MEMORANDUM

To: Board of Directors

Cc: Bill Boyles, Esquire
Biju Mathews, M.D.

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – June 6, 2022

Date: June 1, 2022

The Audit Committee will meet at 11:00 a.m. in the Executive Conference Room.

The Ad Hoc Credentials Review Committee will meet at 11:30 a.m. where the Committee will review credentialing and privileging files as they relate to medical staff appointment/reappointment.

The Quality Committee will convene at 12:00 p.m., which will be followed by the Finance Committee, and then Executive Committee meetings.

The Board of Directors will meet in executive session no earlier than 1:30 p.m. Following the Board of Directors Executive Session, the Education Committee and Board of Directors regularly scheduled meeting will be held immediately following, however no earlier than 2:00 p.m.

The Planning Committee meeting has been canceled.

Members:
Stan Retz, Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Jerry Noffel
Herman Cole, Jr.
Elizabeth Galfo, M.D.
Billy Specht

TENTATIVE AGENDA
AUDIT COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
JUNE 6, 2022 11:00 A.M.
EXECUTIVE CONFERENCE ROOM

Call to Order

I. Review and approval of minutes (March 7, 2022)

Motion: To recommend approval of the March 7, 2022 minutes as presented.

II. Public Comments

III. Audit Engagement Letter MSL – Mr. Bacon

Motion: To recommend approval of the Moore Stephens Lovelace Engagement Letter for the FY22 audit as presented.

IV. Corporate Compliance Update – Mr. Jackson

V. Adjournment

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
AUDIT COMMITTEE

A regular meeting of the Audit Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on March 07, 2022 at 10:30 a.m. in the First Floor Conference Rooms 2/3/4/5. The following members were present:

Stan Retz, Chairperson
Robert Jordan, Jr., C.M.
Herman Cole
Jerry Noffel
Elizabeth Galfo, M.D.
Billy Specht (absent/excused)

Other Attendees:
George Mikitarian, President/CEO
Anual Jackson, Director, Corporate Compliance, Chief Compliance and Audit Officer
Darrell Bacon, Director Financial Planning
Pamela Perez, Administrative Assistant
Nate Davenport, MSL
Farlen Halikman, MSL
Thomasina Middleton, Financial Planning

Call to Order

Mr. Retz called the meeting to order at 10:40 a.m.

Public Comments

None.

FY21 Final Audit Report

Nate Davenport, MSL, gave an overview of the areas of the audit. No adjustments, no comments and no disagreements noted.

The following motion was made by Mr. Retz and seconded by Mr. Cole and approved without objection:

Motion: To recommend to the board of directors to accept the Fiscal Year 2021 audit results and reports:

- ***Audited Financial Statements and Supplementary Information***
- ***Report on Internal Control and Compliance***
- ***Communications with the Board of Directors and Audit Committee***
- ***Management Letter***

Adjournment

There being no further business, the meeting adjourned at 10:46 a.m.

_____
Stan Retz, Chairperson

MSL
CPAs & ADVISORS

May 5, 2022

VIA EMAIL

Dr. George Mikitarian
President/Chief Executive Officer
North Brevard County Hospital District
d/b/a Parrish Medical Center
951 N. Washington Avenue
Titusville, FL 32796

Dear Dr. Mikitarian:

We are pleased to confirm our understanding of the services we are to provide for **North Brevard County Hospital District d/b/a Parrish Medical Center** (the "District") for the year ending September 20, 2022.

AUDIT SCOPE AND OBJECTIVES

We will audit the general purpose financial statements of the District, which comprise the balance sheet as of year ending, and the related statements of income, retained earnings, and cash flows for the year then ended, and the disclosures (collectively, the "financial statements"). Also, the following supplementary information accompanying the financial statements will be subjected to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America, and we will provide an opinion on it in relation to the financial statements as a whole in a report combined with our auditor's report on the financial statements:

1. Required Supplemental Information – Unaudited Schedule Funding Progress – Pension
2. Required Supplemental Information – Unaudited Schedule Funding Progress – OPEB
3. Consolidating Balance Sheets
4. Consolidating Statements of Revenues, Expenses, and Changes in Net Assets

The objectives of our audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and issue an auditor's report that includes our opinion about whether your financial statements are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with auditing standards generally accepted in the United States of America ("GAAS") will always detect a material misstatement when it exists. Misstatements, including omissions, can arise from fraud or error and are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment of a reasonable user made based on the financial statements.

AUDITOR'S RESPONSIBILITIES FOR THE AUDIT OF THE FINANCIAL STATEMENTS

We will conduct our audit in accordance with GAAS and will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion.

As part of an audit in accordance with GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

We will evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management. We will also evaluate the overall presentation of the financial statements, including the disclosures, and determine whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation. We will plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the District or to acts by management or employees acting on behalf of the District.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is an unavoidable risk that some material misstatements may not be detected by us, even though the audit is properly planned and performed in accordance with GAAS. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements. However, we will inform the appropriate level of management of any material errors, fraudulent financial reporting, or misappropriation of assets that comes to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors.

We will obtain an understanding of the District and its environment, including internal control relevant to the audit, sufficient to identify and assess the risks of material misstatement of the financial statements, whether due to error or fraud, and to design and perform audit procedures responsive to those risks and obtain evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentation, or the override of internal control. An audit is not designed to provide assurance on internal control or to identify deficiencies in internal control. Accordingly, we will express no such opinion. However, during the audit, we will communicate to you and those charged with governance internal control related matters that are required to be communicated under professional standards

We have identified the following significant risk(s) of material misstatement as part of our audit planning:

(a) Valuation of Receivables
(b) Completeness of Self Insurance Reserves
(c) Completeness and Valuation of Revenue

We will also conclude, based on the audit evidence obtained, whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of receivables and certain assets and liabilities by correspondence with selected customers, creditors, and financial institutions. We may also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry.

We may, from time to time and depending on the circumstances, use third-party service providers in serving your account.

We may share confidential information about you with these service providers but remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your personal information.

In addition, we will secure confidentiality agreements with all service providers to maintain the confidentiality of your information and we will take reasonable precautions to determine that they have appropriate procedures in place to prevent the unauthorized release of your confidential information to others. In the event that we are unable to secure an appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider. Furthermore, we will remain responsible for the work provided by any such third-party service providers

OTHER SERVICES

We will also assist in preparing the financial statements of District in conformity with U.S. GAAP based on information provided by you.

We, in our sole professional judgment, reserve the right to refuse to perform any procedure or take any action that could be construed as assuming management responsibilities.

RESPONSIBILITIES OF MANAGEMENT FOR THE FINANCIAL STATEMENTS

Our audit will be conducted on the basis that you acknowledge and understand your responsibility for designing, implementing, and maintaining internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error, including monitoring ongoing activities; for the selection and application of accounting principles; and for the preparation and fair presentation of the financial statements in conformity with accounting principles generally accepted in the United States of America. You are also responsible for making drafts of financial statements, all financial records, and related information available to us and for the accuracy and completeness of that information (including information from outside of the general and subsidiary ledgers). You are also responsible for providing us with (1) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, identification of all related parties and all related-party relationships and transactions, and other matters; (2) additional information that we may request for the purpose of the audit; and (3) unrestricted access to persons within the District from whom we determine it necessary to obtain audit evidence. At the conclusion of our audit, we will require certain written representations from you about the financial statements and related matters.

Your responsibilities include adjusting the financial statements to correct material misstatements and confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the District involving (1) management, (2) employees who have significant roles in internal control, and (3) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the District received in communications from employees, former employees, regulators, or others. In addition, you are responsible for identifying and ensuring that the District complies with applicable laws and regulations. You are responsible for the preparation of the supplementary information in conformity with accounting principles generally accepted in the United States of America. You agree to include our report on the supplementary information in any document that contains, and indicates that we have reported on, the supplementary information.

You also agree to include the audited financial statements with any presentation of the supplementary information that includes our report thereon. You agree to make the audited financial statements readily available to users of the supplementary information no later than the date the supplementary information is issued with our report thereon. You agree to assume all management responsibilities for the tax services, financial statement preparation services, and any other nonattest services we provide, oversee the services by designating an individual, preferably from senior management, with suitable skill, knowledge, or experience; evaluate the adequacy and results of the services; and accept responsibility for them.
With regard to electronic dissemination of audited financial statements, including financial statements published electronically on your website, you understand that websites are a means of distributing information and, therefore, we are not required to read the information contained in those sites or to consider the consistency of other information on the website with the original document.

In recent years, the federal government and many states have aggressively increased enforcement efforts under Medicare and Medicaid anti-fraud and abuse legislation. Broadening regulatory and legal interpretations have significantly increased the risk of penalties for providers; for example, broad interpretations of "false claims" laws are exposing ordinary billing mistakes to scrutiny and penalty consideration. An auditor's expertise is in accounting and auditing matters rather than operational, clinical, compliance or legal matters. Accordingly, our audit procedures focus on areas that normally are subject to internal control relevant to financial reporting. An audit conducted in accordance with auditing standards generally accepted in the United States of America does not include audit procedures specifically designed to detect illegal acts that have only an indirect effect on the financial statements (for example, violations of Stark laws or fraud and abuse statutes that result in fines or penalties being imposed on the District). The audit procedures do not include testing compliance with laws and regulations in any jurisdiction related to Medicare and Medicaid anti-fraud and abuse. Management of the District is responsible for the identification of, and the District's compliance with, laws and regulations applicable to its activities, including, but not limited to, those related to Medicare and Medicaid anti-fraud and abuse statutes.

With respect to cost reports that may be filed with a third party (such as federal and state regulatory agencies), we have not been engaged to test in any way, or render any form of assurance on, the propriety or allowability of the specific costs to be claimed on, or charges to be reported in, a cost report. Management is responsible for the accuracy and propriety of all cost reports filed with Medicare, Medicaid, or other third parties.

You acknowledge that as a condition of our agreement to perform an audit, you and the District's management agree to the best of your knowledge and belief to be truthful, accurate, and complete in the representations you make to us during the course of the audit and in the written representations provided to us at the completion of the audit.

Because of the importance of management's representations, contained in your representation letter to us, to the effective performance of our services, the District will release MSL, P.A. ("MSL") and its personnel from any claims, liabilities, costs and expenses relating to our services under this letter attributable to any misrepresentations in the representation letter referred to above or made to us by any member of management. In addition, the District further agrees to indemnify and hold us harmless for any liability and all reasonable costs, including legal fees, that we may incur as a result of the services performed under this engagement in the event there are known misrepresentations made to us by any member of the District's management.

REPORTING

We will issue a written report upon completion of our audit of District's financial statements. Our report will be addressed to the Board of Directors of the District. Circumstances may arise in which our report may differ from its expected form and content based on the results of our audit.

Depending on the nature of these circumstances, it may be necessary for us to modify our opinion or add an emphasis-of-matter or other-matter paragraph to our auditor's report, or if necessary, withdraw from this engagement. If our opinion is other than unmodified, we will discuss the reasons with you in advance. If circumstances occur related to the condition of your records, the availability of sufficient, appropriate audit evidence, or the existence of a significant risk of material misstatement of the financial statements caused by error, fraudulent financial reporting, or misappropriation of assets, which in our professional judgment prevent us from completing the audit or forming an opinion on the financial statements, we retain the right to take any course of action permitted by professional standards, including declining to express an opinion or issue a report, or withdrawing from the engagement.

ENGAGEMENT ADMINISTRATION, FEES, AND OTHER

We will schedule the engagement based in part on deadlines, working conditions and availability of your key personnel. We will plan the engagement on the assumption that your personnel will cooperate and provide assistance by performing tasks such as preparing requested schedules, retrieving supporting documentation, and preparing confirmations. If, for whatever reason, your personnel are unavailable to provide the necessary assistance in a timely manner, it may substantially increase the work we have to do to complete the engagement within the established deadlines, resulting in an increase in fees over our original fee estimate or delay the completion of our work.

Jeff Goolsby is the engagement shareholder and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it.

FEES - Our fees are based on the tasks required, time spent, and level of expertise of the staff used to perform this engagement. Based on our preliminary estimates, the fee will not exceed $140,000. This estimate is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the engagement. Additionally, you will be responsible for any reasonable travel or other out-of-pocket costs incurred.

Invoices for the audit will be due based on the following schedule:

Initial deposit	$ 25,000
September 30, 2022	$ 30,000
October 31, 2022	$ 30,000
November 30, 2022	$ 30,000
December 31, 2022	$ 20,000
Upon Issuance of Report	Balance

Any subsequent discussions, conferences, telephone conversations, correspondence, or related services will be invoiced separately.

In the event we are requested or authorized by the District or are required by government regulation, subpoena, or other legal process to produce our documents or our personnel as witnesses with respect to our engagements for the District, the District will, so long as we are not a party to the proceeding in which the information is sought, reimburse us for our professional time and expenses, as well as the fees and expenses of our counsel, incurred in responding to such requests.

A service charge of 1.5 percent per month will be assessed on any invoice not paid within thirty (30) days of the invoice date. We reserve the right to halt further services until payment on past due invoices is received. In the event that collection procedures are required, you agree to pay all expenses of collection, including collection efforts by our staff, which will be billed at our standard hourly rates, and all attorney's fees and costs actually incurred by our Firm in connection with such collection, whether or not suit is filed thereon.

If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed even if we have not issued our report. You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination.

INITIAL DEPOSIT DUE - We require an initial deposit in the amount of $25,000 for this engagement.

LAW - This agreement will be interpreted in accordance with Florida law and the terms and conditions as required by the Florida Board of Accountancy, where applicable.

You agree that our maximum liability to you for any negligent errors or omissions committed by us in the performance of the engagement will be limited to three times the amount of our fees for this engagement, except to the extent determined to result from our gross negligence or willful misconduct.

The workpapers for this engagement are the property of MSL and constitute confidential information. However, we may be requested to make certain workpapers available to government officials or others pursuant to authority by law or regulation. If requested, access to such workpapers will be provided under the supervision of MSL personnel. We do not waive any rights or privileges granted under federal or state law, statutes, or regulation with regard to client/accountant privileges.

MEDIATION - Parties to this engagement agree that any dispute that may arise regarding the meaning, performance, or enforcement of this engagement will, prior to resorting to litigation, be submitted to mediation upon the written request of any party to the engagement. In the event that the parties cannot agree to a mediator, each will choose one and the two will choose a third, who will serve as sole mediator. The results of this mediation shall be binding only upon agreement of each party to be bound. Costs of any mediation proceeding shall be shared equally by both parties.

TERM - This engagement is for a limited period of time and is further limited by scope. Any other services performed on your behalf shall be by separate agreement. Our audit engagement ends on delivery of our audit report. Any follow-up services will be a separate, new engagement. The terms and conditions of that new engagement will be governed by a new, specific engagement letter for that service. You agree that any claim arising out of this engagement letter shall be commenced within one (1) year of the delivery of the work product to you, regardless of any longer period of time for commencing such claim as may be set by law. A claim is understood to be a demand for money or services, the service of a suit, or the institution of arbitration proceedings against MSL.

If at any time during the engagement, you fail to make prompt payments or cooperate with the staff performing this engagement, we reserve the right to suspend performance until such time as payment is made or cooperation resumes. Our engagement to serve as your independent auditor is contingent upon the results obtained from our client acceptance and continuance due diligence procedures. In the event circumstances arise that cause us to believe that we can no longer adequately meet our obligations, or if we believe that continued performance would require us to compromise our ethical standards, we reserve the right to immediately suspend or terminate this contract. We, in our sole professional judgment, reserve the right to refuse to perform any procedure or take any action that could be construed as assuming management responsibilities.

You understand that if this contract is suspended or terminated, reports or documents may not be prepared timely, and you agree to hold MSL and its employees harmless for any damages suffered. In no event will our Firm be liable for incidental or consequential damages, even if we have been advised of the possibility of such damages.

NON-SOLICITATION - Your management and MSL acknowledge the importance of retaining key personnel. Accordingly, both parties agree that during the period of this agreement and for one year after its expiration or termination, neither party will (a) solicit any shareholder/partner or employee of the other party for employment, or (b) employ any person who was a shareholder/partner or employee of the other

party within four (4) months after the termination of their employment with the other party for any reason, without the advance written consent of the other party.

In any case, if the individual becomes an employee of the other party within the non-solicitation period in violation of the foregoing, the other party agrees to pay the original employer a fee equal to 40 percent (40%) of the individual's annual compensation for the prior full twelve-month period of their prior employment. The fee is due thirty (30) days after the individual becomes an employee of the other party.

ENTIRE AGREEMENT - The terms and conditions set out in this engagement letter constitute the entire agreement between the parties and supersede any verbal or written agreements concerning the above-referenced services.

If the services and terms outlined above are in accordance with your understanding, please sign a copy of this letter and return it to us along with the initial deposit of $25,000. Upon receipt of your signed engagement letter, we will schedule your work.

We very much appreciate this opportunity to be of service to you. If you have any questions, please do not hesitate to contact us.

Sincerely,

MSL, P.A.

The above terms and conditions are accepted
and affirmed.

By: _____

Date: _____

mg
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QUALITY COMMITTEE
Elizabeth Galfo, M.D., Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Billy Specht
Billie Fitzgerald
Herman A. Cole, Jr.
Jerry Noffel
Stan Retz, CPA
Maureen Rupe
Ashok Shah, M.D.
Biju Mathews, M.D., President/Medical Staff
Greg Cuculino, M.D.
Kiran Modi, M.D., Designee
Francisco Garcia, M.D., Designee
Christopher Manion, M.D., Designee
George Mikitarian (non-voting)

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE
MONDAY, JUNE 6, 2022
12:00 P.M.
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the April 4, 2022 meeting.

II. Vision Statement

III. My Story

IV. Dashboard

V. CPOE – Computer Physician Order Entry

VI. Other

VII. Executive Session (if necessary)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE QUALITY COMMITTEE WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING, HE/SHE WILL NEED A RECORD OF PROCEEDINGS AND, FOR SUCH PURPOSES, MAY NEED TO ENSURE A VERBATIM RECORD OF THE PROCEEDINGS IS MADE AND THAT THE RECORD INCLUDES TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

PERSONS WITH A DISABILITY WHO NEED A SPECIAL ACCOMMODATION TO PARTICIPATE IN THIS PROCEEDING SHOULD CONTACT THE ADMINISTRATIVE OFFICES AT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 268-6110. THIS NOTICE WILL FURTHER SERVE TO INFORM THE PUBLIC THAT MEMBERS OF THE BOARD OF DIRECTORS OF NORTH BREVARD MEDICAL SUPPORT, INC. MAY BE IN ATTENDANCE AND MAY PARTICIPATE IN DISCUSSIONS OF MATTERS BEFORE THE NORTH BREVARD COUNTY HOSPITAL DISTRICT BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE. TO THE EXTENT OF SUCH DISCUSSION, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT, BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE AND NORTH BREVARD MEDICAL SUUPORT, INC. SHALL BE CONDUCTED.

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE

A regular meeting of the Quality Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on April 4, 2022 in Conference Room 2/3/4/5, First Floor. The following members were present.

Elizabeth Galfo, M.D., Chairperson
Maureen Rupe, Vice Chairperson
Robert L. Jordan, Jr., C.M.
Herman A. Cole, Jr.
Billie Fitzgerald
Jerry Noffel
Billy Specht
Stan Retz, CPA
Ashok Shah, M.D.
Christopher Manion, M.D.
Biju Mathews, M.D., President/Medical Staff (12:21 p.m.)
George Mikitarian (non-voting)

Members absent:
Gregory Cuculino M.D. (excused)
Kiran Modi, M.D. (excused)
Francisco Garcia, M.D. (excused)

CALL TO ORDER

Dr. Galfo called the meeting to order at 12:05 p.m.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Cole, seconded by Mr. Jordan and approved (10 ayes, 0 nays, 0 abstentions). Dr. Mathews was not present at the time the vote was taken.

ACTION TAKEN: **MOVED TO APPROVE THE FEBRUARY 7, 2022 MINUTES OF THE QUALITY COMMITTEE, AS PRESENTED.**

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

MY STORY

Mr. Graybill shared the story of Josh Barron as told by his father Ridley Barron.

QUALITY DASHBOARD REVIEW

Mr. Loftin reviewed the January Quality Dashboard and discussed each indicator score as it relates to clinical quality and cost. Copies of the Power Point slides presented are appended to the file copy of these minutes.

BEDSIDE MEDICATION BARCODING

Mr. Loftin summarized the process and procedures used by PMC to dispense bedside medication using a system of barcoding to ensure the correct medication is administered to the right patient, every time.

PERINATAL IMMUNIZATION QUALITY PROGRAM

Mr. Loftin reviewed the importance of the Perinatal Immunization Quality Program, the purpose of the state of Florida audit and the program objectives.

OTHER

There was no other business brought before the committee.

ADJOURNMENT

There being no further business to discuss, the Quality Committee meeting adjourned at 12:39 p.m.

Elizabeth Galfo, M.D.
Chairperson

PARRISH®
HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Board of Directors

Quality Committee Presentation

PARRISH HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Quality Agenda

June 2022

1. Approval of Minutes
2. Vision Statement
3. My Story
4. Dashboard
5. CPOE- Computer Physician Order Entry
6. Other
7. Executive Session

Quality Committee

Vision Statement

"Assure affordable access to safe, high quality patient care to the communities we serve."

My Story

Dashboard

Performance dashboard

Description	Definition	Mar	Jan-Mar	Opportunity
Stroke	Stroke management compliance	75%	61%	Goal: 100%
Sepsis	Severe Sepsis and Septic Shock Management bundle compliance	59%	56%	Goal: 76%
Early Elective Delivery	Percentage of elective deliveries among mothers with uncomplicated pregnancies at 37 and 38 weeks gestation	0%	0%	Goal: 0%
HAI	Hospital onset MRSA bacteremia	0.00	2.34	Goal: 0
Readmission	All cause 30 day readmissions	7.22%	9.42%	
Person Centered flow	Inpatient and outpatient emergency department throughput	315	402	
Person Experience	Top box HCAHPs domain score for overall rating	52.3	45.9	Target: 76%

Computerized Provider Order Entry

PARRISH HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Computerized Provider Order Entry

What is CPOE?

- Electronic prescribing systems that intercept errors at the time they are ordered
- Orders are entered into a computer and integrate with patient information, including lab and prescription data
- Order is automatically checked for potential errors

Computerized Provider Order Entry

Benefits of CPOE?

- Prompts that warn against the possibility of drug interaction, allergy or overdose
- Accurate, current information that helps physicians keep up with new drugs
- Drug-specific information that eliminates confusion among drug names that sound alike
- Improved communication between physicians and pharmacists
- Reduced long-term healthcare costs

Computerized Provider Order Entry

Why is it important?

- More then 1 million serious medication errors occur every year in US hospitals[1]
- 20% of medication errors are life-threatening adverse drug events[2]

1. Leapfrog: https://www.leapfroggroup.org/sites/default/files/Files/2020%20CPOE%20Fact%20Sheet.pdf
2. IOM: *To Err is Human*

Computerized Provider Order Entry

Errors

Wrong drug

Drug overdose

Overlooked drug interactions

Overlooked drug allergies

Computerized Provider Order Entry

Leapfrog

Hospitals fully meeting the Leapfrog standard:

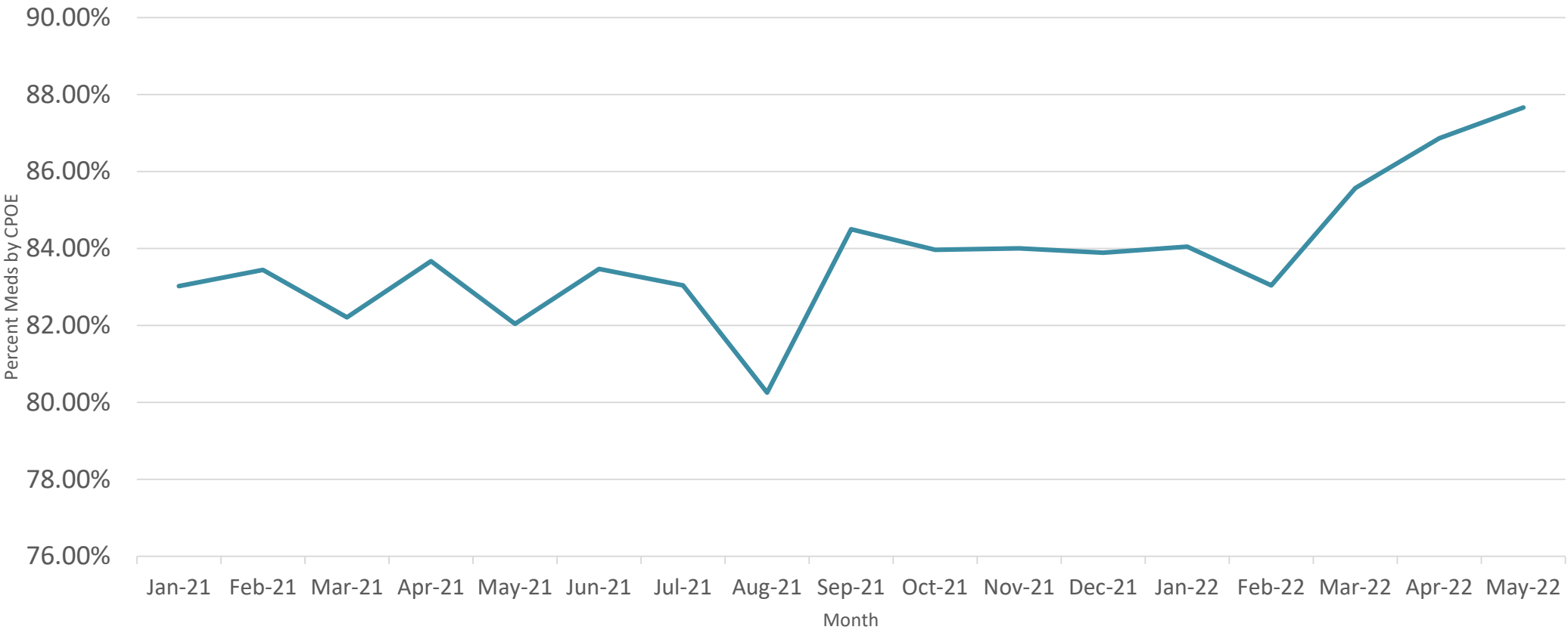
- 85% of medication orders are entered into computer system that includes prescribing-error prevention software

AND

- Demonstrate, via a test, that their CPOE system can alert prescribers to at least 60% of common, serious prescribing errors

Computerized Provider Order Entry

Parrish Performance –



PARRISH HEALTHCARE

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Game Plan

Measure: Computerized Physician Order Entry

- 2021 results:
  - Order entry: 82.9%
  - CPOE test: 62%
- 2022 results:
  - Order entry: 86.7%
  - CPOE test: 63%

Questions?

FINANCE COMMITTEE
Herman A. Cole, Jr. Chairperson
Stan Retz, CPA, Vice Chairperson
Robert L. Jordan, Jr., C.M., (ex-officio)
Jerry Noffel
Billie Fitzgerald
Billy Specht
Maureen Rupe
Ashok Shah, M.D.
Elizabeth Galfo, M.D.
Christopher Manion, M.D.
Biju Mathews, M.D., President/Medical Staff
George Mikitarian, President/CEO (non-voting)

TENTATIVE AGENDA
FINANCE COMMITTEE MEETING - REGULAR
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, JUNE 6, 2022
FIRST FLOOR CONFERENCE ROOMS 2/3/4/5
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)

CALL TO ORDER

I. Review and approve minutes of (April 4, 2022)

Motion: To recommend approval of the April 4, 2022 minutes as presented.

II. Financial Review

III. Audit Engagement Letter MSL – Mr. Bacon

Motion: To recommend the Board of Directors approve the Moore Stephens Lovelace Engagement Letter for the FY22 as presented.

IV. Disposal

Motion: To recommend to the Board of Directors to declare the equipment listed in the requests for Disposal of Obsolete or Surplus Property Forms as surplus and obsolete and dispose of same in accordance with FS274.05 and FS274.96.

V. Executive Session (if necessary)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE FINANCE COMMITTEE WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING, HE/SHE WILL NEED A RECORD OF PROCEEDINGS AND, FOR SUCH PURPOSES, MAY NEED TO ENSURE A VERBATIM RECORD OF THE PROCEEDINGS IS MADE AND THAT THE RECORD INCLUDES TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

PERSONS WITH A DISABILITY WHO NEED A SPECIAL ACCOMMODATION TO PARTICIPATE IN THIS PROCEEDING SHOULD CONTACT THE ADMINISTRATIVE OFFICES, AT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY-EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 268-6110.

THIS NOTICE WILL FURTHER SERVE TO INFORM THE PUBLIC THAT MEMBERS OF THE BOARD OF DIRECTORS OF NORTH BREVARD MEDICAL SUPPORT, INC. MAY BE IN ATTENDANCE AND MAY PARTICIPATE IN DISCUSSIONS OF MATTERS BEFORE THE NORTH BREVARD COUNTY HOSPITAL DISTRICT BOARD OF DIRECTORS FINANCE COMMITTEE. TO THAT EXTENT OF SUCH DISCUSSIONS, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT BOARD OF DIRECTORS FINANCE COMMITTEE AND THE NORTH BREVARD MEDICAL SUPPORT, INC. SHALL BE CONDUCTED.

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
FINANCE COMMITTEE

A regular meeting of the Finance Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on April 4, 2022 in Conference Room 2/3/4/5, First Floor. The following members, representing a quorum, were present:

Herman A. Cole, Jr., Chairperson
Stan Retz, Vice Chairperson
Robert Jordan, Jr., C.M.
Maureen Rupe
Jerry Noffel
Billie Fitzgerald
Billy Specht
Elizabeth Galfo, M.D.
Ashok Shah, M.D.
Christopher Manion, M.D.
Biju Mathews, M.D.
George Mikitarian (non-voting)

Member(s) Absent:
None

A copy of the attendance roster of others present during the meeting is appended to the file copy of these minutes.

CALL TO ORDER

Mr. Cole called the meeting to order at 12:40 p.m.

CITY LIAISON

The Finance Committee recessed at 12:41 p.m. and the Executive Committee convened for the purpose of the report from the City Manager. The Finance Committee resumed at 12:48 p.m.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Jordan seconded by Dr. Shah and approved (11 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED THAT THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS APPROVE THE FEBRUARY 7, 2022 MEETING MINUTES OF THE FINANCE COMMITTEE, AS PRESENTED.**

FINANCIAL REVIEW

Mr. Bacon summarized the February 2022 financial statements of the North Brevard County Hospital District and year to date financial performance of the Health System.

Mr. Mikitarian shared that Administration is working towards short-term and long-term solutions to address the labor shortage that is affecting the economy in general and healthcare systems in particular.

CAPITAL PURCHASE -- PASTEURIZER

Discussion ensued and the following motion was made by Mr. Noffel seconded by Mr. Jordan and approved (11 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED THE FINANCE COMMITTEE APPROVE THE PURCHASE OF A PASTEURIZER AT A TOTAL COST OF $48,891.**

DISPOSAL OF SURPLUS PROPERTY

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Ms. Fitzgerald and approved (11 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO RECOMMEND TO THE BOARD OF DIRECTORS DECLARE THE EQUIPMENT LISTED IN THE REQUEST FOR DISPOSAL OF OBSOLETE OR SURPLUS PROPERTY FORMS AS SURPLUS AND OBSOLETE AND DISPOSE OF SAME IN ACCORDANCE WITH FS274.04 AND FS274.96.**

OTHER

Mr. Noffel inquired about the purchase of a CT Scanning machine. Mr. Mikitarian noted he will provide a list of Radiology equipment marked for future purchase at the next committee meeting.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 1:14 p.m.

Herman A. Cole, Jr.
Chairman

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA

Request for Disposal of Obsolete or Surplus Property

The assets listed below are considered obsolete, inefficient, or have ceased to serve any useful function. Board approval for disposal is required.

Asset Description	Asset Control KN #	Purchase Date	Purchase Price	CE #	Reason for Disposal	Net Book Value (proviced by Finance Dept)
Golf Cart	VIN #	2013	2755.00		No longer	-0-
	FLA64422/AB13657b				Serviceable	Not in the Fixed Asset system

TOTAL BOOK VALUE $0.00

Requesting Department: Plant Engineering

Net Book Value (Finance): [illegible] Finance 12/7/21

Sr. VP Finance/CFO

Board Approved (CFO Signature)

Requestor Notified Finance

Asset Disposed of or Donated

Removed from Asset List (Finance)

Requested Public Entity for Donation

Entity Contact

Telephone

Department Director: [signature] 12.7.21

EMC Member: [signature]

President/CEO: [signature] 5/24/22

[signature] 5/25/2022

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA

Request for Disposal of Obsolete or Surplus Property

The assets listed below are considered obsolete, inefficient, or have ceased to serve any useful function. Board approval for disposal is requested.

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
Infant scale, Acme medical	KN015094	12/23/1987	925.00	PMC02410	Unit is not functional, obsolete and no longer supported.		1.333 Womens ctr / L&D

Requesting Department - Nursery — Department Director manager / M Hodges RN / [signature] 3-16-22 3/16/22

Net Book Value (Finance) _____ — EMC Member [signature]

Sr. VP Finance/CFO _____ — President/CEO _____

Board Approval: (Date) _____ — CFO Signature [signature] 5/24/22

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

[signature] 5/25/2022

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA

Request for Disposal of Obsolete or Surplus Property

The assets listed below are considered obsolete, inefficient, or have ceased to serve any useful function. Board approval for disposal is requested.

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
Schaerer OR table	KN021716	11/8/2001	46,570.26	PMC02581	Unit is obsolete and no longer supported. Removed from service.	-0-	1.351 OR

Requesting Department - OR -351 Department Director [signature] 4/28/22

Net Book Value (Finance) [signature] 5/4/22 EMC Member [signature] 5.3.22

Sr. VP Finance/CFO _____ President/CEO _____

Board Approval: (Date) _____ CFO Signature [signature] 5/24/22

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

[signature] 5/25/2022

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN021716
THRU ASSET NUMBER: KN021716

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
CLASS: MEQ-HOSP MOVEABLE EQUIP - HOSPITAL

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
DEPARTMENT: 1.351 1 O R								
KN021716	SURGICAL TABLE - MIDMARK MOD 7300		ACTIVE	12/17/01	11/06/01		46570.26	0.00
							46570.26	0.00
						TOTAL FOR CLASS:	46570.26	0.00

BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA

Request for Disposal of Obsolete or Surplus Property

The assets listed below are considered obsolete, inefficient, or have ceased to serve any useful function. Board approval for disposal is requested.

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
ICU Blanket warmer	KN028568	1/26/2006	2031.56	PMC00276	Unit is obsolete and no longer supported. Removed from service.	-0-	1.342 ICU

Requesting Department - ICU _____ Department Director Matthew F Gaylord 9/27/22

Net Book Value (Finance) A. Travis 5/4/22 _____ EMC Member _____ 5.3.22

Sr. VP Finance/CFO _____ President/CEO _____

Board Approval: (Date) _____ CFO Signature _____ 5/24/22

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

5/24/2022

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN028568
THRU ASSET NUMBER: KN028568

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
CLASS: MEQ-HOSP MOVEABLE EQUIP - HOSPITAL

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
DEPARTMENT: 1.342	1 ICU 2ND							
KN028568	BLANKET WARMER (CE#03207)		ACTIVE	02/10/06	01/31/06		2031.56	0.00
							2031.56	0.00
						TOTAL FOR CLASS:	2031.56	0.00

Healing Families – Healing Communities®

parrishmed.com

Finance Committee

FYTD April 30, 2022 – Performance Dashboard

Indicator	FYTD 2022 Actual	FYTD 2022 Budget	FYTD 2021 Actual
IP Admissions	2,860	3,167	3,114
LOS	5.6	4.3	5.2
Surgical Procedures	3,005	3,267	3,063
ED Visits	16,861	18,584	17,986
OP Volumes	29,500	32,455	31,266
Hospital Margin %	3.61%	8.88%	11.35%
Investment Income $	-$5.4 Million	$2.7 Million	$12.2 Million
EBIDA Margin %	-8.88%	5.97%	17.23%
EBIDA Margin %- Excluding Invest Income	-2.33%	3.14%	5.84%

EXECUTIVE COMMITTEE
Stan Retz, CPA, Chairman
Robert L. Jordan, Jr., C.M.
Herman A. Cole, Jr.
Elizabeth Galfo, M.D.
Maureen Rupe
George Mikitarian, President/CEO (non-voting)

DRAFT AGENDA
EXECUTIVE COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, JUNE 6, 2022
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5
IMMEDIATELY FOLLOWING FINANCE COMMITTEE

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the April 4, 2022 meeting.

II. Reading of the Huddle

III. Attorney Report – Mr. Boyles

IV. Other

V. Executive Session (to approve minutes)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE BOARD WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING, HE/SHE WILL NEED A RECORD OF PROCEEDINGS AND, FOR SUCH PURPOSES, MAY NEED TO ENSURE A VERBATIM RECORD OF THE PROCEEDINGS IS MADE AND THAT THE RECORD INCLUDES TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

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NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EXECUTIVE COMMITTEE

A regular meeting of the Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on April 4, 2022 in Conference Room 2/3/4/5, First Floor. The following members were present:

Stan Retz, CPA, Chairman
Robert L. Jordan, Jr., C.M., Vice Chairman
Herman A. Cole, Jr.
Maureen Rupe
Elizabeth Galfo, M.D.
George Mikitarian (non-voting)

Members Absent:
None

A copy of the attendance roster of others present during the meeting is appended to the file copy of these minutes.

CALL TO ORDER

Mr. Retz called the meeting to order at 12:41 p.m.

CITY LIAISON

The Finance Committee suspended its agenda and the Executive Committee convened at 12:41 p.m. for the purpose of the report from the City Manager, Mr. Scott Larese. Mr. Larese distributed the FY2021 Annual Report for the city of Titusville and also addressed members questions. The Executive Committee recessed at 12:48 p.m. to resume the Finance Committee.

REVIEW AND APPROVAL OF MINUTES

The Executive Committee reconvened at 1:14 p.m. Discussion ensued and the following motion was made by Mr. Jordan, seconded by Dr. Galfo and approved (5 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED TO APPROVE THE FEBRUARY 7, 2022 MEETING MINUTES OF THE EXECUTIVE COMMITTEE OF THE BOARD, AS PRESENTED.**

READING OF THE HUDDLE

Dr. Galfo read the Weekly Huddle.

PHYSICIAN MANPOWER PLAN

Mr. Jim Lifton, Lifton & Associates, addressed the committee regarding the Draft Physician Manpower Plan. He noted he recently engaged in physician interviews to update the plan. Discussion ensued regarding the Physician Manpower Plan, improving infrastructure and growth, as well as opportunities and challenges facing the Hospital in recruiting physicians to fulfill the needs of the community and service area.

ATTORNEY REPORT

Mr. Boyles informed the committee he will be sending out the CEO evaluation forms this month, and will review the results at the next meeting.

OTHER

There was no other business to discuss.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 2:02 p.m.

Stan Retz, CPA
Chairman

EDUCATION COMMITTEE
Billie Fitzgerald, Chairperson
Maureen Rupe, Vice Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Ashok Shah
Biju Mathews, M.D.
George Mikitarian, President/CEO (Non-voting)

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE
MONDAY, JUNE 6, 2022
IMMEDIATELY FOLLOWING EXECUTIVE SESSION
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Space Coast Health Centers, Inc. Update – Mr. Lewis

II. Other

IV. Executive Session (if necessary)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE EDUCATION COMMITTEE WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING, HE/SHE WILL NEED A RECORD OF PROCEEDINGS AND, FOR SUCH PURPOSES, MAY NEED TO ENSURE A VERBATIM RECORD OF THE PROCEEDINGS IS MADE AND THAT THE RECORD INCLUDES TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

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THIS NOTICE WILL FURTHER SERVE TO INFORM THE PUBLIC THAT MEMBERS OF THE BOARD OF DIRECTORS OF NORTH BREVARD MEDICAL SUPPORT, INC. MAY BE IN ATTENDANCE AND MAY PARTICIPATE IN DISCUSSIONS OF MATTERS BEFORE THE NORTH BREVARD COUNTY HOSPITAL DISTRICT BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE. TO THE EXTENT OF SUCH DISCUSSION, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT, BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE AND NORTH BREVARD MEDICAL SUUPORT, INC. SHALL BE CONDUCTED.

SPACE COAST HEALTH CENTERS INC.

A Florida not-for-profit corporation

Unconditional Care for Everyone

spacecoasthealthcenters.org

Space Coast Health Centers

We live our mission daily and focus on connecting, coordinating, and ensuring patient access

Unconditional Care for Everyone

Space Coast Health Centers

- Primary Care
- Behavioral Care
- OB/GYN Care
- Dental Care
- 836 Century Medical Drive, Titusville
- 5005 Port St John Parkway, Port St John

Space Coast Health Centers

Medical Staff

- Zackary Besner, MD - Internal Medicine/CMO
- Jason Wieseler, Psy.D - Clinical Psychologist
- Renee Soucier, MD - Family Practice
- Johanna Pillado, APRN – Family Practice
- Vidya Hate, MD - OB/GYN (part-time)

Operations Update

- First patients seen - 2/22/21
- Port St John location opened - 3/29/21
- FQHC Look-Alike Application June 2021
- FQHC Look-Alike Survey January 2022
- FQHC Look-Alike approval June 2022

Why and FQHC Look-Alike

- The FQHC Look-Alike status brings us three main improvements

- Enhanced Medicare and Medicaid Reimbursement
- Access to 340B Medication pricing for patients of SCHC
- Easier Access to other Grant Programs to bring additional services to North Brevard County

Community Partners

Focus Organizations

Under the Bridge Ministries (provides food, fellowship, and supplies to the homeless)

North Brevard Charities Sharing Center (provides emergency and long-term housing, supplies, and food)

Life Recaptured (provides housing, support, and training to women impacted by sex trafficking)

Community Partners

Care Partners

Circles Of Care (crisis stabilization, inpatient behavioral, and substance abuse treatment)

Curative Care Centers (STD testing, HIV treatment, and Hepatitus C treatment)

Brevard County Health Department (dental care and immunizations)

Parrish Health Network and Parrish Medical Center

Community Partners

Care Partners

Walkabout Recovery (eight month residential treatment program for Men and will begin the Women's program soon)

DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
JUNE 6, 2022
NO EARLIER THAN 2:00 P.M.,
FOLLOWING THE LAST COMMITTEE MEETING
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Pledge of Allegiance

II. PMC's Vision – *Healing Families – Healing Communities*

III. Approval of Agenda

IV. Review and Approval of Minutes (April 4, 2022 Regular Meeting)

V. Recognitions(s)

VI. Open Forum for PMC Physicians

VII. Public Input and Comments***[1]

VIII. Unfinished Business***

IX. New Business***

A. **North Brevard Medical Support, Inc, Liaison Report –Mr. Retz**

B. **Motion to recommend the Board of Directors approve the Quality Improvement Performance Plan policy, as presented.**

X. Medical Staff Report Recommendations/Announcements

XI. Public Comments (as needed for revised Consent Agenda)

XII. Consent Agenda***

A. Finance
   1. Motion to recommend the Board of Directors approve the Moore Stephens Lovelace Engagement Letter for the FY22 as presented.

2. Motion to recommend to the Board of Directors to declare the equipment listed in the requests for Disposal of Obsolete or Surplus Property Forms as surplus and obsolete and dispose of same in accordance with FS274.05 and FS274.96.

. ***1 Pursuant to PMC Policy 9500-154:

- non-agenda items – 3 minutes per citizen
- agenda items for board action -- 3 minutes per citizen, permitted prior to board discussion for regular agenda action items and prior to board action on consent agenda
- 10 minute total per citizen
- must be related to the responsibility and authority of the board or directly to an agenda item [see items marked ***]

XIII. Committee Reports

A. Quality Committee

B. Finance Committee

C. Executive Committee

D. Educational, Governmental and Community Relations Committee

E. Planning, Physical Facilities & Properties Committee

XIV. Process and Quality Report – Mr. Mikitarian

A. Other Related Management Issues/Information

B. Hospital Attorney - Mr. Boyles

XVI. Other

XVII. Closing Remarks – Chairman

XVIII. Executive Session (if necessary)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE BOARD WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING, HE/SHE WILL NEED A RECORD OF PROCEEDINGS AND, FOR SUCH PURPOSES, MAY NEED TO ENSURE A VERBATIM RECORD OF THE PROCEEDINGS IS MADE AND THAT THE RECORD INCLUDES TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

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ANY MEMBER OF THE PUBLIC THAT WILLFULLY INTERRUPTS OR DISTURBS A MEETING OF THE BOARD OF DIRECTORS IS SUBJECT TO REMOVAL FROM THE MEETING BY AN OFFICER AND SUCH OTHER ACTIONS AS MAY BE DEEMED APPROPRIATE AS PROVIDED IN SECTION 871.01 OF THE FLORIDA STATUTES.

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
BOARD OF DIRECTORS – REGULAR MEETING

A regular meeting of the Board of Directors of the North Brevard County Hospital District operating Parrish Medical Center (the District) was held at 2:40 p.m. on April 4, 2022 in Conference Room 2/3/4/5, First Floor. The following members were present:

Robert L. Jordan, Jr., C.M., Chairman
Stan Retz, Vice Chairman
Herman A. Cole, Jr.
Billy Specht
Elizabeth Galfo, M.D.
Billie Fitzgerald
Ashok Shah, M.D.
Jerry Noffel
Maureen Rupe

Member(s) Absent:

None

A copy of the attendance roster of others present during the meeting is appended to the file copy of these minutes.

CALL TO ORDER

Mr. Jordan called the meeting to order at 2:40 p.m.

PLEDGE OF ALLEGIANCE

Mr. Jordan led the Board of Directors, staff and public in reciting the Pledge of Allegiance.

PMC'S VISION – *Healing Families – Healing Communities®*

Mr. Jordan led the Board of Directors, staff and public in reciting PMC's Vision – *Healing Families – Healing Communities®.*

APPROVAL OF MEETING AGENDA

Mr. Jordan requested approval of the meeting agenda in the packet as revised. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (9 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN*: MOVED TO APPROVE THE REVISED MEETING AGENDA OF THE BOARD OF DIRECTORS OF THE DISTRICT AS PRESENTED.**

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Cole, seconded by Dr. Galfo and approved (9 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN:* MOVE TO APPROVE THE MINUTES OF THE FEBRUARY 7, 2022 REGULAR MEETING OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT DBA PARRISH MEDICAL CENTER, AS PRESENTED.**

RECOGNITIONS

There were no recognitions.

OPEN FORUM FOR PMC PHYSICIANS

There were no physician comments.

PUBLIC COMMENTS

There were no public comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Environment of Care Annual Review

Discussion ensued and the following motion was made by Mr. Cole, seconded by Dr. Galfo, and approved (9 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN:* MOTION TO RECOMMEND THE BOARD OF DIRECTORS APPROVE THE ANNUAL ENVIRONMENT OF CARE REPORT AS PRESENTED.**

CONSENT AGENDA

Discussion ensued regarding the consent agenda, and the following motion was made by Mr. Cole, seconded by Mr. Retz and approved (9 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN*: MOTION TO APPROVE THE FOLLOWING REVISED CONSENT AGENDA ITEMS:**

Consent Agenda

A. Finance

1. Motion to recommend the Board of Directors approve the purchase of a pasteurizer at a total cost of $48,891.

2. Motion to recommend to the Board of Directors to declare the equipment listed in the request for Disposal of Obsolete or Surplus Property Forms as surplus and obsolete and dispose of same in accordance with FS274.05 and FS274.96.

COMMITTEE REPORTS

Quality Committee

Dr. Galfo reported all items were covered during the Quality Committee meeting.

Finance Committee

Mr. Cole reported all items were covered during the Finance Committee meeting.

Executive Committee

Mr. Retz reported all items were covered during the Executive Committee meeting.

Educational, Governmental and Community Relations Committee

Mr. Jordan reported the Education Committee did not meet.

Planning, Physical Facilities and Properties Committee

Mr. Jordan reported the Planning Physical Facilities and Properties Committee did not meet.

PROCESS AND QUALITY REPORT

Mr. Mikitarian took this time to recognize Mr. Anual Jackson for his 10-year anniversary with Parrish Medical Center.

Hospital Attorney

Legal counsel had no report.

OTHER

There was no other business.

CLOSING REMARKS

There were no closing remarks.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 2:44 p.m.

Robert L. Jordan, Jr., C.M.
Chairman

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING PARRISH MEDICAL CENTER
MEDICAL EXECUTIVE COMMITTEE MEETING – REGULAR SESSION MINUTES
May 17, 2022

Present: J. Rojas, MD, M. Navas, MD, K. Patel, MD, I. Rashid, MD, R. Rivera-Morales, MD, C. Manion, MD, C. Jacobs, MD, R. Patel, MD, H. Cole, D. Barimo, MD, A. Ochoa, MD, P. Carmona, MD, C. Fernandez, MD, G. Cuculino, MD, E. Loftin, R. Patel, MD

Absent: B. Mathews, MD, C. McAlpine, G. Mikitarian,

The meeting of the Medical Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was called to order on May 17, 2022 at 5:30 pm in the Conference Center. A quorum was determined to be present.

CALL TO ORDER.

Dr. R. Patel, MD, President, called the meeting to order at 5:32pm.

I. REVIEW AND APPROVAL OF MINUTES

The following motion was made by Dr. Manion, seconded by Dr. Navas, and unanimously approved.

ACTION TAKEN: Motion to approve the Regular Session minutes of April 19, 2022 as written and distributed. ***Motion was made by Dr. Manion, seconded by Dr. Navas, and unanimously approved.***

II. OLD BUSINESS: Return to Autopsy Procedures and Criteria – March 2022

ACTION TAKEN: ***Motion to approve the policy (PolicyStat ID 11043851) as written was made by Dr. Manion, seconded by Dr. Cuculino and unanimously approved.***

III. FOLLOW UP MEC BUSINESS: None

IV. NEW BUSINESS:
Meditech 6.08 Enhancements May 18, 2022
Post Extubation Dysphagia Tool Reflex Order (attached)

Noted for the minutes.

V. Policies for Review: None

VI. Consent Agenda: Infants Born to HIV Positive Mothers (E3652ab) – New Order Set

Motion to approve the Order Set as written and distributed was made by Dr. Manion, seconded by Dr. Cuculino and unanimously approved.

VII. Report from Administration: - None

VIII. Report from the Board – None

The Minutes from the Quality Committee Regular session, March 7, 2022 and the Full Board, Regular session, were entered into the minutes as written.

IX. Committee Reports:

Credentialing & Medical Ethics Committee (Regular Session, May 9, 2022) were entered into the Minutes as written.

X. Open Forum: Dr. Cuculino thanked everyone for their patience and understanding as the ED works to address the wait times, and HOLDS having recently surged.

Dr. Carmona requested (as last year) a $1,000 contribution to the Brevard County Medical Society. ***The request was unanimously granted.***

Adjournment: There being no further business, the meeting adjourned at 5:40pm.

NEXT MEETING June 21, 2022 CR 2/4.

_____ _____

Biju Mathews, MD
President Medical Staff

Christopher Manion, MD
Secretary/Treasurer

Origination:	*01/1996*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*01/2021*
Next Review:	*1 year after approval*
Areas:	*Administration*
Tags:	*9500, TJC*
Applicability:	*Parrish Healthcare System-Wide*

Quality Improvement Performance Plan

I. PURPOSE

The Quality Improvement Performance Plan (QIPP) provides the framework for an integrated system to improve quality, safety, and resource utilization. The Plan is a comprehensive strategy to provide and ensure the best delivery of care for the individual, as well as the community, throughout the continuum of care. The integrated system is composed of a 210 bed hospital and outpatient facilities.

The Parrish Healthcare (PHC) Board of Directors has ultimate authority of the QIPP, with input and operations by PHC administration, medical staff, care partners, and affiliate members. The QIPP supports integration of financial and clinical data and seeks to improve quality of care by decreasing silos and addressing safe, effective, timely, efficient, equitable care that is patient-centered.

By the direction of the Board of Directors through the strategic initiatives, the game plan, and the support and involvement of the management, medical staff, and care partners, a culture exists based upon the principles of collaboration and mutual respect. This culture supports innovation, data management, performance improvement, and commitment to satisfaction and patient safety.

Consistent with our mission of healing experiences for everyone all the time, our goal is to provide care that is:

A. **Safe** – avoiding injuries to patients from the care that is intended to help them;

B. **Timely** – reducing wait time and potentially harmful delays;

C. **Effective** – providing services based on scientific knowledge to those who would benefit, and refrain from providing services to those not likely to benefit;

D. **Efficient** – avoiding waste, including waste of equipment, supplies, ideas and energy; and

E. **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status.

F. **Patient Centered** – providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions

II. DEFINITIONS

A. **Care Partner** Is an inclusive term referring to Parrish Healthcare Care Partners, medical staff members, auxiliary members, and Board of Directors members, as well as any person working for or on behalf of Parrish Healthcare, including but not limited to temporary personnel, consultants, vendors, and

independent contractors, regardless of position.

B. **Parrish Healthcare** is an inclusive term referring to North Brevard County Hospital District d/b/a Parrish Medical Center and its affiliates and North Brevard Medical Support, Inc. d/b/a Parrish Medical Group and its affiliates.

III. GOALS AND OBJECTIVES

A. To develop, maintain quality improvement resources, structures, and processes that support the integrated systems commitment to quality care across the continuum.

B. To improve quality of care across the continuum by decreasing silos, both internal and external.

C. To achieve systems-wide quality improvement goals and objectives through effective interdepartmental and affiliate communication. (See Attachment "B")

D. To collaborate with affiliates to develop and structure quality programs that result in better coordination of care.

E. To coordinate, report, and monitor quality improvement activities within an integrated system.

IV. HOSPITAL GOALS AND KEY MEASURES AND INITIATIVES

Attachment "A" Game Plan and "B" Organizational Chart

Hospital goals and initiatives fall within five pillars:

A. EDUCATE

B. ASSESS

C. UNDERSTAND

D. CARE

E. MAINTAIN

With PHC and its affiliates providing systems integration, the goals and initiatives are aligned with PHC's mission, vision, and values. They are reviewed and revised annually by senior leadership and the Board of Directors to determine whether we have attained the goals for the year. Where PHC does not attain a goal for the year, a corrective action plan is developed, implemented and monitored. The Game Plan is located on ICare.

V. QUALITY IMPROVEMENT PROCESS AND METHODOLOGY

The quality improvement methodology used is the Lean/Six Sigma methodology for process improvement (Attachment "C").

LEAN SIX SIGMA / DMAIC PROCESS

A. DEFINE the problem and set the goal; focus not simply on the outcomes, but on the process. Write a problem statement. Develop a charter; identify who is the customer and what are their requirements. Map the process as it occurs now, to identify areas for improvement. Identify the benefits of making

improvements.

B. MEASURE the defects or process operation. Develop a tool to collect the necessary data. Look to existing sources that you may already be collecting to help measure the problem.

C. ANALYZE the data and discover the causes of the problem. Use brainstorming techniques, bar graphs, etc., to help analyze. Identify the process that needs improving (identify the root cause).

D. IMPROVE the process to remove causes of defects. Test solutions on a small scale to see if they work. If it doesn't work, try another process.

E. CONTROL the process to make sure defects don't occur. Establish standard measures to maintain performance.

VI. AUTHORITY AND ACCOUNTABILITY

The Board of Directors of PhC bears the ultimate responsibility for assuring the quality, safety, and effectiveness of patient care services provided by Medical Staff and other healthcare professional and support staff[1]. The organization's leaders set expectations, develop plans, and implement procedures to assess and improve the quality of the organization's governance, management, clinical and support processes[2]. The Board of Directors shall hold the Medical Staff leadership and Hospital Administration responsible for implementing PI efforts[3]. By way of the Board Quality Committee the Board of Directors will review periodic reports of findings, actions and results from PI activities in order to assess the programs efficiency and effectiveness.

A. Through the development of strategic initiatives, the Board provides direction for the organization's improvement activities. Monthly Game Plan reports provide the Board with a means of evaluating the organization's effectiveness in improving quality and safety, as well as reports from chartered Process Improvement Teams (PITs), and Disease Specific Teams (DSTs).

B. Administration is responsible for implementation of the performance improvement activities of the organization. In order to support these activities, they will provide adequate numbers of human, informational, physical, and financial resources. Staff members will be given sufficient time to participate in PI and safety improvement activities and an adequate number of staff will be assigned to ensure timely progress of the activities. Administration will ensure that needed information and technical support is provided to support the improvement of processes.

C. The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

D. Department leadership is responsible for: education of staff; fostering an environment of collaboration; and assuring involvement of their department in PI activities, both within their department and in the organization-wide program.

   Leaders establish performance and safety improvement activities in conjunction with other departments. Performance improvement activities that do not require a large cross-functional team are the responsibility of the leaders of departments involved in the improvement effort.

E. All care partners are responsible for active involvement in both organization-wide and department/service PI activities. Any care partner may make a suggestion for a process improvement team including risk reduction and suggestions for improving patient safety by contacting the Quality Resource Management (QRM) Department, any member of the Executive Leadership Team, or a member of the Clinical Alignment Team.

F. A member of the Executive Leadership Team along with the Quality Resource Management Department (QRM) will serve as central coordination bodies for process improvement processes for the Clinical Alignment Team, Medical Staff Review Committee (MSRC), DSTs, and all hospital departments.

QRM is responsible for coordinating the gathering of data throughout the integrated health network, network Quality Improvement Performance Plan and analyzing the data for patterns and trends. This data includes but is not limited to patient satisfaction, safety finding, clinical process, and clinical outcomes, etc. The QRM Department reports identified patterns and trends that may require a performance/process improvement initiative to the affected departments and the Clinical Alignment Team. Organizational relationships can be found on ICare.

The QRM Department distributes sentinel event alert information house-wide via any of the following methods: e-mail broadcast for all senior and middle management staff; written summary of information for medical staff and members of the Board of Directors. Action on sentinel event alerts will be taken by the effected departments, but the Clinical Alignment Team has ultimate accountability for oversight of the process.

G. The Six Sigma Governance Council (SSGC) provides routine review of the selection, implementation, project management, and sustainability of all process improvement initiatives using six sigma principles and methodology (refer to Six Sigma Governance Council Structure Policy).

H. Process Improvement initiatives and action plans are approved by the SSGC, Executive Management Committee. They are cross-functional, involve the full continuum of care and multidisciplinary in nature. PI initiatives are facilitated by Six Sigma Black Belts or Green Belts whenever possible. Facilitators use a variety of tools to assist them in reaching the team's goals. Teams will be prioritized based on the strategic goals of the organization, with regard to high risk, high volume, problem prone areas, and urgency. Where ultimate approval of goals is established, PI initiative facilitators report their findings and recommendations to the SSGC or Executive Leadership Team.

I. At a minimum, every 18 months, one high-risk process will be selected for proactive (FMEA) risk assessment. The National Patient Safety Goals, FMEA results, annual updates will be presented to the Clinical Alignment Team. Current National Patient Safety Goals are located on ICare.

Footnote:

1. 42 CFR §482.21 Conditions of participation: Quality assessment and performance improvement program

2. LD 01.03.01: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

3. LD 01.05.01: The hospital has an organized medical staff that is accountable to the governing body.

VII. SCOPE AND ORGANIZATION

A. Responsibilities:

Delegated by the Board of Directors the SSGC is responsible for guidance and ongoing evaluation of quality and safety process improvement committees and/or teams to ensure that their efforts are coordinated and collaborated in accordance with the QIPP plan. It will provide a multi- disciplinary approach to review and prioritize PI activities, evaluating which processes have the greatest impact on patient care, the organization's ability to achieve its mission, and to assure optimal utilization of resources

and time. It also has oversight responsibility for review of systems designed to measure and evaluate the quality and safety of patient care functions, processes, and outcomes.

PI initiatives evaluate care that is safe, effective, person centered, timely and equitable.

B. Category of Activities:

1. Ongoing PI Activities:
   The guidance and monitoring for organizational performance improvement activities is provided by the Executive Leadership Team. The Executive Leadership Team is responsible for oversight of PI, including, but not limited to setting organizational-wide improvement activities to support the organizational goals, monitoring the Process Improvement Teams (PITs), working with education to address PI educational needs, and setting annual plans for PI education. The Executive Leadership Team takes direction from the Board of Directors for strategic plans, goals and objectives for overall organizational improvements, giving priority to those processes that affect a large percentage of patients, place patients at risk, and/or are problem prone, or have patient safety issues.

   Because PHC is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to identified needs from data analysis, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant needs of patients and/or staff, changes in the environment of care, or changes in the community.

2. Clinical Process/Performance Improvement Activities/Medical Staff
   a. The Medical Staff Review Committee (MSRC) provides oversight review and guidance for those individuals with clinical privileges related to clinical process improvement and peer review activities. Their goals are to improve medical care and performance through continued measurement, assessment and improvement of patient care outcomes and processes that are dependent primarily on individuals with clinical privileges; meet the requirements of governmental agencies and hospital accreditation organizations; and, to provide documentation regarding individual practitioner's experience in treatment and performance of procedures to the Medical Staff credentialing process. The Medical Staff Review Committee compositions as well as duties are delineated in the Medical Staff Department section of the Medical Staff Rules and Regulations.
   b. Responsibilities of the MSRC include but are not limited to:
      i. Review of graphical trends of monitoring indicators for operative and other invasive procedures, (e.g., complications, unexpected returns to the O.R., and pre-op/post-op diagnosis conflicts, blood utilization, etc.).
      ii. Case review for trends. Data may be stratified in graph format for trend assessment and evaluation.
      iii. Review and oversight coordination of clinical ordersets, protocols and pathway development that meet standards of care. Utilization of these documents may be a measure of medical staff quality.
      iv. Review of CMS/TJC core measure indicator reports. Data from these reports may be used as the basis for focused studies and PI activities.
      v. Reports of performance improvement monitoring of new clinical programs/activities, e.g., oncology, cardiology, Intensivist program, Hospitalist program etc.

vi. Reports of Sentinel Event Root Cause Analysis investigations involving patient care and adverse outcomes.

vii. Variance reports and/or reports of concern by any member of the medical staff

c. Clinical process reviewers are appointed by respective department Chairs in January of each year. There are assigned clinical process reviewers for each medical staff department. Clinical process reviewers are expected to conduct reviews for their departments when contacted by a QRM Department member and are given 30 days in which to perform the reviews. If the clinical process reviewer does not comply, the Chair of the Department will be notified by a QRM Department member. In the event that the Chair is unavailable, the President of the Medical Staff will be contacted. Appropriate corrective actions are taken when reviewers do not comply.

d. Core monitoring indicator criteria is outlined in the Core Monitoring Indicators **(Attachment "E)".** This criteria list is reviewed by the Medical Staff on an annual basis.

e. The review process is outlined in the Main Algorithm Clinical Process review **(Attachment "F")** for the Indicator Type I algorithm, the indicator Type II algorithm, and the Indicator Type III algorithm.

f. The review process uses indicators and criteria established by the Medical Staff and Hospital staff. The indicators and criteria are based on quality and patient safety as well as current standards of care. **(Attachment "G")**

g. Summary information and recommendations from MSRC will be reported to the Medical Executive Committee (MEC). Improvement opportunities are highlighted and may be used for educational purposes.

h. The President of the Medical Staff is a member of MSRC, and coordinates medical staff involvement in the organization's PI activities through appointments, delegation of committee/ team assignments, and support of patient care monitoring.

3. Designing New Processes/PI Activities:
PHC develops new services, policies and/or procedures based on community needs assessment, stratification of patient population and effect to enhance healthcare value. When developing a new process or program, at a minimum, the following steps are taken:

a. An expert or experienced individual within the organization is assigned the responsibility of developing the new process;

b. Key individuals, who will own the process when it is completed, are assigned to a design team led by the expert/experienced individual; and,

c. This design team develops the new process and incorporates information related to the following concepts;

i. It is consistent with PHC's mission, vision, values, strategic initiatives, and game plan.

ii. It meets the needs and expectations of PHC's key customers.

iii. Uses Evidence Based Standards of Care.

iv. It is consistent with sound business practices.

v. Enhances the value of healthcare.

vi. Is guided by safety.

d. To monitor the new process, service quality indicators are identified. These indicators may be

developed internally or selected from an external benchmark. The indicators are selected utilizing the following criteria: it follows our QIPP plan.

C. The Clinical Alignment Team Membership/Composition:

Membership of the Clinical Alignment Team is multi-disciplinary PHC committee to promote a collective and collaborative perspective for identified improvement opportunities for patient care. Membership is comprised of at least the following:

- Medical Staff
- Quality Resource Management Staff
- Department Leadership
- Community Representatives
- Executive Leadership

VIII. DATA COLLECTION

A. To ensure quality, efficacy, effective and safe care to the population served, data is obtained and reviewed from, but not limited to:

- Performance measures required by regulatory agencies, e.g., CMS and TJC
- Risk Management and Patient Safety issues
- Case Management
- Staffing effectiveness
- Quality control
- Patient, family, and staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety
- Staff reports on medical/health care adverse errors
- Outcomes of processes or services
- Autopsy results, when performed
- Performance measure benchmarking
- Customer market share demographics
- Financial data
- Infection control surveillance and reporting
- Data registries
- Patient Family Advisory Council (PFAC)
- The appropriateness and effectiveness of clinical management

B. The organization also collects data to monitor the performance of processes that involve safety risks or may result in a sentinel event. At a minimum, performance measures will be identified for the following processes:

- Medication use
- Operative and other invasive procedures, such as endoscopy, bronchoscopy, and diagnostic imaging

procedures that place patients at risk

- Use of blood and blood components
- Restraint use
- Care or services provided to high-risk populations
- Outcomes related to resuscitation
- Medical complications
- Patient falls
- National Patient Safety Goals
- Tissue

C. Sentinel Event: Refer to Risk Management Program and Plan Policy #9500-8012

The results of the root cause analysis will be reported to the Clinical Alignment Team, Joint Risk Management Committee, MSRC, MEC, and the Board of Directors.

IX. AGGREGATING AND ANALYZING DATA – Essential to DMAIC Process

Through the measure and analyze phases of our DMAIC methodology, statistical tools are used to analyze and display data. These tools consist of, but are not limited to, run charts, histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. These tools are available on iCare.

All improvement teams and activities are data driven and outcome based. The analysis process includes comparing baseline data, benchmark data and trending data within PHC with other comparable organizations with standards and with best practices. Data are reviewed at Six Sigma Governance Council, FMEA, RCA, Clinical Alignment. Timeframes for data collection are defined within each PI action plan. Data management and analysis are essential to effective performance improvement.

X. UNDESIRABLE PATTERNS AND TRENDS

The following events, but not limited to, will automatically result in analysis:

- Confirmed transfusion reactions
- Significant adverse drug reactions
- Significant medication errors
- Falls that result in injuries
- Hazardous conditions that significantly increase the likelihood of a serious adverse outcome

XI. COMMUNICATION PLAN

Results of our five Game Plan goals are reported monthly to the BOD, discussed by department leaders at staff meetings, and available on iCare. Organizational improvement relies on interactive, open communication paths that are freely and continuously used. In order to achieve the exchange of ideas and information required for a continuously improving organization, communication between all committees, teams, and organizational groups responsible for performance improvement is an expectation. Communications include but are not limited to: periodic progress reports of activities, flowcharts and graphs based on assessment activities, changes in direction or philosophy, and guidance for activities.

XII. ANNUAL REAPPRAISAL

Executive Leadership Team reviews the QIPP program on an ongoing basis for continuous quality improvement. The Clinical Alignment Team evaluates the effectiveness of efficient quality and safety initiatives and reports on a summary basis to the Executive Leadership Team, Joint Risk, MSRC, MEC and the Board of Directors.

XIII. CONFIDENTIALITY, IMMUNITY FROM LIABILITY AND INDEMNIFICATION

All activities set forth in this Quality Improvement Performance Plan, including information collected by any medical staff committee, administrative committee, team, or hospital department in order to evaluate the quality of patient care and identified patient safety issues, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure consistent with the PMC confidentiality policies and procedures. Per Florida Statute 395.0197 and the 1986 Quality Improvement Act, no individual reporting, providing information, opinion, counsel or services to a medical or incident review committee or any other medical staff administrative or governing body committee that evaluates quality of care issues, or as a part of the Medical Staff Review Committee program, shall be liable in a suit for damages based on such reporting, providing information, opinion, counsel or services provided that such individual or institution acts in good faith and with reasonable belief that said actions are warranted in connection with or in furtherance of the functions of Parrish Medical Center. The North Brevard County Hospital District dba Parrish Medical Center agrees to indemnify and hold harmless from all claims against any member of the Medical Staff and all other healthcare/ administrative staff for activities, conducted in good faith and without malice, in support of committee participation in working together on opportunities to improve patient care delivery, treatment and outcomes.

XIV. PERFORMANCE/PROCESS IMPROVEMENT EDUCATION

All new Board of Directors and care partners receive education about Parrish Medical Center's QIPP at their initial orientation. Employees receive annual updates on performance improvement along with other required annual training. Members of the Medical Staff receive education in various venues, including: seminars and education programs; department meetings; committee meetings; and during peer review meetings. Executive Leadership Team, Department Leads and other selected staff are receiving formal education in the Six Sigma methodology. Performance and Process Improvement initiatives are facilitated by Black Belts and Green Belts who have completed this formal training.

All revision dates: 01/2021, 11/2017, 03/2014, 09/2011, 07/2008, 11/2007, 07/2007

Attachments

A: Health Care Integration and Coordination
B: Enterprise Quality Relationships Chart
C: DMAIC Process Flow
D: Internal Process Improvement Communication Report of a Variance or Concern
E: Medical Staff Core Monitoring Indicators

F: Algorithms

G: Medical and Hospital Staff Chart Screening Criteria and Indicators

Approval Signatures

Step Description	Approver	Date
Board of Directors	Robert Jordan: Board Member	pending
President/CEO	George Mikitarian: President/CEO [PP]	05/2022
Executive Management Committee	Executive Management Committee [PP]	05/2022
Policy Management	Policy Management [PP]	05/2022
	LeeAnn Cottrell: Executive Director Information Governance	05/2022

Applicability

North Brevard Medical Support, Parrish Medical Center

Sent for re-approval by Leathers, Emily: Quality Manager — 5/18/2022, 3:04PM EDT

Last Approved by Cottrell, Leeann: Executive Director Information Governance — 5/18/2022, 6:27PM EDT

Sent for re-approval by Leathers, Emily: Quality Manager — 5/19/2022, 12:48PM EDT

Replaced Attachment A

Last Approved by Cottrell, Leeann: Executive Director Information Governance — 5/19/2022, 1:08PM EDT

Approve

Last Approved by Policy Management — 5/19/2022, 1:10PM EDT

Approved; no changes

Last Approved by Executive Management Committee — 5/19/2022, 1:27PM EDT

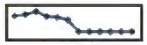
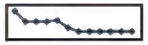
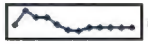
Last Approved by Mikitarian, George: President/CEO — 5/19/2022, 1:29PM EDT

ATTACHMENT "A"

FY20 - Game Plan | Parrish Medical Center Success Pillars

HEALING COMMUNITIES | GROWTH

We will extend the reach of our mission vision and values by achieving and maintaining 10% or less out migration within service area and enhancing access to community health priority areas.

	Goal	YTD	Current Month	Trend Over Time
Cardiology Service Line	<3%		✗	
Ortho Surgery Service Line	<3%		✗	
Oncology Service Line	<3%		✓	

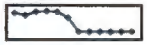
HEALING EXPERIENCES | SERVICE

Our mission is Healing Experiences For Everyone All The Time®. We will achieve and maintain patient experience rankings in the Top 10% nationally.

	Goal	YTD	Current Month	Trend Over Time
Net Promoter Score (HCAHPs)	>85.2			
Overall rating of hospital (HCAHPS)	>83.7		✗	

SYSTEM RELIABILITY | QUALITY & SAFETY

We pledge to be a safe & healing environment. We will achieve and maintain quality indicators in the Top 10% nationally and maintain an "A" patient safety record.

	Goal	YTD	Current Month	Trend Over Time
LeapFrog Safety Score	A		✗	
ALL Cause readmission rate	<8%		✗	
Pt Safety Indicators(PSI-90)	0		✗	

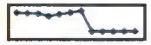
ENGAGED PARTNERS IN CARE | PEOPLE

Our people are inspired by a purposeful mission and aspire to be their best. We will achieve and maintain 100% productivity and retention targets, as well as excellent work environment ratings.

	Goal	YTD	Current Month	Trend Over Time
RN Voluntary Turnover	<15%		✗	
PMC Voluntary Turnover	<15%		✗	
Overall Work Environment Rating	>90%			
PMC Productivity Score	100%		✓	

COMMUNITY INVESTMENT | FINANCE

We will operate with efficiency and effectiveness thru our Lean Six Sigma practices. Achieve and maintain budget targets & fiscal responsibility.

	Goal	YTD	Current Month	Trend Over Time
PMC Budget Score	101%		✗	
Severity Adjusted Length of Stay	4		✗	
OBS % DC	<20%		✗	

✓ Achieving Target

✗ Not Achieving Target

! Watch

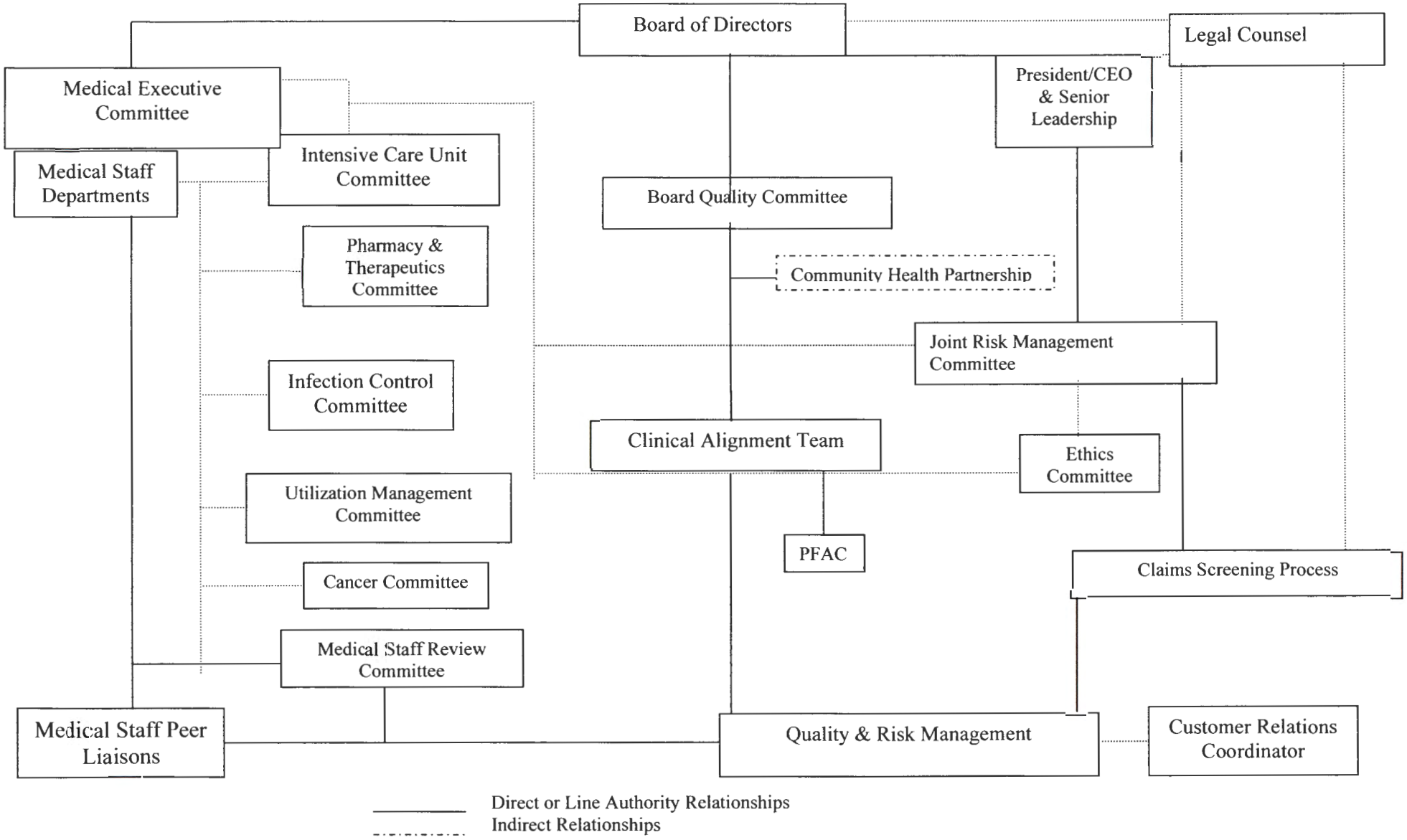
PARRISH HEALTHCARE

parrishhealthcare.com

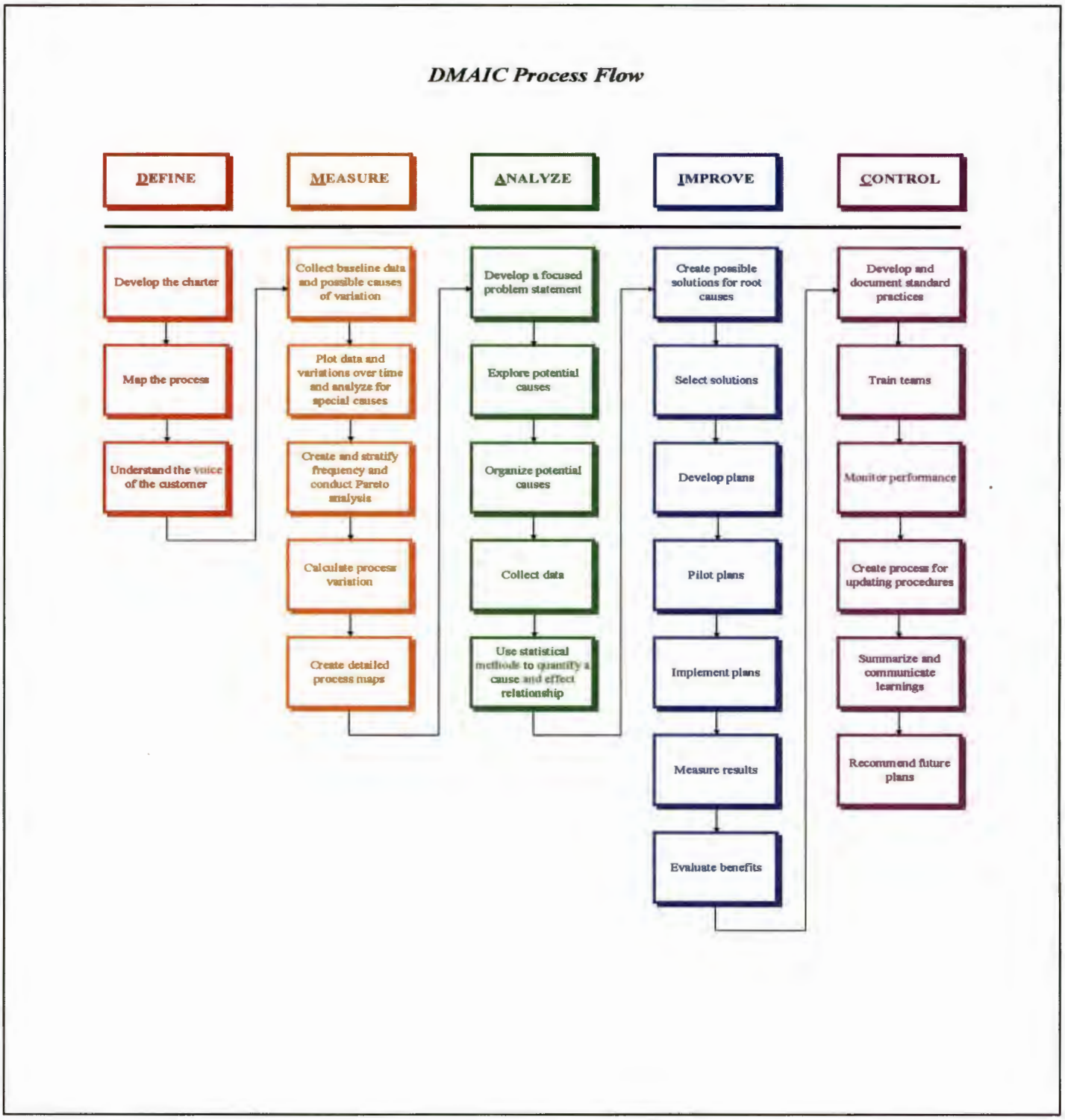
Healing Families-Healing Communities®

ATTACHMENT "B"

ENTERPRISE QUALITY RELATIONSHIPS CHART



ATTACHMENT "C"



ATTACHMENT "D"

Privileged and Confidential

PEER REVIEW WORKSHEET

Date Prepared: _____ Criteria for Review: _____

PT. NAME: _____ DOB: _____ AGE: _____.

MRN: _____ ACCT #: _____

DIAGNOSIS: _____

Date(s) Reviewed: _____

SYNOPSIS OF ISSUE: _____

REVIEWER FINDINGS: _____

SIGNATURE: _____ DEPARTMENT: _____

REVIEWER FINDINGS: _____

SIGNATURE: _____ DEPARTMENT: _____

ATTACHMENT "D"

REVIEWER FINDINGS:_____

SIGNATURE: _____ DEPARTMENT: _____

DATE REVIEW(S) COMPLETE: _____

DATE TO DEPARTMENT: _____ FINDINGS: _____

DATE TO DEPARTMENT: _____ FINDINGS: _____

DATE TO DEPARTMENT: _____ FINDINGS: _____

DATE TO MSRC: _____ FINDINGS: _____

DATE TO MEC: _____ OUTCOME: _____

INVOLVED PARTY RESPONSES ATTACHED SEPARATELY

ATTACHMENT "E"

MEDICAL STAFF
CORE MONITORING INDICATORS

Type I:

- Medical Record Documentation Deficiencies
- Failure to Adhere to Medical Staff Bylaws, Policies, Rules and Regulations
- Disruptive Behavior
- Failure to Respond to Calls
- Issues related to the National Patient Safety Goals
- Issues related to patient care ethics

Type II:

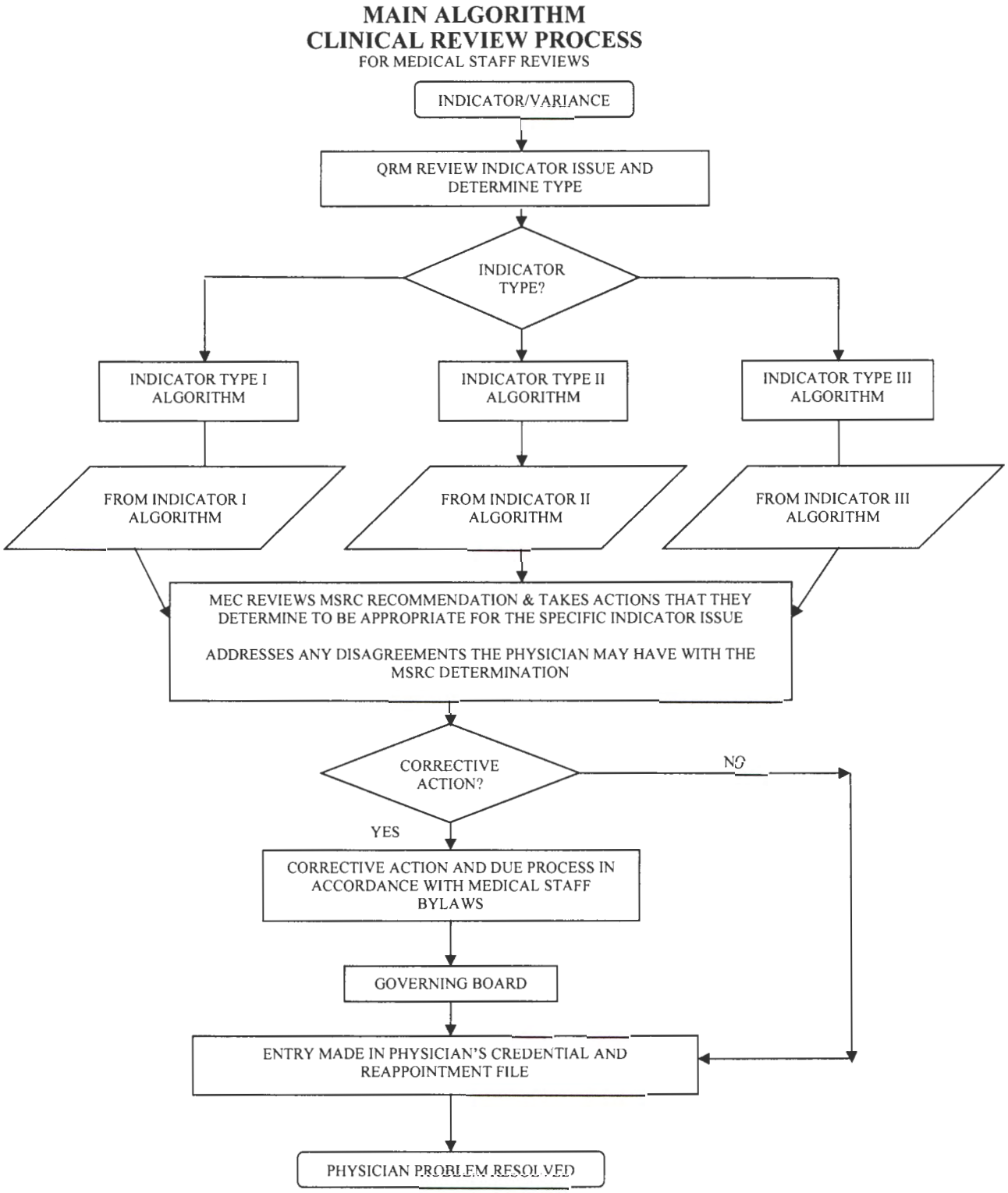
- Unexpected Return to O.R.
- Unexpected Transfer to Tertiary Facility
- Mortalities
- Unexpected Transfer to ICU
- Iatrogenic Injuries
- Transfusion Reaction

Type III:

- Regulatory Quality Indicators
- Cardiac Catheterization Indicators
- Emergency Department Indicators
- Primary Percutaneous Coronary Intervention (PCI) Indicators*
- Cancer Program Indicators
- Joint Commission Core Measures
- Focused Studies
- Blood Transfusions
- Healthcare-acquired Conditions

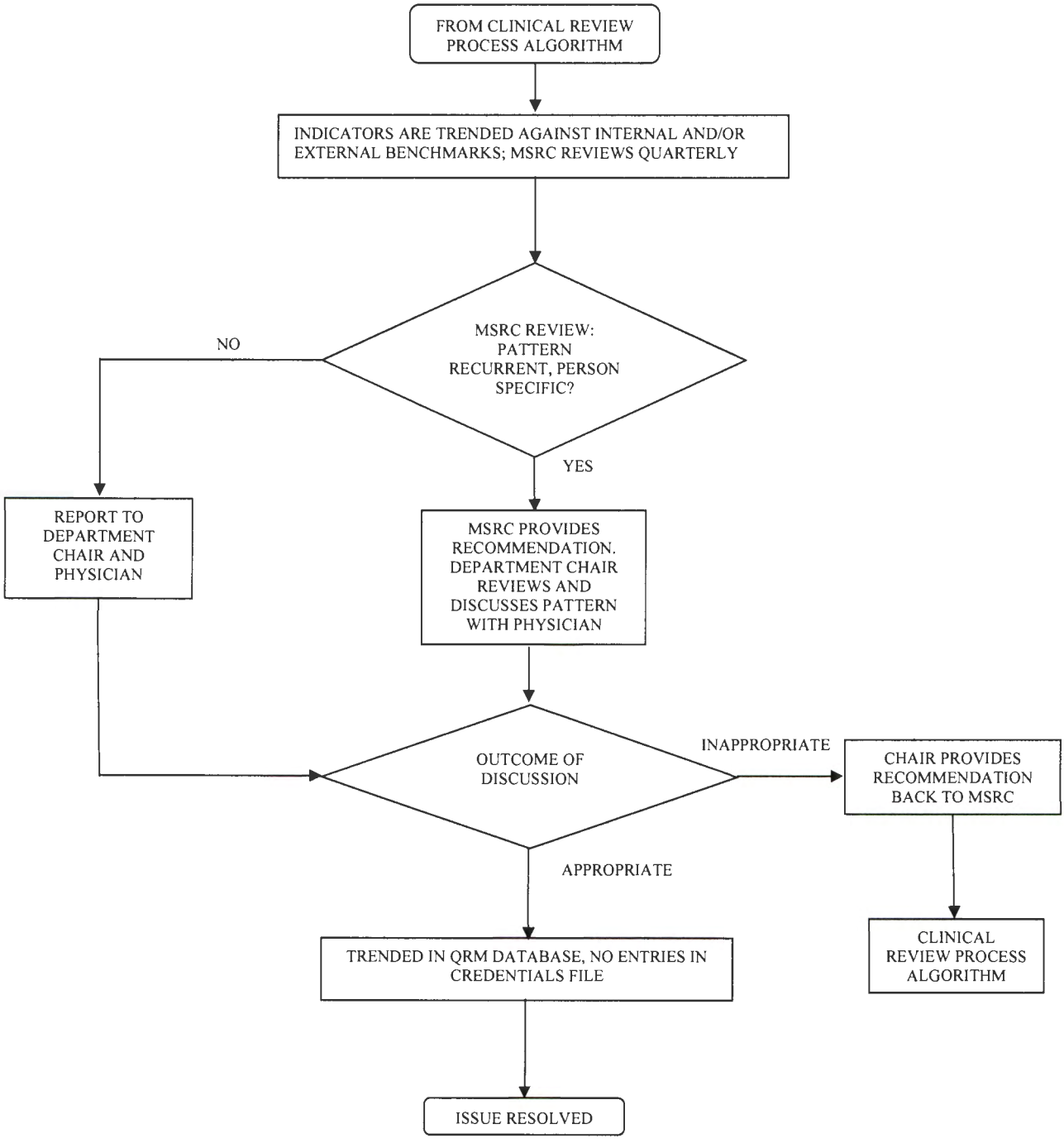
*Refer also to the specific Performance Improvement Flow of Information Diagram for PCI

ATTACHMENT "F" (Page 1 of 5)



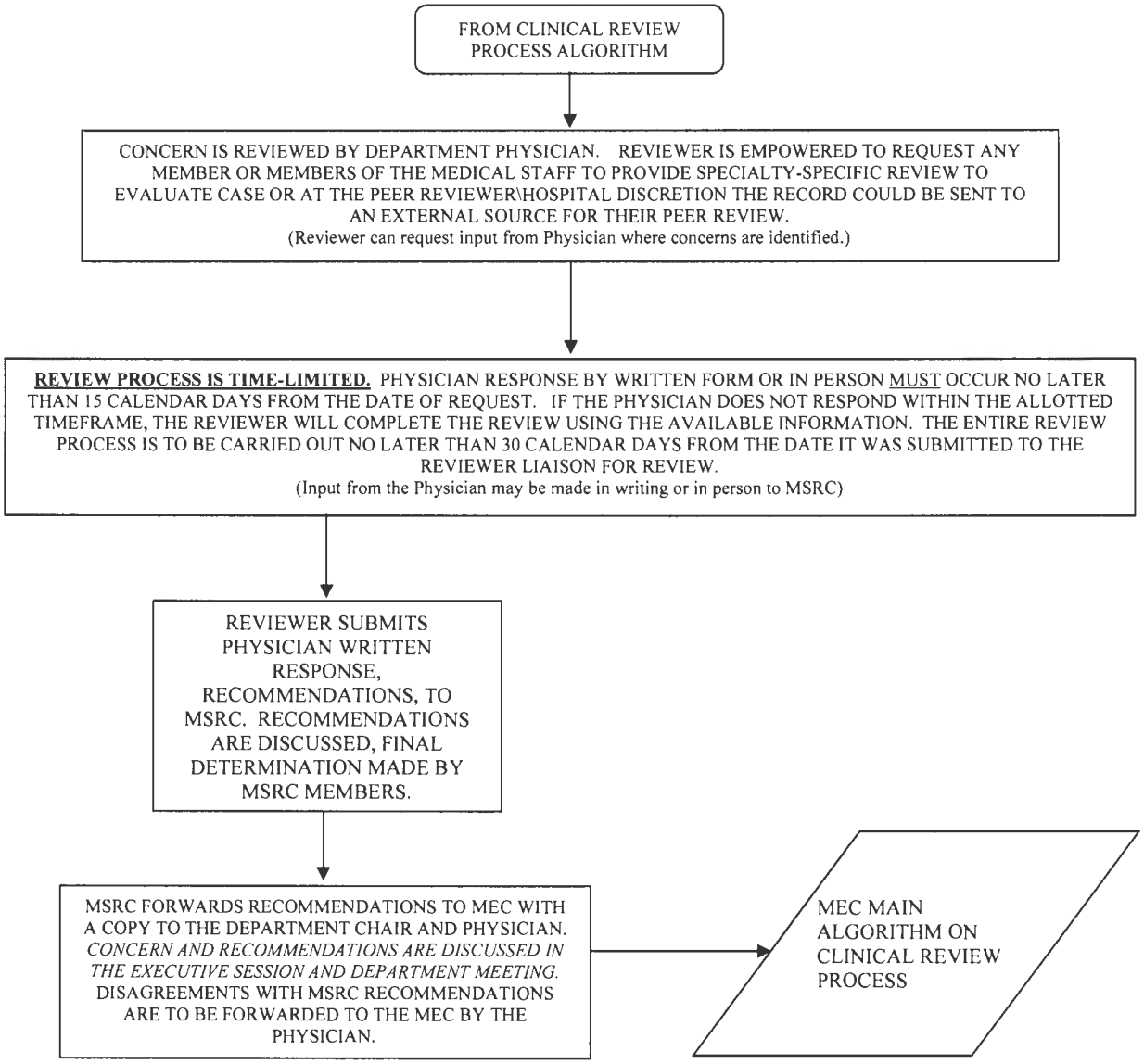
ATTACHMENT "F" (Page 2 of 5)

INDICATOR TYPE I ALGORITHM



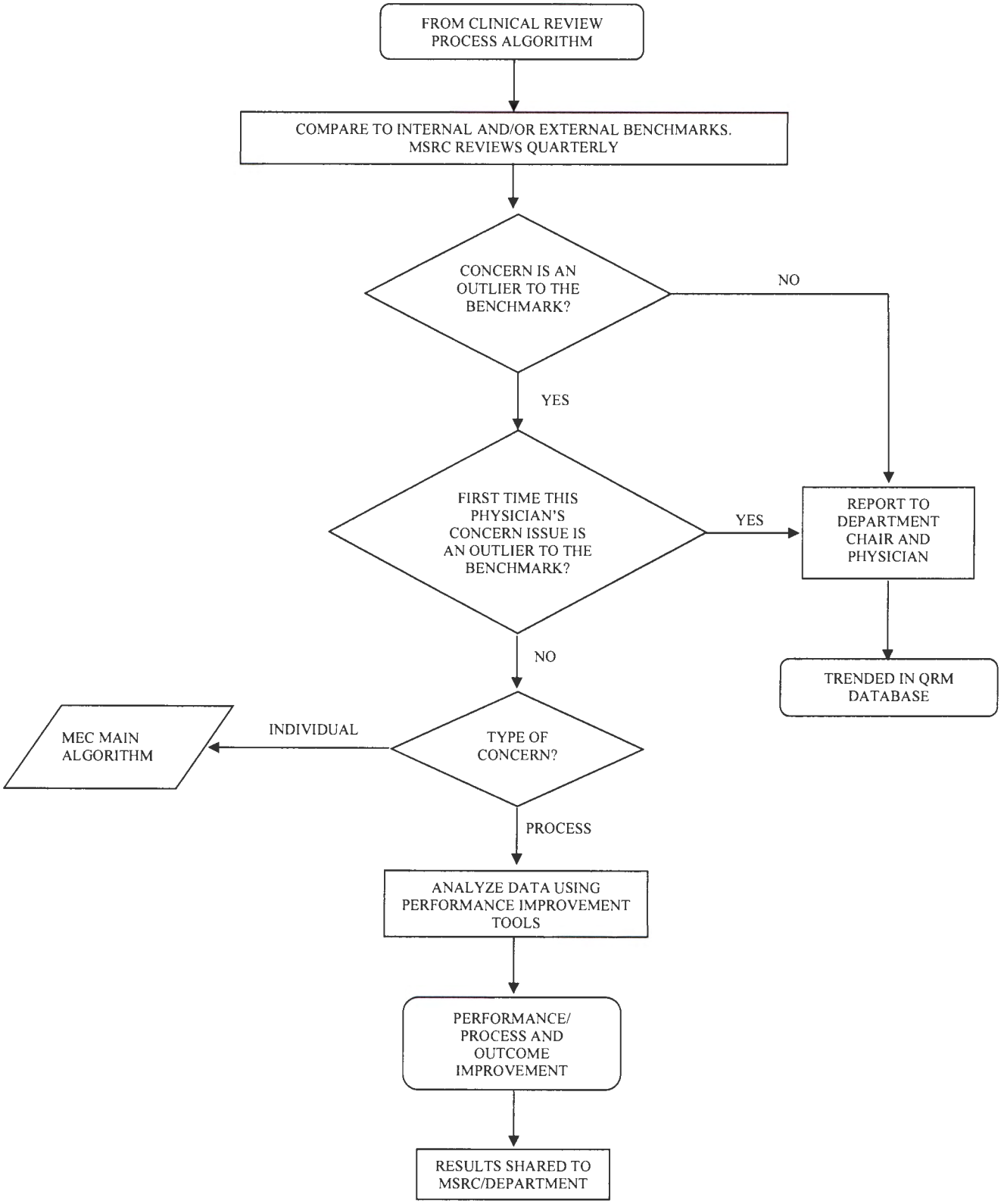
ATTACHMENT "F" (Page 3 of 5)

INDICATOR TYPE II ALGORITHM



ATTACHMENT "F" (Page 4 of 5)

INDICATOR TYPE III ALGORITHM



Parrish Medical Center
Cardiovascular Catheterization Suite Peer Review and Primary Coronary Interventional Program Performance Improvement Flow of Information

Governing Board

Medical Executive Committee and SSGC

Medical Staff Review Committee

Department of Medicine

Medical Director, Cardiovascular Catheterization Suite

Interventional Cardiology Peer Review Committee

Leadership, Critical Care Services
Leadership, Cardiovascular Catheterization Suite

Data Collection Representative (Staff of Cardiovascular Catheterization Suite)

Attachment "G"

PARRISH MEDICAL CENTER
QUALITY & RESOURCE MANAGEMENT DEPARTMENT

MEDICAL and HOSPITAL STAFF
CHART SCREENING CRITERIA and INDICATORS

May include, but not limited to:

Indicators will be trended and reviewed in aggregate, or individually if it is associated with:

a) Organ/System Damage
b) Requires Critical Care
c) Requires Invasive Procedure to Correct/Repair
d) Critical Lab Values not Addressed

Adverse events which result in death, brain damage, spinal injury, fractures, or significant loss of function will be immediately submitted for peer review.

CRITERION #1
ADMISSION FOR ADVERSE RESULTS OF OUTPATIENT MANAGEMENT

CRITERION #2
READMISSION FOR COMPLICATIONS OR INCOMPLETE MANAGEMENT OF PROBLEMS ON PREVIOUS HOSPITALIZATION

CRITERION #3
OPERATIVE/INVASIVE PROCEDURE CONSENT

CRITERION #4
UNPLANNED REMOVAL, INJURY, OR REPAIR OF ORGAN OR STRUCTURE DURING SURGERY OR OTHER INVASIVE PROCEDURE, OR VAGINAL DELIVERY.

CRITERION #5
UNPLANNED RETURN TO O.R., DELIVERY ROOM, SPECIAL PROCEDURES ROOM.

CRITERION #6
SURGICAL AND OTHER INVASIVE PROCEDURE REVIEWS

CRITERION #7
BLOOD LOSS EXCESSIVE OR BLOOD/BLOOD COMPONENT UTILIZATION WHICH IS UNJUSTIFIED, EXCESSIVE, RESULTS IN TRANSFUSION REACTION, OR IS OTHERWISE AT VARIANCE WITH MEDICAL STAFF CRITERIA.

CRITERION #8
HEALTHCARE ACQUIRED CONDITIONS

CRITERION #9
DRUG/ANTIBIOTIC UTILIZATION
CRITERION #10
CARDIAC OR RESPIRATORY ARREST/LOW APGAR SCORE (<5 AT 1 MIN., <7 AT 5 MINUTES)

CRITERION #11
TRANSFER FROM GENERAL CARE TO SPECIAL CARE UNIT

CRITERION #12
OTHER PATIENT COMPLICATIONS

CRITERION #13
HOSPITAL INCURRED PATIENT INCIDENTS

CRITERION #14
ABNORMAL LABORATORY, X-RAY, OTHER TEST RESULTS, OR PHYSICAL FINDINGS NOT ADDRESSED BY PHYSICIAN

CRITERION #15
DEVELOPMENT OF NEUROLOGICAL DEFICIT, WHICH WAS NOT PRESENT ON ADMISSION

CRITERION #16
TRANSFER TO/FROM ANOTHER ACUTE CARE FACILITY

CRITERION #17
DEATH

CRITERION #19
UTILIZATION VARIATIONS ACCORDING TO MEDICAL STAFF CRITERIA

CRITERION #20
RECORD DOCUMENTATION DEFICIENCIES (RDD'S)

CRITERION #21
MEDICAL RECORD DOCUMENTATION DEFICIENCIES - NURSING

CRITERION #22
ANCILLARY DEPARTMENTS

CRITERION #23
PATIENT/FAMILY DISSATISFACTION

CRITERION #24
None at this time

CRITERION #25
MEDICAL STAFF QUALITY CONCERNS

CRITERION #26
ETHICAL PATIENT CARE ISSUES IDENTIFIED BUT NOT ADDRESSED

CRITERION #27
NATIONAL PATIENT SAFETY GOALS NOT FOLLOWED/TJC

CRITERION #28
Care Discovery Measures

CRITERION #29
Unprofessional/abusive behavior - medical staff