Quality, Patient Safety & Compliance Committee
Meeting Agenda
September 24, 2019
2:00 P.M.

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

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
AGENDA
September 24, 2019 at 2:00 p.m.
1515 N. Flagler Dr., Suite 101
West Palm Beach, FL 33401

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

A. Roll Call

2. Agenda Approval

A. Additions/Deletions/Substitutions

B. Motion to Approve Agenda

3. Awards, Introductions and Presentations

4. Disclosure of Voting Conflict

5. Public Comment

6. Meeting Minutes

A. **Staff recommends a MOTION TO APPROVE:**
Committee Meeting Minutes from May 28, 2019. [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]

7A-3 **RECEIVE AND FILE:**
Proposed Meeting Schedule 2020.
(Belma Andric) [Pages 6-7]

7A-4 **RECEIVE AND FILE:**
Compliance and Privacy Dashboard.
(Deborah Hall) [Pages 8-13]

8. Regular Agenda

A. **ADMINISTRATION**

8A-1 **Staff recommends a MOTION TO APPROVE:**
Charter Updates.
(Valerie Shahriari) [Pages 14-23]

B. **COMPLIANCE**

8B-1 **RECEIVE AND FILE:**
Summary of Compliance and Privacy Activities.
(Deborah Hall) [Pages 24-28]

8B-2 **Staff recommends a MOTION TO APPROVE:**
Compliance Work Plan 2019.
(Deborah Hall) [Pages 29-34]

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

8C-1 **RECEIVE AND FILE:**
Patient Relations Dashboards
(Belma Andric) [Pages 35-46]

- Patient Relations Dashboard, School Health.
  (Andrea Steele/Ginny Keller) [Pages 37-39]

- Patient Relations Dashboard, Primary Care Clinics.
  (Andrea Steele/Ana Ferwerda, M.D.) [Pages 40-41]

- Patient Relations Dashboard, Healey Center.
  (Andrea Steele/Terretha Smith) [Pages 42-43]

- Patient Relations Dashboard, Lakeside Medical Center.
  (Andrea Steele/Janet Moreland) [Pages 44-46]

8C-2 **RECEIVE AND FILE:**
Quality & Patient Safety Reports
(Belma Andric) [Pages 47-73]

- Quality and Patient Safety Report, School Health.
  (Andrea Steele/Ginny Keller) [Page 49]

- Quality & Patient Safety Report, Aeromedical.
  (Andrea Steele/Gerry Pagano) [Page 50-55]

- Quality & Patient Safety Report, Primary Care Clinics.
  (Andrea Steele/Ana Ferwerda, M.D.) [Pages 56-59]

8. Regular Agenda (continued)

- Quality & Patient Safety Report, Healey Center.
  (Andrea Steele/Terretha Smith) [Page 60-66]

- Quality & Patient Safety Report, Lakeside Medical Center.
  (Andrea Steele/Janet Moreland) [Pages 67-71]

- Quality and Patient Safety Report, Pharmacy.
  (Andrea Steele/Hyla Fritsch) [Page 72]

- Quality & Patient Safety Report, Trauma Program.
  (Andrea Steele/Sandra Smith) [Page 73]

9. CEO Comments

10. Committee Member Comments

11. Closed Risk Meeting [Under Separate Cover]
Pursuant to Florida Statute Ch. 768.28, 395.0197, 766.101 and 400.119, 400.147

12. Establishment of Upcoming Meetings

- December 10, 2019 (Q3 2019) at 10am (changed from November 26, 2019)

13. Motion to Adjourn

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
SUMMARY MEETING MINUTES
May 28, 2019 10:30 a.m.
39200 Hooker Hwy
Belle Glade, FL 33430

1. Call to Order

Dr. Alonso called the meeting to order at 10:28 am

A. Roll Call

Committee Members present included:
Dr. Alina Alonso, Chairperson; Mary Weeks; Sharon Larson; Dr. Daniel Padron; Brian Lohmann; Sean O'Bannon; Dianne King; Dr. David Bohorquez; James Elder

Committee Members absent included:
None

Staff present included:
Darcy Davis, Chief Executive Officer; Valerie Shahriari, General Counsel; Dr. Belma Andric, Chief Medical Officer; Alyssa Tarter, Risk Manager; Ginny Keller, Administrator of School Health; Terretha Smith, Risk Manager; Stephanie Dardanello, Lakeside Medical Center Administrator; Karen Harris, Vice President of Field Operations; Sandra Smith, Admin-Trauma Services; Gerry Pagano, Director of Medical Transport and Aeromedical Facilities; Dr. Noelle Stewart, FQHC Medical Director; Leticia Stinson, Senior Compliance and Privacy Analyst; Kristine Macaya, Assistant Director of Pharmacy; Shelly Ann Lau, Healey Center Administrator; Dr. Ken Scheppke, Aeromedical Agency Medical Director; David Speciale, Quality Manager; Dr. Hyla Fritsch, Director of Pharmacy Services; Andrea Steele, Corporate Quality Director; Heidi Bromley, Executive Assistant to CEO.

Recording/Transcribing Secretary: Jonathan Dominique

2. Agenda Approval

A. Additions/Deletions/Substitutions

None.

B. Motion to Approve Agenda

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

3. Awards, Introductions and Presentations

None.

4. Disclosure of Voting Conflict

None.

5. Public Comment

None.

6. Meeting Minutes

A. Staff Recommends a MOTION TO APPROVE:
Committee Meeting Minutes from March 26, 2019.

CONCLUSION/ACTION: Mr. Lohman made a motion to approve the committee meeting minutes from November 27, 2018 as presented. The motion was duly seconded by Ms. King. There being no opposition, the motion passed unanimously.

7. Consent Agenda – Motion to Approve Consent Agenda Items

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

A. ADMINISTRATION

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

7A-2 RECEIVE AND FILE:
Committee Attendance.

7A-3 RECEIVE AND FILE:
Compliance Program Work Plan Status for 2019.

This item presents the Compliance Program Work Plan Status for 2019.The Compliance Work Plan 2019 demonstrates areas of concern based on government enforced trends, the OIG 2019 Work Plan, and interviews with senior management.

8. Regular Agenda

A. ADMINISTRATION

8A-1 **Staff recommends a MOTION TO APPROVE**
Chief Compliance and Privacy Officer Position. [Under Separate Cover]
Presented by Steven Hurwitz

Darcy Davis, CEO made some points about the hiring of Ms. Hall and spoke on how valuable she will be as an asset to the organization.

CONCLUSION/ACTION: Mr. Lohmann made a motion to approve the Selection of Deborah Hall to the position of Chief Compliance and Privacy Officer. The motion was duly seconded by Ms. Larson. There being no opposition, the motion passed unanimously.

8A-2 **Staff recommends a MOTION TO APPROVE**

- Amendment to the Quality, Patient Safety and Compliance Committee Charter.
- Revision on the appointments of Committee members. (pg 16)

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

B. COMPLIANCE

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

Deborah Hall, Chief Compliance Officer, presented updates on the current audit plan that was approved in January of 2019.

Compliance workflow status update, to be presented next Quality meeting.

CONCLUSION/ACTION: Received and filed.

9. CEO Comments

Ms. Davis, Chief Executive Officer, thanked everyone for attending the day's events. She, also invited the board members to take the documents outside of the binders and to leave the binders behind.

10. Committee Member Comments

Ms. Weeks spoke on her experience touring the clinics, and how blown away she was by the beauty of the new clinic.

Dr. Andric spoke on the history and process that allowed for the clinic to be where it is today.

Ms. Shahriari speaks on Stark and Anti-kickback Laws and why Lakeside Medical Center physicians will have to be careful to not refer patients directly to the clinics.

Ms. Weeks asked about the opening of the clinics. Dr. Andric speaks on remaining items required to acquire AHCA inspection before final approval to open.

11. Establishment of Upcoming Meetings

- September 24, 2019 (Q2 2019)
- November 26, 2019 (Q3 2019)

12. Motion to Adjourn

There being no further business, the meeting was adjourned at 10:51 am.

______________________________________ ____________________
Dr. Alina Alonso **Date**

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

12 Month Attendance Tracking

	3/26/19	5/28/19	9/24/19	11/26/19
Mary Weeks	X	X		
Sharon Larson	X	X		
Alina Alonso	X	X		
James Elder	X	X		
Sean O'Bannon	E	X		
Dianne King	E	X		
Dr. David Bohorquez	E	X		
Dr. Daniel Padron	X	X		

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

1. **Description:** Proposed Schedule for 2020 Committee Meetings

2. **Summary:**

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

3. **Substantive Analysis:**

   We would like to propose the following:

   March 10, 2020 (Q4 2019)

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

   June 9, 2020 (Q1 2020)

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

   September TBD, 2020 (Q2 2020)

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

   December 8, 2020 (Q3 2020)

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

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

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

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

____
Joel Snook
Chief Financial Officer

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

6. Recommendation:

Staff recommends the committee receive and file the schedule for 2020 Committee Meetings.

Approved for Legal sufficiency:

DocuSigned by:
Valerie Shahriari
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Valerie Shahriari
VP & General Counsel

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

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

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

1. Description: Compliance and Privacy Dashboard

2. Summary:

This item presents the Compliance and Privacy Dashboard for 2nd Quarter of FY 2019.

3. Substantive Analysis:

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

4. Fiscal Analysis & Economic Impact Statement:

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

Reviewed for financial accuracy and compliance with purchasing procedure:

DocuSigned by:
Joel Snook
AA591078372E40E...

Joel Snook
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Quality, Patient Safety, and Compliance Committee receive and file the Compliance and Privacy Dashboard for 2nd Quarter of FY 2019.

Approved for Legal sufficiency:

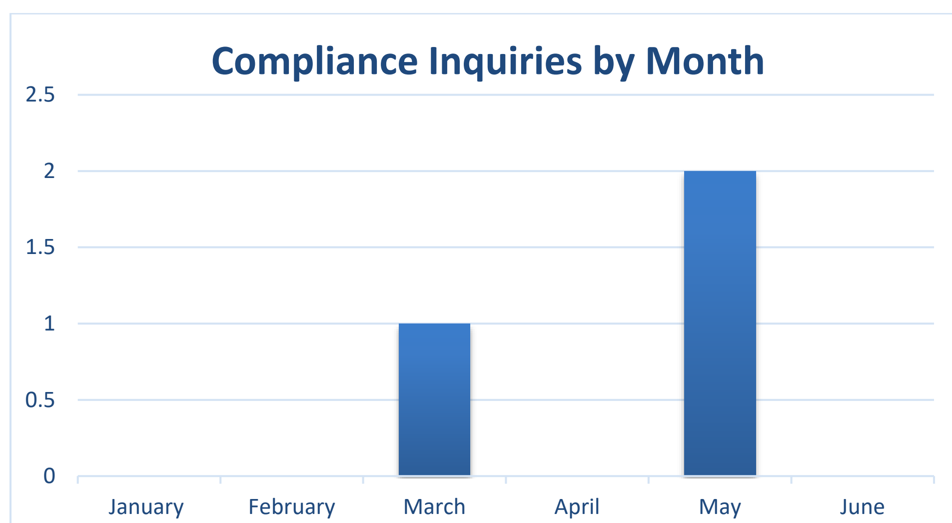
DocuSigned by:
Valerie Shahriari
6141168BCABA47F...
Valerie Shahriari
VP & General Counsel

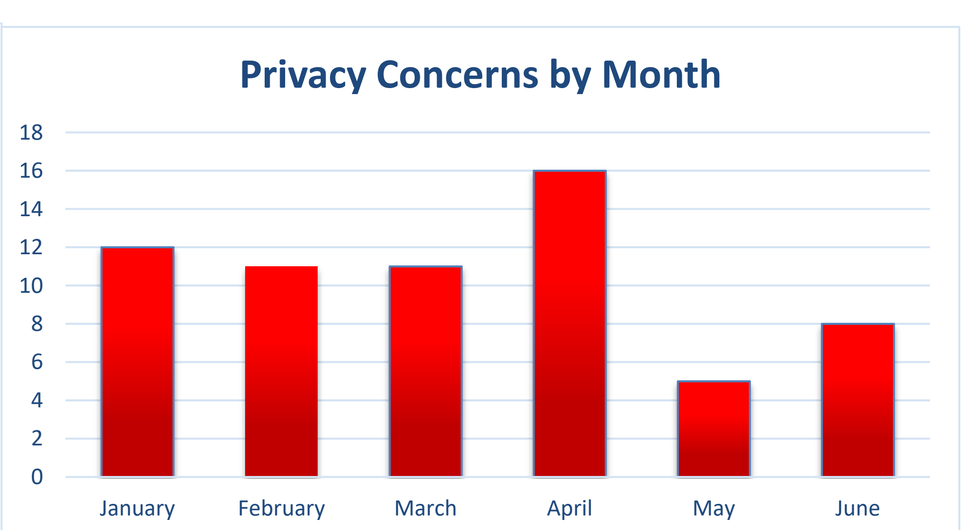
DocuSigned by:
Deborah Hall
F67807AC72D3414...
Deborah Hall
VP, Chief Compliance and Privacy Officer & Internal Audit

DocuSigned by:
Darcy Davis
8A681D19234E4D9...
Darcy J. Davis
Chief Executive Officer

Compliance & Privacy Dashboard

Year to Date: January 1, 2019 – June 30, 2019





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

Privacy Concerns by Month and Entity	Lakeside Medical Center	C. L. Brumback Clinics	E.J. Healey	School Health	Aero Med	Home Office	Total
October							
November							
December							
January	3	7	-	-	-	2	**12**
February	-	6	2	-	1	1	**10**
March	1	5	-	-	-	3	**9**
April	5	7	-	-	-	2	**14**
May	2	1	-	1	-	2	**6**
June	1	2	1	-	-	3	**7**
July							
August							
September							
Total	**12**	**28**	**3**	**1**	**1**	**13**	**58**

Compliance & Privacy Dashboard

Year to Date: January 1, 2019 – June 30, 2019

COMPLIANCE AND PRIVACY REVIEWS AND PROJECTS	October	November	December	January	February	March	April	May	June	July	August	September	Total
Internal Risk Assessment													
OCR Investigation													
Risk Assessment													
OIG Work Plan FY 2019				4	2	3	1	1					11
External Audits					1	1	1		1				4
Total													**15**

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

Compliance & Privacy Dashboard

Year to Date: January 1, 2019 – June 30, 2019

Compliance Call Activity	
Entity	**# of Calls**
LMC	1
Healey	1
District	1
Clinics	2
School Health	0
Managed Care	0
Pharmacy	0

Compliance Exit Interviews
1

IT Security	
Security Incidents	0 Incident Reported

Breach Notifications	
Entity	**# of Letters**
LMC	4
Healey	1
District	2
Clinics	3
Pharmacy	0
School Health	0
Aeromedical	1

Regulatory Inquiries	OIG/SAM CHECK
1 Regulatory Inquiry Processed	Monthly Check 0 Matches

Medical Record Amendments Processed	0 Medical Record Amendments Requested

Compliance and Privacy Education	Health Care District	Lakeside Medical Center	Healey Center	C. L. Brumback Clinics	School Health	Total
October						
November						
December						
January	2	-	-	-	-	2
February	3	-	-	-	-	3
March	2	1	-	-	1	4
April	3	2	-	1	-	6
May	3	5	3	4	-	15
June	2	-	-	-	-	2
July						
August						
September						
Total	15	8	3	5	1	32

Compliance & Privacy Dashboard

Year to Date: January 1, 2019 – June 30, 2019

Compliance and Privacy Activity

January 1, 2019 - June 30, 2019

0.0%
0.5%
0.0%
5.5%
28.9%
25.4%
1.5%
2.5%
2.0%
17.9%
15.9%

- Audit
- Communication
- Compliance Inquiry
- Compliance Line
- Corporate Audit
- Education
- Investigation
- Privacy Concern
- Regulatory Body
- Request to Amend Medical Record
- Security Concern

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

1. **Amendment to the Quality, Patient Safety and Compliance Committee Charter.**

2. **Summary:**

This item presents a proposed amendment to the Quality, Patient Safety and Compliance Committee Charter.

3. **Substantive Analysis:**

The charter was last updated on May 28, 2019. The District proposes amending the Section titled, Meetings. The new language specifies that, regular meetings of the Committee shall be conducted quarterly. Attached for your review is the following documents:

- Updated version of the charter showing the proposed amendment; and,
- A clean version of the charter to be adopted.

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

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

Reviewed for financial accuracy and compliance with purchasing procedure:

Joel Snook, CPA
VP & Chief Financial Officer

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

N/A
Committee Name

Date Approved

6. **Recommendation:**

Staff recommends the Quality, Patient Safety and Compliance Committee approve the amendment to the Quality, Patient Safety and Compliance Charter and forward to the Board for approval.

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

DocuSigned by:
Deborah Hall
F07807AC72B3414...
Deborah Hall
VP & Compliance and Privacy Officer

Darcy J. Davis
Chief Executive Officer

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE CHARTER

PURPOSE

The purpose of the Quality, Patient Safety, Compliance & Patient Privacy Committee of the Health Care District and its Affiliated Entities ("District') is to assist the Board of Commissioners in fulfilling its oversight responsibilities in overseeing the quality, patient safety and risk management activities of the District and promote an organizational "Culture of Safety". The Committee will monitor and oversee the District's process for ensuring compliance with laws and regulations and the District's compliance and privacy program.

COMPOSITION OF COMMITTEE

The Committee shall have at least five (5) but no more than nine (9) members. A minimum of two (2) Board members shall be appointed to the Committee, one of which will chair the Committee, and their term shall be the same as the term of their Board membership. One (1) Committee member shall represent the Glades community and one (1) Committee member shall serve on the District Clinic Board, and (1) Committee member shall be a community member at large. The Board shall appoint Committee members, who are not a Board member, to a four (4) year term, commencing on the date of appointment, with Committee membership limited to two (2) full terms. The composition of the Committee shall be regularly reviewed to ensure that each member meets the requirements set forth by the Board for the Committee. Each member of the Committee shall have expertise and experience in quality, patient safety, legal compliance, healthcare, risk management and/or insurance and such other matters as the Board may deem appropriate.

MEETINGS

Regular meetings of the Committee shall be conducted ~~every other month~~ quarterly. Public notice of each meeting and the date, time and location of same shall be made as required by law. The Chief Executive Officer may cancel and/or reschedule a Regular meeting, upon proper notice to Committee members and the public, if it is determined that a quorum will not be present or for other reasons in consultation with the Chair.

There shall be an agenda for every meeting of the Committee. However, the Committee is not prohibited from discussing and/or taking action on an item or matter not specified in the agenda. Minutes of each meeting shall be accurately taken, preserved and provided to members.

Regular attendance shall be expected for all Committee members. If a member misses more than twenty-five percent (25%) of the Regular Committee meetings during the twelve (12) month calendar period, the Chair shall advise the Board.

The presence of the majority of appointed Committee members shall be necessary at any meeting to constitute a quorum or to transact business. The Board shall promulgate rules of order for the conduct of all Committee meetings. All procedural matters not addressed in said rules of order, by this Charter, or by the Bylaws, shall be governed by the latest edition of "Roberts Rules of Order".

POWERS AND DUTIES

The following functions shall be the common recurring functions of the Committee in carrying out its oversight role.

1. ***Policies & Procedures.*** The Committee shall review and approve policies and procedures developed to promote quality patient care, patient safety, risk management, and compliance.

2. ***Reporting.*** The Committee shall regularly report to the Board of Commissioners about Quality, Patient Safety & Compliance Committee activities, issues, and related recommendations; provide an open avenue of communication between Committee and the Board of Commissioners.

3. ***Quality.*** The Committee shall review, as appropriate, information relating to quality, clinical risk, and performance improvement. Monitor and assess performance against targets of the care delivery system, including clinical performance and member satisfaction with the care experience.

4. ***Patient Safety.*** The Committee evaluate results of Patient Safety Organization including recommended actions and follow-up.

5. ***Quality Improvement Plans.*** The Committee shall review and approve business unit Quality Improvement (QI) plans for quality clinical care, patient safety, and clinical

services improvement strategies. Review and update HCD QI Plan at least every three years (more often if substantial changes are made in the QI Program).

6. ***Internal Systems & Controls.*** The Committee shall oversee the development and implementation of internal systems and controls to carry out the District's standards, policies and procedures relating to risk management, including, without limitation, processes designed to facilitate communication across the organization regarding risk management, patient care loss prevention/control and safety improvement opportunities and activities and the evaluation thereof.

7. ***Risk Management Program.*** The Committee shall review and provide advice on the development and implementation of a corporate risk management program, in conjunction with existing business processes and systems, to facilitate management of the District's clinical and operational risks.

8. ***Credentialing.*** Conduct an annual formal review of the credentialing process and offer revisions to credentialing criteria to reflect best practices and protocols. Review the integrity of systems relating to the selection, credentialing, and competence of physicians and other health care practitioners, including systems for granting or terminating clinical privileges, professional or medical staff or clinical staff membership, peer review, proctoring, and continuing education.

9. ***Risk.*** The Committee shall review asset protection needs of the District, and make recommendations to the Board for approval.

10. ***Risk Management Plans.*** The Committee shall review and approve business unit Risk Management plans.

11. ***Compliance Reports.*** The Committee shall receive and review reports from the Compliance Program that may have a significant effect on the District's compliance activities or have a material impact on the financial statements.

12. ***Policy and Procedure.*** The Committee shall review and approve compliance policies, procedures, plans or the mechanism by which staff shall approve such policies, procedures and plans.

13. ***Board Report.*** The Committee shall report regularly to the District Board of Commissioners regarding the development and implementation of the District compliance plans. Annually, the Committee will evaluate the Chief Compliance and Privacy Officer.

14. ***Compliance Work Plans.*** The Committee shall ensure that the District maintains compliance work plans designed to encourage integrity, accountability in reimbursement and adherence to applicable laws. The compliance plans shall at minimum be designed and implemented to promote compliance and detect and deter non-compliance with regard to:
    a. Medicare, Medicaid and other laws and regulations that apply to the District because of its participation in federal health benefit programs;

b. Laws and regulations dealing with business relationships with physicians including, but not limited to, the anti-kickback statute, Stark Laws and other laws;
c. Federal and state anti-trust law prohibitions regarding anti-competitive conduct;
d. Federal Sentencing Guidelines; and,
e. Laws which apply to the District as a result of its tax exempt status.

15. ***Compliance Program.*** The Committee shall review the Compliance Program for adherence to the OIG's Compliance Guidance's for applicable businesses, including for hospitals, nursing homes, managed care, physician offices, etc.

16. ***Corrective Action.*** The Committee shall review and approve appropriate corrective action steps should a material error or violation of compliance policy and procedure occur.

17. ***Education.*** The Committee shall work with the Chief Compliance Officer, as necessary, to develop effective on-going training.

18. ***Monitor Compliance Program.*** The Committee shall assure that methodologies developed to monitor compliance are appropriate to maximize compliance and assure confidential treatment of material.

19. ***Standard of Conduct.*** The Committee shall periodically review and approve the Standard of Conduct.

QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE CHARTER

PURPOSE

The purpose of the Quality, Patient Safety, Compliance & Patient Privacy Committee of the Health Care District and its Affiliated Entities ("District') is to assist the Board of Commissioners in fulfilling its oversight responsibilities in overseeing the quality, patient safety and risk management activities of the District and promote an organizational "Culture of Safety". The Committee will monitor and oversee the District's process for ensuring compliance with laws and regulations and the District's compliance and privacy program.

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MEETINGS

Regular meetings of the Committee shall be conducted quarterly. Public notice of each meeting and the date, time and location of same shall be made as required by law. The Chief Executive Officer may cancel and/or reschedule a Regular meeting, upon proper notice to Committee members and the public, if it is determined that a quorum will not be present or for other reasons in consultation with the Chair.

There shall be an agenda for every meeting of the Committee. However, the Committee is not prohibited from discussing and/or taking action on an item or matter not specified in the agenda. Minutes of each meeting shall be accurately taken, preserved and provided to members.

Regular attendance shall be expected for all Committee members. If a member misses more than twenty-five percent (25%) of the Regular Committee meetings during the twelve (12) month calendar period, the Chair shall advise the Board.

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POWERS AND DUTIES

The following functions shall be the common recurring functions of the Committee in carrying out its oversight role.

1. ***Policies & Procedures.*** The Committee shall review and approve policies and procedures developed to promote quality patient care, patient safety, risk management, and compliance.

2. ***Reporting.*** The Committee shall regularly report to the Board of Commissioners about Quality, Patient Safety & Compliance Committee activities, issues, and related recommendations; provide an open avenue of communication between Committee and the Board of Commissioners.

3. ***Quality.*** The Committee shall review, as appropriate, information relating to quality, clinical risk, and performance improvement. Monitor and assess performance against targets of the care delivery system, including clinical performance and member satisfaction with the care experience.

4. ***Patient Safety.*** The Committee evaluate results of Patient Safety Organization including recommended actions and follow-up.

5. ***Quality Improvement Plans.*** The Committee shall review and approve business unit Quality Improvement (QI) plans for quality clinical care, patient safety, and clinical

services improvement strategies. Review and update HCD QI Plan at least every three years (more often if substantial changes are made in the QI Program).

6. ***Internal Systems & Controls.*** The Committee shall oversee the development and implementation of internal systems and controls to carry out the District's standards, policies and procedures relating to risk management, including, without limitation, processes designed to facilitate communication across the organization regarding risk management, patient care loss prevention/control and safety improvement opportunities and activities and the evaluation thereof.

7. ***Risk Management Program.*** The Committee shall review and provide advice on the development and implementation of a corporate risk management program, in conjunction with existing business processes and systems, to facilitate management of the District's clinical and operational risks.

8. ***Credentialing.*** Conduct an annual formal review of the credentialing process and offer revisions to credentialing criteria to reflect best practices and protocols. Review the integrity of systems relating to the selection, credentialing, and competence of physicians and other health care practitioners, including systems for granting or terminating clinical privileges, professional or medical staff or clinical staff membership, peer review, proctoring, and continuing education.

9. ***Risk.*** The Committee shall review asset protection needs of the District, and make recommendations to the Board for approval.

10. ***Risk Management Plans.*** The Committee shall review and approve business unit Risk Management plans.

11. ***Compliance Reports.*** The Committee shall receive and review reports from the Compliance Program that may have a significant effect on the District's compliance activities or have a material impact on the financial statements.

12. ***Policy and Procedure.*** The Committee shall review and approve compliance policies, procedures, plans or the mechanism by which staff shall approve such policies, procedures and plans.

13. ***Board Report.*** The Committee shall report regularly to the District Board of Commissioners regarding the development and implementation of the District compliance plans. Annually, the Committee will evaluate the Chief Compliance and Privacy Officer.

14. ***Compliance Work Plans.*** The Committee shall ensure that the District maintains compliance work plans designed to encourage integrity, accountability in reimbursement and adherence to applicable laws. The compliance plans shall at minimum be designed and implemented to promote compliance and detect and deter non-compliance with regard to:
    a. Medicare, Medicaid and other laws and regulations that apply to the District because of its participation in federal health benefit programs;

b. Laws and regulations dealing with business relationships with physicians including, but not limited to, the anti-kickback statute, Stark Laws and other laws;
c. Federal and state anti-trust law prohibitions regarding anti-competitive conduct;
d. Federal Sentencing Guidelines; and,
e. Laws which apply to the District as a result of its tax exempt status.

15. ***Compliance Program.*** The Committee shall review the Compliance Program for adherence to the OIG's Compliance Guidance's for applicable businesses, including for hospitals, nursing homes, managed care, physician offices, etc.

16. ***Corrective Action.*** The Committee shall review and approve appropriate corrective action steps should a material error or violation of compliance policy and procedure occur.

17. ***Education.*** The Committee shall work with the Chief Compliance Officer, as necessary, to develop effective on-going training.

18. ***Monitor Compliance Program.*** The Committee shall assure that methodologies developed to monitor compliance are appropriate to maximize compliance and assure confidential treatment of material.

19. ***Standard of Conduct.*** The Committee shall periodically review and approve the Standard of Conduct.

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

1. Description: Summary of Compliance and Privacy Activities

2. Summary:

This item presents the summary of the District's compliance and privacy activities for the 2nd Quarter of FY 2019.

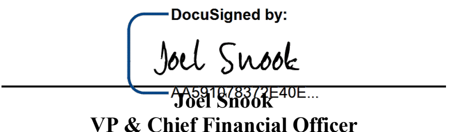
3. Substantive Analysis:

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

4. Fiscal Analysis & Economic Impact Statement:

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

Reviewed for financial accuracy and compliance with purchasing procedure:



Joel Snook
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A
Committee Name

Date Approved

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

6. Recommendation:

Staff recommends the Quality, Patient Safety and Compliance Committee receive and file the District's Summary of Compliance and Privacy Activities for the 2nd Quarter of FY 2019.

Approved for Legal sufficiency:

DocuSigned by:
Valerie Shahriari
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Valerie Shahriari
VP & General Counsel

DocuSigned by:
Deborah Hall
F67807AC72D3414...

Deborah Hall
VP, Chief Compliance and Privacy Officer & Internal Audit

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

Summary of Compliance Activities

January 1, 2019 – June 30, 2019 DRAFT

Highlights

- **Evaluation of Compliance Work Plan for 2019.**

  It was noted that several contracts were outstanding and in progress during this timeframe for various audit and monitoring efforts. Compliance addressed responses to these report and audit activities by re-allocating the audit plan for this quarter to address these outstanding report responses and developed process owner workgroups to address findings and resolution. See further updates in Audit & Monitoring separate receive and file documentation

- **Contract Review and Compliance FMV (Fair Market Valuations)**

  The Compliance Department begun the process of evaluating its current delivery method for conducting FMV analysis and the completion of contract reviews. Compliance is involved in reviewing a majority of the contracts across the District and is the process coordinator for retrieving FMV analysis in alignment with the legal contracting process. Compliance is trying to ensure the following in these valuations:

  Fair Market Value – defined as the value in arms-length transactions consistent with the general market value. General market value means the price an asset would bring as a result of a bona fide bargaining between well informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party on the date of acquisition of the asset or at the time of the service agreement. Usually the fair market value is the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.

  Commercial Reasonableness – defined as an arrangement that would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential designated health services referrals.

  Reasonable Compensation – as described in Section 162 of the Internal Revenue Service ("IRS") code, reasonable compensation is generally considered to be "…on such amount as would ordinarily be paid for like services by like enterprises under like circumstances."

Training and Education

Trainings provided by Compliance and Privacy Department staff:

- New Hire Orientation – monthly training on Compliance, Privacy and Security

Summary of Compliance Activities

January 1, 2019 – June 30, 2019 DRAFT

- G4S Security Staff, Healey Center – HIPAA Privacy training
- C.L. Brumback Clinic Staff Orientation – focused Compliance and Privacy training
- Medically-Assisted Treatment (MAT) program monthly training
- Physician Stacking – compensation concepts for physician payments within more than one service agreement – Lakeside Medical Center

Communication

- The Compliance and Privacy Department is establishing new rapport with its constituents and is being proactive by working through compliance elements?? 25% of all compliance activity is inclusive of communication

Hotline Activity

- 5 hotline calls between January 1, 2019 – June 30, 2019 – We have noted an influx of direct calls/inquiries to compliance during this timeframe outside of the Hotline activity.

HIPAA Privacy Incidents

The Compliance and Privacy Department received 58 privacy concerns for the period between January 1, 2019 and June 30, 2019. Of those 58 concerns, 11 resulted in a breach that required patient notification. Forty-seven (47) privacy concerns were investigated and resolved with no findings that indicated any breach of protected health information. Education was provided to staff when applicable privacy concerns resulted in the need of a corrective measure.

Privacy Walkthroughs

Entity	Findings	Corrective Action Plan
WPB Eligibility Office	1 opportunity for enhancement	Completed
Lake Worth Clinic	3 opportunities for enhancement	Completed
Lakeside Medical Center	5 opportunities for enhancement	Completed
Lantana Clinic	2 opportunities for enhancement	Completed
WPB/Lewis Center Clinics	4 opportunities for enhancement	Completed

Auditing and Monitoring

- ***Policy and Procedural update review and inventory initiated -*** Financial Assistance Policy completed
- ***Contracts Trauma Physicians Reporting phase*** – in progress
- ***Instrument Sterilization*** – Lakeside, C.L. Brumback Dental and Women's Health Clinics – Completed
- ***Transfers Review*** – Lakeside Medical Center – Completed
- ***E&M and Billing*** – in progress review completed by outside vendor, vendor management turnover
- ***Athena Application - chart review clinics*** – significant progress towards closing the gap on focused review of findings and monitoring from audit first part of the year. Workgroup established to address findings and review people, process and technology solutions for re-opening of the patient portal.

Summary of Compliance Activities

January 1, 2019 – June 30, 2019 DRAFT

- ***Americans with Disabilities (ADA) website compliance*** – Workgroup established and kicked off to work with 3 vendors on assessing ADA compliance and review and update for approximately 400+ documentation. Scanning of website is in place and on-going and Compliance has been invited to attend another workgroup for Website redesign. Web content is at 77% compliant. Awaiting final vendor solutions to web content for remaining compliance.
- ***Compliance Site Visits and Attendance for key Leadership Meetings:*** Lakeside Medical Center, E.J. Healey, and C.L. Brumback Clinics

Regulatory Matters

- **Co-Pay Assistance Deemed as Kickbacks, Results in Over $122 Million Settlement for Three Pharmaceutical Companies**
  - On April 4, 2019, the Department of Justice (DOJ) announced three pharmaceutical companies agreeing to pay a total of $122.6 million to resolve allegations that they each violated the False Claims Act by illegally paying the Medicare or Civilian Health and Medical Program (CHAMPVA) copays for their own products, through purportedly independent foundations that the companies used as mere conduits.
- **Tennessee Diagnostic Medical Imaging Services Company Pays $3 Million to Settle Breach Exposing Over 300,000 Patients' Protected Health Information**
  - May 6, 2019: Touchstone Medical Imaging ("Touchstone") has agreed to pay $3,000,000 to the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS), and to adopt a corrective action plan to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Security and Breach Notification Rules. Touchstone, based in Franklin, Tennessee, provides diagnostic medical imaging services in Nebraska, Texas, Colorado, Florida, and Arkansas.

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

1. Description: Compliance Work Plan 2019

2. Summary:

Ongoing evaluation is critical to an effective compliance program. The Compliance Department will perform the reviews from the Compliance Work Plan 2019 in order to:

- Concretely demonstrate to employees and the community the District's strong commitment to honest and responsible provider and corporate conduct
- Identify and report criminal and unethical conduct
- Focus on areas of high risk and focus on any area of concern that has been identified

The Compliance Work Plan 2019 was re-evaluated during this quarter and items were both moved from the plan that were redundant, and revised and moved forward in the plan based on critical review areas to address necessary timely compliance response to several on-going external audit focus areas:

- Athena – review of documentation supporting electronic medical records
- ADA review - compliance for external website
- Chart Audit review - evaluation of specific medical charts

See attached original Work Plan 2019 and Revised Work Plan 2019

3. Substantive Analysis:

The Compliance Work Plan 2019 demonstrates areas of concern based on government enforcement trends, the OIG 2019 Work Plan, and interviews with senior management.

As part of the review process, the Compliance Department will be utilizing:

- On-site visits
- Interviews with personnel involved in management, operations, coding, claim development, patient care, and other related activities
- Reviews of medical and financial records that support claims for reimbursement
- Reviews of written materials and documentation prepared by each business line
- Monitor and trend analysis that seek deviations in specific areas

The Compliance Department will:

- Remain independent of physicians and management
- Have access to existing audit resources and relevant personnel

- Present written evaluative reports on compliance activities
- Specifically identify areas where corrective actions are needed

4. Fiscal Analysis & Economic Impact Statement:

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

Reviewed for financial accuracy and compliance with purchasing procedure:

DocuSigned by:
Joel Snook
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Joel Snook
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A
Committee Name

Date Approved

6. Recommendation:

Staff recommends the Quality, Patient Safety and Compliance Committee approve the Revised Compliance Work Plan 2019.

Approved for Legal sufficiency:

DocuSigned by:
Valerie Shahriari
6141168BCABA47F...
Valerie Shahriari
VP & General Counsel

DocuSigned by:
Deborah Hall
F67807AC72D3414...
Deborah Hall
VP, Chief Compliance and Privacy Officer & Internal Audit

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

Compliance Work Plan 2019

Compliance Auditing Plan				
Quarter	**Entity**	**Source of Risk**	**Review Title**	**Description**
1	LMC and Clinic	Risk Assessment	Instrument Sterilization	Review procedures and assess the level of infection prevention surveillance. **Reporting Phase**
1	LMC	Internal Risk Assessment	Financial Assistance Policy	Review LMC's Financial Assistance Policy to determine if it meets the requirements of 501(r). **Completed**
1	District Wide	Internal Risk Assessment	Privacy Walkthrough	Review of all facilities compliance with privacy laws, regulations, policies, and procedures by visual observation of day-to-day operations and services and review of forms and policy for Notice of Privacy Practices and patient requests for records in compliance with policy. **Completed**
1	Clinics/LMC/ Healey	Internal Risk Assessment	Confidential Communication	Review policies, procedures, and documentation regarding requests for confidential communication. **Completed**
1	Clinics (MAT Program)	Internal Risk Assessment	Program Consents	Review a random sample of completed consents to determine its use is consistent with the performance criterion. **In progress**
2	Healey Center	OIG Workplan	Nursing Facility Staffing Levels	Examine nursing staffing levels and related policies and procedures to ensure compliance with CMS requirements. **In progress**
2	District Wide	Internal Risk Assessment	Advanced Beneficiary Notice (ABN)	Verify practices for notifying patients of their financial liability. **In progress**
2	Clinics/LMC	Internal Risk Assessment	Authorization for Uses and Disclosures	Obtain and review a sample of authorizations obtained to permit disclosure for consistency with the established performance criterion the policies and procedures require. **In progress**

Compliance Work Plan 2019

2	District Wide	Internal Risk Assessment	Privacy Walkthrough	Review of all facilities compliance with privacy laws, regulations, policies, and procedures by visual observation of day-to-day operations and services and review of forms and policy for Notice of Privacy Practices and patient requests for records in compliance with policy. **Completed**
3	LMC	Internal Risk Assessment	Hospital Discharge Notice (Medicare)	Review all policies, procedures, and processes associated with delivery of the notice of discharge. Propose Delay
3	Healey Center	Internal Risk Assessment	Infection Prevention and Control Program	Review facility's infection prevention and control program including all related policies and procedures. Propose Delay
3	District Wide	Internal Risk Assessment	Privacy Walkthrough	Review of all facilities compliance with privacy laws, regulations, policies, and procedures by visual observation of day-to-day operations and services and review of forms and policy for Notice of Privacy Practices and patient requests for records in compliance with policy. Propose Delay
3	District Wide	OCR Investigation	Business Associate Agreement Audit	Review policies, procedures, and internal controls for identifying and engaging business associates. Gather exhaustive list of Business Associate Agreements and Memorandum of Understanding in preparation for potential Office for Civil Rights audit. Review a sample of business associate agreements per business unit for compliance with District policies and federal requirements. Propose Delay
3	District Wide	Risk Assessment	Physician Compensation and Medical Directorships	Review a sample of Physicians with Professional Services Agreements to assure the Physician and/or group are paid per the terms of the contract with required documentation and following the Professional Services Policy. Move to Q4
4	Healey Center	Internal Risk Assessments	Transfer, Discharge, and Bed hold Process	Review policies and procedures, notice of bed hold, notice for transfer/discharge, and related preparation and documentation.
4	LMC	Internal Risk Assessment	Adverse Events	Verify that Lakeside is properly reporting any incidences of identified serious preventable errors.
4	Clinics (Behavioral Health)	Internal Risk Assessment	Telehealth	Review billing and documentation for accuracy per policy.

Compliance Work Plan 2019

4	District Wide	Internal Risk Assessment	Privacy Walkthrough	Review of all facilities compliance with privacy laws, regulations, policies, and procedures by visual observation of day-to-day operations and services and review of forms and policy for Notice of Privacy Practices and patient requests for records in compliance with policy.
4	District Wide	OCR Investigation	Encryption	Obtain and review the policies and procedures regarding the encryption and decryption of ePHI. Including documentation of processes regarding the use and management of the confidential process.
4	District Wide	OCR Investigation	Notice of Privacy Practices	Review whether the uses and disclosures of PHI are consistent with the District's notice of privacy practices and business units have made good faith attempts to provide written notice to individuals.

Compliance Monitoring Plan

The purpose of the Compliance Monitoring Plan is to:

1. **Review claims on a retrospective and concurrent basis to ensure the accuracy, integrity and consistency of billings for a sample of Medicare, Medicaid and other third party payor claims;**
2. **Ensure sampled claims meet state and federal requirements, national coding standards and other regulatory rules, payor contract terms, regulations and requirements.**
3. **Ensure that all charges reported for claim and billing purposes are supported by appropriate documentation in the medical record.**
4. **Review claims and related records to identify potential under and over payments.**

Entity	Key Measurements	Description
LMC	Inpatient and Outpatient Audit	External auditors to complete a DRG/Billing and Documentation audit for Inpatient and Outpatient coding, documentation and billing audit.

Compliance Work Plan 2019

CLINICS/ DENTAL	Provider Evaluation and Management Audit (E&M)	Acevedo Consulting to complete an E&M and billing audit for all providers in the 1st Qtr Calendar Year 2019 and repeat 3rd Qtr 2019. Dental provider to be complete audit in process for Dentrix. - In Progress- Turnover at Consulting firm
HCD ALL BUSINESS UNITS	Office of Civil Rights (OCR) HIPAA Risk Assessment	Audit completed by SecureState. OCR Desk Audit - Updated to Ransomware 2019
CLINIC	Review of Consents and Medical Record Content	MK Medical Solutions to complete an audit of Athena Charts to assure complete consents and content belonging to correct patient, 1st Qtr 2019 - Completed – Work team established
HCD	Compliance Program Effectiveness Assessment	Crowe to complete Compliance Program Effectiveness Assessment – - Updated to 2020

All audits in the 2019 Audit Work Plan are subject to change due to Compliance issues raised and requiring audit/investigation during quarter. The Office of Inspector General (OIG) 2019 Work Plan is a dynamic changing document that is updated by the OIG monthly. All new items identified by the OIG as identified as a risk for HCD, these will be incorporated into the Work Plan.

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

1. Description: Patient Relations Dashboards

2. Summary:

This agenda item provides the patient relations dashboard for the 3rd Trimester of the 2018-2019 school year for School Health and 2nd Quarter of 2019 for C. L. Brumback Primary Care Clinics, Edward J. Healey Nursing and Rehabilitation Center, and Lakeside Medical Center.

3. Substantive Analysis:

See attached reports.

4. Fiscal Analysis & Economic Impact Statement:

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

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

____

Joel Snook
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

______________________________ ______________________________

Quality, Patient Safety, and Compliance Committee — Date Approved

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

6. Recommendation:

Staff recommends the Committee receive and file this information.

Approved for Legal sufficiency:

DocuSigned by:
Valerie Shahriari
6141168BCABA47F...

Valerie Shahriari
VP & General Counsel

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

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

PATIENT RELATIONS DASHBOARD

School Health 3rd Trimester

April-Jun 2019

COMPLAINTS/GRIEVANCES

CATEGORY	JUL	AUG	SEP	OCT	NOV	DEC	T1 2018	JAN	FEB	MAR	T2 2019	APR	May	Jun	T3 2019	2018/2019
	#	#	#	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
Care & Treatment							0	2			2	1	2		3	5
Communication							0	2	1	3	5	1			1	6
Nursing Related							0	3			3	1			1	4
Respect Related							0	1			1				1	2
TOTAL:	0	0	0	0	0	0	0	8	1	3	11	3	2	0	5	16
Complaints/ No Letter Required								5	1	3	8	3	2		5	13
Grievances/Letter Sent ≤ 7 days								3			3					3
Grievances/Letter Sent > 7 days																
Total Completed Events:	355,806							(207,240) 563,046				(165,280) 728,326				728,326

SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

JAN: **2 Care & TX:**

1) Parents wanted RN to administer asthma inhaler without a physician's authorization and became so enraged that school and local police assistance had to be requested. After being escorted away, they returned with the proper paperwork and accused the RN of assault when the student did use the inhaler and said the RN and nursing supervisor forced the usage. They made verbal threats to both the RN and supervisor. School District and HCD administration had to get involved. Parents were told that further incidents would result in permanent removal of their child from the school. No further incidents have occurred.

2) Mother of student with truancy issues told school that the reason for current absence was due to our RN's failure to administer nebulizer treatment for her son's respiratory issues despite the fact that the RN had not seen the student in weeks. The medication order was for PRN treatments and mother wanted the RN to administer per her directions. After the principal got involved, a new order was obtained for daily medication for 2 days and then to be continued PRN.

2 Communication:

1) RN received a call from a doctor's office and was asked about a particular student. The RN described the student's mother in a derogatory manner and then learned that she was on speakerphone and both the mother and student were in the room. The parent complained to the school administrator and the RN was counseled and disciplined by her nursing supervisor. She was remorseful and wrote a letter of apology to the parent.

2) A student who was injured at home and used a scooter to get around in school, was reportedly speeding on campus and had a near fall. She complained of a sore leg and no other injuries. The RN administered first aid, called mom and the student returned to class. The mother read the school staff's incident report and accused the RN of "blatantly denying knowledge of a bruised hand and fabricating the incident's information to cover her negligence". RN and staff "tag-teamed/placing blame on her child." The RN denied all of the accusations and the teacher confirmed the hand injury was there before the "almost fall" in the cafeteria. The nursing supervisor met with the principal to report all of the accusations and details.

	3 Nursing Related: **1)** Father complained to the supervisor that the injury assessment by the RN on his child was inaccurate. He felt the injury was much worse when he saw it the next day. The father did not see the child until the next day when he came to the father's house. The nursing supervisor spoke with the father and explained injuries with bruising often change color as they heal and do appear different than at the time of the injury. **2)** A parent complained that the RN did not follow her instructions for administering a PRN Tylenol order. The parent wanted med given every 4 hours. The supervisor explained the difference in a PRN order and a daily specific time order for medications. **3)** RN reportedly having difficulty dealing with staff and students, per school administration. The supervisor has counseled the RN and has asked school administration to provide further documentation as to the nurse's deficiencies to determine next steps.
	1 Respect Related: **1)** The student was being observed/assessed in the clinic due to not feeling well after running in PE and the RN noted an increase in heart rate that promoted an EMS call. The assistant principal was in the clinic and asked the student about possible drug use. Upon father's arrival, the RN attempted to speak to the father as privately as possible. Father was upset with the RN for her accusatory and embarrassing inquiry "if his daughter was vaping." He felt it should have been in private and not in the clinic doorway where everyone could hear. Father later said he took his daughter for drug testing which was negative but was diagnosed with a cardiac condition. He requested an apology from the school RN. The supervisor spoke with the father and apologized for the RN's behavior and the RN has apologized as well.
Feb:	**1 OTHER:** Mother reported to school AP nurse grabbed her child's arm. AP intern made DCF referral, sighting this was school district policy. DCF case was closed, False accusation.
Mar:	**3 Communication:** **1-2)** Two nurses attempting to access home bound services for a pregnant student, who miss understood, and relayed an inaccurate conversation to the parent. **3)** Parent complained how the nurse handled her daughters asthmatic attack.
Apr:	**1 Care & Treatment:** Student fell on the stairs running to class and hurt her ankle. Student received First Aid but parent was not notified. Student saw orthopedist and has a sprain and was put in a walking boot. **1 Communication:** Mother was upset about the frequent phone calls she received from the nurse and principal trying to reach her to pick up her son, a Pre-K student, who seemed very lethargic and sleepy. Mother was in the hospital and wanted child sent on bus to day care where she picked him up later. **1 Nursing Related:** Mother called and complained her son was not receiving his medication each day. A plan was put in place for him to get his medication as ordered.
May:	**2 Care & Treatment:** 1) Nurse administered Epi for allergic reaction and called EMS. EMS administered subsequent dose and transferred. Mother on seen at time of EMS. Father upset regarding medical bill. 2) Principal received a complaint nurse was rude when administering student daily oral med. Nursing supervisor counseled nurse.
Jun:	**NONE**

COMPLIMENTS																
	JUL	AUG	SEP	OCT	NOV	DEC	T1 2018	JAN	FEB	MAR	T2 2019	APR	MAY	JUN	T3 2019	2018/2019
	#	#	#	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
# COMPLIMENTS RECEIVED	0	0	0	0	0	0	0	3	2	4	9	4	5	0	9	18

SUMMARY OF COMPLIMENTS

JAN:	**3-Compliments:** **1)** A parent credited the RN with saving her child's life by teaching a class to the teachers about seizures. One teacher recognized the signs in a student and encouraged the parent to follow up. The student was diagnosed with a seizure condition and is now on medication. **2)** A nursing supervisor commended her RN's exceptional performance during two school staff members' cardiac emergencies. Both required EMS intervention and she performed CPR on one of the adults. **3)** A parent complimented the RN on the care she has been providing her diabetic son. The parent expressed that she does not worry when her son is in school due to the nurse's attentive care.
FEB:	**2- Compliments:** **1)** Supervisor recognizes; School nurse assisted with readying the health room for a state review by cleaning and organizing the clinic while the school nurses continued to provide care to students. **2)** Supervisor recognizes; Clinical nurse specialist, Kate Higgins, assisted school nurses in readying records for state review. Our audit provided to be the best we have ever had and Kate's support was key to this results.
MAR:	**4 Compliments:** **1) Respectful**-Principal complimented school nurse on the way she handled a telephone call from a very agitated parent. **3) Nursing Related-** School nurse received a "Thank You" card from a student who had precepted with her in PBA student nurse program; School principal received a phone call from a parent who appreciated the care provided by the school nurse for her son who was injured in PE ; The quick actions of the nurse had a good outcome for a teacher who was sent to the ER with a severe headache, forgetfulness and high blood presser. She was DX with a stoke and hospitalized.
APR:	**4 Compliments:** **1) Communication:** RN assisted in a health matter to everyone's satisfaction and school administration complemented nurse on resolution. **3) All aspects of care:** RN worked closely with school districts case manager to assist in obtaining services for a student in a timely manner; School administration was grateful for the support the RN gave them on Kindergarten round-up.; PE Coach and his wife credit the school nurse with saving his life. He came to the nurse with a swollen hand and arm. The nurse did a nursing assessment and referred him to the ER. He went to the ER and ended up with two 5 hour surgeries. They were very appreciative.
MAY:	**5 Compliments:** **Nursing Related** **1)** Parent thanked nurse for MD referral after student had several nose bleeds. MD noted nodule on students thyroid and student awaiting biopsy results. **2**) Principal received an email from a parent complimenting the nurse for her exceptional care of her daughter after a fall in school. Student FX her right wrist. **3)** Assistant Principal emailed nursing supervisor how pleased she was with the school nurses welcoming environment in the health room. **4)** Principal received an email from parent complimenting the school nurse on her management and emergency care of her son with epilepsy. **5)** Principal received an email from the parent complimenting the school nurse on her ethics and attention given to her special needs son with medical issues, keeping him safe on campus.
JUN:	**NONE**

PATIENT RELATIONS DASHBOARD

2019

January thru June

COMPLAINTS/GRIEVANCES

CATEGORY	JAN	FEB	MAR	Q1 2019	APR	MAY	JUN	Q2 2019	JULY	AUG	SEPT	Q3 2019	OCT	NOV	DEC	Q4 2019	2019
	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
Care & Treatment	7	6	2	15	6	3	3	12				0				3	30
Communication	2	3	2	7	3			3				0				0	10
Discharge				0	0			0				0				0	0
Environmental		1		1	0			0				0				0	1
Finance	1			1	0	1		1				0				0	2
Medical Records			1	1	0			0				0				0	1
Nursing Related				0	0			0				0				0	0
Clinical Support Staff				0	0			0				0				0	0
Other			1	1	0		1	1				0				1	3
Pharmacy Related	2			2	2			2				0				0	4
Physician Related			2	2	0			0				0				0	2
Respect Related	1	2		3	2	1	1	4				0				1	8
TOTAL:	13	12	8	33	13	5	5	23	0	0	0	0	0	0	0	5	61
Complaints/No Letter Required	5	7	4	16	5	2	2	9				0				0	25
Grievances/Letter Sent ≤ 7 days	8	5	4	17	8	3	3	14				0				0	31
Grievances/Letter Sent > 7 days	0	0	0	0	0	0	0	0				0				0	0
LETTERS NOT SENT FOR GRIEVANCES	0	0	0	0	0	0	0	0				0				0	0

Q1 encounters: 35,625 Q2 encounters: 37,071 Q3 encounters: Q4 encounters:

SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

APR:	Of the 13 occurrences, there were 5 complaints and 8 grievances which occurred across 4 service areas (6 - Primary Care, 3 - Dental, 3 - Pharmacy, 1 - SA Program) at eight (8) different clinic locations . The top trend was related to Care & Treatment and some examples included complaints related to the length of time it takes to 1) obtain an authorization, 2) register at the front desk, and 3) process a refill request.
MAY:	Of the 5 occurrences, there were 2 complaints and 3 grievances which occurred across 4 service areas (6 - Primary Care, 3 - Dental, 3 - Pharmacy, 1 - SA Program) at eight (8) different clinic locations . The top trend was related to Care & Treatment,accounting for 60% of all monthly Complaints and Greivances. Examples include: poor customer service, disrespectful behavior, and inapproprоate care during a dental appointment.
JUN:	Of the 5 occurrences, there were 2 complaints and 3 grievances which occurred across 2 service areas (3 - Primary Care and 2 - Dental) at five (5) different clinic locations . The top trend was related to Care & Treatment,accounting for 60% of all monthly Complaints and Greivances. The "Other" complaint was related to a patients experience at an outside contracted laboratory. Other examples include complaints about wait times in the clinic.

COMPLIMENTS

	JAN	FEB	MAR	Q1 2019	APR	MAY	JUN	Q2 2019	JULY	AUG	SEPT	Q3 2019	OCT	NOV	DEC	Q4 2019	2019
	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
# COMPLIMENTS RECEIVED	1	9	13	23	8	5	14	27				0				0	50

SUMMARY OF COMPLIMENTS

APR:	8 compliments were received across 6 clinics of which: 2 were specific to Dentists, 2 were related to specific Primary Care Support Staff, 4 were related to Primary Care - Clinic Staff.
MAY:	5 compliments were received across 4 clinic locations of which: 1 was specific to a Primry Care Provider, 1 was specific to an Office Coordiantor, and 3 were related to the overall care provided at two different clinics.
JUN:	14 compliments were received across 8 clinic locations of which: 2 was related to Primary Care Support Staff, 3 were related to the Substance Abuse Prograam Support Staff, 1 was specific to a Delray Nurse, 5 were related to Dental teams, 1 was related to Womens Health services, 1 was related to a Practice Manager, and 1 compliment was submitted by a PCC employee about another employee (Registrar).

PATIENT RELATIONS DASHBOARD

Location: Healey Center
Period: 2nd Quarter (April-June 2019)

REGULATORY

Survey Type & Date	April 10, 2019: Annual AHCA re-survey. All citations were cleared.

Average number of residents: 119

GRIEVANCES

CATEGORY	JAN #	FEB #	MAR #	Q1 TOTAL	APRIL #	MAY #	JUN #	Q2 TOTAL	JUL #	AUG #	SEP #	Q3 TOTAL	OCT #	NOV #	DEC #	Q4 TOTAL	2019 TOTAL
Care & Treatment			2	2	2	3	1	6									8
Communication	2	2	1	5		1		1									6
Environmental		3	1	4	2	1	1	4									8
Medical Records						1	1	2									2
Noise Issue		1		1	1			1									2
Nursing Related	2	5	1	8	2	4	2	8									16
Nutrition	3	3	1	7	1	10	2	13									20
Other		5	2		1	6	4	11									11
Pain Management				7		1		1									8
Personal Belongings	5	6	9	20	7	6	7	20									40
Respect Related						2	2	4									4
TOTAL GRIEVANCES:	12	25	17	54	16	35	20	71	0	0	0	0	0	0	0	0	125
SOURCE OF CONCERNS																	
Verbal: Patient/Family	12	25	17	54	16	35	20	71				0				0	125
RESOLUTION TURN AROUND TIME																	
# Resolved w/i 72 Hrs. Per Policy	11	20	12	43	14	27	13	54				0				0	43
# Not Resolved w/i 72 Hrs. Per Policy	1	5	5	11	2	8	7	17				0				0	11

SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

April: Personal Belongings	A summary of the grievance revealed 9 out 119 residents' submitted grievances. 3 residents accounted for multiple grievances. Some of the concerns reported included missing and damaged clothing which were all resolved by locating clothing and if not located clothing were replaced. One resident reported that electric razor was damanged and was replaced. A total of 14 were resolved within 24-72 hours. One resident reported concerns with lancets used to perform blood sugar checks and trials of different types of lancets were done for residents comfort.
MAY: Nutrition	Analysis of the grievances indicated a total of 23 of 119 residents reported 35 total concerns during the month. 8 resident each acounted for 2 or more grievances. A summary of the grievance included food related complaints such as "breakfast tray only had eggs, danish and coffee"; "kitchen did not deliver requested fruits and resident refused it because it was too late when it was delivered", preference of specific meats with breakfast, special requests from kitchen, and not receiving snack that was requested. 27 of 35 grievances were resolved within 24-72 hours. Delay in the resolution of other grievances beyond 72 hours include awaiting outside laundry return due to missing items, discussion of residents preferences with food items and two grievances had multiple complaints among several different departments.
June: Personal Belongings	A summary of the grievances revealed 20 of 119 residents' had written grievances. 3 of the 16 residents accounted for two or more grievances. There were a total of 20 grievances filed, It appears that personal belongings accounted forf 7 of the filed grievances which included mostly missing clothing items. One resident reported that he left money in the pocket of his pants that were sent to the outside laundry service. 13 of 20 were resolved withing 24 to 72 hours. 7 were not resolved within 72 hours due to pending arrival of personal clothing from outside laundry, 2 awaiting response from outside transportation services and staff education.

COMPLIMENTS

# COMPLIMENTS RECEIVED	JAN	FEB	MAR	Q1	APRIL	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	2019
	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
	2	3	1	6	2	18	19	39				0				0	41

SUMMARY OF COMPLIMENTS

April:	A summary of a the compliments during the quarter details gratitude for excellent customer service and overall care provided by staff.
MAY:	
June:	

PATIENT RELATIONS DASHBOARD

Location: Lakeside Medical Center
Reporting Period: January - June 2019

GRIEVANCES

	JAN #	FEB #	MAR #	Q1 TOTAL	APR #	MAY #	JUN #	Q2 TOTAL	JUL #	AUG #	SEP #	Q3 TOTAL	OCT #	NOV #	DEC #	Q4 TOTAL	2019 TOTAL
Care & Treatment	1	3	2	6	2	0	0	2									8
Communication	1	0	0	1	0	1	1	2									3
Discharge	0	0	1	1	0	0	0	0									1
Nursing Related	0	2	0	2	0	0	0	0									2
Nutrition	2	1	0	3	0	0	0	0									3
Other	2	4	0	6	4	0	0	4									10
Pain Management	1	1	0	2	3	0	0	3									5
Personal Belongings	0	0	0	0	1	0	0	1									1
Pharmacy	0	0	0	0	0	0	1	1									1
Physician Related	1	6	3	10	2	0	1	3									13
Respect Related	0	0	0	0	0	0	1	1									1
TOTAL CATEGORIES:	8	17	6	31	12	1	4	17									48

SOURCE OF CONCERNS

	JAN #	FEB #	MAR #	Q1 TOTAL	APR #	MAY #	JUN #	Q2 TOTAL	JUL #	AUG #	SEP #	Q3 TOTAL	OCT #	NOV #	DEC #	Q4 TOTAL	2019 TOTAL
Verbal: Patient/Family	7	15	4	26	11	1	2	14									40
Employee	0	2	1	3	1	0	1	2									5
Physician	1	0	0	1	0	0	1	1									2
Social Media	0	0	1	1	0	0	0	0									1
TOTAL # OF CONCERNS:	8	17	6	31	12	1	4	17									48

TOTAL NUMBER OF CONCERNS

	JAN #	FEB #	MAR #	Q1 TOTAL	APR #	MAY #	JUN #	Q2 TOTAL	JUL #	AUG #	SEP #	Q3 TOTAL	OCT #	NOV #	DEC #	Q4 TOTAL	2019 TOTAL
Complaints/No Letter Required	8	16	3	27	8	1	4	13									40
Grievances/Letter Sent ≤ 30 days	0	1	3	4	4	0	0	4									8
Grievances/Letter Sent > 30 days	0	0	0	0	0	0	0	0									0
TOTAL # OF CONCERNS:	8	17	6	31	12	1	4	17									48

SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

JAN: Discharged patient's condition worsened several days after discharge; Unsubstantiated claim about lack of communication; Isolation patient complained about disposable dinnerware; Patient wanting more protein; Patient wanting entire family to stay the night; Sickle cell patient unhappy with pain management; ER patient unhappy with physician's pain management.

FEB:	Staff issue with Anesthesiologist; Patient wanted to direct care; Patient wanted to leave AMA; Issue with insulin administration before meal was delivered; Isolation patient unhappy with food temperature and presentation (styrofoam); Complaint about an ant; Patient's wife unhappy with wait time for AMR transfer; Lab test not drawn in ER because it is not resulted in-house (send-out); Physician sent patient for surgery without scheduling; Unsubstantiated privacy complaint; Staff issue with OB physician; ER Physician complaint (handled by CMO); ER Physician complaints (pain management and rudeness) also handled by CMO; Unsubstantiated complaint about nurse's inappropriate comment; Family of elderly patient wanted to accompany patient during respiratory test.
MAR:	Unsubstantiated complaint about a diagnosis; Patient perceived that nursing assistant didn't want to bathe her, handled by Nurse Manager; Physician unresponsive to nursing -CMO handled; Unsubstantiated complaint about discharge; Physician rude to patient - handled by CMO; Physician would not allow 18 year daughter in her mother's delivery.
APR:	Patient complaint about cotton in ear from a year ago; Patient complaint about wait time for pain meds; Patient believes that the patients should be seen in ER, in the order of arrival, regardless of complaint; Confused patient unhappy with transfer for GI; Unfounded complaint about a remark made by CNA; Visitor with mulch chip in foot referred to Risk Management; Patient with personal issues with her spouse; Pain management issue with ER physician being handled by CMO; Patient with pain management issue due to her daughter bringing her pain meds from home; Unsubstantiated complaint about a missing necklace; Anesthesiologist rude to patient -referred to CMO.
MAY:	Patient's daughter complained that the call bell was answered, in a rude manner.
JUN:	Issue with OB doctor's bedside manner referred to CMO; Delay in med delivery to floor (new tech was educated); Communication misunderstanding with physician resolved; Nurse unable to obtain info physician wanted (re-educated).

COMPLIMENTS	JAN	FEB	MAR	Q1	APR	MAY	JUN	Q2	JUL	AUG	SEP	Q3	OCT	NOV	DEC	Q4	2019
	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	#	#	#	TOTAL	TOTAL
# COMPLIMENTS RECEIVED	14	4	3	21	1	0	7	8									29

Comments on Compliments

JAN: Case managers complimented for going above and beyond for our patients; Plant Ops and EVS staff complimented for their hard work relocating offices; Plant Ops complimented for immediate response/resolution of construction issue; Nurse complimented for her willingness to float from department to department; OB nurse complimented for remaining with newborn beyond her shift to ensure adequate staffing; CNA complimented for excellent patient care; ICU nurses complimented on a great job stabilizing a patient prior to airlift; Nursing Supervisor complimented on her teamwork in the ER; Another Nursing Supervisor complimented on her teamwork in dialysis; Case manager complimented on contacting Adult Protective Services to ensure a patient's future safety.

FEB: Housekeeper complimented by Nursing Supervisor for going above and beyond; Nursing Supervisor complimented by a nurse for how she handled a critical situation involving several people; OB nurse complimented for her persistence that possibly saved the baby and mom; Mother of ER patient called to compliment the entire ER staff.

MAR: Fire/Rescue Chief and Captain appreciative of the service received in the ER; ER Nurse volunteered at the Very Special Arts Festival; Resident, Dr. Lepoff, found the cause of a patient's uncontrolled hypertension, she suffered with for 18 years.

APR: Telemetry nurse complimented by ER nurse for going above and beyond.

MAY: None

JUNE: 4 nurses, DON, Nursing Supervisor were recognized for teamwork, during an emergent delivery; Materials management employee recognized for going above and beyond.

HEALTH CARE DISTRICT
QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
September 24, 2019

1. Description: Quality & Patient Safety Reports

2. Summary:

This agenda item provides quality and patient safety reports for the 3rd Trimester of school year 2018-2019 for School Health and 2nd Quarter of 2019 for Aeromedical, C. L. Brumback Primary Care Clinics, Edward J. Healey Nursing and Rehabilitation Center, Lakeside Medical Center, Pharmacy, and Trauma.

3. Substantive Analysis:

See attached reports.

4. Fiscal Analysis & Economic Impact Statement:

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

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel Snook
Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Quality, Patient Safety, and Compliance Committee

Date Approved

6. Recommendation:

Staff recommends the Committee receive and file this information.

Approved for Legal sufficiency:

DocuSigned by:
Valerie Shahriari
6141108BCABA47F...

Valerie Shahriari
VP & General Counsel

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

DocuSigned by:
Darcy Davis
8A681D19234E4D9...

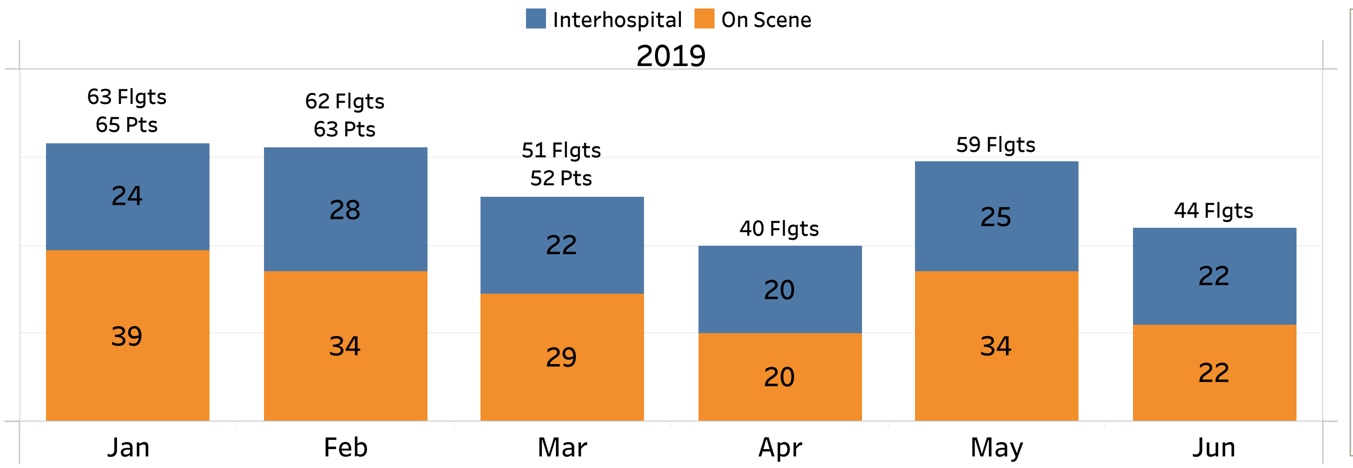
Darcy J. Davis
Chief Executive Officer

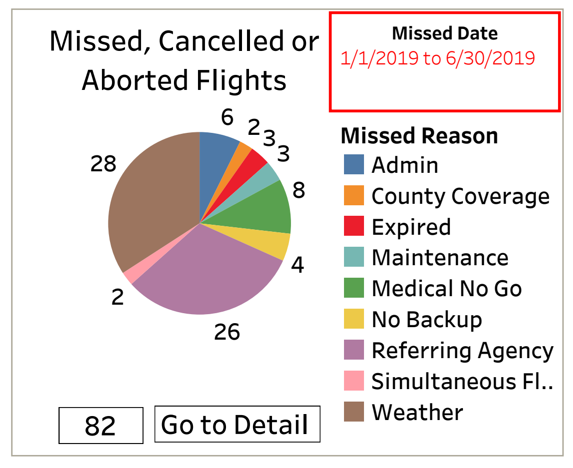
School Health
Quality Report (School Year 2018-2019)
3rd Trimester

MEASURE SET:										ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL
Demographics	**T1 2018/2018 (Aug - Dec)**			**T2 2018/2019 (Aug - March)**			**T3 2018/2019 (Aug - June)**			**T3 2018/2019**
Total Completed Events	355,806			563,046			732,202			
Office Visits	161,790			263,591			340,739			
Medications	80,294			137,566			186661			
Procedures	49,912			83,299			111504			
Record Review - *Immunizations/Physical Exams/School Registrations*	47,891			54,614			63,766			
Consultations	15,919			23,976			29532			
Return Rate	**T1 2018/2018 (Aug - Dec)**			**T2 2018/2019 (Aug - March)**			**T3 2018/2019 (Aug - June)**			**T3 2018/2019**
	Num/Den	%	Goal	Num/Den	%	Goal	Num/Den	%	Goal	
Total Number of Students Remained in School	130,628	80.8%	>80%	211,725	80.4%	>80%	273,309	80.3%	>80%	
Total Number of Students Excused from School	31,019	19.2%	<20%	51,559	19.6%	<20%	67,013	19.7%	<20%	
Continuum of Care	**T1 2018/2018 (Aug - Dec)**			**T2 2018/2019 (Aug - March)**			**T3 2018/2019 (Aug - June)**			**T3 2018/2019**
	Num/Den	%	Goal	Num/Den	%	Goal	Num/Den	%	Goal	
Total Number of Student Pregnancies Identified	54			82			98			9 students are already with HMHB and some are receiving care with private physicians.
Number of Student Pregnancies who have been referred to Healthy Mothers / Healthy Babies	45	83.3%	>95%	77	93.9%	>95%	82	83.7%	>95%	
Mandated Screenings	**T1 2018/2018 (Aug - Dec)**			**T2 2018/2019 (Aug - March)**			**T3 2018/2019 (Aug - June)**			**T3 2018/2019**
	Num/Den	%	Goal	Num/Den	%	Goal	Num/Den	%	Goal	
Vision - Number of Schools (county-wide) with Mandated Grades	145			145			145			Unresponsive parents to: 3 or more contacts by letter and or phone; Fl. Heiken offers vouchers for free eye exames that parents can take advantage of. There are still 483 vouchers which were sent to parents that still have not been used.
Vision - Total # of Schools (w/ Mandated Grades) with **Completed Screenings**	94	64.8%	>45%	145	100.0%	>95%	145	100.0%	>95%	
Vision - Total # of **Students Screened**	31953			48243			50266			
Vision - Total # of Students Requiring Referral for Further Evaluation	2875			4606			4596			
Vision - Completed **Outcomes**		0.0%	See 3rd Tri for Goal		0.0%	See 3rd Tri for Goal	2764	60.1%	>65%	
Hearing - Number of Schools (county-wide) with Mandated Grades	145			145			145			Unresponsive parents to: 3 or more contacts by letter and or phone; School District Audiology also provides hearing exams for parents to take advantage of free program.
Hearing - Total # of Schools (w/ Mandated Grades) with **Completed Screenings**	94	64.8%	>45%	145	100.0%	>95%	145	100.0%	>95%	
Hearing - Total # of **Students Screened**	21353			35063			36786			
Hearing - Total # Students Requiring Referral for Further Evaluation	523			814			828			
Hearing - Completed **Outcomes**		0.0%	See 3rd Tri for Goal		0.0%	See 3rd Tri for Goal	613	74.0%	>75%	
Scoliosis - Number of Schools (county-wide) with Mandated Grades	41			41			41			Unresponsive parents to: 3 or more contacts by letter and or phone. School nurses case manage and make appropriate referals.
Scoliosis - Total # of Schools (w/ Mandated Grades) with **Completed Screenings**	23	56.1%	>45%	41	100.0%	>95%	41	100.0%	>95%	
Scoliosis - Total # of **Students Screened**	5910			11356			11356			
Scoliosis - Total # of Students Requiring Referral for Further Evaluation	50			105			106			
Scoliosis - Completed **Outcomes**		0.0%	See 3rd Tri for Goal		0.0%	See 3rd Tri for Goal	60	56.6%	>60%	
BMI - Number of Schools (county-wide) with Mandated Grades	145			145			145			
BMI - Total # of Schools (w/ Mandated Grades) with **Completed Screenings**	113	77.9%	>45%	145	100.0%	>95%	145	100.0%	>95%	
BMI - Total # of **Students Screened**	26930			36322			36370			
BMI - Total # of Students Requiring Referral for Further Evaluation	6566			8841			8845			
BMI - Completed **Outcomes**		0.0%	See 3rd Tri for Goal		0.0%	See 3rd Tri for Goal	189	2.1%	>2%	

Aeromedical Quality Report

Flight Date
01/01/2019 to 06/30/2019





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

2019	<20	>20	EMB >20
Jan	28	9	0
Feb	23	8	1
Mar	24	4	0
Apr	12	7	0
May	28	4	1
Jun	17	2	0

Average Times for Scene Flights

Month, Year of F..	On Sce..	Disp To En..	Disp To On
anuary 2019	7m 11s	4m 21s	14m 54s
Fe ruary 2019	8m 3s	4m 34s	15m 57s
March 2019	9m 57s	3m 42s	13m 19s
April 2019	7m 8s	4m 54s	16m 9s
May 2019	9m 5s	4m 3s	15m 21s
une 2019	9m 16s	4m 43s	13m 52s

Utilization

	2019					
	Jan	Feb	Mar	Apr	May	Jun
Hours Utilized	94.33	92.76	76.52	62.49	105.10	61.51
% Hours Utilized	8.8%	9.2%	6.9%	6.9%	10.0%	6.5%
Availa le Hours	1,069	1,005	1,116	908	1,056	948
% Availa le Hours	96%	93%	100%	84%	95%	88%

*EMB - East of 20 Mile Bend

MISSED FLIGHTS REASONS

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

OTHER DEFINITIONS

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

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

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

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

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

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

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

Detailed RunTime report TH135

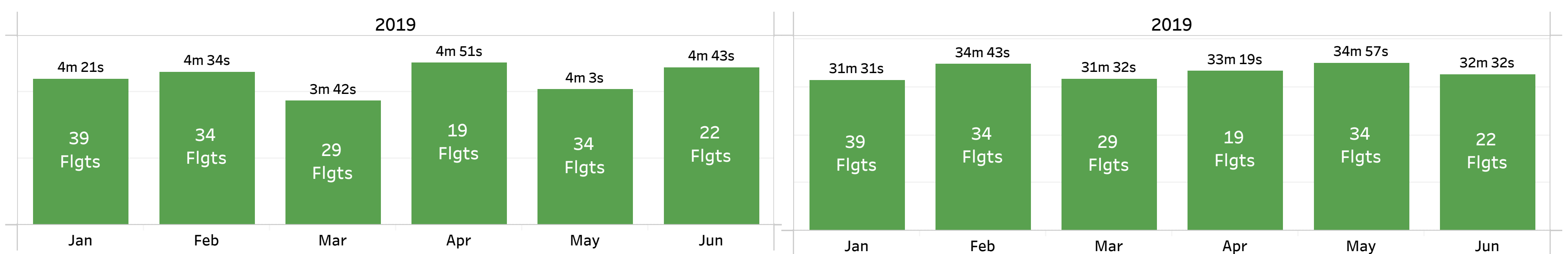
Flight Date
01/01/2019 to 06/30/2019

< 15 Minutes

< 70 Minutes

Dispatch To Enroute Average

Dispatch To Hospital Average



Flight Detail

Flight Num..	Flight Date	Pt Type	Time Call Dispatched	Disp To Enro..	Time Arrival To Hospit..	Disp to Hosp	TimeOnSce..	Pickup Location	Destination	To Enrou	To Hosp
2019-30842	01/01/2019	TRAUMA	01/01/2019 08:32:40	3m 55s	01/01/2019 08:54:57	22m 16s	7m 8s	PALM BEACH STATE (COMMUNI..	STMY (64FD)	3.92	22.28
2019-30857	01/02/2019	TRAUMA	01/02/2019 16:34:14	5m 49s	01/02/2019 17:01:02	26m 48s	5m 42s	POLO FIELD WELLINGTON 33414	STMY (64FD)	5.83	26.80
2019-30862	01/03/2019	TRAUMA	01/03/2019 14:56:07	5m 13s	01/03/2019 15:19:37	23m 30s	5m 56s	COMMUNITY PARK 33413	DCH (48FD)	5.22	23.50
2019-30867	01/04/2019	TRAUMA	01/04/2019 15:16:49	4m 10s	01/04/2019 15:39:41	22m 52s	5m 51s	H L JOHNSON SCHOOL 33470	STMY (64FD)	4.17	22.87
2019-30873	01/05/2019	TRAUMA	01/05/2019 09:23:08	4m 7s	01/05/2019 09:48:37	25m 28s	4m 49s	CITRUS GROVE & SEMINOLE PR..	STMY (64FD)	4.13	25.48
2019-30875	01/05/2019	TRAUMA	01/05/2019 09:52:06	0m 10s	01/05/2019 10:12:06	20m 0s	5m 28s	STATION 27 33414	STMY (64FD)	0.17	20.00
2019-30876	01/05/2019	TRAUMA	01/05/2019 22:25:57	5m 49s	01/05/2019 23:19:43	53m 46s	14m 52s	LAKESIDE MEDICAL CENTER 33..	STMY (64FD)	5.83	53.77
2019-30879	01/06/2019	TRAUMA	01/06/2019 15:34:21	5m 49s	01/06/2019 16:06:39	32m 17s	7m 59s	MOROSO / PBIR 33478	STMY (64FD)	5.83	32.30
2019-30882	01/07/2019	TRAUMA	01/07/2019 15:40:05	3m 34s	01/07/2019 16:02:23	22m 18s	5m 22s	STATION 20 33414	STMY (64FD)	3.58	22.30
2019-30891	01/10/2019	TRAUMA	01/10/2019 16:10:23	2m 4s	01/10/2019 16:37:14	26m 51s	6m 35s	INDIANTOWN RD AND TAYLOR ..	STMY (64FD)	2.08	26.85
2019-30892	01/10/2019	CARDIAC	01/10/2019 16:56:27	4m 28s	01/10/2019 17:28:16	31m 49s	7m 55s	20363 ANTOINETTE ST	PBG (87FD)	4.47	31.82
2019-30895	01/11/2019	TRAUMA	01/11/2019 11:05:20	5m 49s	01/11/2019 11:28:23	23m 3s	6m 8s	PBSC (PBCC) 33461	DCH (48FD)	5.83	23.05
2019-30898	01/12/2019	TRAUMA	01/12/2019 14:43:33	4m 16s	01/12/2019 15:07:12	23m 38s	6m 10s	SOUTHSHORE FIELD	STMY (64FD)	4.27	23.65
2019-30899	01/12/2019	TRAUMA	01/12/2019 14:45:19	2m 22s	01/12/2019 15:15:27	30m 7s	4m 27s	US 27/ WILLARD SMITH RD	DCH (48FD)	2.38	30.13
2019-30900	01/12/2019	NEUROLOGY	01/12/2019 17:28:02	5m 16s	01/12/2019 18:08:53	40m 51s	5m 0s	LAKESIDE MEDICAL CENTER 33..	STMY (64FD)	5.28	40.85

MileBend
All

Flight Type
On Scene

Patient Type
- ANEURYSM - THO..
- BURN
- CARDIAC
- DECOMPRESSION
- NEONATAL
- NEUROLOGY
- OBSTETRIC
- OTHER
- PEDIATRIC NON T..
- REIMPLANTATION
- TRANSPLANT
- TRAUMA

Trauma Hawk
Aeromedical Program
Health Care District Palm Beach County

Services

TOTAL FLIGHTS 319

Flight Date
01/01/2019 to 06/30/2019

2019

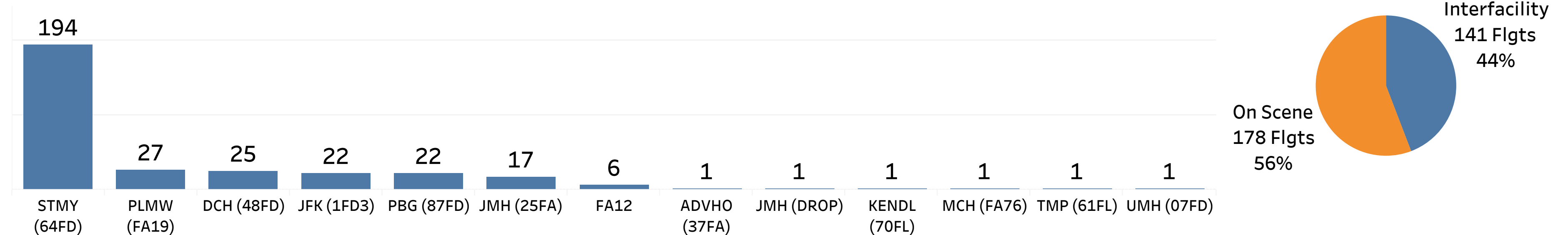
Pt Type
All

Legend: ANEURYSM - THOR OR A.. | BURN | CARDIAC | NEONATAL | NEUROLOGY | OBSTETRIC | OTHER | PEDIATRIC NON TRAUMA | TRANSPLANT | TRAUMA

Month	Total	Labeled values
Jan	63	38 60%
Feb	62	33 53%
Mar	51	11 22%; 31 61%
Apr	40	16 40%
May	59	9 15%; 11 19%; 34 58%
Jun	44	10 23%; 24 55%

Axis: 0, 10, 20, 30, 40, 50, 60, 70

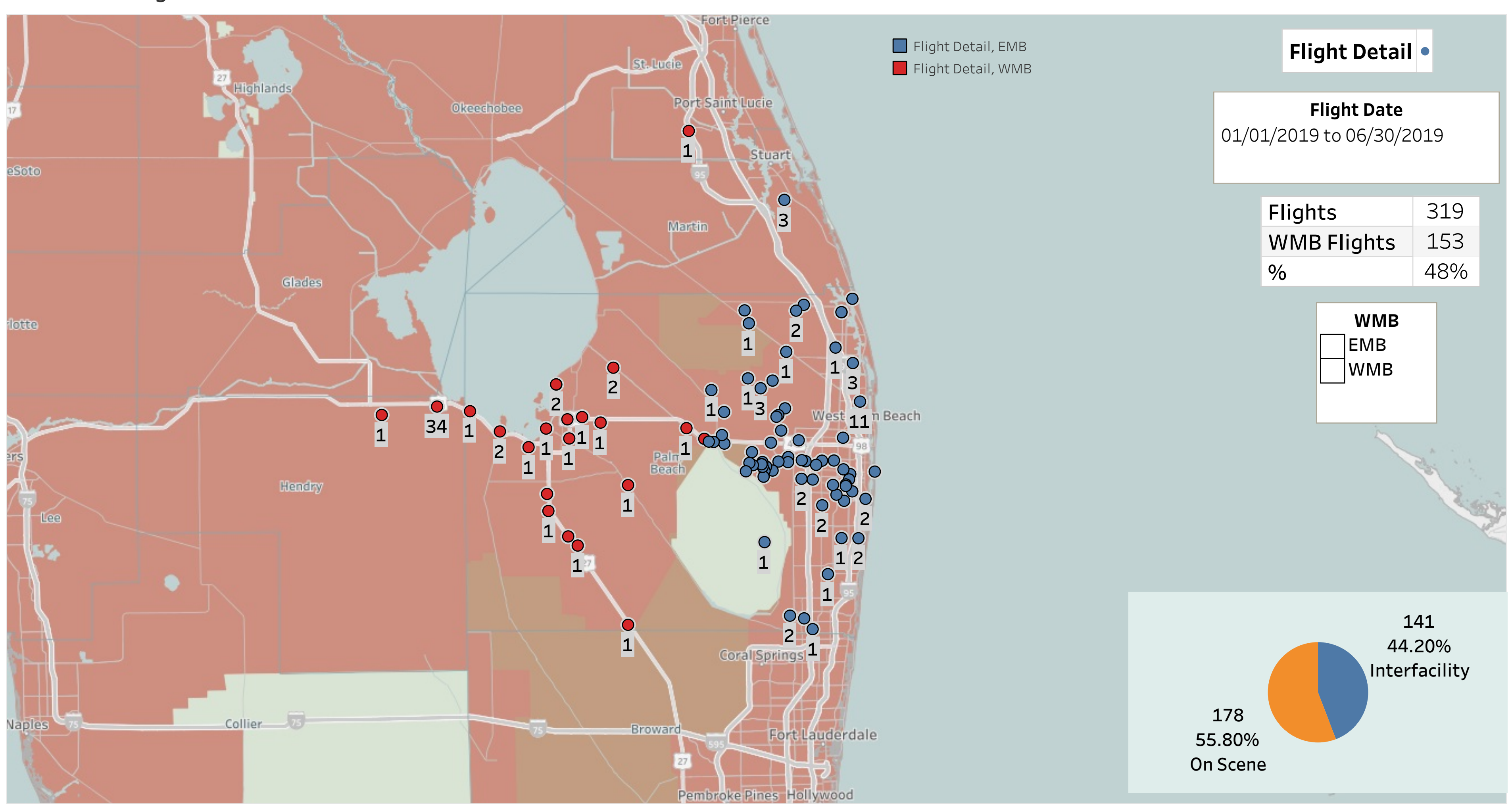
Destination



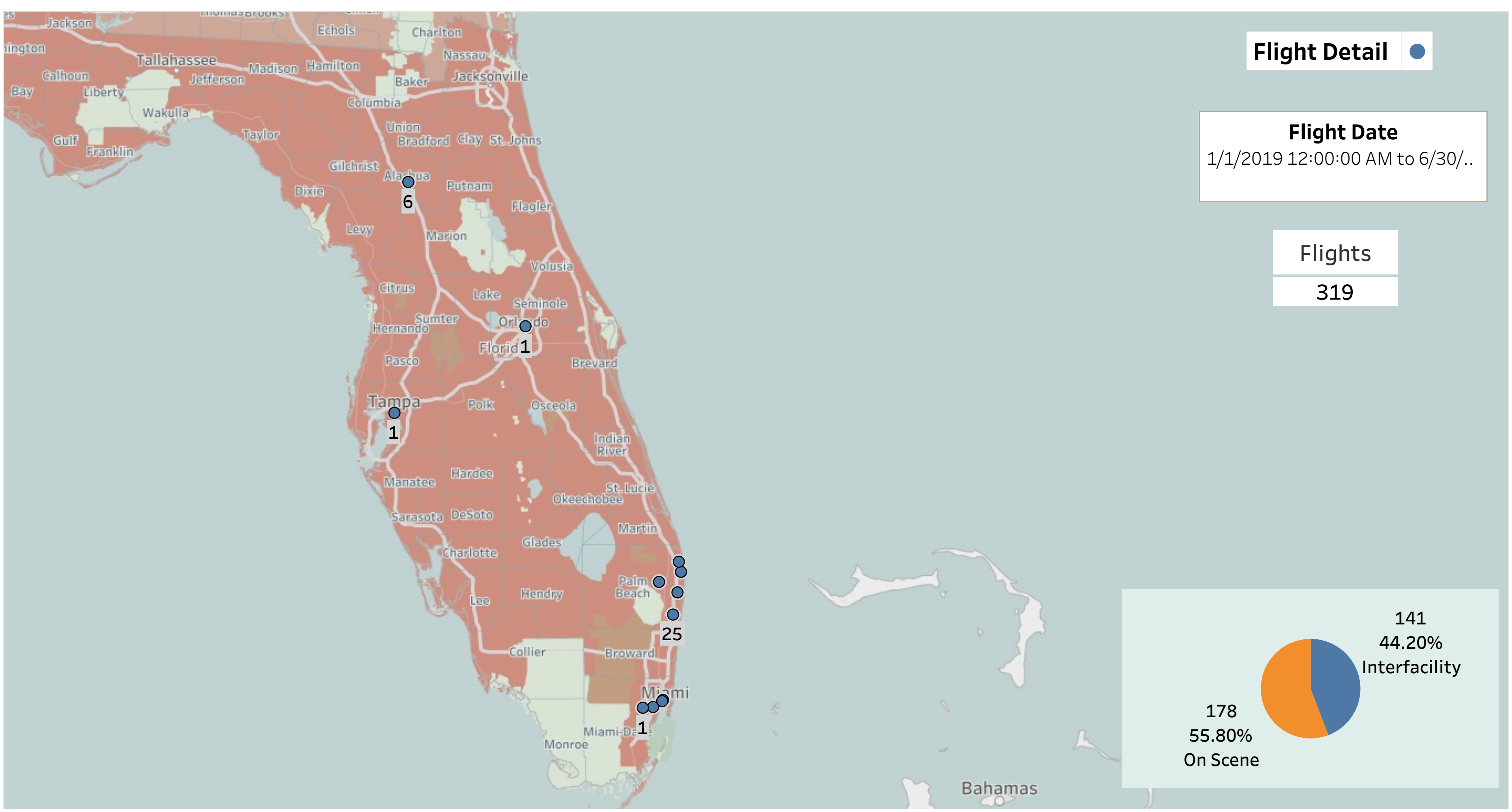
Interfacility
141 Flgts
44%

On Scene
178 Flgts
56%

TH135 Landing Locations



TH135 Receiving Locations



C.L. BRUMBACK PRIMARY CARE CLINICS

YTD June 2019

CHILDHOOD IMMUNIZATION

80% Healthy People 2020 Goal

60% HRSA

% USA 2017	% FL 2017	CL Clinics 2019
40.24%	35.69%	50.00%

Findings: 1. Lowest rates in, Pneumococcal, Rotavirus and Influenza 2. Reconciliation of vaccines with Florida Shots is still faulty

Interventions: 1. Create call list for patient access to schedule appointments for those due for vaccines. 2. Work with Athena for Recociliation workflow.

CL Clinics 2018
42%

CERVICAL CANCER SCREENING

93% Healthy People 2020 Goal

65% HRSA

% USA 2017	% FL 2017	CL Clinics 2019
55.67%	60.59%	61.00%

Findings: 1. Difficulty getting records from outside providers that have performed the screening. 2. Patients are showing as non-compliant although they did not have an encounter in the measurement year

Interventions: 1. Develop care teams to improve efficiencies in following up on requested medical records. 2. Develop a custom report. 3. Woman's Health Director provided Pap smear guidance and cervical cancer guideline updates to teams

CL Clinics 2018
61 %

WEIGHT SCREENING AND COUNSELING FOR CHILDREN AND ADOLESCENTS

90% HRSA

% USA 2017	% FL 2017	CL Clinics 2019
65.85%	77.73%	80.00%

Findings: 1. Providers not dropping the order group at every visit.

Interventions: 1. Train providers that health education should be given at every visit regardless of reason for visit.

CL Clinics 2018
79 %

ADULT WEIGHT SCREENING AND FOLLOW UP

90% HRSA

% USA 2017	% FL 2017	CL Clinics 2019
63.85%	82.36%	98.00%

CL Clinics 2018
94 %

C.L. BRUMBACK PRIMARY CARE CLINICS
YTD June 2019

TOBACCO USE SCREENING AND CESATION INTERVENTION

	% USA 2017	% FL 2017	CL Clinics 2019	CL Clinics 2018
Value	87.50%	91.08%	97.00%	95 %

93% HRSA

ASTHMA PHARMACOLOGIC THERAPY

	% USA 2017	% FL 2017	CL Clinics 2019	CL Clinics 2018
Value	86.62%	84.84%	97.00%	99 %

99% HRSA

Findings: 1. Asthma medication must dated as active in 2019 to be compliant and some therapies that were first prescribed in 2018 may not have updated dates.

Interventions: 1. Providers have been trained to update the dates. 2. Send cases to individual providers to update medication list if still active.

CORONARY ARTERY DISEASE (CAD): LIPID THERAPY

	% USA 2017	% FL 2017	CL Clinics 2019	CL Clinics 2018
Value	80.72%	80.49%	92.00%	89%

81% HRSA

ISCHEMIC VASCULAR DISEASE (IVD): Antiplatelet Therapy

	% USA 2017	% FL 2017	CL Clinics 2019	CL Clinics 2018
Value	79.27%	75.08%	90.00%	85 %

86% HRSA

C.L. BRUMBACK PRIMARY CARE CLINICS

YTD June 2019

COLORECTAL CANCER SCREENING

	% USA 2017	% FL 2017	CL Clinics 2019
Rate	42.02%	42.33%	49.00%

82% HRSA
70.5% 2020 Healthy People Goal

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. Develop a custom report 4. Work on importing colonscopy quality data into Athena.

CL Clinics 2018: 60 %

HIV LINKAGE TO CARE

	% USA 2017	% FL 2017	CL Clinics 2019
Rate	84.52%	73.94%	100%

85% HRSA

CL Clinics 2018: 60%

PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP

	% USA 2017	% FL 2017	CL Clinics 2019
Rate	66.15%	73.17%	89.00%

83% HRSA

CL Clinics 2018: 92 %

DENTAL SEALANTS

	% USA 2017	% FL 2017	CL Clinics 2019
Rate	50.71%	54.92%	88%

75% HRSA

CL Clinics 2018: 87%

C.L. BRUMBACK PRIMARY CARE CLINICS

YTD June 2019

HYPERTENSION

80% HRSA

% USA 2017	% FL 2017	CL Clinics 2019
62.71%	60.43%	72.00%

Findings: 1. Providers failing to give short term follow up for uncontrolled BP 2. non-adherence to medication regimen

Interventions: 1. Reeducate on short interval follow up for uncontrolled hypertension and advancement of therapy 2. Encourage use of combination pills. 3. Pharmacy will begin sending patient messages to providers to recommend changing to combination therapy when appropriate.

CL Clinics 2018
71%

DIABETES

67% HRSA

% USA 2017	% FL 2017	CL Clinics 2019
67.05%	64.70%	57.00%

Findings: 1. Patients are non-compliant with therapy for various reasons (pill burden, fear of insulin, lack of understanding the disease). 2. Clinical inertia

Interventions: 1. Collaborate with pharmacy on educating patients on medications and medication reconciliation. 2. Build care teams to include health educator to address high risk patients. 3. Provide lunch and learns on Diabetes management

CL Clinics 2018
73%

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
2nd Quarter 2019
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
High Risk Long Stay Residents with Pressure Ulcer	Goal: <75% Q2 2019: 53%		Goal: <75% Q1 2019: 71% Q4 2018: 79% Q3 2018: 78%
New/Worse Pressure Ulcer(s)	Goal: <75% Q2 2019: 0%		Goal: <75% Q1 2019: 0% Q4 2018: 0% Q3 2018: 0%
Experiencing One or More Falls with Major Injury	Goal: <75% Q2 2019: 0%		Goal: <75% Q1 2019: 0% Q4 2018: 0% Q3 2018: 0%

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
2nd Quarter 2019
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
Falls (L)	Goal: <75% Q2 2019: 5%		Goal: <75% Q1 2019: 6% Q4 2018: 5% Q3 2018: 6%
Who Have Depressive Symptoms	Goal: <75% Q2 2019: 0%		Goal: <75% Q1 2019: 0% Q4 2018: 0% Q3 2018: 0%
Who Lose Too Much Weight	Goal: <75% Q2 2019: 68%		Goal: <75% Q1 2019: 34% Q4 2018: 33% Q3 2018: 33%

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
2nd Quarter 2019
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**
Who Received an Antipsychotic Medication (L)	Goal: <75% Q2 2019: 44%		Goal: <75% Q1 2019: 38% Q4 2018: 58% Q3 2018: 75%
Who Received an Antipsychotic Medication (S)	Goal: <75% Q2 2019: 0%		Goal: <75% Q1 2019: 0% Q4 2018: 0% Q3 2018: 0%
Who Received Anti-Anxiety or Hypnotic Medication	Goal: <75% Q2 2019: 3%		Goal: <75% Q1 2019: 5% Q4 2018: 47% Q3 2018: 44%

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
2nd Quarter 2019
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
Who Self Report Moderate to Severe Pain (L)	Goal: <75% Q2 2019: 64%		Goal: <75% Q1 2019: 60% Q4 2018: 66% Q3 2018: 45%
Who Self Report Moderate to Severe Pain (S)	Goal: <75% Q2 2019: 0%		Goal: <75% Q1 2019: 0% Q4 2018: 0% Q3 2018: 94%
Who Were Physically Restrained	Goal: <75% Q2 2019: 0%		Goal: <75% Q1 2019: 0% Q4 2018: 0% Q3 2018: 0%

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
2nd Quarter 2019
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
Whose Behavioural Symptoms Affect Others	Goal: <75% Q2 2019: 17%		Goal: <75% Q1 2019: 44% Q4 2018: 58% Q3 2018: 46%
Increase ADL Help (L)	Goal: <75% Q2 2019: 30%		Goal: <75% Q1 2019: 17% Q4 2018: 17% Q3 2018: 17%
With a Catheter Inserted and Left in the Their Bladder	Goal: <75% Q2 2019: 51%		Goal: <75% Q1 2019: 72% Q4 2018: 81% Q3 2018: 47%

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
2nd Quarter 2019
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
With a Urinary Tract Infection	Goal: <75%; Q2 2019: 34%		Goal: <75%; Q1 2019: 75%; Q4 2018: 33%; Q3 2018: 57%
Low Risk LSRs Who Lose Control of their Bowel or Bladder	Goal: <75%; Q2 2019: 41%		Goal: <75%; Q1 2019: 55%; Q4 2018: 42%; Q3 2018: 42%
Move Independent Worsens (L)	Goal: <75%; Q2 2019: 36%		Goal: <75%; Q1 2019: 13%; Q4 2018: 3%; Q3 2018: 29%

Edward J. Healey Rehabilitation and Nursing Center
Quality Report
2nd Quarter 2019
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**
Improvement in Function (S) **Higher % Better**	2% 1% Goal: >1% 0% **0%** Q2 2019		2% Goal: >1% 1% 0% **0%** **0%** **0%** Q1 2019 Q4 2018 Q3 2018

QUALITY CORE MEASURES REPORT

2nd Quarter 2019 - 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 267 minutes.
Denominator: Measure sampled population for any ED Patient from the facility's emergency department.

TJC

AVG FL 288 min
LMC Goal <288 min

	Apr (28/47)	May (28/41)	Jun (26/35)	Q2 (82/123)
Minutes	277	255	230	259
%	60%	68%	74%	67%

Findings: The goal of <288 minutes was met.
Interventions: Top 5 Cases were reviewed by the CMO. No action required.

2019 — LMC Goal: < 288 min

	Q1 (62/120)
Minutes	265
%	52%

2018 — LMC Goal: <267min

	Q4 2018	Q3 2018	Q2 2018	Q1 2018
Minutes	273	280	264	286
%	46%	46%	50%	36%

Emergency Department: ED-2a

Median time from decision to admit time to ED departure for admitted patients.

Numerator: Admitted and departed ED in less than 79 mins.
Denominator: Measure sampled population or any ED Patient from the facility's emergency department.

TJC

AVG FL 115 min
LMC Goal <115 min

	Apr (28/47)	May (28/41)	Jun (28/35)	Q2 (84/123)
Minutes	109	97	100	99
%	60%	68%	74%	67%

Findings: The goal of <115 minutes was met.

Interventions: Top 5 cases were reviewed by CMO. No action required.

2019 — LMC Goal: <115 min

	Q1 (38/120)
Minutes	98
%	52%

2018 — LMC Goal: <79 min

	Q4 2018	Q3 2018	Q2 2018	Q1 2018
Minutes	90	97	94	103
%	41%	38%	37%	33%

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.**

TJC

AVG FL 96%
LMC Goal 98%

Apr (0/0)	May (0/0)	Jun (0/0)	Q2 (0/0)

Findings: October 2019 -March 2020 Influenza Season.
Interventions: Meeting scheduled for planning purposes and review of current policies and procedures.

2019 — LMC Goal: >98%

	Q1 (128/130)
%	98%

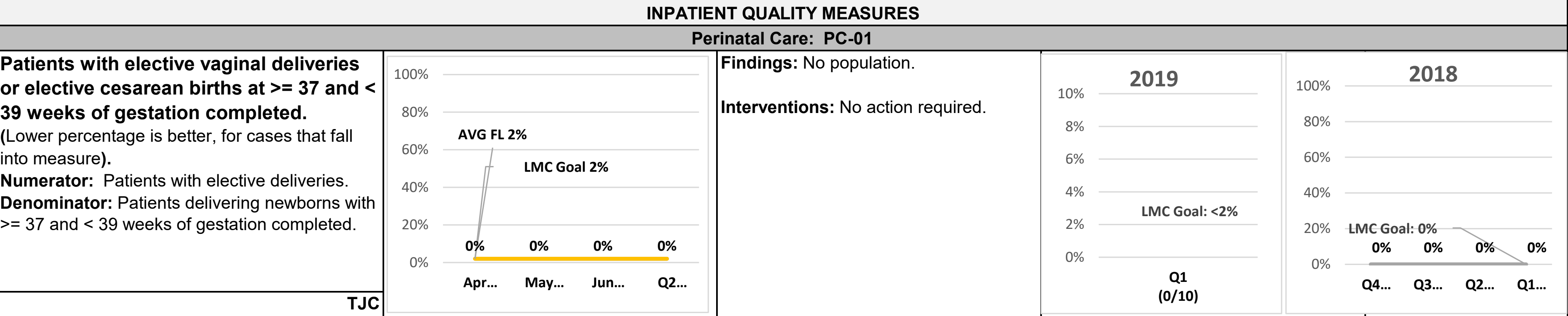
2018 — LMC Goal: > 98%

	Q4 2018	Q3 2018	Q2 2018	Q1 2018
%	94%	N/A	N/A	94%

QUALITY CORE MEASURES REPORT
2nd Quarter 2019 - Preliminary
Sampled Population

INPATIENT QUALITY MEASURES

Perinatal Care: PC-01



Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed.
(Lower percentage is better, for cases that fall into measure**).**
Numerator: Patients with elective deliveries.
Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed.

TJC

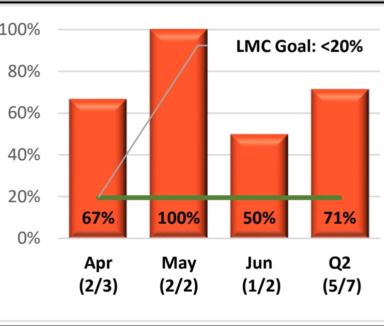
Findings: No population.

Interventions: No action required.

Perinatal Care: PC-02

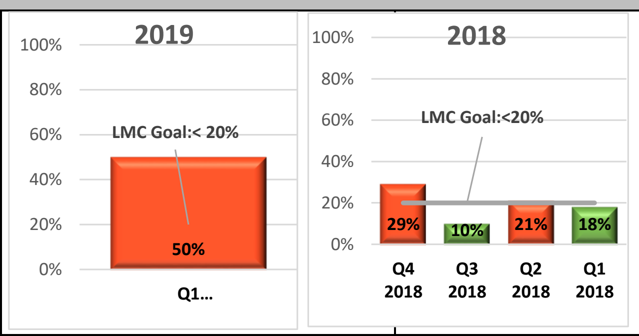
Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth
(Lower percentage is better).
Numerator: Patients with cesarean births.
Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation.

TJC



Findings: All 5 cases were reviewed by the CMO. Gestational ages ranged from 37 to 40 weeks. C-Sections were performed due to Fetal Macrosomia, Non- reassuring Fetal Heart Rate, Failed Induction and Arrest of Descent. Based physician documentation the C-Sections were required based on ACOG standards.

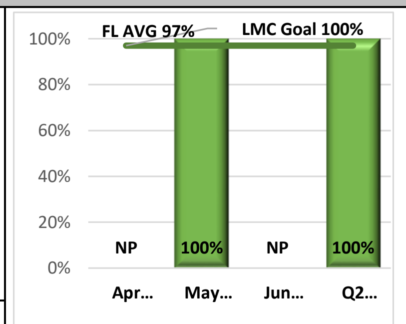
Interventions: No further action required.



Perinatal Care: PC-03

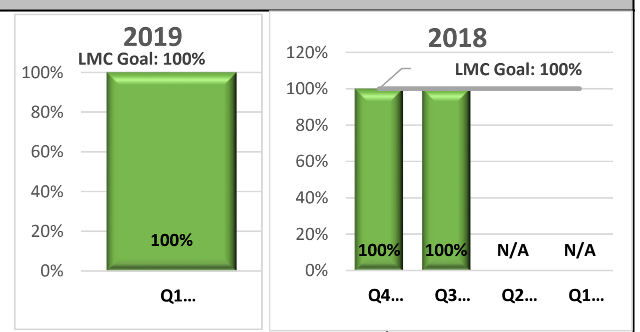
Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns
(Higher percentage is better).
Numerator: Patients with antenatal steroids initiated prior to delivering preterm newborns.
Denominator: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed.

TJC



Findings: The goal of >97% was met.

Interventions: No action required.



Notes:

QUALITY CORE MEASURES REPORT
2nd Quarter 2019 - Preliminary
Sampled Population

INPATIENT QUALITY MEASURES

PERINATAL CARE: PC-04

Health Care-Associated Bloodstream Infections in newborns.
(Lower percentage is better)
Numerator: Newborns with septicemia or bacteremia.
Denominator: Live born newborns.

TJC

Findings: No population.

Interventions: No action required.

PERINATAL CARE: PC-05

Exclusive breast milk feeding during the newborn's entire hospitalization.
(Higher percentage is better)
Numerator: Number of moms Exclusively Breast Feeding.
Denominator: Single term newborns discharged alive from the hospital.

TJC

Findings: Based on review of all cases (73%) of the sampled population both breast and bottle fed, (23%) bottle fed only and (4%) strictly breast fed.

Interventions: August represent breast feeding awareness month. Promotional and educational activities are planned.

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.

TJC

Findings: The goal of 0% was not met. The 2 cases were reviewed by the CMO. 1 newborn was transferred due to Maxillary Alveolar Ridge Mass and 1 received 10 days of antibiotic therapy based on the Septic work up and Phototherapy related to ABO Incompatibility.

Interventions: No intervention required.

QUALITY CORE MEASURES REPORT
2nd Quarter 2019 - Preliminary
Sampled Population

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

FL AVG 60% | LMC Goal >60%

	Apr...	May...	Jun...	Q2...
Rate	86%	78%	40%	71%

Findings: The goal of >60% was met. The 6 failed cases were reviewed by the Sepsis Committee and the CMO.

Interventions: Concurrent review of all cases and education for physicians and staff.

2019 — LMC Goal: >60%

	Q1 (15/17)
Rate	88%

2018 — LMC Goal: >60%

	Q4 2018	Q3 2018	Q2 2018	Q1 2018
Rate	65%	57%	79%	72%

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.

CMS/TJC

AVG FL 2% | LMC Goal 0%

	Apr (0/0)	May (0/0)	Jun (0/0)	Q2 (0/0)
Rate	NP	NP	NP	NP

Findings: No population.

Interventions: No action required.

2019 — LMC Goal: 0%

	Q1 (0/0)
Rate	N/A

2018

	Q4 2018	Q3 2018	Q2 2018	Q1 2018
Rate	N/A	N/A	N/A	N/A

*Perinatal Care: PC-06 - New Measure :Started 1st Quarter 2019

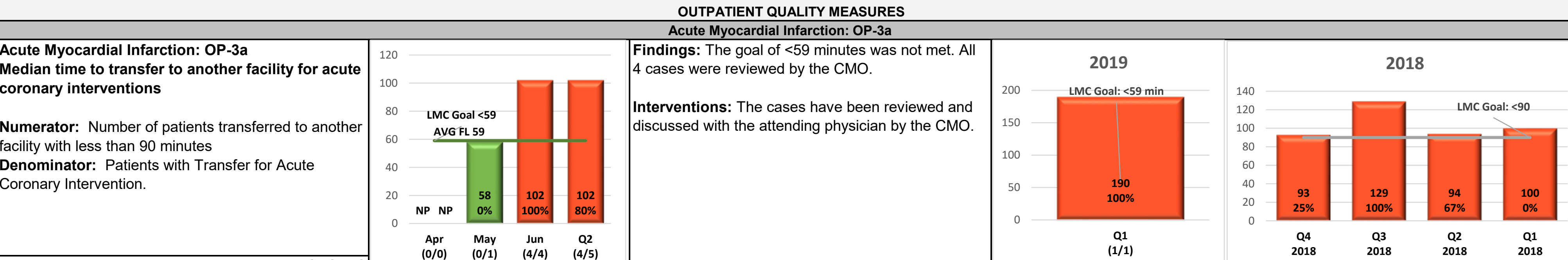
The Florida Averages Data from Hospital Compare was obtained from the Florida Hospital Association.

Lakeside Medical Center
Health Care District Palm Beach County

QUALITY CORE MEASURES REPORT
2nd Quarter 2019 - 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

Numerator: Number of patients transferred to another facility with less than 90 minutes
Denominator: Patients with Transfer for Acute Coronary Intervention.

CMS/TJC

Findings: The goal of <59 minutes was not met. All 4 cases were reviewed by the CMO.

Interventions: The cases have been reviewed and discussed with the attending physician by the CMO.

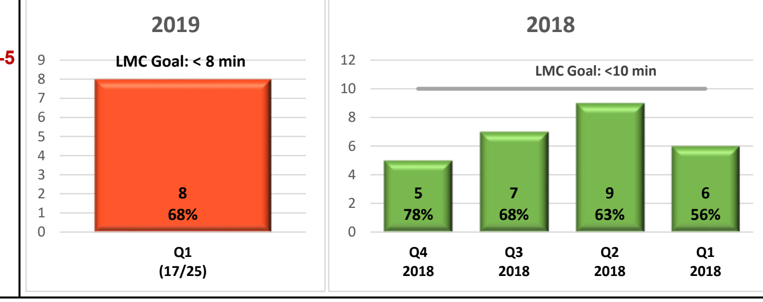
Chest Pain: OP-5

Median time to EKG (Goal 10 mins).

Numerator: Number of patients received EKG within 10min upon arrival to ED.
Denominator: Emergency Department AMI or Chest Pain patients (with Probable Cardiac Emergency Department AMI or Chest Pain patients (with Probable Cardiac Chest Pain).

CMS/TJC

Data will no longer be reported after 1Q 2019 (encounter dates January 1 through March 31, 2019). The last data submission deadline for OP-5 will be August 1, 2019.

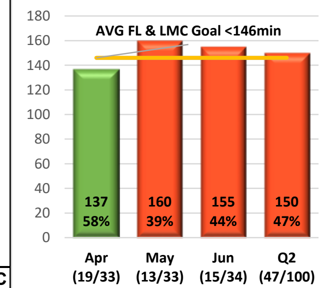


Emergency Department Throughput: OP-18

Median time from ED arrival to discharge home or transferred.

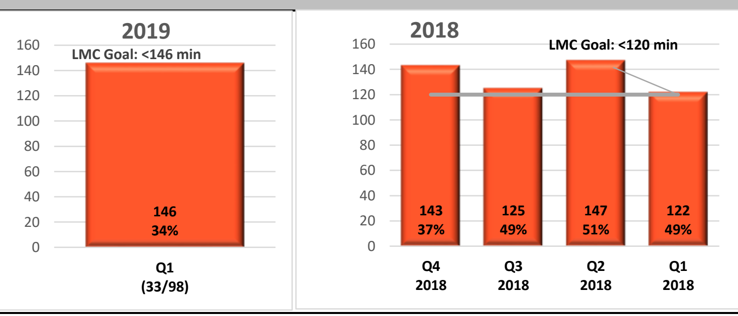
Numerator: Number of patients discharged in less than 120 minutes.
Denominator: Any ED patient from the facility's emergency department.

CMS/TJC



Findings: The goal of <146 minutes was not met. The top 5 cases were reviewed by the CMO and the findings were due to but not limited to AMR transport and bed availability due to increased census.

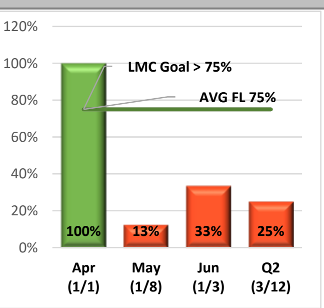
Interventions: Collaboration with AMR to establish services at LMC continues.



Stroke: OP-23

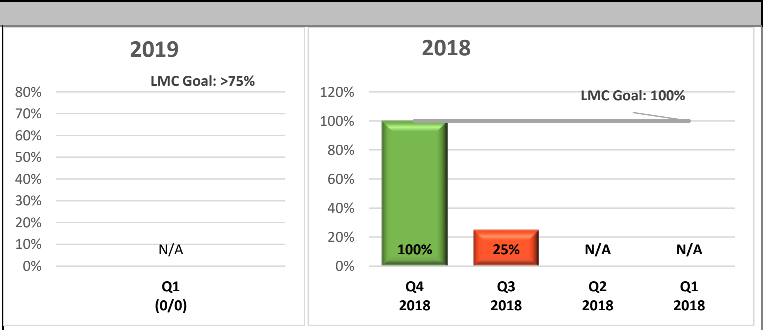
Stroke patient arriving in ED w/in 2 hours of onset of symptoms who had CT or MRI results w/in 45 mins of arrival. (Higher percentage is better).
Numerator: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients.
Denominator: Emergency Department Acute Ischemic Stroke or Hemorrhagic 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 >75% was not met. Top 4 cases were reviewed by the CMO. Findings were due to but not limited to determination of last known well, and presentation of symptoms.

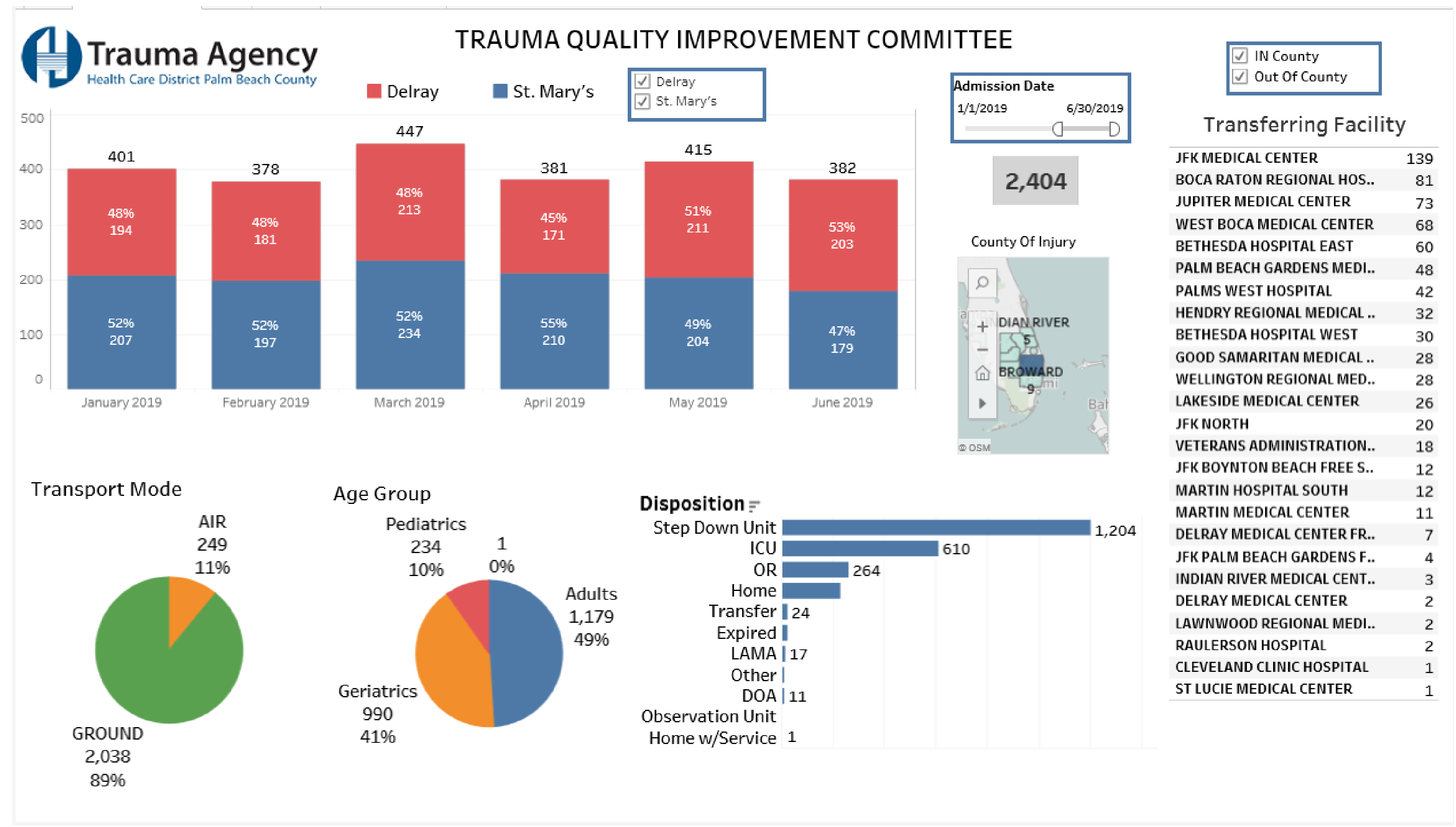
Interventions: Cases were reviewed by CMO. No further action required.



Pharmacy Services
Quality Report
2nd Quarter 2019

Measure Set:				ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL				Previous Quarters								
Pharmacy Quality Measures	2019 Q2				2019 Q1			2018 Q4			2018 Q3			2018 Q2		
	Goal	Total			Goal	Total		Goal	Total		Goal	Total		Goal	Total	
340B utilization		#	%			#	%		#	%		#	%		#	%
Total HCD prescriptions sold (excludes RW)		58,672				62,036			70,485			63,875			72,679	
340B prescription fills sold			100.0			62,050	100.0		69,947	99.2		62,907	98.5		72,250	99.4
Central Fill (refills)		10,913	65.2	Central Fill pharmacy co-located with West Palm pharmacy so number indicative for Delray and Lantana pharmacies only now		21,419	34.5		21,930	31.4		22,003	34.5		17,990	24.9
Ready when promised (non-waiters)	>90%				>90%			>90%			>90%			>90%		
Belle Glade		5,539	99.9			5,259	99.9		5,732	99.6		5,992	99.9		5,904	99.8
Delray		11,379	98.3			11,843	99.6		11,924	99.4		10,854	99.0		13,107	99.0
Jupiter						3,240	100.0		3,326	100.0		3,033	99.8		2,693	99.9
Lake Worth												8,503	96.5		11,006	96.3
Lantana		18,322	97.1			18,695	98.9		19,684	98.7		12,338	97.3		11,073	97.9
West Palm		16,000	99.1			13,007	99.2		12,738	98.9		12,137	96.8		12,888	93.3
Prescriptions designated as waiters	<25% per site				<25% per site			<25% per site			<25% per site			<25% per site		
Belle Glade		1,291	18.9			1,585	23.2		1,501	20.8		833	12.2		1,446	19.7
Delray		1,682	12.9			1,682	12.4		1,541	11.4		2,101	16.2		1,723	11.6
Jupiter						61	1.8		77	2.3		173	5.4		339	11.2
Lake Worth												644	7.0		653	5.6
Lantana		2,971	14.0			3,928	17.4		3,098	13.6		3,119	20.2		2,731	19.8
West Palm		3,600	18.4			3,958	23.3		3,643	22.2		4,113	25.3		3,756	22.6
Prescriptions returned to stock	<5% per site			Outbound notification system in the process of implementation; Will notify patients of medications ready to be picked up	<5% per site			<5% per site			<5% per site			<5% per site		
Belle Glade		399	5.8			341	5.0		499	6.9		523	7.7		533	7.3
Delray		1,364	10.4			1,368	10.1		1,396	10.4		1,408	10.9		947	6.4
Jupiter						116	3.5		138	4.1		176	5.5		94	3.1
Lake Worth												787	8.6		754	6.5
Lantana		1,992	9.4			1,903	8.4		2,158	9.5		1,199	7.8		948	6.9
West Palm		2,159	11.0			1,891	11.1		2,255	13.8		2,154	13.3		1,989	12.0
Total wait time in minutes (waiters)	<30 mins	23.14 Minutes			<30 mins	23.14 Minutes		<30 mins	21.3 Minutes		<30 mins	23.1 Minutes		<30 mins	21.72 Minutes	
Belle Glade		19.9 mins				19.8 mins			20.5 mins			19.8 mins			17.8 mins	
Delray		19.5 mins				21.2 mins			19.3 mins			21.2 mins			19.3 mins	
Jupiter						8.9 mins			7.1 mins			7.2 mins			6.8 mins	
Lake Worth												23.6 mins			25.6 mins	
Lantana		25.2 mins				34.4 mins			30.6 mins			28.8 mins			23.2 mins	
West Palm		30.9 mins				31.4 mins			28.8 mins			38.1 mins			37.6 mins	
Total out of stock fills	<5% per site				<5% per site			<5% per site			<5% per site			<5% per site		
Belle Glade		165	2.4			151	2.2		211	2.9		140	2.1		151	2.1
Delray		176	1.4			127	0.9		152	1.1		152	1.2		132	1.1
Jupiter						156	4.7		155	4.6		155	4.8		157	5.2
Lake Worth												73	0.8		308	2.6
Lantana		672	3.1			846	3.7		775	3.4		416	2.6		292	2.1
West Palm		677	3.4			554	3.3		225	1.4		262	1.6		310	1.8

Quality Audit Results	
CQI Compliance Audit	Quarterly CQIs completed in compliance with Board requirements
Control Substance Reconciliation Audit	No discrepancies during the quarter
Florida Board of Pharmacy Inspection	Lantana recently inspected with no negative findings reported
Mobile Van Deliveries	771 Prescriptions (WPB and Delray locations only)



Trauma Agency
Health Care District Palm Beach County
TRAUMA QUALITY IMPROVEMENT COMMITTEE
Delray
St. Mary's
Delray
St. Mary's
Admission Date
1/1/2019
6/30/2019
2,404
County Of Injury
IN County
Out Of County
Transferring Facility
JFK MEDICAL CENTER 139
BOCA RATON REGIONAL HOS.. 81
JUPITER MEDICAL CENTER 73
WEST BOCA MEDICAL CENTER 68
BETHESDA HOSPITAL EAST 60
PALM BEACH GARDENS MEDI.. 48
PALMS WEST HOSPITAL 42
HENDRY REGIONAL MEDICAL .. 32
BETHESDA HOSPITAL WEST 30
GOOD SAMARITAN MEDICAL .. 28
WELLINGTON REGIONAL MED.. 28
LAKESIDE MEDICAL CENTER 26
JFK NORTH 20
VETERANS ADMINISTRATION.. 18
JFK BOYNTON BEACH FREE S.. 12
MARTIN HOSPITAL SOUTH 12
MARTIN MEDICAL CENTER 11
DELRAY MEDICAL CENTER FR.. 7
JFK PALM BEACH GARDENS F.. 4
INDIAN RIVER MEDICAL CENT.. 3
DELRAY MEDICAL CENTER 2
LAWNWOOD REGIONAL MEDI.. 2
RAULERSON HOSPITAL 2
CLEVELAND CLINIC HOSPITAL 1
ST LUCIE MEDICAL CENTER 1
January 2019 401 48% 194 52% 207
February 2019 378 48% 181 52% 197
March 2019 447 48% 213 52% 234
April 2019 381 45% 171 55% 210
May 2019 415 51% 211 49% 204
June 2019 382 53% 203 47% 179
Transport Mode
AIR 249 11%
GROUND 2,038 89%
Age Group
Pediatrics 234 10%
1 0%
Adults 1,179 49%
Geriatrics 990 41%
Disposition
Step Down Unit 1,204
ICU 610
OR 264
Home
Transfer 24
Expired
LAMA 17
Other
DOA 11
Observation Unit
Home w/Service 1

Health Care District
PALM BEACH COUNTY