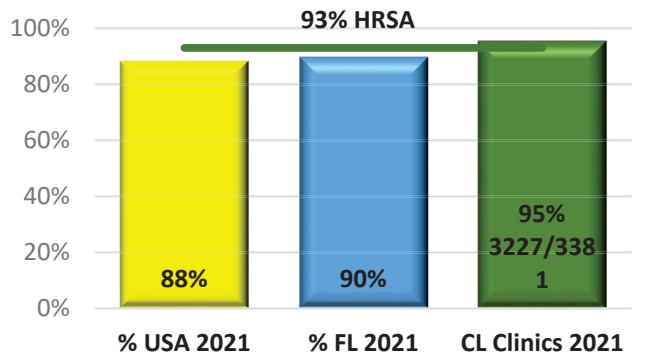
### WEIGHT SCREENING AND COUNSELING FOR CHILDREN AND ADOLESCENTS



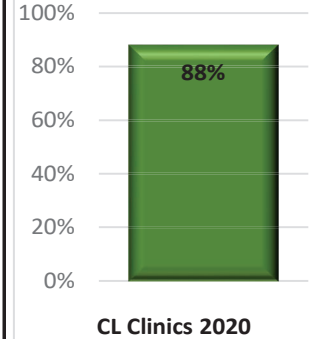
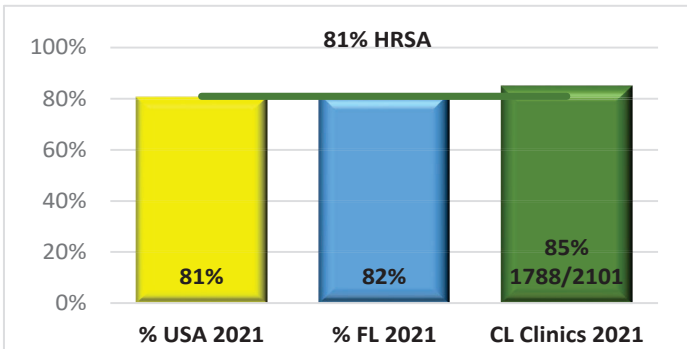
### ADULT WEIGHT SCREENING AND FOLLOW UP



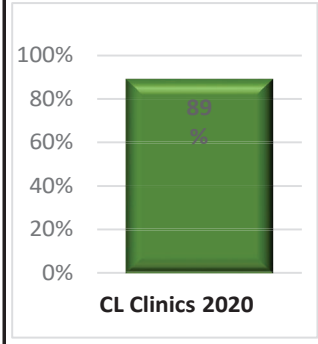
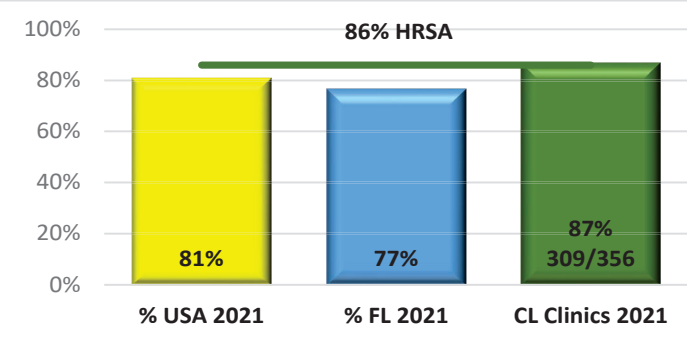
### TOBACCO USE SCREENING AND CESSATION INTERVENTION



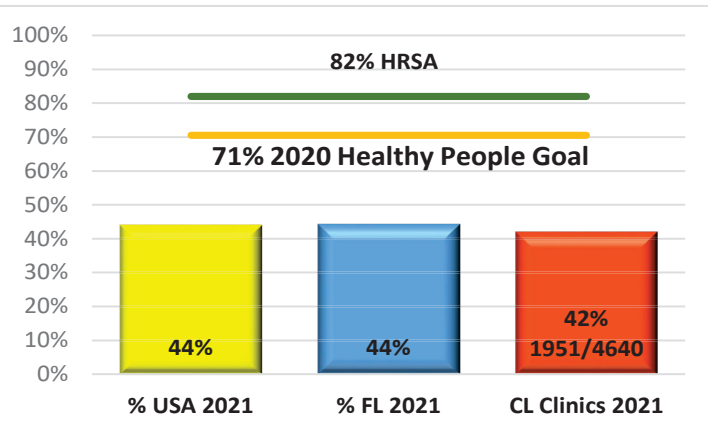
**CORONARY ARTERY DISEASE (CAD): LIPID THERAPY**



**ISCHEMIC VASCULAR DISEASE (IVD): Antiplatelet Therapy**

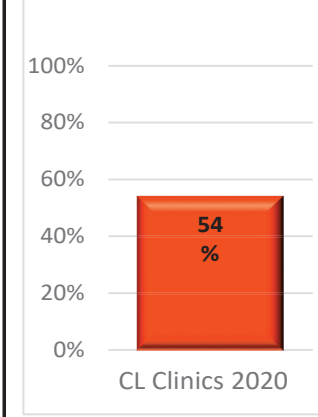


**COLORECTAL CANCER SCREENING**

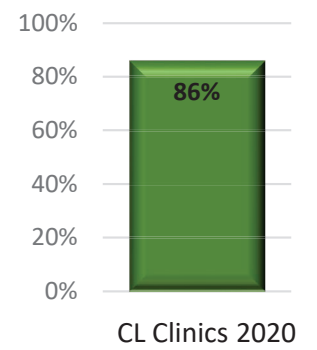
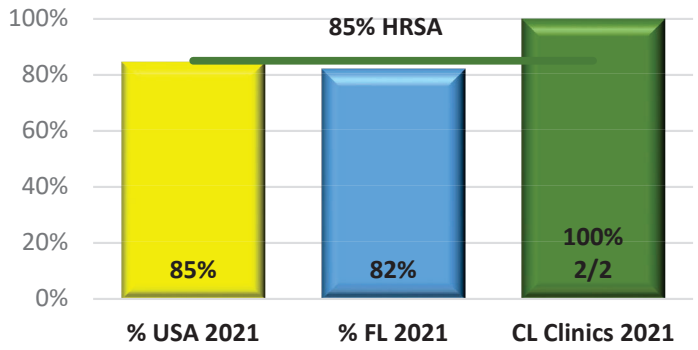


**Findings:** 1. Difficulty in getting FIT test returned from patient. 2. Some patients may have colonoscopies in Allscripts that have not been updated in Athena.

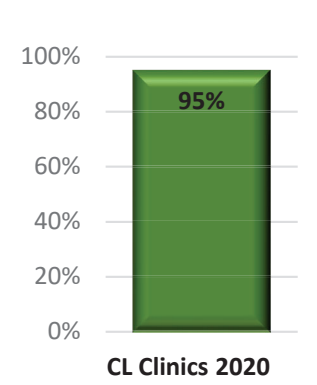
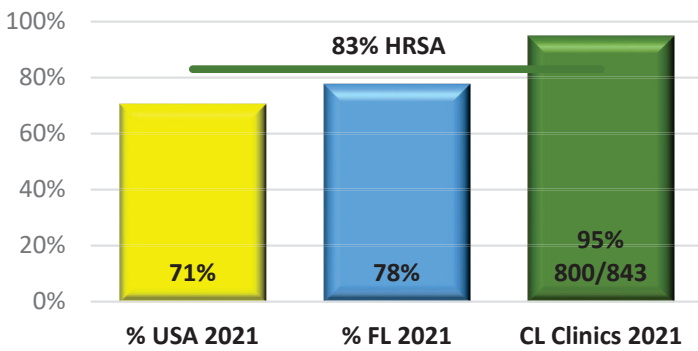
**Interventions:** 1. Encourage POD. 2. More robust patient follow up through phone call reminders. 3. Custom report developed and dashboard created 4. Work on importing colonoscopy quality data into Athena. 5. Plan charity colonoscopy program with community partners for uninsured patients.



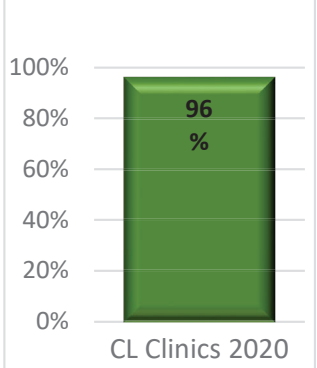
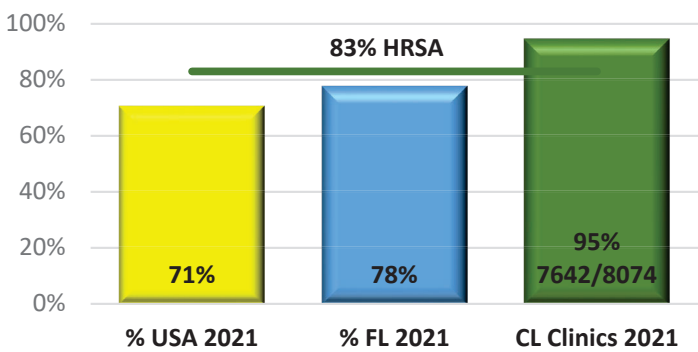
### HIV LINKAGE TO CARE



### PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP SPECIAL POPULATION: HOMELESS

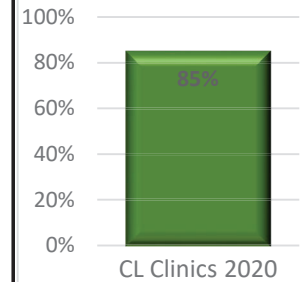
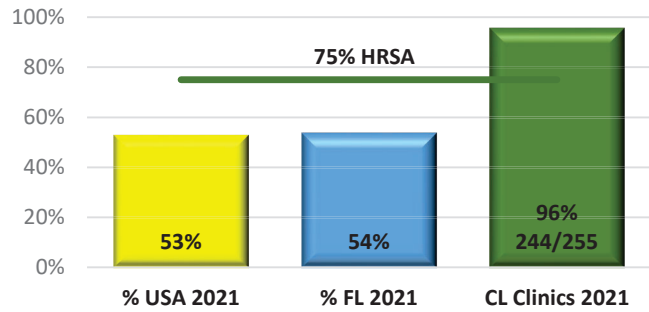


### PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP

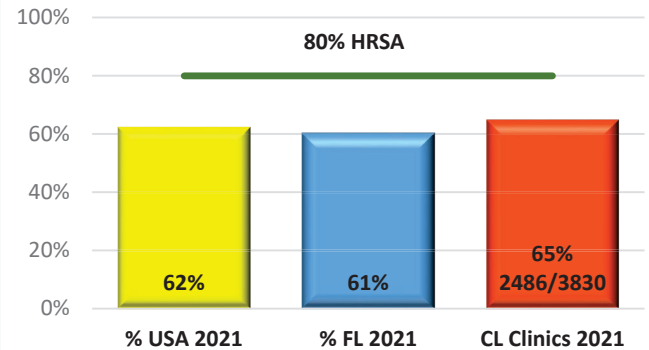




### DENTAL SEALANTS

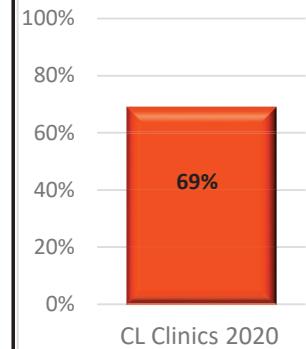


### HYPERTENSION

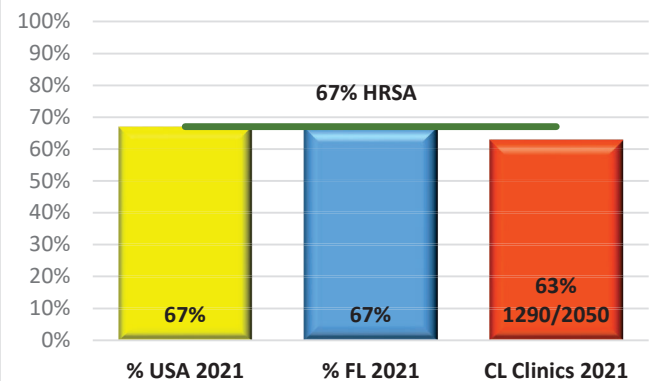


**Findings:** 1. These patients only include patients seen during the months of January and February, 2021. 2. the metric improved by 4% when comparing to the month of February.

**Interventions:** 1. The SOP for BP cuff from the AHA is finalized. Training will start at the beginning of May with the clinic nurses. Kara Baker will lead the training. 2. The new metric definition report including the 2020 population is been finalized to present the updated measure next month. 3. The call center will receive the monthly list of patients that are uncontrolled, needs data and do not have an appointment to schedule appointments. 4. The hypertension guidelines for C L Brumbak are bee revised during the month of May to set a future training for medical providers.

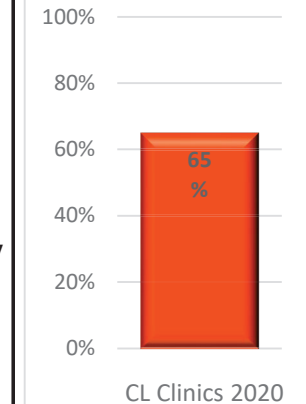


### DIABETES



**Findings:** There has been an increase in the number of patients with uncontrolled diabetes 63% vs. 55% in February.

**Interventions:** 1. POC HgbA1c testing implemented to increase patient compliance. 2. The list of 130 patients with uncontrolled diabetes or no A1c during 2021 was provided to the call center to set appointments. 3. The Diabetes Care and Education Specialist. 4. The diabetes distress scale pilot project is currently stopped as the Delray Clinic was not ready to implement. Currently we are evaluating if implementation can be done at Belle Glade Clinic. 5. The Diabetes Care and Education Specialist is currently setting up meetings with Associate Medical Director to start reviewing content of each educational module of the self- education diabetes program.



### Clinic Service Center Stats

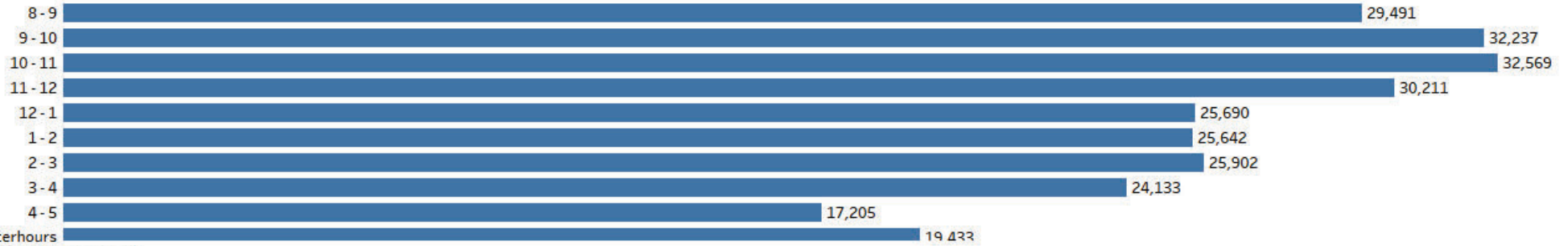
Start Date  
1/1/2021

End Date  
3/31/2021

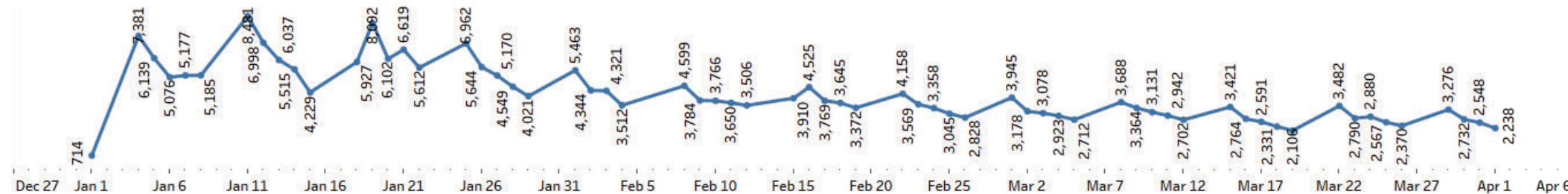
<b>Number of Calls</b>	<b>262,513</b>
<b>Unique Phone Numbers</b>	<b>88,205</b>

Anonymous numbers counted individually

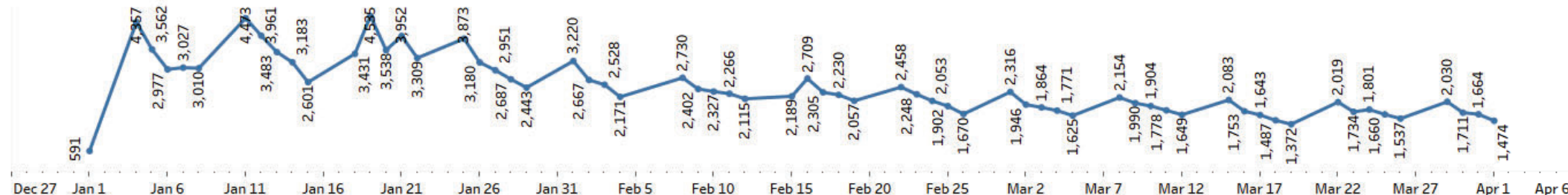
2021



### Calls Received



### Unique Numbers

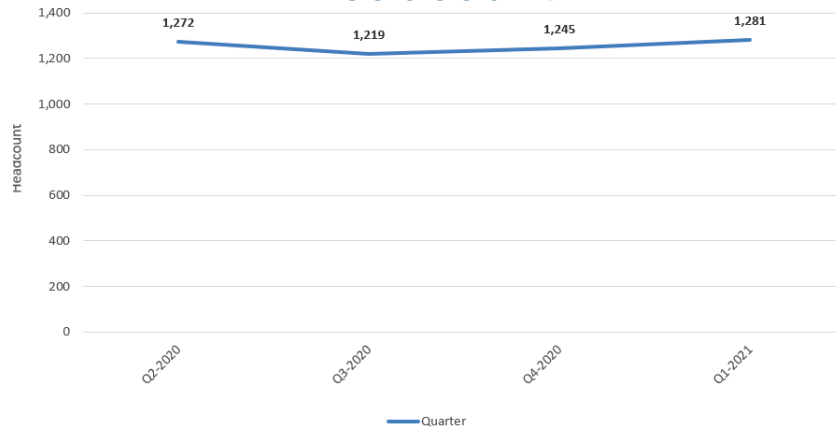




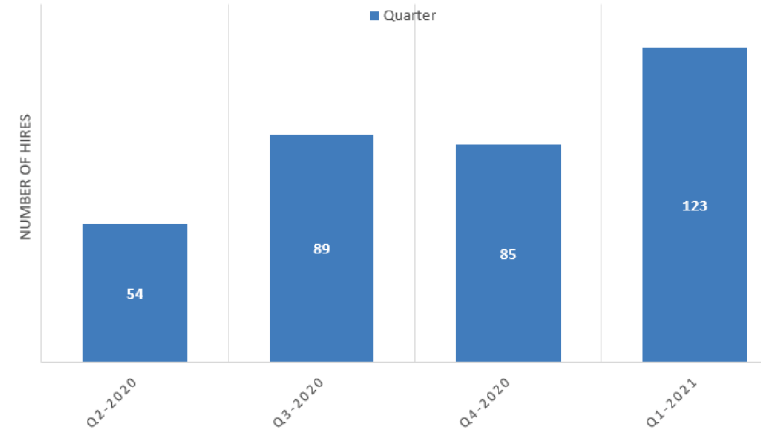
# HCD HR Dashboard- Attrition

## Q2 2020 – Q1 2021

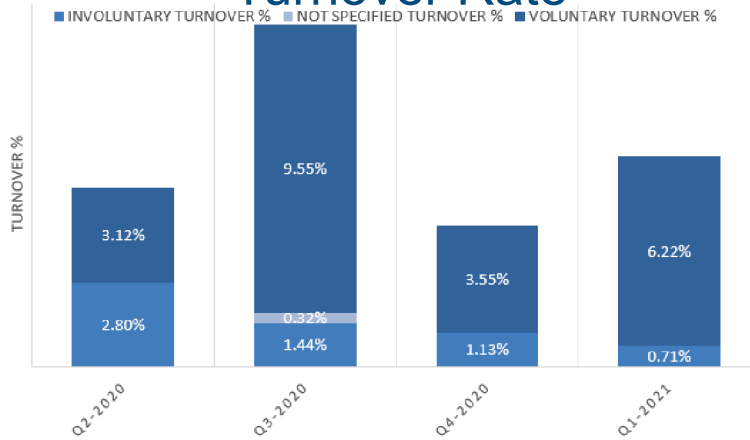
### Headcount



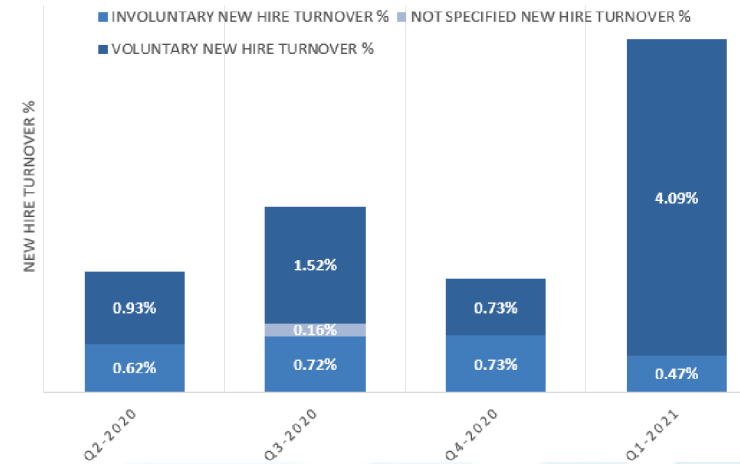
### New Hires



### Turnover Rate



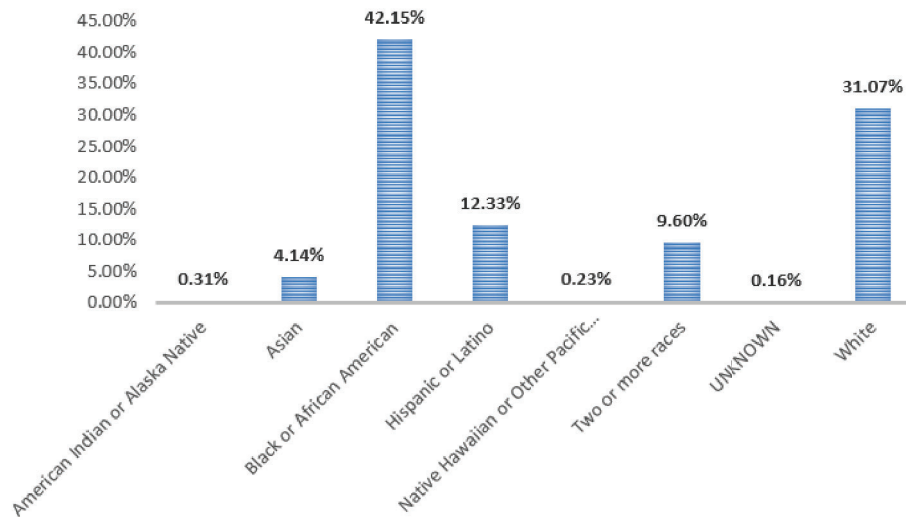
### New Hire Turnover Rate





# HCD HR Dashboard- *Diversity* Q2 2020 – Q1 2021

Minority Headcount  
**68.76%**



Average Age

**46.47**

Female Percentage

**80.41%**

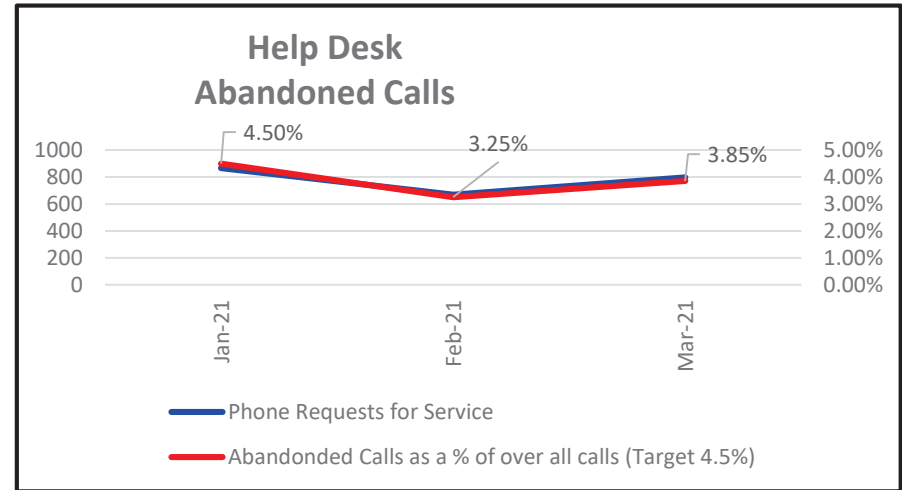
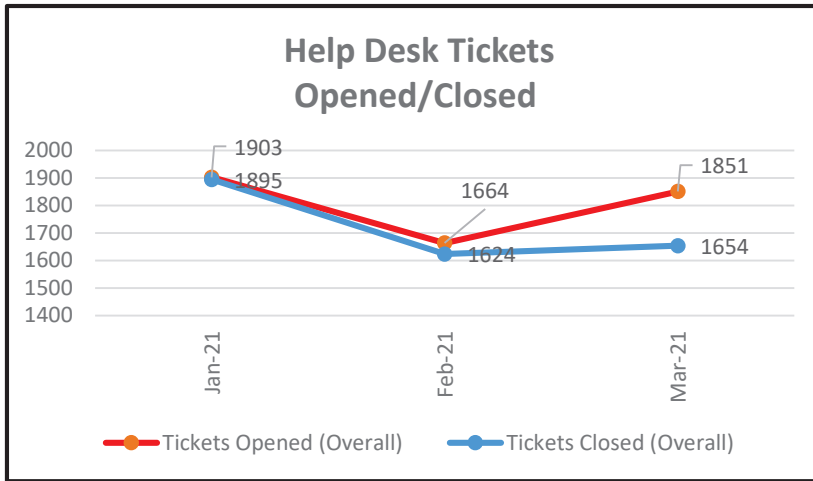
## Mission Critical Application Availability

Application	Function	Jan '21	Feb'21	Mar'21	SLA
ADP	Human Resources	100%	100%	100%	99.9%
AthenaHealth	Clinics medical record	100%	100%	100%	99.9%
Dentrix	Dental medical record	100%	100%	100%	99.9%
Doximity	Telemedicine	100%	100%	100%	99.9%
eFinance Plus	Finance	100%	100%	100%	99.9%
MatrixCare	The Healey medical record	100%	100%	100%	99.9%
Medhost	LMC medical record	100%	100%	100%	99.9%
Phreesia	Vaccine Self Scheduling	100%	99.5%	98.5%	99.9%

Date	Major outages
2/19/21 Phreesia	1 hour - Communication issue with Athena
3/08/21 Phreesia	2 hr 45 - Dashboard unavailable



# IT Dashboard



## Cybersecurity Investigations

Period 01/1/2021 – 03/31/2021

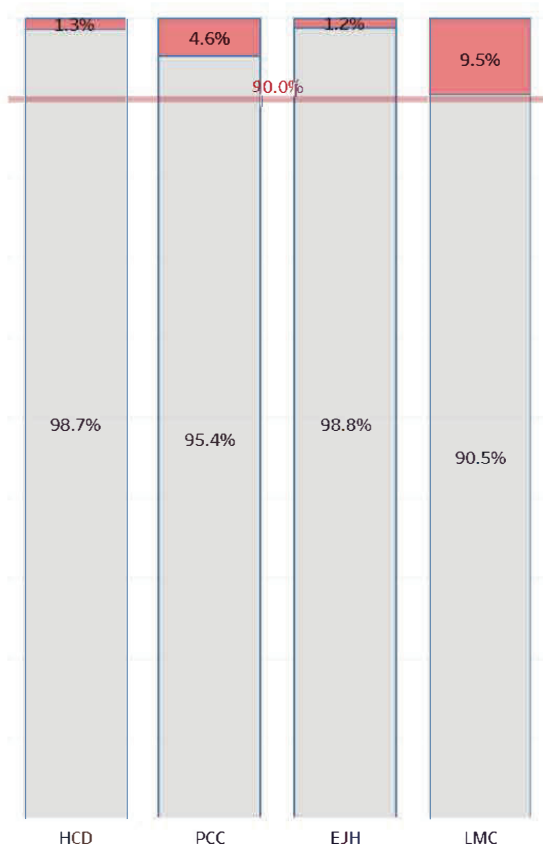
Status	Cases	% of Total
Closed	191	100%
In Progress	0	0
<b>Total</b>	<b>191</b>	<b>100%</b>

Comparisons	Cases
Q12021	191
2020	390
2019	78

Outcome	Cases	% of Total
Investigated	191	100%
Reportable	0	0%
<b>Total</b>	<b>191</b>	<b>100%</b>

# LEGAL CONTRACTS MANAGEMENT

Outliers

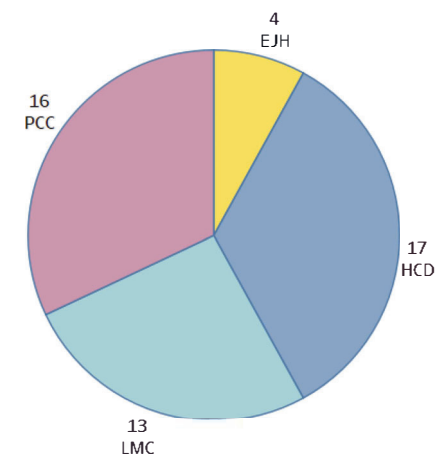


Contract Metrics by Site

Location	2021 Q1					Grand Total
	Expedited	New	Outliers	Total Closed	Total Pending	
EJH	1 1%	11 13%	1 1%	12 14%	58 70%	83 100%
HCD	29 19%	52 34%	2 1%	47 30%	25 16%	155 100%
LMC	1 2%	24 38%	6 10%	20 32%	12 19%	63 100%
PCC	20 23%	28 32%	4 5%	18 21%	17 20%	87 100%

\* New + Expedited = Incoming Requests for the Quarter

Average Weekly Pending by Location



Location

EJH	EJ Healey Center	<span style="color: yellow;">■</span>
HCD	Health Care District	<span style="color: blue;">■</span>
LMC	Lakeside Medical Center	<span style="color: teal;">■</span>
PCC	CL Brumbak Primary Care Clinics	<span style="color: purple;">■</span>

Metric

<b>Avg Pending</b>	Average Pending Weekly
<b>Expedited</b>	Expedited Requests (5-7 days targeted)
<b>New</b>	New Requests (45 days targeted)
<b>Outliers</b>	Outliers (processed after 45 days)
<b>Total Closed</b>	Total Closed
<b>Total Pending</b>	Total Pending



# Edward J. Healey Rehabilitation and Nursing Center

## Quality Report

### 1st Quarter 2021

#### Percentages

#### MDS 3.0 Facility Level Quality Measure Report

Note: Comparison Group National Percentile QMs that cross the threshold equal to or greater than 75 percentile is emphasized on the survey or any internal quality improvement initiative

	Current Quarter	Actions Taken When Indicator Not Meeting Goal	Previous Quarters
<b>High Risk Long Stay Residents with Pressure Ulcer</b>	<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>67%</p> <p>Q1 2021</p>	<p><b>Findings:</b> 7 residents were admitted with pressure ulcers, 3 residents had a re-current pressure ulcer in which 2 has since resolved.</p> <p><b>Interventions:</b> (1) Weekly review /assessment of wound progress, prevention initiatives, therapy evaluation, and nutritional consult. (2) Review accuracy of coding pressure ulcer on the MDS assessment. (3) Evaluation of wound by Wound MD.</p>	<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>76% 46% 62%</p> <p>Q4 2020 Q3 2020 Q2 2020</p>
<b>New/Worse Pressure Ulcer(s)</b>	<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal:...</p> <p>3.1%</p> <p>0%</p> <p>Q1 2021</p>		<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>2.9% 1.7% 2%</p> <p>Q4 2020 Q3 2020 Q2 2020</p>



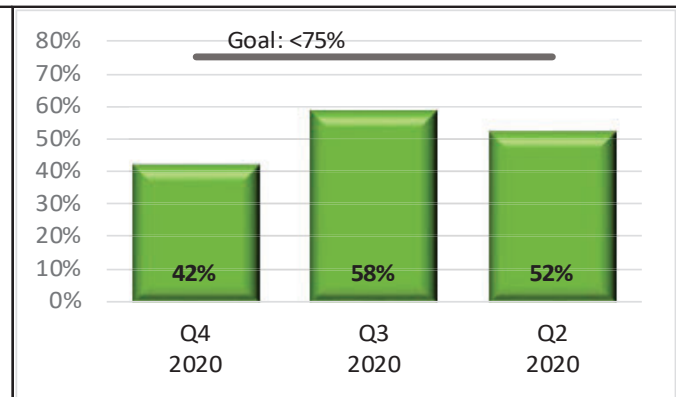
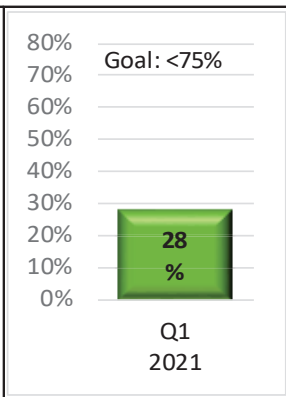
<p><b>Experiencing One or More Falls with Major Injury</b></p>	<p>80% Goal: &lt;75% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p><b>20%</b></p> <p>Q1 2021</p>		<p>80% Goal: &lt;75% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p><b>19%</b> <b>18%</b> <b>0%</b></p> <p>Q4 2020 Q3 2020 Q2 2020</p>
<p><b>Falls (L)</b></p>	<p>80% Goal: &lt;75% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p><b>5%</b></p> <p>Q1 2021</p>		<p>80% Goal: &lt;75% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p><b>6%</b> <b>7%</b> <b>9%</b></p> <p>Q4 2020 Q3 2020 Q2 2020</p>
<p><b>Who Have Depressive Symptoms</b></p>	<p>80% Goal: &lt;75% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p><b>0%</b></p> <p>Q1 2021</p>		<p>80% Goal: &lt;75% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p><b>0%</b> <b>0%</b> <b>0%</b></p> <p>Q4 2020 Q3 2020 Q2 2020</p>

<p><b>Who Lose Too Much Weight</b></p>	<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p>17%</p> <p>Q1 2021</p>		<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p>25%</p> <p>31%</p> <p>15%</p> <p>Q4 2020 Q3 2020 Q2 2020</p>
<p><b>Who Received an Antipsychotic Medication (L)</b></p>	<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p>20%</p> <p>Q1 2021</p>		<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p>22%</p> <p>29%</p> <p>29%</p> <p>Q4 2020 Q3 2020 Q2 2020</p>
<p><b>Who Received an Antipsychotic Medication (S)</b></p>	<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p>0%</p> <p>Q1 2021</p>		<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p>0%</p> <p>0%</p> <p>0%</p> <p>Q4 2020 Q3 2020 Q2 2020</p>

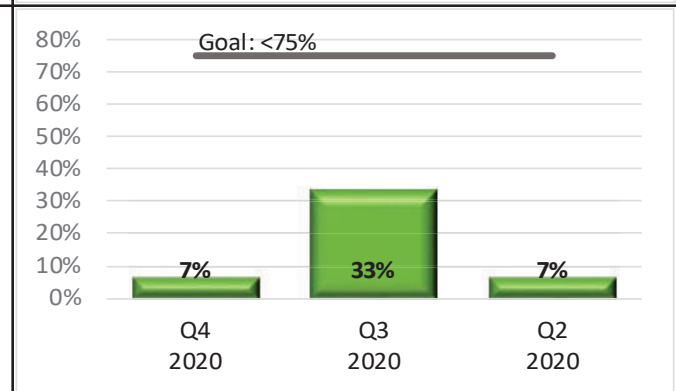
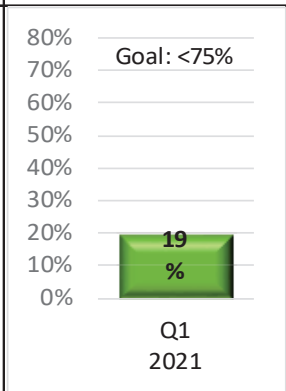
<p><b>Who Received Anti-Anxiety or Hypnotic Medication</b></p>	<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p><b>39%</b></p> <p>Q1 2021</p>		<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p><b>59%</b> <b>58%</b> <b>49%</b></p> <p>Q4 2020 Q3 2020 Q2 2020</p>
<p><b>Who Were Physically Restrained</b></p>	<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p><b>0%</b></p> <p>Q1 2021</p>		<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p><b>0%</b> <b>0%</b> <b>0%</b></p> <p>Q4 2020 Q3 2020 Q2 2020</p>
<p><b>Whose Behavioural Symptoms Affect Others</b></p>	<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p><b>24%</b></p> <p>Q1 2021</p>		<p>80% Goal: &lt;75%</p> <p>70%</p> <p>60%</p> <p>50%</p> <p>40%</p> <p>30%</p> <p>20%</p> <p>10%</p> <p>0%</p> <p><b>38%</b> <b>39%</b> <b>31%</b></p> <p>Q4 2020 Q3 2020 Q2 2020</p>

<p><b>Increase ADL Help (L)</b></p>	<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>21% Q1 2021</p>		<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>17% 21% 47% Q4 2020 Q3 2020 Q2 2020</p>
<p><b>With a Catheter Inserted and Left in the Their Bladder</b></p>	<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>0% Q1 2021</p>		<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>46% 41% 74% Q4 2020 Q3 2020 Q2 2020</p>
<p><b>With a Urinary Tract Infection</b></p>	<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>63% Q1 2021</p>		<p>80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Goal: &lt;75%</p> <p>38% 37% 64% Q4 2020 Q3 2020 Q2 2020</p>

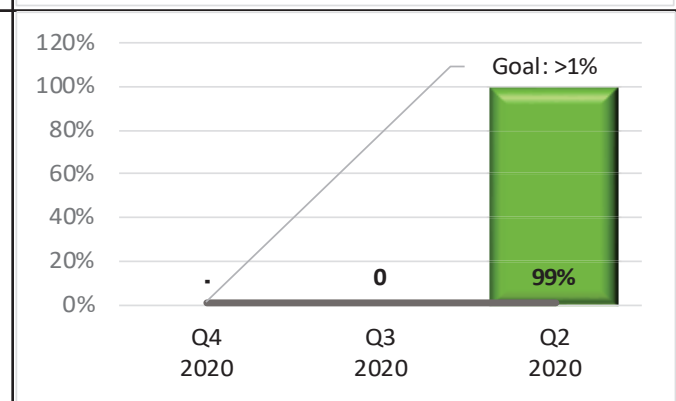
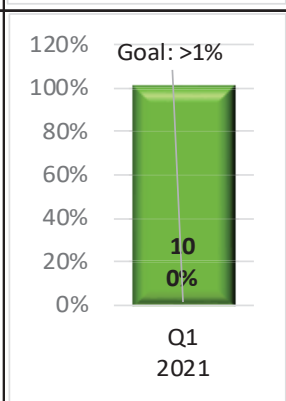
**Low Risk LSRs Who Lose Control of their Bowel or Bladder**



**Move Independent Worsens (L)**



**Improvement in Function (S) Higher % Better**



## QUALITY CORE MEASURES REPORT

### 1st Quarter (January - March 2021) - Preliminary

#### Sampled Population

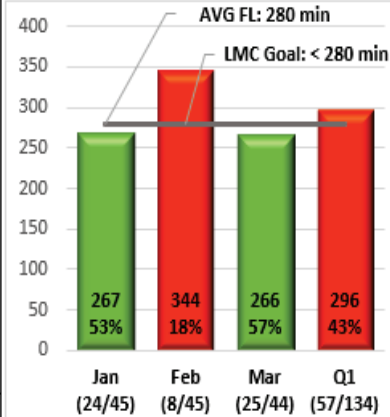


#### INPATIENT QUALITY MEASURES

##### Emergency Department: ED-1a

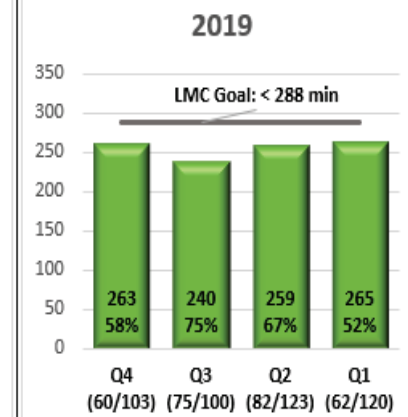
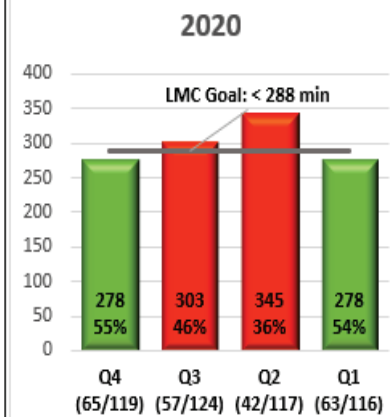
**Median time from ED arrival to ED departure for admitted patients.**

**Numerator:** Departed ED in less than 280 minutes.  
**Denominator:** Measure sampled population for any ED Patient from the facility's emergency department.



**Findings:** The goal of <280 minutes was not met for this quarter. The top (5) cases were reviewed by the ACMO. During the month of February there was an increase in the median time for ED departure due higher census and bed availability.

**Interventions:** The nursing and medical staff provided appropriate care and no further action was required.

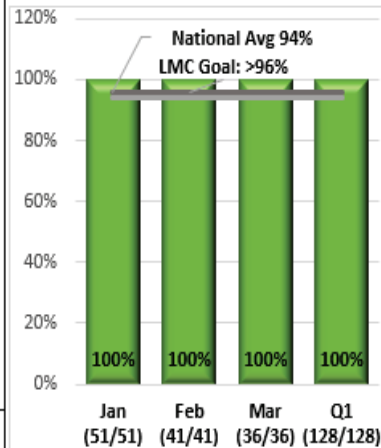


TJC

#### IMM-2 Influenza Immunization

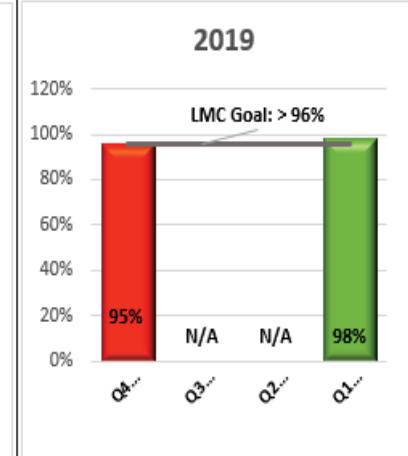
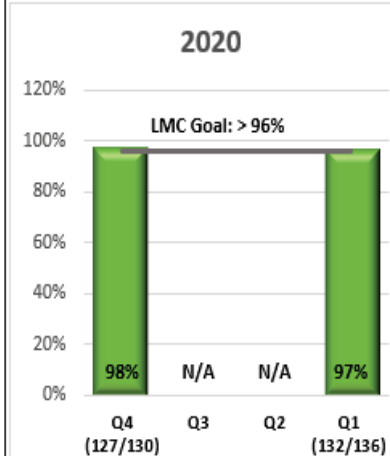
**Immunizations (seasonal):**

**Numerator:** Number hospitalized inpatients 6 months or older screened for seasonal Influenza immunization status and vaccinated if indicated.  
**Denominator:** Acute care hospitalized inpatients age 6 months and older discharged during: October, November, December, January, February or March.



**Findings:** The goal of >96% was met for this quarter.

**Interventions:** No action was required.



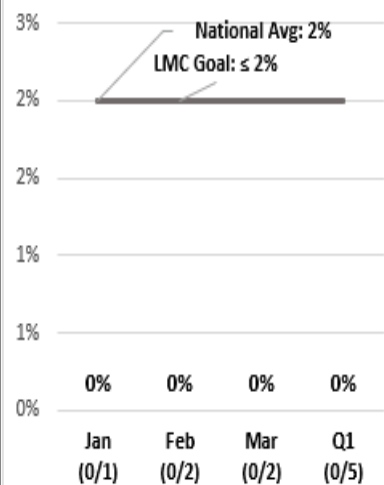
TJC

**INPATIENT QUALITY MEASURES**

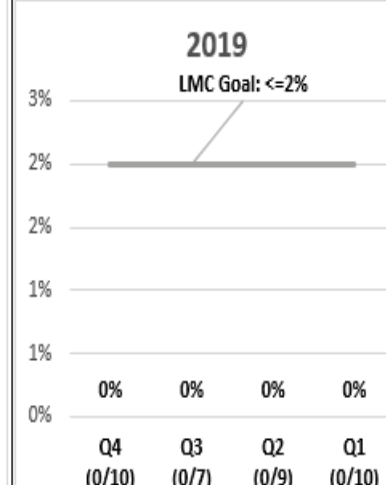
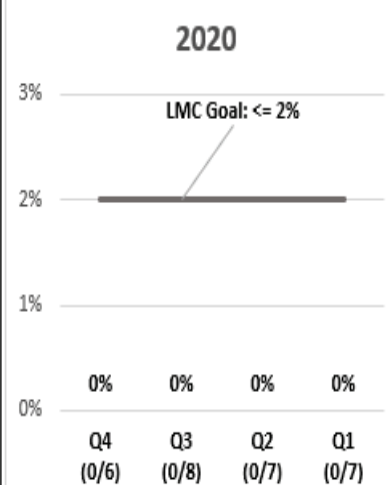
**Perinatal Care: PC-01**

**Patients with elective vaginal deliveries or elective cesarean births at  $\geq 37$  and  $< 39$  weeks of gestation completed.**  
(Lower percentage is better, for cases that fall into measure).

**Numerator:** Patients with elective deliveries.  
**Denominator:** Patients delivering newborns with  $\geq 37$  and  $< 39$  weeks of gestation completed.



**Findings:** The goal of  $\leq 2\%$  was met for this quarter.  
**Interventions:** No action was required.

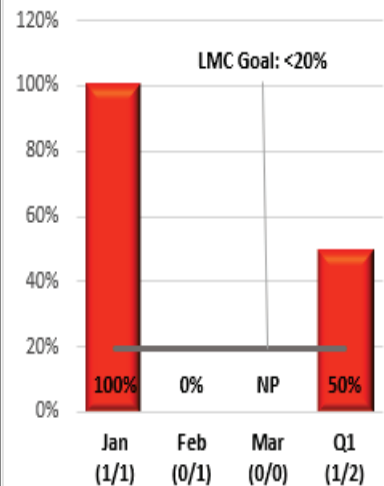


CMS/TJC

**Perinatal Care: PC-02**

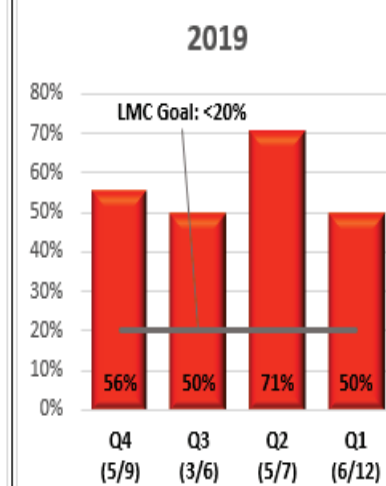
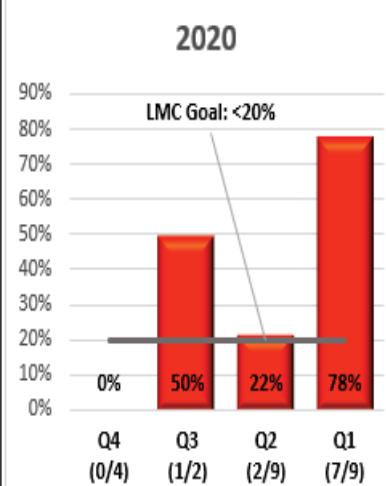
**Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth**  
(Lower percentage is better).

**Numerator:** Patients with cesarean births.  
**Denominator:** Nulliparous patients delivered of a live term singleton newborn in vertex presentation.



**Findings:** The goal of  $<20\%$  was not met for this quarter. The one case was reviewed and care rendered was appropriate.

**Interventions:** No action was required.



TJC

**INPATIENT QUALITY MEASURES**

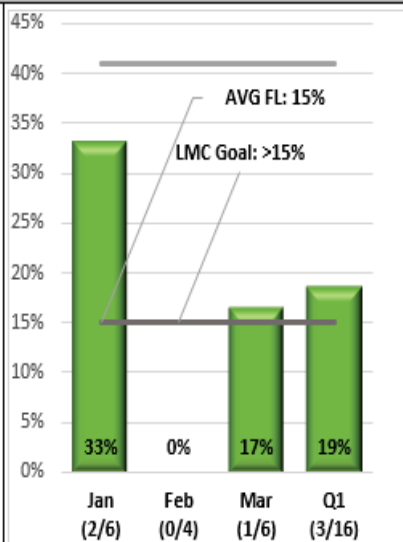
**Perinatal Care: PC-05**

**Exclusive breast milk feeding during the newborn's entire hospitalization.**

(Higher percentage is better)

**Numerator:** Number of moms Exclusively Breast Feeding.

**Denominator:** Single term newborns discharged alive from the hospital.



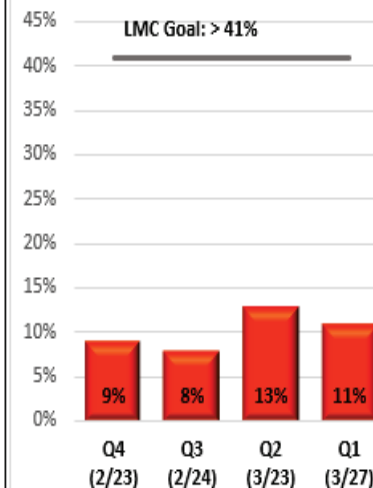
**Findings:** The goal of 15% was not met for this quarter. Based on review of all of the sampled population (3) strictly breast fed, (8) both breast and bottle fed and (5) bottle fed only.

**1Q (January-March) 2021:**

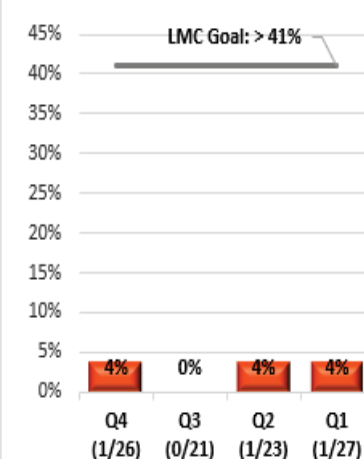
**Total Deliveries:** (18) Live Births (17) Breast Feeding Stats: (3) strictly breast fed (9)breast and bottle fed and (5) bottle fed only.

**Interventions:** The OB staff continue to attend the monthly scheduled Breastfeeding Coalition Meetings. For on go training and education, all staff attended a Virtual Breast Feeding Conference in April 2021 hosted by the Breastfeeding Coalition.

**2020**



**2019**



TJC

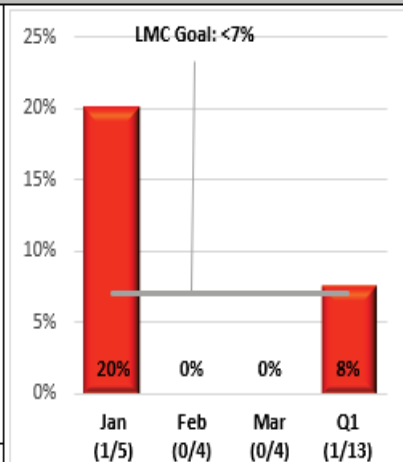
**Perinatal Care: PC-06**

**Unexpected Complications in Term Newborns.**

(Lower percentage is better)

**Numerator:** Newborns with severe complications and moderate complications.

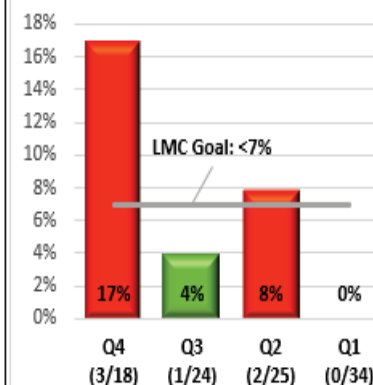
**Denominator:** Liveborn single term newborns 2500 gm or over in birth weight.



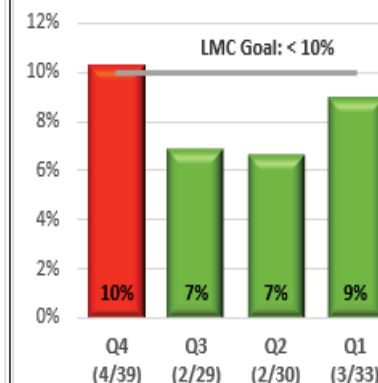
**Findings:** The goal of <7% was not met for this quarter. The (1) case was reviewed by the ACO.

**Interventions:** The nursing and medical staff provided appropriate care and no action was required.

**2020**



**2019**



TJC



**INPATIENT QUALITY MEASURES**

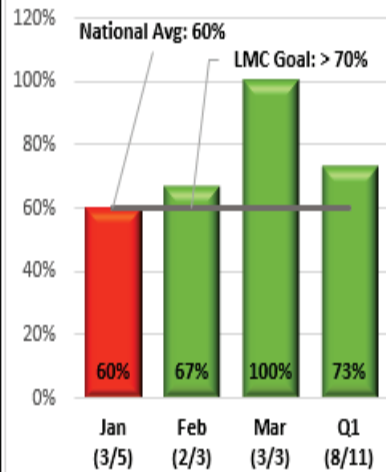
**Sepsis: SEP-1**

**Early management bundle, severe sepsis/septic shock. Special Note: Measure is not publicly reported by Hospital Compare.**

**Numerator:** Patients who received ALL of the following within three hours of presentation of severe sepsis; Specific Labs, Hydration, Examination (i.e. B/P Antibiotics, Perfusion assessment).

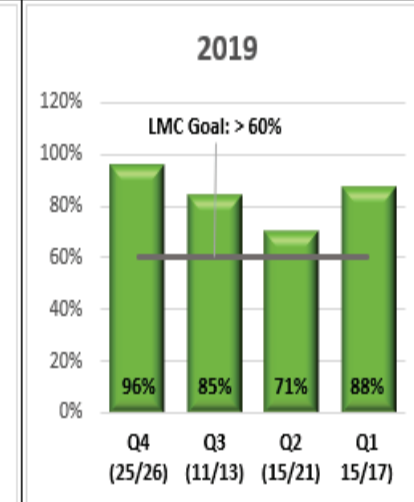
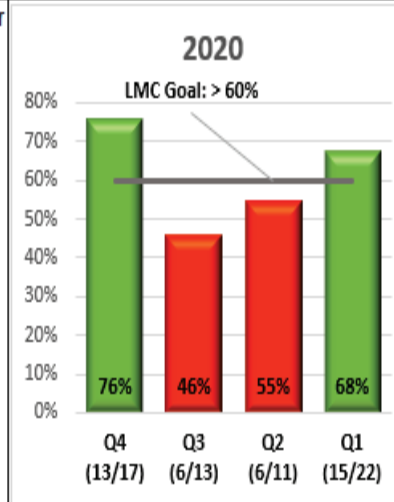
**Denominator:** Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis or Septic Shock.

CMS/TJC



**Findings:** The goal of > 70% was met for the quarter.

**Interventions:** Concurrent review of all cases continue. All failed cases are reviewed and discussed in full detail at the Sepsis Committee Meeting. All involved staff and physicians are notified and educated of findings.



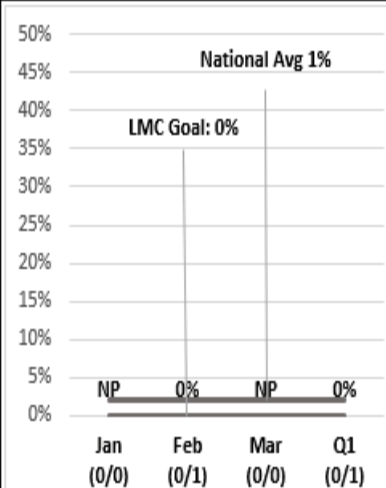
**Venous Thrombosis: VTE-6**

**Hospital Acquired Preventable VTE. (Lower percentage is better)**

**Numerator:** Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date.

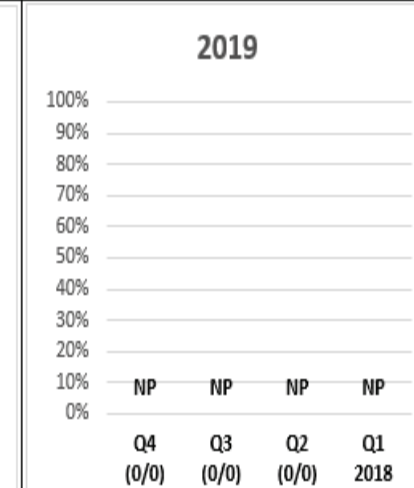
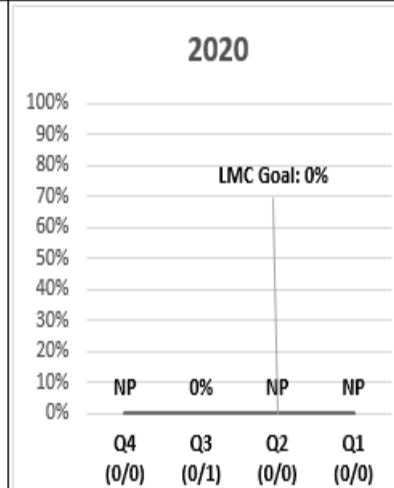
**Denominator:** Patients who developed confirmed VTE during hospitalization.

TJC



**Findings:** The goal of 0% of cases was met for this quarter.

**Interventions:** No action was required.



Averages are reported from the National Healthcare and Quality Research December 2020 Data

## QUALITY CORE MEASURES REPORT

### 1st Quarter (January - March 2021) - Preliminary

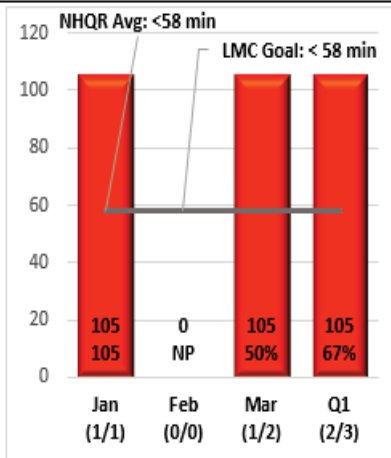
#### Sampled Population



#### OUTPATIENT QUALITY MEASURES

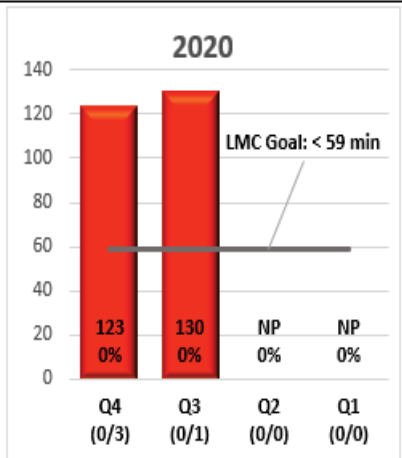
##### Acute Myocardial Infarction: OP-3a

**Acute Myocardial Infarction: OP-3a**  
**Median time to transfer to another facility for acute coronary interventions. (Higher percentage is better).**  
**Numerator:** Number of patients transferred to another facility within less than 58 minutes  
**Denominator:** Patients with Transfer for Acute Coronary Intervention.



**Findings:** The goal of <58 minutes was not met for this quarter.

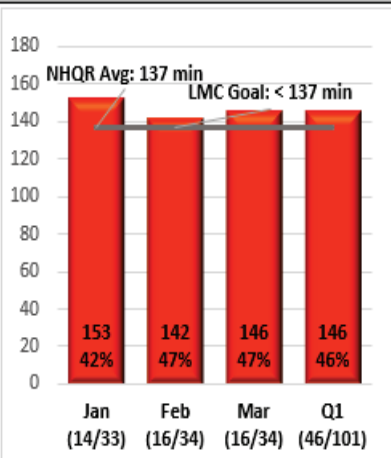
**Interventions:** The (3) cases were reviewed by the ACMO and no action was required.



CMS

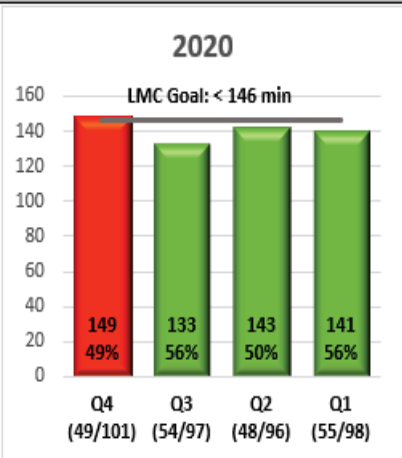
##### Emergency Department Throughput: OP-18

**Median time from ED arrival to discharge home or transferred.**  
**Numerator:** Number of patients discharged in less than 137 minutes.  
**Denominator:** Any ED patient from the facility's emergency department.



**Findings:** The goal of <137 minutes was not met for this quarter. The top (5) cases were reviewed by the ACMO.

**Interventions:** Care and treatment was rendered appropriately and no action was required.



CMS/TJC

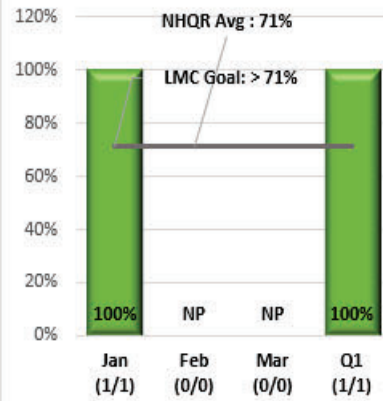
**OUTPATIENT QUALITY MEASURES**

**Stroke: OP-23**

**Stroke patient arriving in ED w/in 2 hours of onset of symptoms who had CT or MRI results w/in 45 mins of arrival. (Higher percentage is better).**

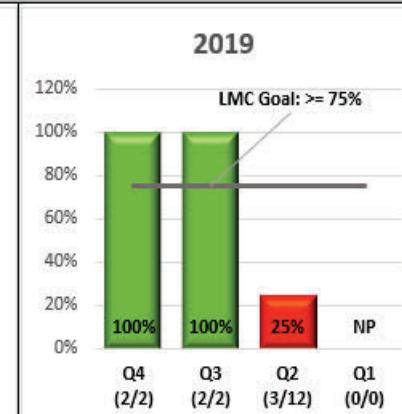
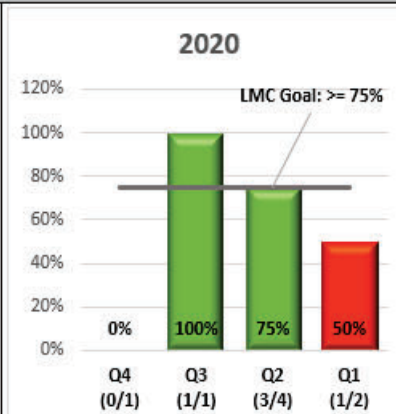
**Numerator:** Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients.  
**Denominator:** Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well with an order for a head CT or MRI scan.

CMS/TJC



**Findings:** The goal of >71% was met for this quarter.

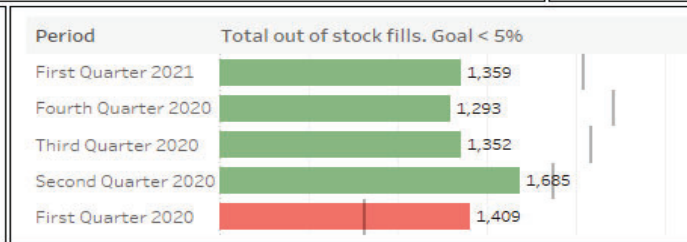
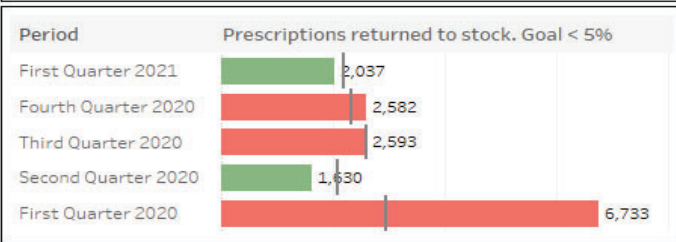
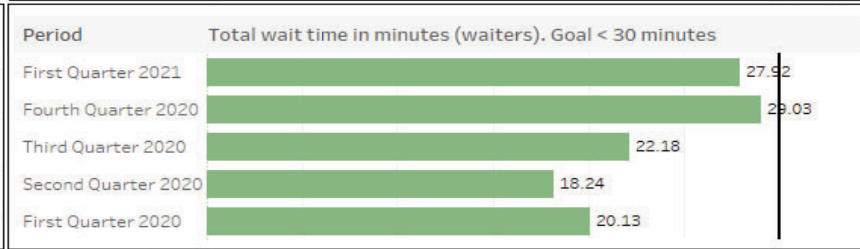
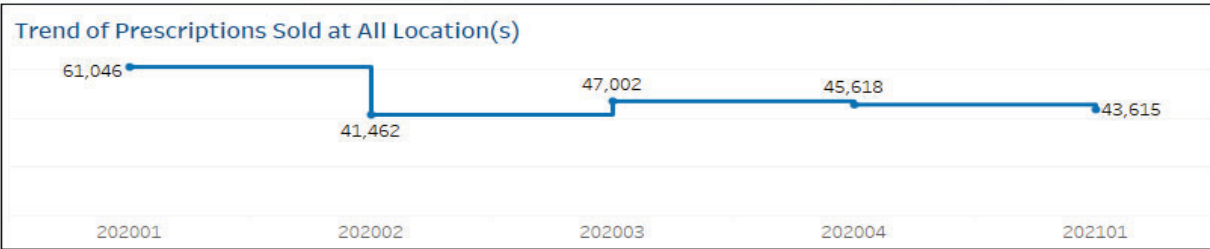
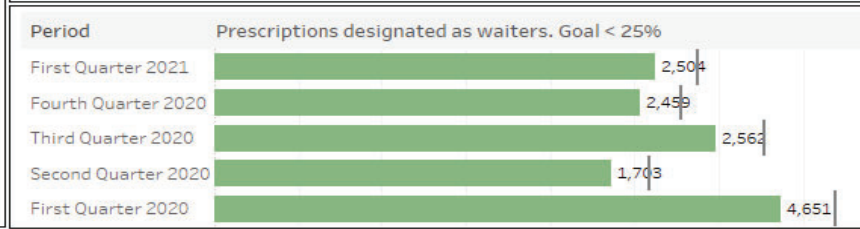
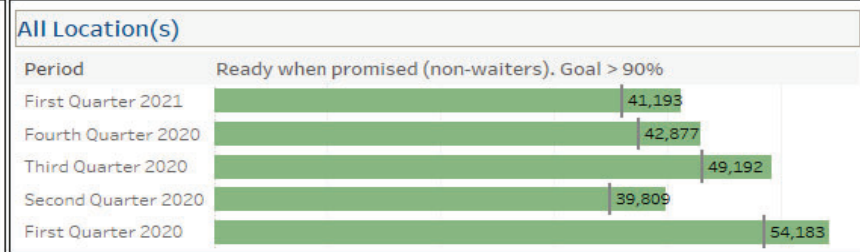
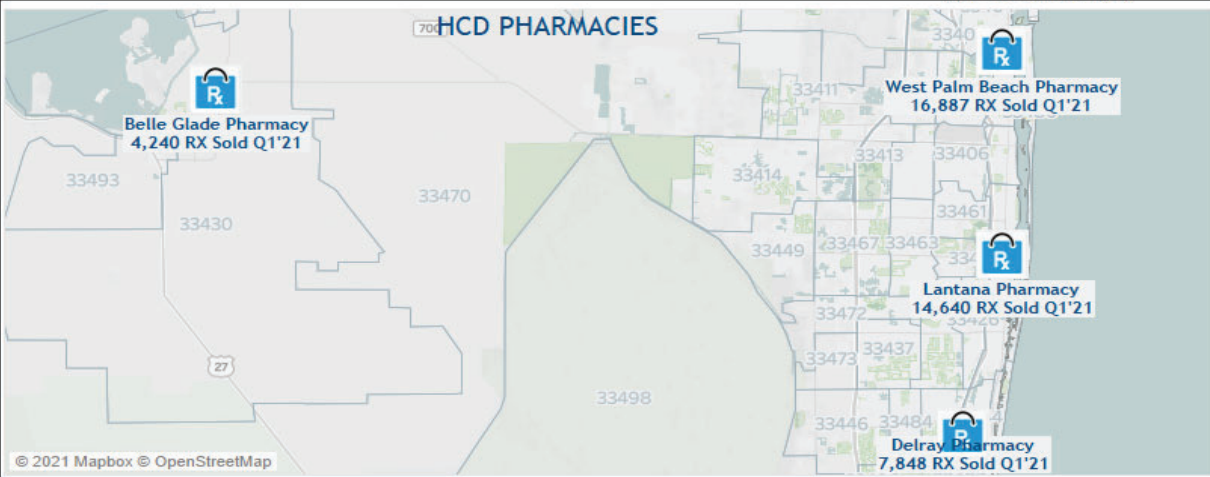
**Interventions:** No action was required.



Averages are reported from the National Healthcare and Quality Research December 2020 Data



## Pharmacy Services Quality Report Report as of First Quarter 2021 All Location(s)



**Mail Order Prescriptions (All Locations)**

8,437

**Number of Packages (All Locations)**

3,265



## TRAUMA SYSTEM UTILIZATION

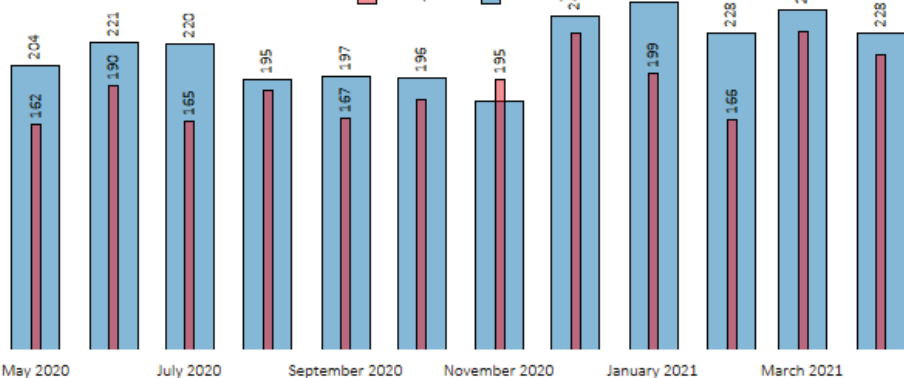
### TOTAL TRAUMA PATIENTS (PBC)

Q1 2021: **1,316**  
 Q1 2020: **1,218**  
 Variance: **+98**

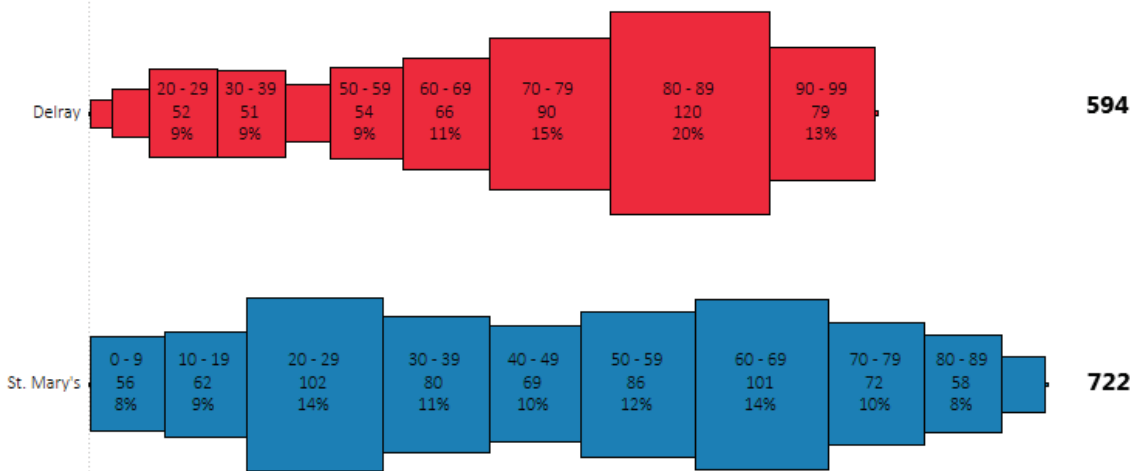
### TRAUMA CENTER VOLUME BY MONTH

(May 2020 - April 2021)

Delray St. Mary's



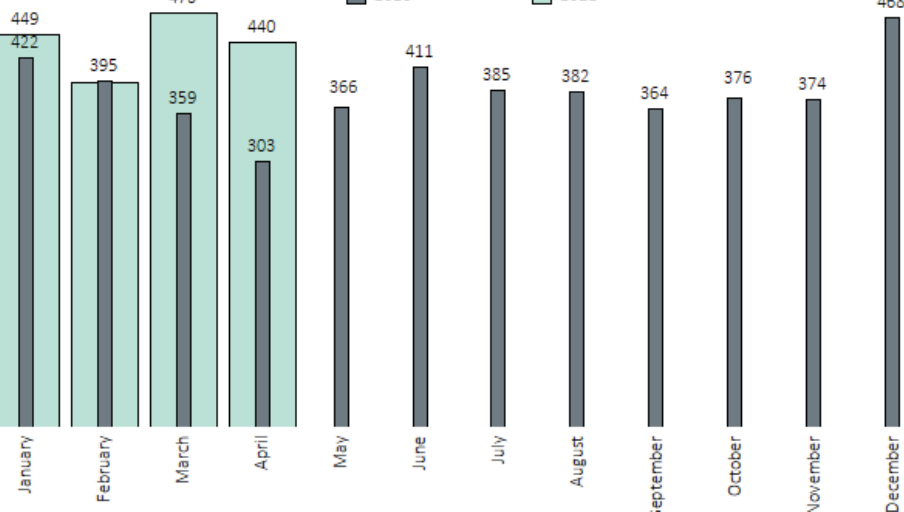
### DECADE OF AGE BREAKDOWN BY TRAUMA CENTER (Q1 2021)



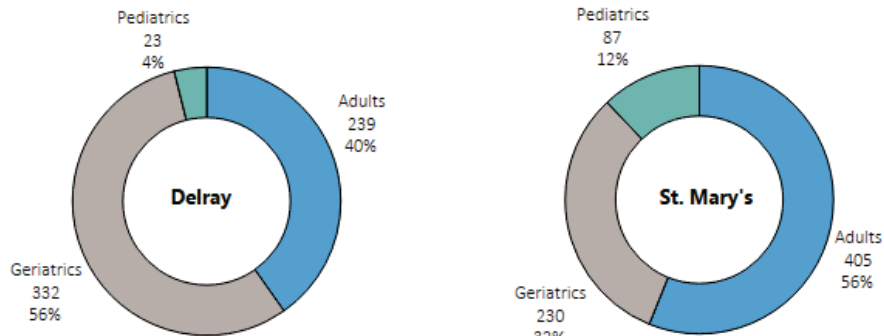
### MONTHLY TRAUMA CENTER VOLUME BY YEAR

(January 2020 - April 2021)

2020 2021

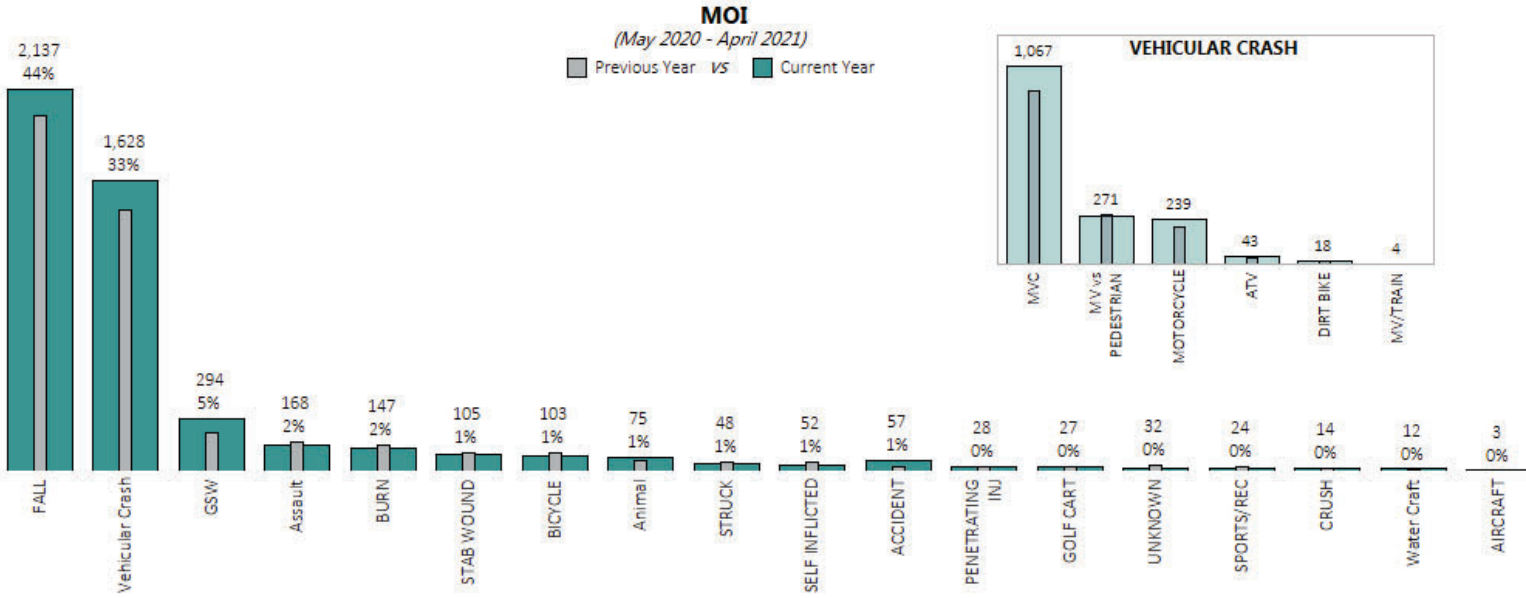


### AGE GROUP BY TRAUMA CENTER (Q1 2021)





## MECHANISM OF INJURY (PBC Trauma System)

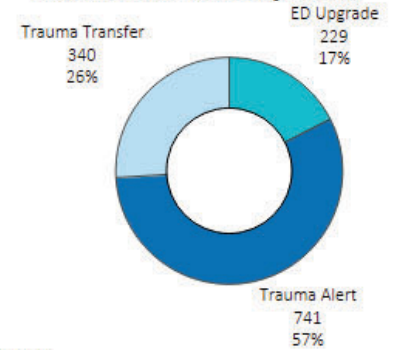


### TOTAL TRAUMA PATIENTS

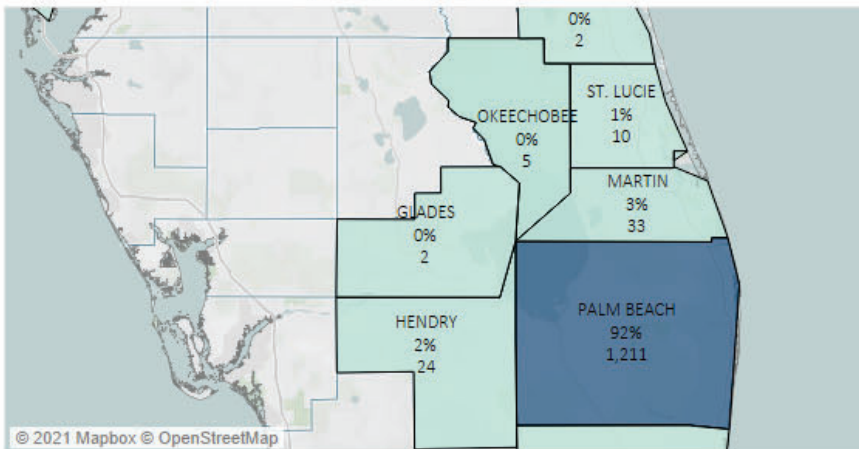
Q1 2021: **1,316**  
 Rolling YTD: **4,882**  
 Variance: **+346**  
 Rolling Year (Current): May 2020 - April 2021  
 Variance = Current Rolling Year - Previous Rolling Year

Adults	644
Geriatrics	562
Pediatrics	110

### ACTIVATION LEVEL (Q1 2021)



### INJURY MAP (Q1 2021)



### YEARS OF AGE BY DECADE (Q1 2021)

