Health Care District
PALM BEACH COUNTY

# Quality, Patient Safety & Compliance Committee
# Meeting Agenda
# September 25, 2018
# 10:00 A.M.

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

Health Care District
PALM BEACH COUNTY

**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE**
**AGENDA**
**September 25, 2018 at 10:00 a.m.**
**1515 N. Flagler Dr., Suite 100**
**West Palm Beach, FL 33401**

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

   A. Roll Call

2. **Agenda Approval**

   A. Additions/Deletions/Substitutions

   B. Motion to Approve Agenda

3. **Awards, Introductions and Presentations**

   A. Fiscal Year 2018 Health Center Quality Improvement Award. (Belma Andric)

   B. Lakeside Medical Center Emergency Department Update. (Dr. Scheppke)

4. **Disclosure of Voting Conflict**

5. **Public Comment**

6. **Meeting Minutes**

   A. **Staff recommends a MOTION TO APPROVE:**
   Committee Meeting Minutes from May 22, 2018. [Pages 1-6]

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 7]

   7A-3 **RECEIVE AND FILE:**
   Compliance and Privacy Dashboard.
   (Ellen Pentland) [Pages 8-13]

## 8. Regular Agenda

### A. ADMINISTRATION

8A-1 **Staff recommends a MOTION TO APPROVE:**
Amendment to the Quality, Patient Safety and Compliance Committee Charter.
(Ellen Pentland) [Page 14-23]

8A-2 **Staff recommends a MOTION TO APPROVE:**
Annual Evaluation – Chief Compliance and Privacy Officer.
(Darcy Davis) [Page 24-27]

### B. CORPORATE QUALITY & PATIENT SAFETY DASHBOARDS

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

- Patient Relations Dashboard, School Health.
(Belma Andric/Ginny Keller) [Pages 28-30]

- Patient Relations Dashboard, Primary Care Clinics.
(Belma Andric/Noelle Stewart, M.D.) [Pages 31]

- Patient Relations Dashboard, Healey Center.
(Belma Andric/Terretha Smith) [Pages 32-33]

- Patient Relations Dashboard, Lakeside Medical Center.
(Belma Andric/Janet Moreland) [Pages 34-35]

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

- Quality & Patient Safety Report, School Health.
(Belma Andric/Ginny Keller) [Page 36-38]

- Quality & Patient Safety Report, Aeromedical.
(Belma Andric/Gerry Pagano) [Page 39]

- Quality & Patient Safety Report, Primary Care Clinics.
(Belma Andric/Noelle Stewart, M.D.) [Page 40-43]

- Quality & Patient Safety Report, Healey Center.
(Belma Andric/Terretha Smith) [Page 44]

- Quality & Patient Safety Report, Lakeside Medical Center.
(Belma Andric/Janet Moreland) [Pages 45-47]

- Quality and Patient Safety Report, Pharmacy.
(Belma Andric/Hyla Fritsch) [Page 48]

- Quality & Patient Safety Report, Trauma Program.
  (Belma Andric/Sandra Smith) [Pages 49]

C. **COMPLIANCE**

8C-1 **RECEIVE AND FILE:**
Summary of Compliance and Privacy Activities.
(Ellen Pentland) [Pages 50-54]

8C-2 **Staff recommends a MOTION TO APPROVE:**
Revised Compliance Work Plan 2018.
(Ellen Pentland) [Pages 55-61]

D. **CORPORATE RISK MANAGEMENT CLOSED MEETING**
[Under Separate Cover]

**9. CEO Comments**

**10. Committee Member Comments**

**11. Establishment of Upcoming Meetings**

- November 27, 2018

**12. Motion to Adjourn**

Health Care District
PALM BEACH COUNTY

**QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE**
**SUMMARY MEETING MINUTES**
**May 22, 2018, 10:00 a.m.**
**1515 N. Flagler Drive**
**West Palm Beach, FL 33401**

## 1. Call to Order

Dr. Alonso called the meeting to order at 10:15 a.m.

A. Roll Call

Committee Members present included: James Elder, Sean O'Bannon, Dianne King, Mary Weeks, and Dr. Alina Alonso.

Staff present included: Darcy Davis, Valerie Shahriari, Dr. Belma Andric and Ellen Pentland.

Recording/Transcribing Secretary: Sandra Jaime.

## 2. Agenda Approval

A. Additions/Deletions/Substitutions

None.

B. Motion to Approve Agenda

**CONCLUSION/ACTION: Sean O'Bannon made a motion to approve the agenda as presented/amended. The motion was duly seconded by Mary Weeks. There being no opposition, the motion passed unanimously.**

## 3. Awards, Introductions and Presentations

A. 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 27, 2018.

**CONCLUSION/ACTION: James Elder made a motion to approve the committee meeting minutes from March 27, 2018 as presented. The motion was duly seconded by Dianne King. There being no opposition, the motion passed unanimously.**

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

**CONCLUSION/ACTION: Mary Weeks made a motion to approve the Consent Agenda items. The motion was duly seconded by Sean O'Bannon. There being no opposition, the motion passed unanimously.**

**A. ADMINISTRATION**

7A-1 RECEIVE AND FILE:
May 22, 2018 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 Privacy Dashboard

8. **Regular Agenda**

**A. ADMINISTRATION**

8A-1 **Staff recommends a MOTION TO APPROVE:**
Health Care District Committee Charter Update.
(Valerie Shahriari)

Valerie Shahriari presented the updates to the committee which will provide a consistency and Glades representation on sub-committees and cross over to the Clinics Board. She noted that this will also be applied to the Finance and Audit Committee Charter and will be taken to their meeting today. Mary Weeks asked about the credentialing section of charter and what role the committee plays in this process as she has not seen any credentialing come before this committee. Dr. Andric stated that the Health Care District Board has the final approval and decision after being reviewed by the Medical Executive Committee. Mary asked if conducting this annually was enough. Valerie Shahriari stated that this committee will review Greely's update and ongoing quality process. She explained that this committee monitors quality, however the committee can recommend additions to the process and have the opportunity to offer suggestions. Valerie also mentioned that Greeley has a multi-year plan for implementation and that future reports will be shared and discussed with the committee for process review from a quality standpoint.

**CONCLUSION/ACTION: Mary Weeks made a motion to approve the Charter update. The motion was duly seconded by Sean O'Bannon. There being no opposition, the motion passed unanimously.**

## B. CORPORATE QUALITY & PATIENT SAFETY DASHBOARDS

8B-1 RECEIVE AND FILE:

- Patient Relations Dashboard, School Health

  The committee had no questions or comments on this dashboard.

- Patient Relations Dashboard, Primary Care Clinics

  Dr. Alonso noted that she appreciated the total number of patients represented being noted this meeting, as previously requested. Dr. Alonso also applauded the Clinics for their compliments outweighing their complaints. There were no other questions or comments from the committee.

- Patient Relations Dashboard, Healey Center

  The committee had no questions or comments on this dashboard.

- Patient Relations Dashboard, Lakeside Medical Center

  It was noted that under Summary of Top Complaint/Grievance Categories, that the environmental complaint should have read "paint in the ED" and not pain. There were no additional questions or comments on this dashboard.

**CONCLUSION/ACTION: Received and filed.**

8B-2 RECEIVE AND FILE:

- Quality & Patient Safety Report, School Health

  Dr. Alonso congratulated Ginny Keller on all metrics being in the Green. There were no additional questions or comments from the committee on this dashboard.

- Quality & Patient Safety Report, Aeromedical

  Dr. Alonso commented on hours utilized and asked if we could be criticized for not utilizing the helicopter enough. Dr. Andric stated that there is not a standard national number and that we do utilize dual transport or simultaneous flights. Dr. Andric also stated that the District is considering stationing a helicopter at Lakeside to more readily available and the data supports this decision. Mary Weeks added that she is surprised there is a significant need in the Belle Glade area. Gerry Pagano stated that we want to lower the response and transport time. Dr. Kenneth Scheppke supported this by saying we would be addressing

both needs in the areas of critical transport and a higher level of care by "bringing the ED, as well as a lifesaving component to the patient". Dr. Alonso asked for details on canceled and aborted flights. Gerry explained that referring agencies cancel when it is determined that the case do not warrant a trauma alert among other reasons and canceled means that prior to the engine being started the call was canceled. Gerry also explained that aborted occurs when the flight is initiated but called off. It was noted that a breakdown of calls from Belle Glade/Western communities or those west of the 20 mile bend would be brought back to the next meeting, as Mary Weeks and Dr. Alina Alonso are interested in this number.

- Quality & Patient Safety Report, Primary Care Clinics

  Andrea stated that the Primary Care Clinics plan on bringing a presentation on the topic of vaccines to the September meeting. She stated that the Clinics area still working on this goal and the presentation will help explain why we are not reaching the desired goal. Dr. Andric mentioned that the conversion from AllScripts to Athena has posed a problem in reporting data, however this will improve in the coming months. Mary Weeks stated that she would like to see the data involved in follow through on the fit tests; who is give a test, and how is it returned? Dr. Andric stated that positive fit tests are referred to a gastrointestinal doctor for a colonoscopy. Mary Weeks requested follow through data on this particular test. Dr. Alonso would like the Clinics to consider making smoking cessation a quality goal this year, including pediatric education on vaping dangers.

- Quality & Patient Safety Report, Healey Center

  Dr. Alonso questioned the pressure ulcers goal range. Karen Harris and Terretha Smith clarified that it was between 0-2 stage goal. Dr. Alonso also asked for clarification on the goal entered for anti-anxiety and hypnotic medications. Terretha Smith noted that the goal should read 7.5 and not 9.0 as listed. Dr. Alonso asked about the Urinary Tract Infections and Catheter reports in red and asked how many of those were permanent catheters? Terretha reported that (2) were permanent, (3) provided self-care and this number includes readmissions. Mary Weeks inquired on the number of new admissions and the turnover rate at The Healey Center, along with the center's capacity. Terretha reported that the turnover rate was low and approximately (10) per month, while the capacity was 120 with (1) bed hold.

- Quality & Patient Safety Report, Lakeside Medical Center

  Dr. Alonso commented on the number of employees receiving their flu shots as being a low number. Dianne King stated that she could provide insight into raising the employee immunization rate, which is currently low at 38%. She will meet with the respective staff and provide feedback for possible implementation. Sylvia Hall from Lakeside, also mentioned that there is a meeting scheduled later this month to train staff and ensure they are all clear

on the process in place. Darcy noted that this quarter reflects both ED groups, as the new ED group did not start until February 1st. Next quarter will reflect the new ED group only and the new measures the have implemented. Dr. Scheppke noted that the last item on the dashboard labeled, Pain-Management OP-21, should not continue to be followed and will not be reported in the future. Additionally, Sylvia Hall noted that items OP-4, OP-20 along with OP-21 will no longer be reported and are no longer being measured per CMS. Dianne King complimented Lakeside staff on their sepsis numbers and measures.

- Quality & Patient Safety Report, Pharmacy

  Andrea stated that the most notable items were the Lake Worth location added a second pharmacist on May 7, 2018 to address longer wait times and that they were looking into a plan for expansion. They will bring back more information on the plan in September.

- Quality & Patient Safety Report, Trauma

  It was noted that all metrics were in the Green for quarter 1 and there were no questions or comments.

**CONCLUSION/ACTION: Received and filed.**

## C. COMPLIANCE

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

Ellen Pentland wanted to make note to the committee, that going forward the dashboard under the consent agenda will be strictly year-to-date and next fiscal year will show comparisons. Then the summary will consist of only a summary of events and not a repeat of the same data. Dr. Alonso asked what the nature of most of the findings were. Ellen stated that they consisted mostly of computers being left on, not logged off or locked, the use of wrong fax numbers and employees not using their name badges in order to be properly identified. Dr. Alonso also asked for information pertaining to the breaches listed, where patient notifications were made. Ellen stated that these involved information being sent to the wrong patient, or a patient leaving the hospital with someone else's discharge instructions. Dianne King inquired about the use of personal cell phones for medical order and information. Ellen stated that she has made it clear to staff that our policy is not to text any orders or medical information. We are looking into whether Athena has any capability for this that would be protected.

**CONCLUSION/ACTION: Received and filed.**

**D. CORPORATE RISK MANAGEMENT CLOSED MEETING**

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

**9. CEO Comments**

None.

**10. Committee Member Comments**

None.

**11. Establishment of Upcoming Meetings**

- July 24, 2018 - Cancelled
- September 25, 2018
- November 27, 2018

**12. Motion to Adjourn**

There being no further business, the meeting was adjourned at 11:43 a.m.

**Dr. Alina Alonso, Chair** **Date**

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

**12 Month Attendance Tracking**

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

# HEALTH CARE DISTRICT
## Quality, Patient Safety and Compliance Committee
## September 25, 2018

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

**2. Summary:**

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

**3. Substantive Analysis:**

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

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

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

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A
Dawn Richards
VP & Chief Financial Officer

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

N/A
Committee Name

Date Approved

## 6. Recommendation:

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

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Ellen Pentland
Chief Compliance and Privacy Officer

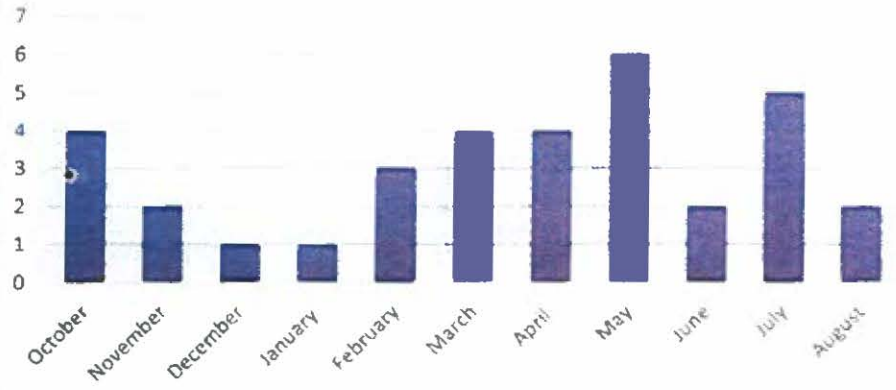
Darcy J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

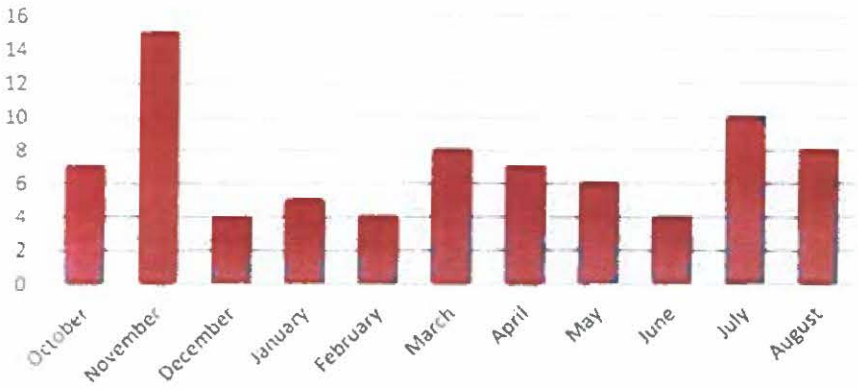
# Compliance & Privacy Dashboard

**Year to Date: October 1, 2017 – August 31, 2018**

## Compliance Inquiries by Month




## Privacy Concerns by Month




| Compliance Inquiries by Month and Entity | C.L. Brumback Clinics | Health Care District | Healthy Palm Beaches | Home Office | Healey | Lakeside Medical Center | Total |
|---|---|---|---|---|---|---|---|
| October | 2 | 0 | 0 | 1 | 0 | 1 | 4 |
| November | 1 | 0 | 0 | 0 | 0 | 1 | 2 |
| December | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| January | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| February | 0 | 1 | 2 | 0 | 0 | 0 | 3 |
| March | 3 | 0 | 0 | 1 | 0 | 0 | 4 |
| April | 2 | 1 | 0 | 0 | 0 | 1 | 4 |
| May | 3 | 1 | 0 | 0 | 0 | 2 | 6 |
| June | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| July | 3 | 1 | 0 | 0 | 0 | 1 | 5 |
| August | 1 | 0 | 0 | 0 | 1 | 0 | 2 |
| Total | 18 | 5 | 2 | 2 | 1 | 6 | 34 |

| Privacy Concerns by Month and Entity | Lakeside Medical Center | C.L. Brumback Clinics | E.J. Healey | Home Office | Total |
|---|---|---|---|---|---|
| October | 1 | 4 | 0 | 2 | 7 |
| November | 1 | 4 | 2 | 1 | 8 |
| December | 2 | 0 | 0 | 0 | 2 |
| January | 0 | 2 | 0 | 3 | 5 |
| February | 0 | 1 | 1 | 1 | 3 |
| March | 2 | 6 | 0 | 0 | 8 |
| April | 0 | 4 | 0 | 3 | 7 |
| May | 2 | 3 | 0 | 1 | 6 |
| June | 2 | 1 | 0 | 1 | 4 |
| July | 0 | 4 | 1 | 5 | 10 |
| August | 1 | 6 | 1 | 0 | 8 |
| Total | 11 | 36 | 5 | 17 | 68 |

Health Care District
PALM BEACH COUNTY

# Compliance & Privacy Dashboard

**Year to Date: October 1, 2017 – August 31, 2018**

| COMPLIANCE AND PRIVACY REVIEWS AND PROJECTS | October | November | December | January | February | March | April | May | June | July | August | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal Risk Assessment | 2 | 0 | 1 | 1 | 2 | 2 | 4 | 3 | 3 | 0 | 2 | 20 |
| OCR Investigation | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Risk Assessment | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| OIG Work Plan FY 2018 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| External Audits | 3 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 7 |
| Total | 5 | 1 | 2 | 3 | 2 | 4 | 5 | 3 | 5 | 0 | 2 | 32 |

| Privacy Walkthroughs | Home Office | C.L. Brumback Clinics | Lakeside Medical Center | Eligibility Office | Healey Center | Total |
|---|---|---|---|---|---|---|
| October | 0 | 0 | 0 | 0 | 0 | 0 |
| November | 0 | 0 | 1 | 0 | 0 | 1 |
| December | 0 | 5 | 0 | 0 | 1 | 6 |
| January | 1 | 1 | 0 | 0 | 0 | 2 |
| February | 0 | 1 | 0 | 1 | 0 | 2 |
| March | 0 | 2 | 0 | 0 | 0 | 2 |
| April | 0 | 1 | 0 | 0 | 0 | 1 |
| May | 0 | 3 | 0 | 1 | 0 | 4 |
| June | 0 | 0 | 0 | 0 | 0 | 0 |
| July | 0 | 0 | 1 | 0 | 0 | 1 |
| August | 0 | 1 | 0 | 1 | 0 | 2 |
| Total | 1 | 14 | 2 | 3 | 1 | 21 |

| Compliance and Privacy Education | Health Care District | Lakeside Medical Center | Healey Center | C.L. Brumback Clinics | School Health | Total |
|---|---|---|---|---|---|---|
| October | 3 | 1 | 1 | 1 | 1 | 7 |
| November | 3 | 2 | 1 | 1 | 0 | 7 |
| December | 1 | 2 | 0 | 0 | 0 | 3 |
| January | 2 | 2 | 0 | 2 | 0 | 6 |
| February | 2 | 0 | 0 | 0 | 0 | 2 |
| March | 2 | 0 | 0 | 0 | 0 | 2 |
| April | 2 | 0 | 0 | 0 | 0 | 2 |
| May | 1 | 0 | 0 | 0 | 0 | 1 |
| June | 1 | 0 | 1 | 0 | 0 | 2 |
| July | 1 | 0 | 1 | 0 | 0 | 2 |
| August | 1 | 0 | 1 | 1 | 1 | 4 |
| Total | 19 | 7 | 5 | 5 | 2 | 38 |

Health Care District
PALM BEACH COUNTY

# Compliance & Privacy Dashboard

**Year to Date: October 1, 2017 – August 31, 2018**

| Compliance Call Activity | |
|---|---|
| Entity | # of Calls |
| LMC | 9 |
| Healey | 0 |
| District | 26 |
| Clinics | 17 |
| School Health | 0 |
| Managed Care | 0 |
| Pharmacy | 0 |

| Compliance Exit Interviews |
|---|
| 4 |

| IT Security | |
|---|---|
| Security Incidents | 2 Incident Reported |
| Cybersecurity Emails | 1 Emails Reported |

| Breach Notifications | |
|---|---|
| Entity | # of Letters |
| LMC | 0 |
| Healey | 3 |
| District | 3 |
| Clinics | 5 |
| Pharmacy | 2 |
| School Health | 0 |
| Aeromedical | 1 |

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

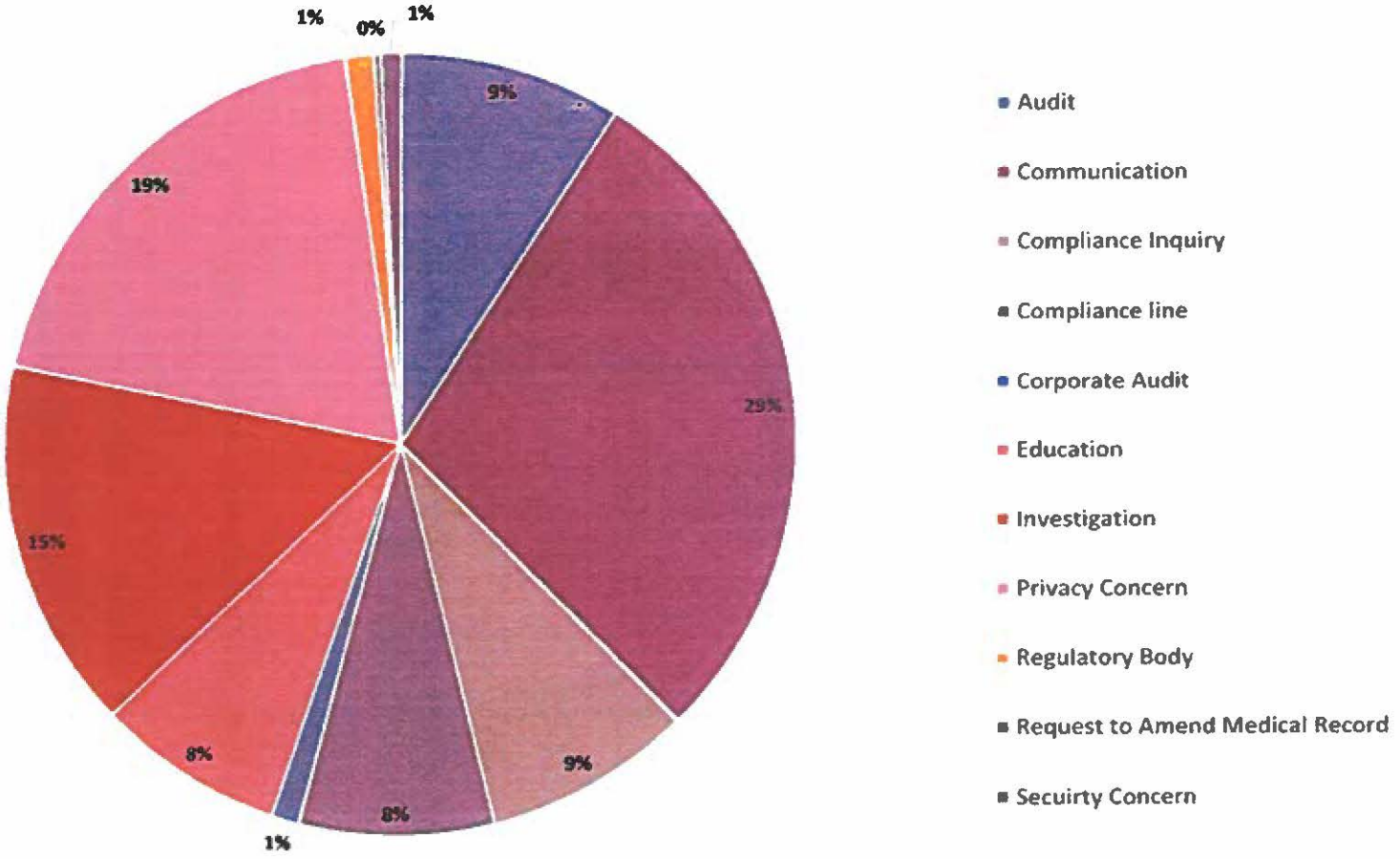
| Medical Record Amendments Processed | 1 Medical Record Amendments Requested |
|---|---|

Health Care District
PALM BEACH COUNTY

# Compliance & Privacy Dashboard

**Year to Date: October 1, 2017 – August 31, 2018**

## Compliance and Privacy Activity
## October 1, 2017- August 31, 2018



# HEALTH CARE DISTRICT
# QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
# September 25, 2018

## 1. Description: Amendment to the Quality, Patient Safety and Compliance Committee Charter.

## 2. Summary:

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

## 3. Substantive Analysis:

The charter was last updated on November 28, 2017. The District proposes amending the Section titled, Composition of Committee and Board Reporting. The new language specifies that (1) committee member shall represent the Glades community and additionally that (1) committee member shall also serve on the District Clinic Board. The new language also specified the Committee will evaluate the Chief Compliance and Privacy Officer Annually. Additionally, the term of Board members appointed to the Committee will now be the same as the term they are serving on the Board. Attached for your review are the following documents:

- Updated version of the charter showing the proposed amendments; 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:

N/A

Dawn Richards
VP & Chief Financial Officer

## 5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

## 6. Recommendation:

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

Approved for Legal sufficiency:

Valerie Shahrian
VP & General Counsel

Ellen Pentland
Chief Compliance Officer

Darry 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

~~A minimum of two (2) Board members shall be appointed to the Committee, one of which will chair the committee. The remainder of t~~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. ~~Additionally, a~~One (1) Committee member shall represent the Glades community and one (1) Committee member shall serve on the District Clinic Board. The Board shall appoint Committee members, who are not a Board member, to a four (4) year term 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. 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 five (5) 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.

### 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. The Board shall appoint Committee members, who are not a Board member, to a four (4) year term 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. 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 five (5) 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.

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e. Laws which apply to the District as a result of its tax exempt status.

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

# HEALTH CARE DISTRICT BOARD
# QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
# September 25, 2018

## 1. Description: Annual Evaluation – Chief Compliance and Privacy Officer

## 2. Summary:

This agenda item presents the annual evaluation of Ellen Pentland, Chief Compliance and Privacy Officer

## 3. Substantive Analysis:

The charter of this committee and the recommendation of the Auditor General indicate that the annual evaluation of the Chief Compliance and Privacy Officer are reviewed and approved by this committee. The Chair of the Committee has consulted with management and an HCD evaluation form are attached for consideration.

## 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
Dawn Richards
VP & Chief Financial Officer

## 5. Reviewed/Approved by Committee:

| N/A | N/A |
|---|---|
| Committee Name | Date Approved |

## 6. Recommendation:

Management recommends the Committee review the prepared performance evaluation and approve a final annual evaluation for the Chief Compliance and Privacy Officer.

Approved for Legal sufficiency:

Valerie Shahrokhi
VP & General Counsel

Darcy J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

DEDICATED TO THE HEALTH OF OUR COMMUNITY www.hcdpb.org

# HEALTH CARE DISTRICT OF PALM BEACH COUNTY
# LEADERSHIP PERFORMANCE APPRAISAL FORM

## APPRAISAL TYPE

☐ Initial Orientation ☐ 3 Month ☑ Annual
☐ Position Orientation ☐ 6 Month

## EMPLOYEE INFORMATION

EMPLOYEE: Ellen Pentland EMPLOYEE ID: 0

DEPARTMENT: Compliance DATE OF HIRE:

JOB TITLE: Chief Compliance Officer

## SCORING

OUTSTANDING (3): Consistently exceeds expectation. Example for others.
EXCELLENT (2): Always meets expectation. Supervisor has complete confidence.
NEEDS IMPROVEMENT (1): Does not always meet expectation. Less than 100% confidence.

| RATING FACTOR | DESCRIPTION | RATING |
|---|---|---|
| Leadership | Leads by example, demonstrating a consistently positive attitude. Develops a flexible work environment/culture that facilitates exceptional customer service, communication and performance. | 3 |
| Customer Service | Exhibits and promotes exceptional customer service to all internal and external customers. | 2 |
| Cooperation | Builds and maintains strong working relationships. Is quick to assist staff and colleagues. Adapts well to change. | 3 |
| Communication | Effectively communicates with others through verbal and non-verbal methods. All communication, including email, is courteous and respectful. | 2 |
| Decision Making | Makes informed, reasoned and expedient decisions, consistently demonstrating sound judgment. Keeps supervisor and colleagues informed of issues of importance. | 3 |
| Initiative | Works autonomously. Takes action in developing new methods, procedures and approaches with little to no guidance. | 3 |
| Job Knowledge | Demonstrates the fundamental skills, methods, and procedures required for current job functions. | 3 |
| Professionalism | Presents self in mature and responsible manner, including attire and punctuality. Exhibits strong ethical character in the workplace. | 3 |
| Quality of Work | Final work product is accurate, thorough, and timely. Achieves established goals. | 3 |
| Compliance | Is aware of, and promotes, adherence to all appropriate compliance and safety policies/procedures. Completes mandatory training (Compliance, HIPAA, etc.) on time. Supervisor has verified with the employee that the conflict of interest form has been completed this evaluation period. | 3 |
| Wellness | Enhances work environment by promoting and supporting wellness through development and implementation of a wellness initiative. Provides consistent rewards and recognition where appropriate. | Implemented |

OVERALL SCORE 28

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Health Care District
PALM BEACH COUNTY

DEDICATED TO THE HEALTH OF OUR COMMUNITY www.hcdpb.org

Employees receiving three or more ratings of "Does Not Meet Expectation" will be ineligible for the performance based pay increase. Additionally, employees receiving three or more ratings of "Does Not Meet Expectation" may be placed on a probationary period up to 60-days. Failure to improve performance during the probationary period may result in separation of employment.

GOALS and SUPERVISOR/MANAGER'S

Ellen makes the complex world of health care compliance less intimidating by working with HCD leaders and team members to continually educate them on key areas of importance. Ellen's approach to concerns is collaborative and supportive as she is able to improve the organization by focusing on process improvement. Ellen is a valuable resource for HCD and is an essential asset to the organization. Goals for next year include keeping the Board and leadership teams aware of changing shifts within the healthcare industry and continued assistance to the executive team as significant strategic initiatives are undertaken.

EMPLOYEE COMMENTS:

I acknowledge that I have seen and discussed this performance appraisal with my supervisor:

EMPLOYEE SIGNATURE DATE

SIGNATURES:

IMMEDIATE SUPERVISOR DATE

NEXT LEVEL SUPERVISOR DATE

DEPARTMENT DIRECTOR DATE

HUMAN RESOURCES DATE

OFFICER DATE

***Note: Managers supervising clinical staff are required to submit evaluations of clinical competencies along with the Performance Appraisal.**

Previous

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# HEALTH CARE DISTRICT
# QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
# September 25, 2018

## 1. Description: Patient Relations Dashboards

## 2. Summary:

This agenda item provides the patient relations dashboard for the 3rd Trimester of the 2017-2018 school year for School Health and 2nd Quarter of 2018 for C. L. Brumback Primary Care Clinics, Edward J. Healey Nursing and Rehabilitation Center, and Lakeside Medical Center.

## 3. Substantive Analysis:

See attached reports.

## 4. Fiscal Analysis & Economic Impact Statement:

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

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Dawn Richards
VP & Chief Financial Officer

## 5. Reviewed/Approved by Committee:

N/A

Quality, Patient Safety, and Compliance Committee

Date Approved

## 6. Recommendation:

Staff recommends the Committee receive and file this information.

# HEALTH CARE DISTRICT
# QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
# September 25, 2018

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

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

Darcy J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

# PATIENT RELATIONS DASHBOARD

**School Health 3rd Trimester**

**April-Jun 2018**

## COMPLAINTS/GRIEVANCES

| CATEGORY | 2017/2018 TOTAL | JUL # | AUG # | SEP # | OCT # | NOV # | DEC # | T1 2017/2018 TOTAL | JAN # | FEB # | MAR # | T2 2017/2018 TOTAL | APR # | May # | Jun # | T3 2017/2018 TOTAL | 2016/2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care & Treatment | 3 | | | | 1 | | 1 | 2 | | | | 0 | | 1 | | 1 | 2 |
| Communication | 5 | | 1 | | | | | 1 | 3 | | | 3 | 1 | | | 1 | 4 |
| TOTAL: | 8 | 0 | 1 | 0 | 1 | 0 | 1 | 3 | 3 | 0 | 0 | 3 | 1 | 1 | 0 | 2 | 6 |
| Complaints/No Letter Required | 7 | | 1 | | | | 1 | 2 | 3 | | | 3 | 1 | 1 | | 2 | 5 |
| Grievances/Letter Sent ≤ 7 days | 1 | | | | 1 | | | 1 | | | | 0 | | | | 0 | 1 |
| Grievances/Letter Sent > 7 days | 0 | | | | | | | 0 | | | | 0 | | | | 0 | 0 |
| Total Completed Events: | 715,371 | 339,400 | | | | | | | 207,773 | | | | 168,198 | | | | 830,538 |

## SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

**APR:** **Findings:** Mother submitted verbal complaint to the Assistant Principal. The student overheard the first nurse state to the second nurse that the student was to young to have this medical condition. The student felt like the nurse didn't believe her.
**Intervention:** Nursing supervisor investigated incident with all parties and counseled nurse about privacy issues. Nurse did not mean it as it was taken. Nurse will not do this again.

**MAY:** **Findings:** Received a verbal complaint from mother that her son tripped on the stairs and hurt his ankle. She stated, nurse never looked at ankle just asked him if he wanted ice, and never called her. He was seen by Ortho and returned to school on crutches with a note requesting extra time or use of the elevator to get to class, DX. sprained ankle.
**Intervention:** Nursing supervisor investigated complaint and followed-up with phone call to parent. Welligent nursing notes revealed good nursing assessment and student referred to physician if ankle worsened. Advised nurse to notify parent via phone or letter for all injuries at school.

**JUN:** NONE

## COMPLIMENTS

| | 2017/2018 TOTAL | JUL # | AUG # | SEP # | OCT # | NOV # | DEC # | T1 2017/2018 TOTAL | JAN # | FEB # | MAR # | T2 2017/2018 TOTAL | APR # | MAY # | JUN # | T3 2017/2018 TOTAL | 2016/2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # COMPLIMENTS RECEIVED | 6 | 0 | 1 | 0 | 3 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 4 |

## SUMMARY OF COMPLIMENTS

**APR:** None

**MAY:** Clinical nurse specialist observed school nurse going over and above to help a student in her school. The school nurse offered the student a dry pair of sneakers that were her own shoes. The nurse had a second pair of shoes in the clinic which were nursing clogs that she wore. Requesting gift card to award school nurse.

**JUN:** IT staff member, Anthony Stamile, received a compliment for assisting supervisor securing a loaner laptop due to her computer crashing. This occurred on the last day of work for school nurses and having the laptop to use for fixing and approving time cards was imperative.

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

# PATIENT RELATIONS DASHBOARD

## 2nd Quarter 2018

## April through June

### COMPLAINTS/GRIEVANCES

| CATEGORY | 2018 TOTAL | JAN # | FEB # | MAR # | Q1 2018 TOTAL | APR # | MAY # | JUN # | Q2 2017 TOTAL | JUL # | AUG # | SEP # | Q3 2018 TOTAL | OCT # | NOV # | DEC # | Q4 2018 TOTAL | 2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care & Treatment | 12 | 1 | 6 | 6 | 10 | 2 | | | 2 | | | | | | | | | 26 |
| Communication | 2 | 2 | 1 | 1 | 1 | | | 1 | 1 | | | | | | | | | 7 |
| Environmental | 0 | | | | 0 | | | | 0 | | | | | | | | | 1 |
| Medical Records | 2 | | | | | 1 | 1 | | 2 | | | | | | | | | 0 |
| Nursing Related | 1 | 1 | | 1 | 1 | | | | 0 | | | | | | | | | 4 |
| Other | 4 | 1 | 1 | 1 | 0 | 1 | 1 | 2 | 4 | | | | | | | | | 15 |
| Pharmacy Related | 0 | | | | 0 | | | | 0 | | | | | | | | | 3 |
| Physician Related | 3 | | | 2 | 2 | | 1 | | 1 | | | | | | | | | 21 |
| Respect Related | 4 | 1 | | 2 | 2 | | 1 | 1 | 2 | | | | | | | | | 3 |
| TOTAL: | 28 | 6 | 8 | 13 | 16 | 4 | 4 | 4 | 12 | | | | | | | | | 66 |
| Complaints/No Letter Required | 18 | 3 | 5 | 3 | 11 | 2 | 3 | 2 | 7 | | | | | | | | | 20 |
| Grievances/Letter Sent ≤ 7 days | 17 | 2 | 1 | 9 | 12 | 2 | 1 | 2 | 5 | | | | | | | | | 22 |
| Grievances/Letter Sent > 7 days | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | 12 |
| LETTERS NOT SENT FOR GRIEVANCES | 4 | 1 | 2 | 1 | 4 | 0 | 0 | 0 | 0 | | | | | | | | | 11 |

Q1 encounters: 35,946 Q2 encounters: 35,264 Q3 encounters: Q4 encounters:

### SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

| | |
|---|---|
| APR: | Of the 4 Occurrances there were 2 compliants and 2 Grievances which occurred across 3 clinic locations (2 Dental,1 Womens Health, and 1 Primary Care). Top category was related to unsatisfactory care & treatment. |
| MAY: | Of the 4 Occurrences there were 3 complaints and 1 Grievance which occurred across 3 clinic locations (All Primary Care) Top category was related to poor communication by a physician and lack of respect from a registration specialist. |
| JUN: | Of the 4 Occurrences there were 2 complaints and 2 Grievances which occurred across 3 clinic locations (All Primary Care) Top categories were related to poor communication by a Dentist and lack of respect from a Medical provider. |

### COMPLIMENTS

| | 2018 TOTAL | JAN # | FEB # | MAR # | Q1 2018 TOTAL | APR # | MAY # | JUN # | Q2 2018 TOTAL | JUL # | AUG # | SEP # | Q3 2018 TOTAL | OCT # | NOV # | DEC # | Q4 2018 Total | 2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # COMPLIMENTS | 105 | 18 | 29 | 29 | 76 | 22 | 3 | 4 | 29 | | | | | | | | | 316 |

### SUMMARY OF COMPLIMENTS

| | |
|---|---|
| APR: | 22 compliemnts were received across 7 clinics of which: 6 were specific to Dental employees, 4 were for Dental Clinic Teams, 2 were specific to Primary Care Providers and 9 were for Primary Care Clinic Teams. |
| MAY: | 3 compliments were received across 3 clinic locations of which all 3 were for Primary Care Clinic Teams |
| JUN: | 4 compliments were received across 4 clinic locations of which 1 was for a Dentist, 2 were for Medical Provders, and 1 was for a team member in Primary Care. |

Healey Center
Health Care District Palm Beach County

# PATIENT RELATIONS DASHBOARD
## 2nd Quarter 2018
## April through June

| REGULATORY | |
|---|---|
| **Survey Type & Date** | **Survey Findings Summary & Actions:** Complaint Survey on July 5-6, 2108 all complaints were unsubstatiated. Annual Pharmacy Inspection conducted in June with no citations. |

**Average number of residents: 119**

**GRIEVANCES**

| CATEGORY | 2018 TOTAL | JAN # | FEB # | MAR # | Q1 TOTAL | APRIL # | MAY # | JUN # | Q2 TOTAL | JUL # | AUG # | SEP # | Q3 TOTAL | OCT # | NOV # | DEC # | Q4 TOTAL | 2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care & Treatment | 30 | 9 | 2 | 7 | 18 | 3 | 4 | 5 | 12 | | | | | | | | | 59 |
| Communication | 10 | 4 | 3 | 1 | 8 | 1 | 1 | | 2 | | | | | | | | | 8 |
| Discharge | 1 | 1 | | | 1 | | | | 0 | | | | | | | | | 1 |
| Environmental | 13 | 1 | 7 | 3 | 11 | | 2 | | 2 | | | | | | | | | 23 |
| Noise Issue | 4 | 1 | 1 | | 2 | | 2 | | 2 | | | | | | | | | 3 |
| Nursing Related | 16 | 5 | 1 | 4 | 10 | 4 | 2 | | 6 | | | | | | | | | 17 |
| Nutrition | 19 | 6 | 3 | 4 | 13 | 1 | 3 | 2 | 6 | | | | | | | | | 40 |
| Other | 23 | 4 | | 3 | 7 | 6 | 4 | 6 | 16 | | | | | | | | | 54 |
| Personal Belongings | 25 | 5 | 3 | 3 | 11 | 6 | 5 | 3 | 14 | | | | | | | | | 35 |
| Physician Related | 1 | 1 | | | 1 | | | | 0 | | | | | | | | | 8 |
| TOTAL GRIEVANCES: | 142 | 37 | 20 | 25 | 82 | 21 | 23 | 16 | 60 | | | | | | | | | 259 |
| **RESOLUTION TURN AROUND TIME** | | | | | | | | | | | | | | | | | | |
| # Resolved w/i 72 Hrs. Per Policy | 135 | 37 | 17 | 23 | 77 | 21 | 21 | 16 | 58 | | | | | | | | | 252 |
| # Not Resolved w/i 72 Hrs. Per Policy | 7 | 0 | 3 | 2 | 5 | 0 | 2 | 0 | 2 | | | | | | | | | 7 |

| SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES | |
|---|---|
| **April:** | Personal Belongings and Other: Analysis of the grievances involving Other included concerns such as; a resident wanting to give money to a staff member, medicaid transportation, disliking of laundry soap, and request of personal coffee pot in room. There were a total of 6 missing/lost items and clothing included under personal belongings. 1 resident reported missing $300 in cash, staff was able to find the money in the resident room. The resident was educated and encouraged to use the resident banking services. One trend identified involved residents falsely reporting missing items with the expectation that the facility will reimburse or replace the item. None of the grievances indicated abuse, neglect, exploitation or misappropriation and all were resolved with satisfactory resolution. |
| **May:** | Personal Belongings: A summary of the grievances revealed 17 of 119 residents had written grievances. 4 of the 17 residents accounted for multiple grievances. There were a total of 23 grievances filed, personal belonging the higest with a total of 5. These included money and I-pad of which both were found, razor, laundry bleaching of clothing, and missing socks. A total of 21 were resolved within 24-72 hours and 2 resolved with 96 hours due to multiple attempts to reach family member in both cases. Family and Resident interviews were conducted during this month. |
| **June:** | Care and Treatment: The data indicated 12 residents submitted a total of 16 grievances for the month, Care and Treatment were the highest with a total 6. A summary of the grievances included family member requested medication modification, resident felt staff had an attitude, cable television issues in room, and appointments. All were resolved within 72 hours with a satisfactory resolution and there were no indications of abuse, neglect, exploitation. |

## COMPLIMENTS

| | 2018 TOTAL | JAN # | FEB # | MAR # | Q1 TOTAL | APRIL # | MAY # | JUN # | Q2 TOTAL | JUL # | AUG # | SEP # | Q3 TOTAL | OCT # | NOV # | DEC # | Q4 TOTAL | 2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **# COMPLIMENTS RECEIVED** | 20 | 2 | 3 | 1 | 6 | 5 | 4 | 5 | 14 | | | | | | | | | 36 |

## 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:** | |

Lakeside Medical Center
Health Care District Palm Beach County

# PATIENT RELATIONS DASHBOARD

## 2nd Quarter 2018

## April through June

### COMPLAINTS/GRIEVANCES

| | 2018 TOTAL | JAN # | FEB # | MAR # | Q1 TOTAL | APR # | MAY # | JUN # | Q2 TOTAL | JUL # | AUG # | SEP # | Q3 TOTAL | OCT # | NOV # | DEC # | Q4 TOTAL | 2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitting/Registration | 1 | 1 | | | 1 | | | | 0 | | | | 0 | | | | 0 | 0 |
| Care & Treatment | 7 | | 1 | 1 | 2 | 3 | 2 | | 5 | | | | 0 | | | | 0 | 15 |
| Communication | 2 | | | | 0 | 1 | | 1 | 2 | | | | 0 | | | | 0 | 6 |
| Discharge | 2 | | | | 0 | 1 | 1 | | 2 | | | | 0 | | | | 0 | 0 |
| Environmental | 3 | 1 | | | 1 | 1 | 1 | | 2 | | | | 0 | | | | 0 | 1 |
| Nursing Related | 4 | 3 | 1 | | 4 | | | | 0 | | | | 0 | | | | 0 | 8 |
| Nutrition | 1 | | 1 | | 1 | | | | 0 | | | | 0 | | | | 0 | 0 |
| Other | 3 | 1 | | 1 | 2 | | | 1 | 1 | | | | 0 | | | | 0 | 7 |
| Pain Management | 1 | | | | 0 | | | 1 | 1 | | | | 0 | | | | 0 | 1 |
| Personal Belongings | 1 | | | | 0 | | | 1 | 1 | | | | 0 | | | | 0 | 2 |
| Physician Related | 11 | 5 | 1 | | 6 | 2 | 1 | 2 | 5 | | | | 0 | | | | 0 | 7 |
| Respect Related | 2 | | | 1 | 1 | | | 1 | 1 | | | | 0 | | | | 0 | 4 |
| TOTAL CATEGORIES: | 38 | 11 | 4 | 3 | 18 | 8 | 5 | 7 | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 51 |

### TOTAL NUMBER OF CONCERNS

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints/No Letter Required | 34 | 10 | 4 | 3 | 17 | 8 | 4 | 5 | 17 | | | | 0 | | | | 0 | 16 |
| Grievances/Letter Sent ≤ 30 days | 4 | 1 | | | 1 | | 1 | 2 | 3 | | | | 0 | | | | 0 | 9 |
| Grievances/Letter Sent > 30 days | 0 | | | | 0 | | | | 0 | | | | 0 | | | | 0 | 0 |
| TOTAL # OF CONCERNS: | 38 | 11 | 4 | 6 | 18 | 8 | 5 | 7 | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 25 |

Q1 encounters: 8,433 Q2 encounters: 8,014 Q3 encounters: Q4 encounters:

### SUMMARY OF TOP COMPLAINT/GRIEVANCE CATEGORIES

| | |
|---|---|
| APR: | Two complaints were family requesting patient be helped to bedside commode in an unsafe manner; Patient family did not want the fall precaution leaf on door; Patient family thought the a/c was too cold - patient did not agree; ER complaint about wait time was caused by Radiology computer issue, now resolved; Two ER doctor complaints referred to Elite and resolved |
| MAY: | ER patient thought she would have to pay for a repeat x-ray/unhappy with nursing care; Unsubstantiated complaint about reason for discharge from ER; Visitor spotted a raccoon; Complaint about a nurse's responsiveness was referred to nurse manager; ER physician complaint referred to Elite and resolved. |

| | |
|---|---|
| **JUN:** | ER physician complaint addressed and resolved by Elite; Patient unhappy with ER Mid-Level's communication style, addressed and resolved by Elite; Former patient having difficulty getting prescription filled; Patient missing flip-flops, found; Unsubstantiated complaint about medication administration; Patient with previous issue with ER physician did not want to be seen by him again, addressed and resolved by Elite. |

**COMPLIMENTS**

| | 2018 TOTAL | JAN # | FEB # | MAR # | Q1 TOTAL | APR # | MAY # | JUN # | Q2 TOTAL | JUL # | AUG # | SEP # | Q3 TOTAL | OCT # | NOV # | DEC # | Q4 TOTAL | 2017 TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **# COMPLIMENTS RECEIVED** | 34 | 8 | 3 | 4 | 15 | 3 | 12 | 4 | 19 | | | | 0 | | | | 0 | 34 |

| | |
|---|---|
| **APR:** | Visitor complimented a nurse on his "awesome care"; Nursing Supervisor recognized an employee for volunteering to come in early to help co-workers; Dietary employee recognized for his honesty and helpfulness. |
| **MAY:** | Twelve compliments reported after a critical OB patient arrived via ambulance; the team was able to save the mom's life; included were OR staff, Lab, Nursing Supervisor, OB doctor; Anesthesiologist and Nurse Anesthetist, ER nurse and housekeeping. |
| **JUN:** | Nursing Supervisor was complimented for helping the ER; Patient complimented Med/Surg for the awesome care she received during her 6-day stay; Tracy Miller was complimented "She made me feel comfortable, welcome and at peace about my stay here." |

# HEALTH CARE DISTRICT
# QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
# September 25, 2018

## 1. Description: Quality & Patient Safety Reports

## 2. Summary:

This agenda item provides quality and patient safety reports for the 3rd Trimester of the 2017-2018 school year for School Health and the 2nd Quarter of 2018 for Aeromedical, C. L. Brumback Primary Care Clinics, Edward J. Healey Nursing and Rehabilitation Center, Lakeside Medical Center, Pharmacy, and Trauma.

## 3. Substantive Analysis:

See attached reports.

## 4. Fiscal Analysis & Economic Impact Statement:

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

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Dawn Richards
VP & Chief Financial Officer

## 5. Reviewed/Approved by Committee:

N/A

Quality, Patient Safety, and Compliance Committee

Date Approved

## 6. Recommendation:

Staff recommends the Committee receive and file this information.

# HEALTH CARE DISTRICT
# QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE
# September 25, 2018

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

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

Darcy J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

# School Health
## Quality Report (School Year 2017-2018)
### 3rd Trimester

| MEASURE SET: | | | | | | | | | | ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL |
|---|---|---|---|---|---|---|---|---|---|---|
| **Demographics** | **T1 2017/2018 (Aug - Dec)** | | | **T2 2017/2018 (Aug-March)** | | | **T3 2017/2018 (Aug-June)** | | | **T3 2017/2018** |
| **Total Completed Events** | 339,400 | | | 550,902 | | | 715,371 | | | |
| Office Visits | 155,933 | | | 265,128 | | | 343,460 | | | |
| Medications | 77,621 | | | 132,996 | | | 181252 | | | |
| Procedures | 44,949 | | | 75,113 | | | 101043 | | | |
| Record Review - *Immunizations/Physical Exams/School Registrations* | 47,563 | | | 58,380 | | | 64986 | | | |
| Consultations | 13,334 | | | 19,285 | | | 24630 | | | |
| **Return Rate** | **T1 2017/2018 (Aug - Dec)** | | | **T2 2017/2018 (Aug-March)** | | | **T3 2017/2018 (Aug-June)** | | | **T3 2017/2018** |
| | Num/Den | % | Goal | Num/Den | % | Goal | Num/Den | % | Goal | |
| **Total Number of Students Remained in School** | 126,293 | 81.0% | >80% | 212,853 | 80.3% | >80% | 275,881 | 80.3% | >80% | |
| **Total Number of Students Excused from School** | 29,618 | 19.0% | <20% | 51,985 | 19.6% | <20% | 67,579 | 19.7% | <20% | |
| **Continuum of Care** | **T1 2017/2018 (Aug - Dec)** | | | **T2 2017/2018 (Aug-March)** | | | **T3 2017/2018 (Aug-June)** | | | **T3 2017/2018** |
| | Num/Den | % | Goal | Num/Den | % | Goal | Num/Den | % | Goal | |
| Total Number of Student Pregnancies Identified | 59 | | | 82 | | | 101 | | | |
| Number of Student Pregnancies who have been referred to Healthy Mothers / Healthy Babies | 58 | 98.3% | >95% | 81 | 98.8% | >95% | 97 | 96.0% | >95% | |
| **Mandated Screenings** | **T1 2017/2018 (Aug - Dec)** | | | **T2 2017/2018 (Aug-March)** | | | **T3 2017/2018 (Aug-June)** | | | **T3 2017/2018** |
| | Num/Den | % | Goal | Num/Den | % | Goal | Num/Den | % | Goal | |
| **Vision** - Students in Mandated Grades with Permission to Screen | 27612 | | | 43289 | | | 43359 | | | |
| **Vision** - Total # of Students Screened in Mandated Grades | 27214 | 98.6% | >45% | 42958 | 99.2% | >95% | 43144 | 99.5% | >95% | |
| **Vision** - Total # of Students Requiring Referral for Further Evaluation | 2438 | | | 3832 | | | 3857 | | | |
| **Vision** - Completed Outcomes | | 0.0% | See 3rd Tri for Goal | | 0.0% | See 3rd Tri for Goal | 2498 | 64.8% | >65% | |
| **Hearing** - Students in Mandated Grades with Permission to Screen | 26504 | | | 42145 | | | 42217 | | | |
| **Hearing** - Total # of Students Screened in Mandated Grades | 26173 | 98.8% | >45% | 41871 | 99.3% | >95% | 42039 | 99.6% | >95% | |
| **Hearing** - Total # Students Requiring Referral for Further Evaluation | 558 | | | 897 | | | 909 | | | |
| **Hearing** - Completed Outcomes | | 0.0% | See 3rd Tri for Goal | | 0.0% | See 3rd Tri for Goal | 705 | 77.6% | >75% | |
| **Scoliosis** - Students in Mandated Grades with Permission to Screen | 2834 | | | 7172 | | | 7137 | | | |
| **Scoliosis** - Total # of Students Screened in Mandated Grades | 2811 | 99.2% | >45% | 7164 | 99.9% | >95% | 7131 | 99.9% | >95% | |
| **Scoliosis** - Total # of Students Requiring Referral for Further Evaluation | 33 | | | 86 | | | 87 | | | |
| **Scoliosis** - Completed Outcomes | | 0.0% | See 3rd Tri for Goal | | 0.0% | See 3rd Tri for Goal | 51 | 58.6% | >60% | |
| **BMI** - Students in Mandated Grades with Permission to Screen | 14708 | | | 24518 | | | 24508 | | | |
| **BMI** - Total # of Students Screened in Mandated Grades | 14651 | 99.6% | >45% | 24461 | 99.8% | >95% | 24497 | 100.0% | >95% | |
| **BMI** - Total # of Students Requiring Referral for Further Evaluation | 3364 | | | 5783 | | | 5790 | | | |
| **BMI** - Completed Outcomes | | 0.0% | See 3rd Tri for Goal | | 0.0% | See 3rd Tri for Goal | 171 | 3.0% | >2% | |

Health Care District
PALM BEACH COUNTY

# Aeromedical
# Quality Report
# 2nd Quarter 2018

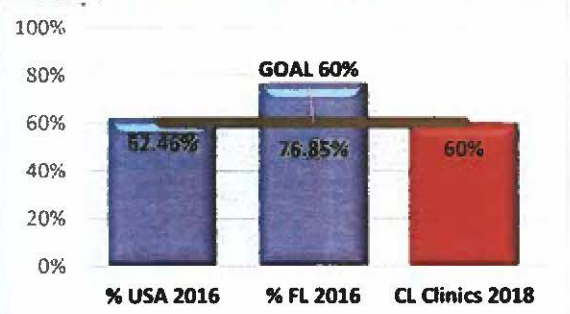
| | | April | | May | | June | | Q2 2018 | | Q1 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Hours Available for Service (36 per day) | | 1044 | 97% | 1053 | 94% | 1080 | 100% | 3177 | 97% | 3213 | 99% |
| Hours Utilized | | 55 | 5.3% | 60 | 5.7% | 70 | 6.5% | 185 | 5.8% | 241 | 7.5% |
| Total Patients Transported | | 52 | | 49 | | 44 | | 145 | | 174 | |
| Dual Patients Transported | | | | | | | | | | 3 | |
| Scene Flights | | 38 | 73% | 38 | 78% | 24 | 55% | 100 | 69% | 122 | 71% |
| Interfacility Flights | | 14 | 27% | 11 | 22% | 20 | 45% | 45 | 31% | 49 | 29% |
| Missed, Cancelled, Aborted Calls - Total | | 8 | | 44 | | 13 | | 65 | | 43 | |
| | Medical Decision | | | 1 | | 2 | | 3 | | 3 | |
| | Weather | 2 | | 22 | | 4 | | 28 | | 8 | |
| | No Backup | | | 1 | | | | 1 | | 1 | |
| | Simultaneous flights | | | 2 | | | | 2 | | 1 | |
| | Maintenance | | | | | | | 0 | | 2 | |
| | County Coverage | 1 | | 4 | | 1 | | 6 | | 4 | |
| | Admin | | | 1 | | 1 | | 2 | | 1 | |
| | Cancelled by Referring Agency | 5 | | 13 | | 5 | | 23 | | 23 | |
| Call to scene < 20 min | | 26 | 68.4% | 34 | 89.5% | 17 | 70.8% | 77 | 77.0% | 104 | 85.2% |
| Call to scene > 20 min | | 12 | 31.6% | 4 | 10.5% | 7 | 29.2% | 23 | 23.0% | 18 | 14.8% |
| | Call to scene > 20 min West of 20 Mile Bend | 11 | 92% | 4 | 100% | 7 | 100% | 22 | 96% | 16 | 89% |
| Time on Scene | | 08m 33s | | 07m 28s | | 07m 28s | | 07m 50s | | 07m 25s | |
| Dispatched to Enroute | | 04m 08s | | 03m 51s | | 03m 27s | | 03m 49s | | 04m 02s | |
| Dispatched to On-Scene | | 16m 20s | | 11m 53s | | 15m 14s | | 14m 29s | | 14m 23s | |

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

# C. L. BRUMBACK PRIMARY CARE CLINICS

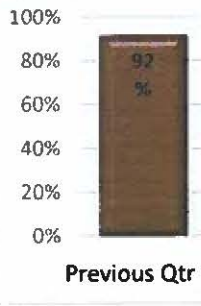
## YTD JUNE 2018

### ADULT WEIGHT SCREENING AND FOLLOW UP

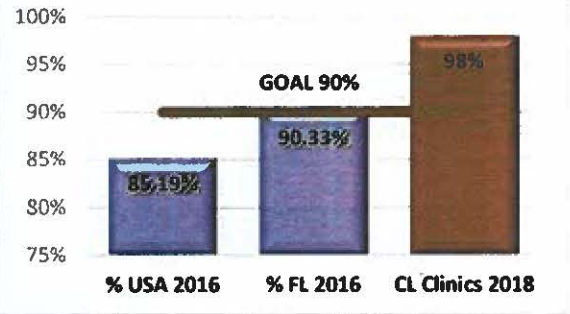


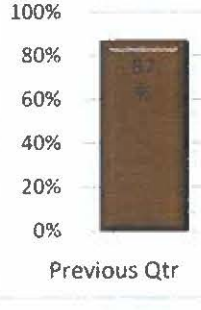

**Findings:** 1. Failure to document follow up plan. 2. Providers are not reviewing Quality Measure tab at every visit.

**Interventions:** Train all staff on approriate documentation of PAP history and surgical history. 2. reeducate providers that every visit is an opportunity to provide prevenative screening no matter the reason for visit.




### TOBACCO USE SCREENING AND CESATION INTERVENTION




### ASTHMA PHARMACOLOGIC THERAPY


**Findings:** Measure definition specifies "persistent asthma" for pharmacologic therapy while EMR is capturing all types of asthma

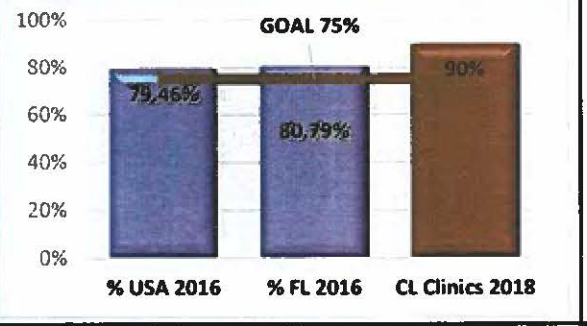
**Interventions:** Investigate documentation workflow for capturing this measure in the new EMR

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

# C. L. BRUMBACK PRIMARY CARE CLINICS

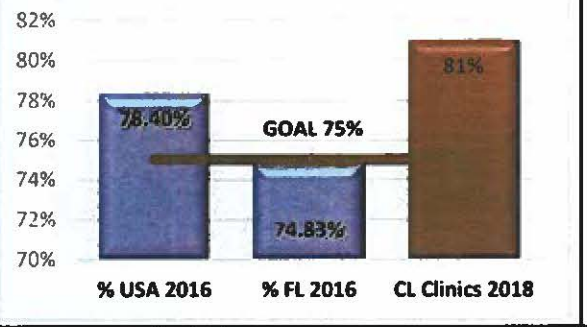
## YTD JUNE 2018

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



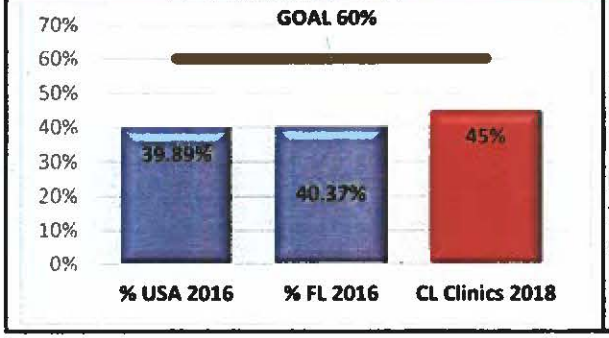


### ISCHEMIC VASCULAR DISEASE (IVD)





### COLORECTAL CANCER SCREENING




**Findings:** 1. Patient non compliance with returning FIT test 2. Failure to transfer previous colrectal cancer screening to new EMR

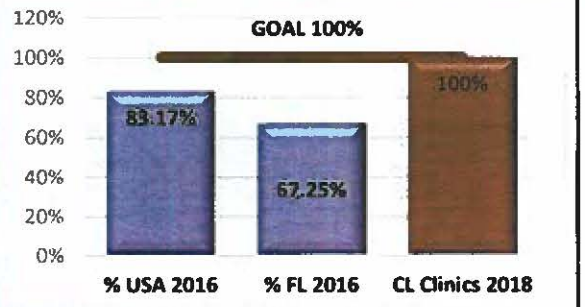
**Interventions:** 1. Continue to encourage POD. Keep FIT Test log to trigger staff follow-up on test that need to be returned. 2. Retrain staff to check Quality tab at every visit and to update information.

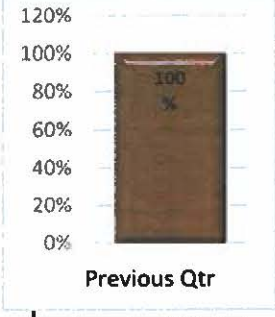
C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

# C. L. BRUMBACK PRIMARY CARE CLINICS

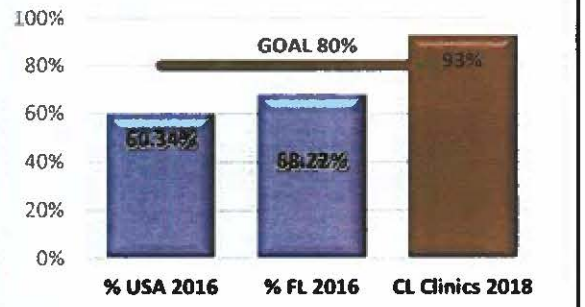
## YTD JUNE 2018

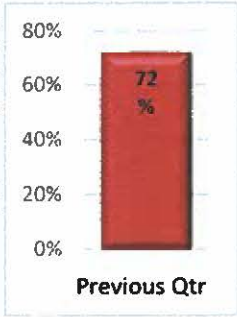
### HIV LINKAGE TO CARE



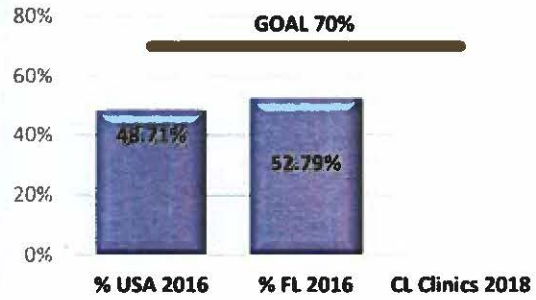




### PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP

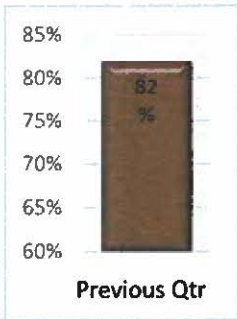



### DENTAL SEALANTS




**Measure report not available**

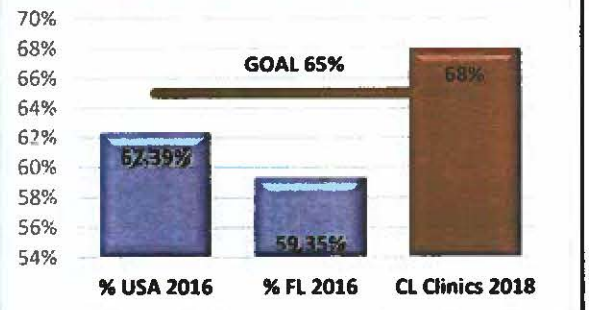


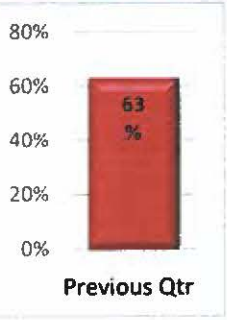
C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

# C. L. BRUMBACK PRIMARY CARE CLINICS

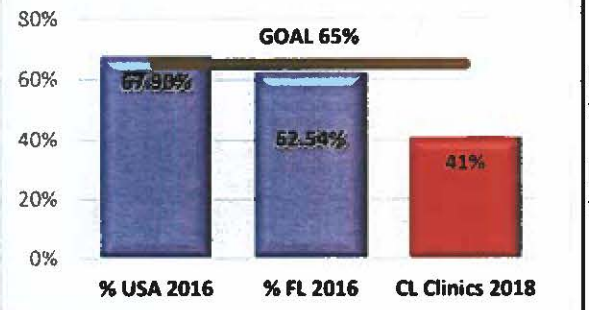
## YTD JUNE 2018

### HYPERTENSION



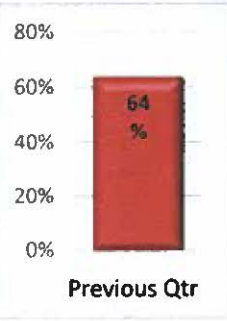




### DIABETES




**Findings:** A1C lab completed with results in ALLSCRIPTS, however lab results not transferred to Athena.

**Interventions:** Train staff to update Quality Measure Tab in Athena with A1c data from Allscripts



Healey Center
Health Care District Palm Beach County

# Edward J. Healey Rehabilitation and Nursing Center
## Quality Report
## 2nd Quarter 2018
## Percentages

**Total average patients served per month: 119**

| Measure Set: Casper Report | Comparison Group | | ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL | Previous Quarters | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MDS 3.0 Facility Level Quality Measure Report** Note: Comparison Group National Percentile QMs that cross the threshold equal to or greater than 75 percentile is emphasized on the survey or any internal quality improvement initiative | 2018 Q2 | | 2018 Q2 | 2018 Q1 | | | | 2017 Q4 | | | | 2017 Q3 | | | |
| | Goal | EJH Percentile | | % USA | % FL | GOAL | % EJH | % USA | % FL | GOAL | % EJH | % USA | % FL | GOAL | % EJH |
| High Risk Long Stay Residents With **Pressure Ulcer** | < 75 | 88 | **Findings:** Of the 85 residents included in the sample set, only 9 were identified with a pressure ulcer. 5 admitted and 4 acquired of which 2 have since resolved. 2 residents were non-compliant with their plan of care despite risks and ongoing education on refusal of care. 1 resident continued to attend school at PBSC 4x/week until mid-May.<br>**Interventions:** 1. Risk assessment is completed on admission, weekly X 4weeks and as needed. 2. Skin checks weekly & as needed. 3. Use of Interact Stop & Watch upon identification of any change in condition. 4. Review of preventative measures and revision of care plans as needed. 5. Nutritional assessment and Therapy evaluation if indicated. 6. Medical work-up and eval by Practitioner 7. Weekly review at the IDT Focus meeting. | 6.2 | 6.6 | 0>st2 | 8.4 | 6.1 | 6.6 | | 8.3 | 6.2 | 6.8 | 0>st2 | 9.8 |
| **New/worse** Pres Ulcer (S) | < 75 | 0 | | 1.0 | 0.5 | 0.0 | 0.0 | 0.8 | 0.4 | | 0.0 | 0.8 | 0.5 | 0.0 | 0.0 |
| Experiencing One or More **Falls with Major Injury** | < 75 | 0 | | 3.5 | 2.8 | 0.0 | 0.0 | 3.5 | 2.9 | | 0.0 | 3.5 | 2.9 | 0.0 | 0.0 |
| **Falls** (L) | < 75 | 5 | | 45.6 | 41.1 | 12.0 | 22.2 | 45.5 | 40.9 | | 15.5 | 45.4 | 40.9 | 12.0 | 14.8 |
| Who Have **Depressive Symptoms** | < 75 | 0 | | 4.8 | 1.2 | 1.0 | 0.0 | 4.8 | 1.1 | | 0.0 | 5.0 | 1.1 | 1.0 | 0.0 |
| Who **Lose Too Much Weight** | <75 | 7 | | 7.9 | 7.9 | 6.0 | 6.0 | 7.4 | 7.9 | | 10.3 | 7.9 | 7.8 | 6.0 | 6.1 |
| Who Received an **Antipsychotic Medication (L)** | < 75 | 75 | **Findings:** Of the 105 residents, only 20 residents were included in the sample set.<br>**Interventions:** 1. Residents who are admitted on antipsychotic medications are referred to Psych. 2. Medical records review to ensure medications have appropriate diagnoses. 3. Monitoring of behaviors every shift and review at Psych meeting for gradual dosage reduction attempts. 4. Non-pharmacological interventions prior to medicating the resident. | 15.1 | 14.4 | 15.0 | 17.8 | 15.4 | 14.8 | | 16.8 | 15.5 | 15.1 | 15.0 | 17.0 |
| Who Received an **Antipsychotic Medication (S)** | <75 | 0 | | 2.1 | 2.2 | 2.0 | 0.0 | 2.2 | 2.2 | | 0.0 | 2.2 | 2.2 | 2.0 | 0.0 |
| Who Received **Anti-anxiety or Hypnotic Medication** | <75 | 45 | | 7.7 | 7.5 | 9.0 | 8.8 | 7.9 | 8.2 | | 8.4 | 8.1 | 8.2 | 9.0 | 9.9 |
| Who Self Report Moderate to Severe **Pain (L)** | <75 | 51 | | 6.3 | 4.0 | 5.0 | 9.6 | 5.4 | 3.4 | | 6.8 | 5.6 | 3.4 | 5.0 | 7.1 |
| Who Self Report Moderate to Severe **Pain (S)** | < 75 | 84 | **Findings:** Of the 9 residents, only 2 residents were identified in the sample set & both were admitted with a Dx: Chronic Pain.<br>**Interventions:** 1. Pain assessment upon admission, quarterly, and as needed. 2. Medication management by the Medical Practitioner. 3. Pain monitoring every shift by Licensed Nurse. 4. Non-pharmacological interventions. 5. Pain Management Consult as needed. | 13.1 | 9.0 | 2.0 | 33.3 | 9.6 | 13.5 | | 0.0 | 13.5 | 9.8 | 2.0 | 0.0 |
| Who Were **Physically Restrained** | <75 | 0 | | 0.4 | 0.3 | 0.0 | 0.0 | 0.4 | 0.3 | | 0.0 | 0.4 | 0.3 | 0.0 | 0.0 |
| Whose **Behavioural Symptoms** Affect Others | <75 | 57 | | 21.1 | 15.3 | 12.0 | 8.3 | 21.3 | 15.7 | | 4.5 | 21.4 | 16.7 | 3.0 | 2.8 |
| **Increase ADL Help** (L) | <75 | 35 | | 16.0 | 14.1 | 10.0 | 8.8 | 15.2 | 13.7 | | 9.3 | 15.2 | 13.9 | 10.0 | 8.3 |
| with a **Catheter** Inserted and Left in Their Bladder | <75 | 56 | | 2.5 | 1.9 | 1.9 | 3.8 | 2.1 | 1.6 | | 5.8 | 2.2 | 1.7 | 6.0 | 6.9 |
| With a **Urinary Tract Infection** | <75 | 54 | | 3.1 | 3.0 | 3.0 | 5.1 | 3.5 | 3.5 | | 2.6 | 3.7 | 3.8 | 3.0 | 2.6 |
| Low Risk LSRs Who Lose Control of Their **Bowel or Bladder** | <75 | 46 | | 48.2 | 54.4 | 47.0 | 42.3 | 47.8 | 54.4 | | 50.0 | 47.6 | 54.6 | 47.0 | 47.1 |
| **Move Independent Worsens** (L) | <75 | 19 | | New indicators, will provide data in the future. | | | | | | | | | | | |
| **Improvement in Function** (S) Higher % Better | <75 | 90 | | | | | | | | | | | | | |

Lakeside Medical Center
Health Care District Palm Beach County

**QUALITY CORE MEASURES REPORT**
**2nd Quarter April - June 2018**
**PRELIMINARY REPORT**

| Inpatient Quality Measures | AVG FL* | AVG LMC 2017 | LMC GOAL | Sampled Population (defined by Press Ganey**) | Patient Encounters: 8014 2 Q '18 | Actions Taken When Indicator not Meeting Goal | Patient Encounters: 8443 1Q '18 | Patient Encounters: 8,356 4Q '17 | Patient Encounters: 7,835 3Q '17 | Patient Encounters: 8,733 2Q '17 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Emergency Department: ED-1a**<br>**Median time from ED arrival to ED departure for admitted patients.**<br>**Numerator:** Departed ED in less than 267 minutes.<br>**Denominator:** Measure sampled population for any ED Patient from the facility's emergency department.<br>CMS/TJC | 258 mins | 257 mins | <267 mins | 45/90 | 264 mins 50% | **Findings:** The goal was met for ED arrival to ED departure for admitted patients.<br><br>**Interventions:** Reviewed an analyze the 3 months of data collection for ED statistics by ED manager for improvement opportunities on patient flow. The results have been discussed with physicians and frontline staff to develop and implement improvement strategies. Meeting scheduled September 21st with Medhost to review ER process, timelines and timestamp from presentation to admission or transfer. | 286 mins 36% | 283 mins 49% | 283 mins | 248 mins ***** |
| **Emergency Department: ED-2a**<br>**Median time from decision to admit time to ED departure for admitted patients.**<br>**Numerator:** Admitted and departed ED in less than 79 mins.<br>**Denominator:** Measure sampled population or any ED Patient from the facility's emergency department.<br>CMS/TJC | 92 mins | 94 mins | <79 mins | 33/90 | 94 mins 37% | **Finding:** Based on review of 4 cases found that the median time from decision to admit to ED departure ranges from 3-7.5 hours. Consideration given to findings of the patients condition, stabilization and treatment.<br><br>**Interventions:** Reviewed process for transitions of care with each service line. The policy and procedure for Admission Report Process has been reviewed an implemented. | 183 mins 33% | 89 mins 39% | 118 mins | 83 mins |
| **Immunizations (seasonal): IMM-2**<br>**Influenza Immunization**<br>**Numerator:** Number hospitalized inpatients 6 months or older screened for seasonal Influenza immunization status and vaccinated if indicated.<br>**Denominator:** Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March.<br>CMS/TJC | 97% | 90% | >98% | NA | NA | **Findings:** NA<br><br>**Interventions:** | 94% | 82% | N/A | N/A |
| **Perinatal Care: PC-01**<br>**Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed.**<br>**(Lower percentage is better, for cases that fall into measure).**<br>**Numerator:** Patients with elective deliveries.<br>**Denominator:** Patients delivering newborns with >= 37 and < 39 weeks of gestation completed.<br>TJC | 2% | 0% | 0% | 0/10 | 0% | **Findings:** Goals were met.<br><br>**Interventions:** No actions required. | 0% | 0% | 0% | 0% |
| **Perinatal Care: PC-02**<br>**Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth**<br>**(Lower percentage is better).**<br>**Numerator:** Patients with cesarean births.<br>**Denominator:** Nulliparous patients delivered of a live term singleton newborn in vertex presentation.<br>TJC | | 31% | <20% | 3/14 | 21% | **Findings:** All three records were reviewed. C-Sections were performed due to findings but not limited to Prolonged Active Phase of Labor, Non-Reassuring FHR, Failed Dilatation with Pitocin Augmentation and Cephalopelvic Disproportion.<br>The C-Sections were required based on ACOG standards.<br>**Interventions:** No further actions required. | 18% | 31% | 17% | 31% |
| **Perinatal Care: PC-03**<br>**Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns**<br>**(Higher percentage is better).**<br>**Numerator:** Patients with antenatal steroids initiated prior to delivering preterm newborns.<br>**Denominator:** Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed<br>TJC | | 100% | 100% | 0/0 | NP **** | **Findings:** No population.<br><br>**Interventions:** No actions required. | NP **** | N/A | 100% | 100% |

Lakeside Medical Center
Health Care District Palm Beach County

**QUALITY CORE MEASURES REPORT**
**2nd Q April - June 2018**
**PRELIMINARY REPORT**

| Inpatient Quality Measures | AVG FL* | AVG LMC 2017 | LMC GOAL | Sampled Population (defined by Press Ganey**) | Patient Encounters: 8014 2nd Q'18 | Actions Taken When Indicator not Meeting Goal | Patient Encounters: 8443 1Q '18 | Patient Encounters: 8,356 4Q '17 | Patient Encounters: 7,835 3Q '17 | Patient Encounters: 8,733 2Q '17 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Perinatal Care: PC-04**<br>**Health Care-Associated Bloodstream Infections in newborns (Lower percentage is better).**<br>**Numerator:** Newborns with septicemia or bacteremia.<br>**Denominator:** Live born newborns<br>TJC | | 0 | 0 | 0 | NP **** | **Findings:** No population<br>**Interventions:** No actions required. | NP **** | N/A | 0 | 0 |
| **Perinatal Care: PC-05**<br>**Exclusive breast milk feeding during the newborn's entire hospitalization.**<br>**(Higher percentage is better)**<br>**Numerator:** Number of moms Exclusively Breast Feeding.<br>**Denominator:** Single term newborns discharged alive from the hospital.<br>TJC | | 14% | >13% | 2/29 | 7% | **Findings:** Based on review of all cases (79% ) of the sampled population both breast and bottled fed. (14%) bottle fed only and (7%) strictly breast fed.<br>**Interventions:** To promote exclusive Breastfeeding educational classes are being scheduled for moms prior to delivery at the physicians office. Educational brochures and handouts on breastfeeding are given to the patients that present to the unit prior to delivery for antepartum services. | 4% | 16% | 3% | 17% |
| ***Sepsis: SEP-1**<br>**Early management bundle, severe sepsis/septic shock**<br>**Special Note: Measure is not publicly reported by Hospital Compare.**<br>**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).<br>**Denominator:** Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis or Septic Shock.<br>CMS/TJC | 57% | 76% | >60% | 11/14 | 79% | **Findings:** The goal was met for Early management bundle, severe sepsis/septic shock.<br>**Interventions:** Concurrent chart reviews are completed for all Sepsis cases. All failed cases are reviewed for improvement opportunities. Failed cases are reviewed by the CMO/ Nursing Manager and the findings are presented and discussed with physicians/frontline staff. | 72% | 74% | 74% | 77% |
| **Numerator:** Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date.<br>**Denominator:** Patients who developed confirmed VTE during hospitalization.<br>CMS/TJC | 1% | 0% | 0% | 0/0 | NP **** | **Findings:** No population<br>**Interventions:** No actions required | NP **** | 0% | 0% | 0% |

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

**Press Ganey

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

**** NP= No Patients

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

Lakeside Medical Center
Health Care District Palm Beach County

**QUALITY CORE MEASURES REPORT**
**2nd Quarter April - June 2018**
**PRELIMINARY REPORT**

| Outpatient Quality Measures | AVG FL * | AVG LMC 2017 | LMC GOAL | Sampled Population (defined by Press Ganey**) | Patient Encounters: 8014 2Q '18 | Actions Taken When Indicator not Meeting Goal | Patient Encounters: 8443 1Q '18 | Patient Encounters: 8,356 4Q '17 | Patient Encounters: 7,835 3Q '17 | Patient Encounters: 8,733 2Q '17 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Acute Myocardial Infarction: OP-3a**<br>**Median time to transfer to another facility for acute coronary interventions**<br>**Numerator:** Number of patients transferred to another facility with less than 90 minutes<br>**Denominator:** Patients with Transfer for Acute Coronary Intervention.<br>CMS/TJC | 56 mins | 114 mins | <90 mins | 1/3 | 94 mins 67% | **Findings:** Based on review of all 3 cases Median time for transfer to another facility for acute coronary intervention range from 1-2.5 hrs.<br>**Interventions:** Chart review findings are discussed with Dr. Padron Chief Medical Officer and Dr. Perezalonso ED Director for the purpose of establishing improvement opportunities during the transfer process. Planning continues with AMR contract implementation. | 100 mins 0% | 100 mins 0% | 94 mins | N/A |
| **Chest Pain: OP-5**<br>**Median time to EKG (Goal 10 mins)**<br>**Numerator:** Number of patients received EKG within 10min upon arrival to ED.<br>**Denominator:** Emergency Department AMI or Chest Pain patients (with Probable Cardiac Emergency Department AMI or Chest Pain patients (with Probable Cardiac Chest Pain).<br>CMS/TJC | 7 mins | 6 mins | <10 mins | 17/27 | 9 mins 63% | **Findings:** The goal was met for Median time to EKG completion. Based on review of 4 cases Median time for EKG ranged from 35 minutes to 1hour relative to initial presentation and patients complaints.<br>**Interventions:** Audit records not meeting goal and share with CMO/Nurse Manager. Complete PDSA (Plan do study Act) to determine areas of opportunities for improvement. | 6 mins 56% | 7 mins | 2 mins | 6.5 mins |
| **Emergency Department Throughput: OP-18**<br>**Median time from ED arrival to discharge home or transferred**<br>**Numerator:** Number of patients discharged in less than 120 minutes.<br>**Denominator:** Any ED patient from the facility's emergency department.<br>CMS/TJC | 141 mins | 124 mins | <120 mins | 50/99 | 147 mins 51% | **Findings:** Based on review of 5 cases Median time from ED arrival to discharge ranged from 6.5-9 hrs. relative to the complexity of the patient condition and treatment plan. Conditions ranged from Severe encephalopathy (transferred to Orlando), Hyperglycemia, Urinary retention , AMI, Neurology.<br>**Interventions:** Discuss chart review findings with Dr. Padron Chief Medical Officer and Dr. Perezalonso ED Director for review with ED physicians and staff for establishment of improvement opportunities. Future goals include discussion to add additional service lines ( Orthopedics, GI etc.). | 122 mins 49% | 139 mins 45% | 137 mins ***** | 111 mins |
| **Stroke: OP-23**<br>**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).**<br>**Numerator:** Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients.<br>**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.<br>CMS/TJC | 75% | 100% | 100% | 0/0 | N/A | **Findings:** No population.<br>**Interventions:** No actions required. | N/A | N/A | N/A | N/A |

*The October 2018 Hospital Compare Preview Report for reporting period July 27th through August 25,2018 has been used to update the current Florida Averages for the following Core Measures noted in column 2: OP-3a, OP-5, OP-18 and OP-23.
** Press Ganey
***** Correction made to 2nd Quarter 2017 OP-18 previous documentation 129 mins.

Health Care District
PALM BEACH COUNTY

# Pharmacy Services
# Quality Report
# 2nd Quarter 2018

| Measure Set: | | | | ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL | Previous Quarters | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pharmacy Quality Measures** | | **2018 Q2** | | | | **2018 Q1** | | | **2017 Q4** | | | **2017 Q3** | | | **2017 Q2** | |
| | Goal | Total | | | Goal | Total | | Goal | Total | | Goal | Total | | Goal | Total | |
| **340B utilization** | | # | % | | | # | % | | # | % | | # | % | | # | % |
| **Total HCD prescriptions sold (excludes RW)** | | 72,679 | | | | 70,737 | | | 74,511 | | | 66,111 | | | 69,898 | |
| **340B prescription fills sold** | | 72,250 | 99.4 | | | 70,238 | 99.3 | | 73,560 | 98.7 | | 65,746 | 99.4 | | 68,070 | 97.4 |
| **Central Fill** | | 17,990 | 24.9 | Only at WPB, Lantana, Lake Worth, Delray locations | | 4,648 | | | | | | | | | | |
| **Ready when promised (non-waiters)** | | | | | | | | | 52,657 | 97.9 | | 51,129 | 98.2 | | 52,240 | 98.2 |
| Belle Glade | >90% | 5,904 | 99.8 | | >90% | 5,482 | 99.9 | >90% | 5,360 | 99.9 | >90% | 5,529 | 99.9 | >90% | 5,578 | 99.5 |
| Boca Raton | | | | | | 1,659 | 99.0 | | 230 | 97.5 | | | | | | |
| Delray | | 13,107 | 99.0 | | | 9,182 | 98.2 | | 10,677 | 96.8 | | 9,822 | 96.3 | | 9,776 | 97.1 |
| Jupiter | | 2,893 | 99.9 | | | 2,261 | 100.0 | | 801 | 99.8 | | | | | | |
| Lake Worth | | 11,006 | 96.3 | | | 10,474 | 92.4 | | 10,420 | 95.2 | | 8,327 | 96.2 | | 8,178 | 96.2 |
| Lantana | | 11,073 | 97.9 | | | 10,463 | 99.3 | | 9,857 | 97.8 | | 12,311 | 99.2 | | 12,000 | 98.9 |
| West Palm | | 12,888 | 93.3 | | | 13,999 | 97.8 | | 15,112 | 98.3 | | 15,140 | 99.3 | | 15,916 | 99.3 |
| **Prescriptions designated as waiters** | | | | | | | | | 16,078 | | | 14,192 | | | 13,667 | |
| Belle Glade | <25% per site | 1,446 | 19.7 | | <25% per site | 2,233 | 28.9 | <25% per site | 2,247 | 29.5 | <25% per site | 2,033 | 28.9 | <25% per site | 2,128 | 25.9 |
| Boca Raton | | | | | | 463 | 21.8 | | 201 | 46.6 | | | | | | |
| Delray | | 1,723 | 11.6 | | | 2,880 | 23.9 | | 2,942 | 21.3 | | 3,499 | 26.3 | | 3,637 | 25.0 |
| Jupiter | | 339 | 11.2 | | | 806 | 26.3 | | 1,217 | 60.3 | | | | | | |
| Lake Worth | | 653 | 5.6 | | | 1,588 | 13.2 | | 1,939 | 15.7 | | 1,342 | 13.9 | | 2,141 | 18.8 |
| Lantana | | 2,731 | 19.8 | | | 4,450 | 29.8 | | 4,357 | 30.7 | | 3,494 | 22.1 | | 3,257 | 20.0 |
| West Palm | | 3,756 | 22.6 | | | 3,967 | 22.1 | | 3,175 | 17.4 | | 3,824 | 20.2 | | 2,704 | 13.2 |
| **Prescriptions returned to stock** | | | | | | | | | 5,571 | | | 5,134 | | | 3,970 | |
| Belle Glade | <5% per site | 533 | 7.3 | Outbound notification system being assessed; budgeted for fiscal year 2019 - outbound messaging would notify patients that they have medications ready to be picked up and should reduce return to stocks and by doing so, hopefully improving compliance. | <5% per site | 453 | 5.9 | <5% per site | 464 | 6.1 | <5% per site | 433 | 5.7 | <5% per site | 476 | 5.7 |
| Boca Raton | | | | | | 77 | 3.6 | | 18 | 4.2 | | | | | | |
| Delray | | 947 | 6.4 | | | 906 | 7.5 | | 1,160 | 8.4 | | 1,032 | 7.7 | | 887 | 5.9 |
| Jupiter | | 94 | 3.1 | | | 120 | 3.9 | | 38 | 1.9 | | | | | | |
| Lake Worth | | 754 | 6.5 | | | 751 | 6.2 | | 892 | 7.2 | | 761 | 7.9 | | 746 | 6.6 |
| Lantana | | 948 | 6.9 | | | 775 | 5.2 | | 946 | 6.7 | | 956 | 6.9 | | 938 | 5.7 |
| West Palm | | 1,989 | 12.6 | | | 1,720 | 9.6 | | 2,053 | 11.2 | | 1,952 | 10.3 | | 1,812 | 8.8 |
| **Total wait time in minutes (waiters)** | | 21.72 Minutes | | | | 19.62 minutes | | | 20.71 minutes | | | 21.37 minutes | | | 22.61 minutes | |
| Belle Glade | <30 mins | 17.8 mins | | | <30 mins | 16.57 mins | | <30 mins | 16.74 minutes | | <30 mins | 16.1 minutes | | <30 mins | 18.19 minutes | |
| Boca Raton | | | | | | 11.19 mins | | | 10.23 minutes | | | | | | | |
| Delray | | 19.3 mins | | | | 25.93 mins | | | 29.81 minutes | | | 26.31 minutes | | | 25.92 minutes | |
| Jupiter | | 6.8 mins | | | | 7.86 mins | | | 10.8 minutes | | | | | | | |
| Lake Worth | | 25.6 mins | | | | 31.11 mins | | | 26.87 minutes | | | 24.37 minutes | | | 26.7 minutes | |
| Lantana | | 23.2 mins | | | | 18.39 mins | | | 21.72 minutes | | | 18.48 minutes | | | 18.82 minutes | |
| West Palm | | 37.6 mins | | New staff members | | 26.32 mins | | | 28.79 minutes | | | 21.61 minutes | | | 23.41 minutes | |
| **Total out of stock fills** | | | | | | | | | 3,050 | | | 2,489 | | | 2,290 | |
| Belle Glade | <5% per site | 151 | 2.1 | | <5% per site | 113 | 1.5 | <5% per site | 162 | 2.1 | <5% per site | 149 | 2.0 | <5% per site | 188 | 2.4 |
| Boca Raton | | | | | | 68 | 3.2 | | 28 | 5.4 | | | | | | |
| Delray | | 132 | 1.1 | | | 256 | 2.1 | | 532 | 3.8 | | 490 | 3.6 | | 210 | 1.5 |
| Jupiter | | 157 | 5.2 | | | 85 | 2.8 | | 179 | 6.4 | | | | | | |
| Lake Worth | | 308 | 2.6 | | | 882 | 6.8 | | 958 | 7.4 | | 459 | 4.6 | | 496 | 4.7 |
| Lantana | | 292 | 2.1 | | | 357 | 2.4 | | 421 | 2.9 | | 485 | 3.1 | | 453 | 2.9 |
| West Palm | | 310 | 1.8 | | | 408 | 2.2 | | 770 | 4.2 | | 908 | 4.8 | | 943 | 5.0 |

Health Care District
PALM BEACH COUNTY

# Trauma
# Quality Report
# 2nd Quarter 2018
# Percentages

| Measure Set: | 2018 Q2 | | | ACTIONS TAKEN WHEN INDICATOR NOT MEETING GOAL | Previous Quarters | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2018 Q1 | | | 2017 Q4 | | | 2017 Q3 | | |
| **Eligibility** | Num/Den | % | Goal | | Num/Den | % | Goal | Num/Den | % | Goal | Num/Den | % | Goal |
| Total Number of Records Entered Beyond Three Business Days | 76 | 5.7% | <5% | Change of staff at the Trauma Center resulted in a delay of entering records within 3 business days. Trainings were issued at the District to bring the new hires up to speed. This issue has since been corrected. | 52 | 4.6% | <5% | 41 | 3.6 | <5% | 32 | 3.2 | <5% |
| Total Number of Trauma Patients Seen | 1321 | | | | 1116 | | | 1117 | | | 996 | | |
| **Referral Hospital Length of Stay** | | | | | | | | | | | | | |
| Referral Hospital Length of Stay > 6 Hours | 16 | 4.0% | <5% | | 5 | 1.5 | <5% | 5 | 1.5 | <5% | 3 | 1.0 | <5% |
| Total Number of Interfacility Transfers | 409 | | | | 337 | | | 337 | | | 293 | | |

**Trauma Agency TQIC Case Review**

| Type of Review | Total | % of Total Cases Reviewed |
|---|---|---|
| Total DOA Cases Reviewed | 13 | 14% |
| Total Hospice Cases Reviewed | 41 | 43% |
| Total Non-Viable Cases Reviewed | 32 | 33% |
| Total Non-Trauma Related Determinations Reviewed | 1 | 1% |
| Total Cases Presented for Further Quality Analysis and Review | 6 | 6% |
| Total Pre-Hospital Issues Identified, Discussed, and Presented for Educational Opportunities | 3 | 3% |
| Total Cases Reviewed for Delray Medical Center | 51 | 53% |
| Total Cases Reviewed for St. Mary's Medical Center | 45 | 47% |

**Trauma Agency Quality Metrics Review**

| Type of Review | Occurance | Result |
|---|---|---|
| Total ME Cases Reviewed for Fallout | 482 | 1 Case Resulted in Fallout |
| Total Interfacility Cases Reviewed for Appropriate Transfer, Missed Opportunities, and Timeliness | 498 | 409 Appropriate Transfers<br>86 Consulted Appropriately<br>3 Missed Opportunities |
| St. Mary's Site Visit Data Reviews, Trainings and Meetings Held | 4 | 4 PI Recommendations Made |
| Delray Site Visit Data Reviews, Trainings and Meetings Held | 3 | 3 PI Recommendations Made |
| Trauma Agency Educational Outreaches Completed *(EMS, PBC Schools, Acute Care Facilities, Trauma Centers, FHP, and General Public)* | 32 | 5 Topics |

# HEALTH CARE DISTRICT
## Quality, Patient Safety and Compliance Committee
## September 25, 2018

**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 timeframe of April 1, 2018 to August 31, 2018 of FY 2018.

**3. Substantive Analysis:**

The purpose of this summary is to provide an overview of compliance activities and actions. The OIG recommends reporting on a regular basis to the governing body, CEO, and compliance committee with regard to planning, 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

N/A
Dawn Richards
VP & Chief Financial Officer

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

N/A
Committee Name

Date Approved

## 6. Recommendation:

Staff recommends the Quality, Patient Safety and Compliance Committee receive and file the District's Summary of Compliance and Privacy Activities for the timeframe of April 1, 2018 to August 31, 2018 of FY 2018.

Approved for Legal sufficiency:

Valerie Shahrnari
VP & General Counsel

Ellen Pentland
Chief Compliance and Privacy Officer

Darcy J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

# Summary of Compliance Activities

## April 1, 2018 – August 31, 2018

### Highlights

- **Annual Compliance and Privacy Education**

  Annually, the District educates its workforce on Compliance and Privacy awareness. This education is intended to familiarize the workforce with the District's Compliance and Privacy Program, and to help staff understand their responsibilities under the Districts code of conduct, and compliance and privacy policies. This training takes place in the summer and includes employees at all Health Care District of Palm Beach County locations. This year the annual education was conducted in classroom style lecture at the Healey Center to all of its employees over the course of 2 weeks to accommodate all working shifts

- **Monthly Compliance and Privacy Mini Modules**

  The Compliance Department has revamped the delivery method of the annual training to staff. The annual education is broken down to twelve (12) mini modules that are delivered one (1) module per month to all employees.

- **Workgroup Initiatives**

  As part of our ongoing initiative to breakdown silos and encourage quick action and productive decision making between facilities and departments, the Compliance and Privacy team holds monthly and quarterly workgroups on varying topics. On a quarterly basis the Non-Discrimination in healthcare workgroup, the Billing workgroup, and HIPAA/Privacy workgroup. These workgroups meet to discuss current topics, regulatory changes, and policy and procedure updates.

### Training and Education

Trainings provided by Compliance and Privacy Department staff:

- New Hire Orientation – monthly training on Compliance, Privacy and Security
- Non-Discrimination in Healthcare - Quarterly Meeting
- Billing Workgroup- Quarterly Meeting
- HIPAA Workgroup- Quarterly Meeting
- Compliance Connection- Third Quarter 2018 Issue
- Compliance Connection –Security
- Compliance, Privacy, and Code of Conduct Mini Module Training- All Staff

Health Care District
PALM BEACH COUNTY

# Summary of Compliance Activities

## April 1, 2018 – August 31, 2018

- Compliance Annual Education: E.J. Healey Center On-site
- Finance Department
- School Health Education Day
- C.L. Brumback Clinic Staff Orientation
- Medically-Assisted Treatment (MAT) program training
- HIPAA Privacy Training, G4S Staff

### Communication

- 28% of all compliance activity is inclusive of communication

### Hotline Activity

- 33 hotline calls between April 1, 2018 – August 31, 2018

### HIPAA Privacy Incidents

For the period of April 1, 2018 through August 31, 2018 the Compliance Department received thirty-five (35) privacy concerns, of those concerns five (5) resulted in a breach that required patient notification. Sixteen (16) privacy concerns were investigated and resolved with no findings that eluded to a breach of protected health information. Fourteen (14) privacy concerns have no substantiation and the issue was closed. Education was provided to staff when applicable for privacy concerns this period as corrective action.

### Privacy Walkthroughs

| Entity | Findings | Corrective Action Plan |
|---|---|---|
| Belle Glade Clinic | 2 opportunities for enhancement | Completed |
| Jerome Golden & Lewis Center | 3 opportunities for enhancement | Completed |
| Jupiter Clinic | 1 opportunity for enhancement | Completed |
| Delray Beach Clinic | 3 opportunities for enhancement | Completed |
| Eligibility (Belle Glade) | 1 opportunity for enhancement | Completed |
| Eligibility (Delray Beach) | 0 opportunities for enhancement | Completed |
| Lakeside Medical Center | 1 opportunity for enhancement | Completed |

### Auditing and Monitoring

- Review of Athena Consents
- Controls Over Opioid Treatment Programs
- Discharge Disposition
- Limited Data Sets and Data Use Agreements
- Joint Commission Mock Survey: Lakeside Medical Center
- Asset Inventory of Laptops and iPads

Health Care District
PALM BEACH COUNTY

# Summary of Compliance Activities

## April 1, 2018 – August 31, 2018

- Uses and Disclosures of Facility Patient Directory Review: Lakeside Medical Center & E.J. Healey
- Skilled Nursing National Background Screening

### Regulatory Matters

- **OCR Levies Close to $80M in HIPAA Privacy Rule Fines**
  - The Office for Civil Rights has assessed close to $80 million in fines in 55 cases of HIPAA Privacy Rule violations since the rule took effect in April 2003. The office has investigated complaints against many types of entities, including national pharmacy chains, major medical centers, group health plans, hospital chains, and small providers. The most common types of entities that OCR has required to take corrective action were general hospitals, private practices and physicians, outpatient facilities, pharmacies, and health plans. The compliance issues investigated most by OCR are, in order of frequency; Impermissible uses and disclosures of PHI, Lack of safeguards of PHI, Lack of patient access to PHI, Lack of administrative safeguards of ePHI, Use or disclosure of more than the minimum necessary PHI. For the first half of this year, OCR has reported only two HIPAA settlements and one HIPAA decision from an HHS Administrative Law Judge, amounting to around $7.9 million in fines.
- **New OCR Guidelines on Software Vulnerabilities and Patching**
  - The Department of Health and Human Services Office for Civil Rights (OCR) recently issued a cybersecurity report that focuses on software bugs and patches. Software bugs are mistakes in a software code that can negatively impact how the software operates. These bugs can create computer system vulnerabilities and put electronic protected health information (ePHI) at risk. Patches are fixes to the software bugs that correct the software operation. They can be applied to software and firmware on all types of devices, such as phones, computers, servers and routers. In its report, OCR revealed that in late 2017, researchers discovered a widespread vulnerability in nearly all of the computer processors that were sold over the past decade, affecting millions of devices. These vulnerabilities allowed malware to bypass data access controls and potentially access sensitive data, and are known as Spectre and Meltdown.
- **More Individual Records Exposed in First Six Months of 2018 than in All of 2017**
  - The number of individuals affected by the breaches has grown significantly year over year, as well. On the OCR Breach Portal, over 3.7M individual records were exposed in the first 6 months of 2018. Compare that to the 2.68M individuals affected in all of 2017. All 50 states have data breach notification laws no two exactly the same, which makes compliance with multijurisdictional incidents difficult without investing in incident response tools. These laws continue to evolve. Seven states had new or amended data breach notification laws go into effect this year alone. Four more states have signed bills that will go into effect later this year, and well over a dozen proposed and pending pieces of state legislation remain active.

# HEALTH CARE DISTRICT
## Quality, Patient Safety and Compliance Committee
## September 25, 2018

## 1. Description: Revised Compliance Work Plan 2018

## 2. Summary:

Ongoing evaluation is critical to an effective compliance program. The Compliance Department will perform the reviews from the Compliance Work Plan 2018 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

## 3. Substantive Analysis:

The Compliance Work Plan 2018 demonstrates areas of concern based on government enforcement trends, the OIG 2018 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

Based on identified concerns and changes in Business Practice, the Work Plan was revised to reflect changes in the 2018 Work Plan.

## 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
Dawn Richards
VP & Chief Financial Officer

## 5. Reviewed/Approved by Committee:

N/A
Committee Name

Date Approved

## 6. Recommendation:

Staff recommends the Quality, Patient Safety and Compliance Committee approve the revised 2018 Compliance Work Plan.

Approved for Legal sufficiency.

Valerie Shahrian
VP & General Counsel

Ellen Pentland
Chief Compliance and Privacy Officer

Darryl J. Davis
Chief Executive Officer

Health Care District
PALM BEACH COUNTY

# Compliance Work Plan 2018

| Compliance Auditing Plan | | | | |
|---|---|---|---|---|
| **Quarter** | **Entity** | **Source of Risk** | **Review Title** | **Description** |
| 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. |
| 1 | LMC | Internal Risk Assessment | Physician Documentation Review | Review a random sample of ED patient records for name of treating provider, progress notes, date and time of admission, discharge, and discharge disposition. |
| 1 | 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 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. |
| 1 | Clinics and E J Healey | Internal Risk Assessment | Review Laboratory Billing | Review a sample of laboratory billings and payments to assure we have been billed and are paying for qualified patients per laboratory contracts. **This will continue into 2nd Quarter. **Postponed: Working with District Cares and IT on reports.** |
| 1 | Clinics/LMC | Internal Risk Assessment | Clinic Adjustment from Audit | Review payment adjustments to ensure that total amounts were appropriately calculated per payer. |
| 2 | LMC and E.J. Healey | Internal Risk Assessment | Uses and Disclosures of Facility Patient Directory | Review policies, procedures, and internal controls for patient names in facility directory and compliance to policies and Privacy Rule. |
| 2 | Home Office | Internal Risk Assessment | Permitted Use and Disclosure of PHI and ePHI for other than TPO | Review policy and procedure for release of PHI and ePHI. Review a random sample monthly for each business unit in the Records Department for compliance with policy, and requested documents for what was release to assure compliance with public records requests and HIPAA. |

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Health Care District
PALM BEACH COUNTY

# Compliance Work Plan 2018

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|---|---|---|---|---|
| 2 | District-Wide | Internal Risk Assessment | Privacy Walkthrough | Review of a facilities compliance with privacy laws, regulations, policies, and procedures by visual observation of day-to-day operations and services. |
| 2 | District-Wide | Risk Assessment | Asset Inventory of Laptops and IPads | Review the asset inventory of devices that contain ePHI. Assess inventory to user and confirm all accounted for and correct user in possession of device. |
| 2 | LMC | Internal Risk Assessment | Review Medicare Outpatient Observation Notice (MOON) | Review a sample of Medicare and Commercial insurance records to determine if LMC is providing the written MOON and an oral explanation to patients in observation for more than 24 hours. Compliance will verify that the medical record includes documentation of the delivery of the MOON. |
| 3 | Home Office | Internal Risk Assessment | Permitted Use and Disclosure of PHI and ePHI for other than TPO | Review policy and procedure for release of PHI and ePHI. Review a random sample monthly for each business unit in the Records Department for compliance with policy, and requested documents for what was release to assure compliance with public records requests and HIPAA. |
| 3 | District-Wide | Internal Risk Assessment | Limited Data Sets and Data Use Agreements | Review compliance with Limited Data Sets and Data Use Agreements. |
| 3 | E.J. Healey | OIG Work Plan FY 2018 | Skilled Nursing National Background Screening | Review the process and procedure for background screening for skilled nursing employees. |
| 3 | District-Wide | Internal Risk Assessment | Privacy Walkthrough | Review of a facilities compliance with privacy laws, regulations, policies, and procedures by visual observation of day-to-day operations and services. |
| 3 | LMC | Internal Risk Assessment | Discharge Disposition | Review policies, procedures and internal controls for hospital discharge disposition. The discharge status code assignment and the resultant post-acute care transfer payment methodology will be reviewed for financial opportunities as well as compliance risks. A sample of charts will be reviewed to determine the accuracy of hospital discharge code assignments. |
| 3 | Clinics | Internal Risk Assessment (NEW) | Athena Consents | Assess Athena processes for consent to treat and processes for other paper documents. Audit random sample of medical records between May 20th and June 20th 2018 to determine compliance with consents to treat. |

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Health Care District
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# Compliance Work Plan 2018

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| 3 | District-Wide | OIG Work Plan 2018 | Controls over Opioid Treatment Programs | Review policies and procedures for Health Care District controls over Opioids |
| 4 | Aeromedical | Internal Risk Assessment | Billing Audit | Review procedures, internal controls, and sample all payors for Aeromedical billing. **(Postponed, billing now outsourced. Policies and procedures are still in progress. Moved to first quarter 2019).** |
| 4 | District-wide | OIG WorkPlan 2018 | Physician Professional Services and Medical Director | Review all HCD and Affiliate Physician Professional Services and Medical Director agreements and documentation supporting payment per the agreements. This audit has been started in the fourth quarter; however, due to volume of information and new audit priority it will continue into first quarter 2019 until complete. |
| 4 | District-Wide | Internal Risk Assessment | Privacy Walkthrough | Review of a facilities compliance with privacy laws, regulations, policies, and procedures by visual observation of day-to-day operations and services. |
| 4 | District-Wide | Internal Risk Assessment | Minimum Necessary request for PHI | Review policies and procedures related to minimum necessary request and evaluate the content to the specified criteria. Review requests made on a routine and recurring basis and determine if they are limited to the PHI reasonably necessary to achieve the purpose of the disclosure. |
| 4 | LMC | Internal Risk Assessment | Financial Assistance Policy | Review LMC's Financial Assistance Policy to determine if it meets the requirements of 501(r). Moved to fourth quarter per Dawn Richards' (CFO) request due to IRS audit. **8/2/18 at the request of CFO moved to first quarter, 2019.** |
| 4 | District-Wide | Internal Risk Assessment | Volunteer, Student and Resident Onboarding Process Review | Review of procedures to ensure proper onboarding including required training, background checks, and paperwork. Review a sample of documentation to ensure compliance with requirements. **Moved to fourth quarter per Karen Harris VP of Field Operations.** |
| 4 | Clinics | Internal Risk Assessment **(NEW)** | Referral Clerk Record Audit | Review patient records processed and scanned by CLBPCC referral clerk staff to AthenaHealth EHR and determine charts containing wrong patient information. This audit will be ongoing until completed and assessment of any regulatory issues. |



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Health Care District
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# Compliance Work Plan 2018

## 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** | DRG validation, Medical Necessity, Coding Validation; Chart to Bill Audits; Modifier Usage; Claims Error Rates | Review a total of at least thirty (30) charts during the first quarter of FY2018. Education occurred after audit. Audit was completed by ATOS prior to January 26, 2018. |
| **CLINICS/ DENTAL** | Coding Validation; Professional Fee Audits; Diagnosis Accuracy; Chart to Bill Audits; Modifier Usage; Claims Error Rates | Perform a baseline audit during the first quarter of Medical providers, which will review a total of fifteen (15) charts per provider. Provider education was completed January 4, 2018. Additional Audits to be completed by Acevedo Consulting in the first quarter of 2019. A Dental Auditor to be determined. |
| **HEALEY** | Coding Validation, Chart to Bill Audits; Diagnosis Sequencing; MDS Measures | Completed first quarter 2018. |



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Health Care District
PALM BEACH COUNTY

# Compliance Work Plan 2018

| | | |
|---|---|---|
| **HCD ALL BUSINESS UNITS** | Office of Civil Rights (OCR) HIPAA Risk Assessment | Audit completed by SecureState. |
| **LMC** | LMC ED Facility Audit | Acevedo Consulting completed an Emergency Department (ED) audit for facility charges in the fourth quarter. Education to be completed in the same quarter. |
| **HCD** | Mock Tabletop IT Security Incident Response Plan Drill | Test our IT Security Incident Response Plan in conjunction with SecureState in a tabletop drill in third quarter 2018. |

All audits in the 2018 Audit Work Plan are subject to change due to Compliance issues raised and requiring audit/investigation during quarter. The Office of Inspector General (OIG) 2018 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.



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