SOUTH BROWARD HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF COMMISSIONERS OF THE SOUTH BROWARD HOSPITAL DISTRICT

INCLUDING REPRESENTATIVES OF THE MEDICAL STAFF OF EACH OF ITS HOSPITALS

June 26, 2024

A Regular Meeting of the Board of Commissioners of the South Broward Hospital District (S.B.H.D.) was held in person, and by video and telephone conference, on Wednesday, June 26, 2024, at 5:37 p.m., in the Perry Board Room, 3111 Stirling Road, Hollywood, Florida, 33312.

The following members were present:

Ms. Elizabeth Justen	Chairwoman	In person
Mr. Steven Harvey	Vice Chairman	In person
Mr. Douglas Harrison	Secretary Treasurer	In person
Mr. Jose Basulto		Via WebEx
Mr. Brad Friedman		In person
Dr. Luis Orta		Via WebEx

The following member was absent:

Ms. Laura Raybin Miller

A registration sheet listing attendees in person is on file in the Executive Office.

---

1. CALL TO ORDER / PUBLIC MEETING CERTIFICATION

There being a physical quorum present, Ms. Justen called the meeting to order and noted that public participation is welcome. She confirmed which Board members were in attendance, noting that Mr. Basulto and Dr. Orta were attending via WebEx.

Mr. Frank Rainer, Senior Vice President and General Counsel, confirmed and provided certification that all public notice and open meeting (Sunshine) legal requirements had been complied with for this meeting.

2. PRESENTATIONS

There were no presentations.

3. APPROVAL OF MINUTES

a. Request Board Approval of the Minutes of the Regular Meeting Held on May 22, 2024

A copy of the Minutes is on file in the Executive Office.

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE MINUTES OF THE REGULAR MEETING HELD ON MAY 22, 2024

4. ***BOARD REGULAR BUSINESS***

a. Report from the President of the Medical Staff, Memorial Regional Hospital, Joe DiMaggio Children's Hospital, and Memorial Regional Hospital South; Nigel Spier, M.D.

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

Nigel Spier, M.D., presented the Executive Committee Report regarding recommendations for appointments, advancements, etc., convened on June 19, 2024, submitted for consideration, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Basulto, that:

THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL REGIONAL HOSPITAL, JOE DIMAGGIO CHILDREN'S HOSPITAL, AND MEMORIAL REGIONAL HOSPITAL SOUTH

The Motion ***carried*** unanimously.

2) Request Board Approval of the Performance Improvement Plan

Holly Neville, M.D., Chief Physician and Associate Chief Medical Officer of Memorial Healthcare System, presented the Performance Improvement Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE PERFORMANCE IMPROVEMENT PLAN FOR MEMORIAL REGIONAL HOSPITAL, JOE DIMAGGIO CHILDREN'S HOSPITAL, AND MEMORIAL REGIONAL HOSPITAL SOUTH

The Motion ***carried*** unanimously.

3) Request Board Approval of the Utilization Review Plan

Dr. Neville presented the Utilization Review Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE UTILIZATION REVIEW PLAN FOR MEMORIAL REGIONAL HOSPITAL, JOE DIMAGGIO CHILDREN'S HOSPITAL, AND MEMORIAL REGIONAL HOSPITAL SOUTH

The Motion ***carried*** unanimously.

b. <u>Report from the Chief of Staff, Memorial Hospital West; Fausto De La Cruz, M.D.</u>

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

Fausto De La Cruz, M.D., presented the Executive Committee Report regarding recommendations for appointments, advancements, etc., convened on June 10, 2024, submitted for consideration, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

> ***THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL HOSPITAL WEST***

The Motion ***carried*** unanimously.

2) Request Board Approval of the Performance Improvement Plan

Dr. De La Cruz presented the Performance Improvement Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE PERFORMANCE IMPROVEMENT PLAN FOR MEMORIAL HOSPITAL WEST***

The Motion ***carried*** unanimously.

3) Request Board Approval of the Utilization Review Plan

Dr. De La Cruz presented the Utilization Review Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE UTILIZATION REVIEW PLAN FOR MEMORIAL HOSPITAL WEST***

The Motion ***carried*** unanimously.

c. Report from the Chief of Staff, Memorial Hospital Miramar; Juan Villegas, M.D.

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

Juan Villegas, M.D., presented the Executive Committee Report regarding recommendations for appointments, advancements, etc., convened on June 12, 2024, submitted for consideration, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL HOSPITAL MIRAMAR

The Motion ***carried*** unanimously.

2) Request Board Approval of the Performance Improvement Plan

Dr. Villegas presented the Performance Improvement Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

THE BOARD OF COMMISSIONERS APPROVES THE PERFORMANCE IMPROVEMENT PLAN FOR MEMORIAL HOSPITAL MIRAMAR

The Motion ***carried*** unanimously.

3) Request Board Approval of the Utilization Review Plan

Dr. Villegas presented the Utilization Review Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

THE BOARD OF COMMISSIONERS APPROVES THE UTILIZATION REVIEW PLAN FOR MEMORIAL HOSPITAL MIRAMAR

The Motion ***carried*** unanimously.

d. Report from the Chief of Staff, Memorial Hospital Pembroke; Narendra Upadhyaya, M.D.

1) Request Board Approval of the Executive Committee Report Regarding Recommendations for Appointments, Advancements, etc.

In the absence of Narendra Upadhyaya, M.D., Dr. Neville presented the Executive Committee Report regarding recommendations for appointments, advancements,

etc., convened on June 3, 2024, submitted for consideration, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES RECOMMENDATIONS OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF AT MEMORIAL HOSPITAL PEMBROKE***

The Motion ***carried*** unanimously.

2) Request Board Approval of the Performance Improvement Plan

Dr. Neville presented the Performance Improvement Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE PERFORMANCE IMPROVEMENT PLAN FOR MEMORIAL HOSPITAL PEMBROKE***

The Motion ***carried*** unanimously.

3) Request Board Approval of the Utilization Review Plan

Dr. Neville presented the Utilization Review Plan, a copy of which is on file in the Executive Office.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE UTILIZATION REVIEW PLAN FOR MEMORIAL HOSPITAL PEMBROKE***

The Motion ***carried*** unanimously.

e. <u>Financial Report; Mr. David Smith, Executive Vice President and Chief Financial Officer</u>

1) Request Board Approval of the Financial Reports for the Months of April and May 2024

Mr. Smith first presented the financial report for the month of April 2024, and took questions.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE FINANCIAL REPORT FOR THE MONTH OF APRIL 2024***

The Motion ***carried*** unanimously.

Mr. Smith then presented the financial report for the month of May 2024, and took questions.

Mr. Friedman ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE FINANCIAL REPORT FOR THE MONTH OF MAY 2024

The Motion ***carried*** unanimously

2) Request Board Approval of Resolution No. 500, Amending Fiscal Year 2023-2024 Budgeted Operating Expenditures of the South Broward Hospital District

Mr. Smith read Resolution No. 500 and clarified the reason for the amendment.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES RESOLUTION NO. 500, AMENDING FISCAL YEAR 2023-2024 BUDGETED OPERATING EXPENDITURES OF THE SOUTH BROWARD HOSPITAL DISTRICT

There being no further discussion, a roll call vote was taken.

Mr. Harvey	Yes
Mr. Harrison	Yes
Mr. Friedman	Yes
Mr. Basulto	Yes
Dr. Orta	Yes
Ms. Justen	Yes

The Motion ***carried*** unanimously.

f. Legal Report; Mr. Frank Rainer, Senior Vice President and General Counsel

Mr. Rainer had nothing to report.

5. REPORTS TO THE BOARD; REPORTS FROM BOARD OFFICERS AND STANDING COMMITTEES

a. Contracts Committee Meeting Held on June 18, 2024; Mr. Steven Harvey, Chairman

Mr. Harvey presented the Minutes of the Contracts Committee Meeting held on June 18, 2024, a copy of which is on file in the Executive Office. Mr. Vedner Guerrier, Executive Vice President and Chief Transformation Officer, then gave details of the individual contracts.

1) Request Board Approval of the Renewal Physician Employment Agreement between Robin Nemery, M.D., for Chief, Pediatric Endocrinology Services, and South Broward Hospital District

Mr. Harrison ***moved, seconded*** by Mr. Friedman, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN ROBIN NEMERY, M.D., FOR CHIEF, PEDIATRIC ENDOCRINOLOGY SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT***

The Motion ***carried*** unanimously.

2) Request Board Approval of the Renewal Physician Employment Agreement between Tamar Levene, M.D., for Medical Director, Pediatric General Surgery, and Associate Program Director, General Surgery Residency Services, and South Broward Hospital District

Mr. Friedman ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN TAMAR LEVENE, M.D., FOR MEDICAL DIRECTOR, PEDIATRIC GENERAL SURGERY, AND ASSOCIATE PROGRAM DIRECTOR, GENERAL SURGERY RESIDENCY SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT***

The Motion ***carried*** unanimously.

3) Request Board Approval of the Renewal Physician Employment Agreement between Blane Shatkin, M.D., for Medical Director, Wound Care and Hyperbaric Medicine Services, and South Broward Hospital District

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN BLANE SHATKIN, M.D., FOR MEDICAL DIRECTOR, WOUND CARE AND HYPERBARIC MEDICINE SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT***

The Motion ***carried*** unanimously.

4) Request Board Approval of the Renewal Physician Employment Agreement between Noureldin Abdelhamid, M.D., for Medical Director, Neurohospitalist and Medical Stroke Program Services, and South Broward Hospital District

Mr. Friedman ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN NOURELDIN ABDELHAMID, M.D., FOR MEDICAL DIRECTOR, NEUROHOSPITALIST AND MEDICAL STROKE PROGRAM SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT

The Motion ***carried*** unanimously.

5) Request Board Approval of the Renewal Physician Employment Agreement between Christopher Seaver, M.D., for Adult General Surgery, and Clerkship Director for Undergraduate Medical Education Services, and South Broward Hospital District

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN CHRISTOPHER SEAVER, M.D., FOR ADULT GENERAL SURGERY, AND CLERKSHIP DIRECTOR FOR UNDERGRADUATE MEDICAL EDUCATION SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT

The Motion ***carried*** unanimously.

6) Request Board Approval of the Renewal Physician Employment Agreement between Omair Abbasi, M.D., for Inpatient Psychiatry, and Associate Program Director, Psychiatry Residency Program Services, and South Broward Hospital District

Mr. Friedman ***moved, seconded*** by Mr. Harvey, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN OMAIR ABBASI, M.D., FOR INPATIENT PSYCHIATRY, AND ASSOCIATE PROGRAM DIRECTOR, PSYCHIATRY RESIDENCY PROGRAM SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT

The Motion ***carried*** unanimously.

7) Request Board Approval of the Renewal Physician Employment Agreement between Laurence Davidson, M.D., for Pediatric Neurosurgery Services, and South Broward Hospital District

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN LAURENCE DAVIDSON, M.D., FOR PEDIATRIC NEUROSURGERY SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT

The Motion ***carried*** unanimously.

8) Request Board Approval of the Renewal Physician Employment Agreement between Edward Bove, M.D., for Teaching / Education Mentor Services for the Pediatric Cardiac Program, and South Broward Hospital District

Mr. Friedman ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PHYSICIAN EMPLOYMENT AGREEMENT BETWEEN EDWARD BOVE, M.D., FOR TEACHING / EDUCATION MENTOR SERVICES FOR THE PEDIATRIC CARDIAC PROGRAM, AND SOUTH BROWARD HOSPITAL DISTRICT***

The Motion ***carried*** unanimously.

9) Request Board Approval of the Renewal Professional Services Agreement between Pediatric Critical Care of South Florida, P.A., for Pediatric Critical and Cardiac Care Professional and Administrative Services, and South Broward Hospital District

A discussion took place regarding the cost of the services, and whether this could be brought in-house instead. Mr. Guerrier confirmed that there was no increase in fees.

Mr. Harrison ***moved, seconded*** by Mr. Harvey, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE RENEWAL PROFESSIONAL SERVICES AGREEMENT BETWEEN PEDIATRIC CRITICAL CARE OF SOUTH FLORIDA, P.A., FOR PEDIATRIC CRITICAL AND CARDIAC CARE PROFESSIONAL AND ADMINISTRATIVE SERVICES, AND SOUTH BROWARD HOSPITAL DISTRICT***

The Motion ***carried***, with Dr. Orta voting nay.

Mr. Guerrier then reported on additional contracts, presented for information only.

10) Request Board Approval of the Minutes of the Contracts Committee Meeting Held on June 18, 2024

Ms. Justen ***moved, seconded*** by Mr. Harrison, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE MINUTES OF THE CONTRACTS COMMITTEE MEETING HELD ON JUNE 18, 2024***

The Motion ***carried*** unanimously.

b. Finance Committee Meeting Held on June 18, 2024; Ms. Elizabeth Justen, Chairwoman

Ms. Justen presented the Minutes of the Finance Committee Meeting held on June 18, 2024, a copy of which is on file in the Executive Office. Mr. Veda Rampat, Vice President and Treasurer, then gave details of the items discussed at the meeting.

1) Request Board Approval of the Minutes of the Finance Committee Meeting Held on June 18, 2024

Mr. Harvey ***moved, seconded*** by Mr. Harrison, that:

> ***THE BOARD OF COMMISSIONERS APPROVES THE MINUTES OF THE FINANCE COMMITTEE MEETING HELD ON JUNE 18, 2024***

The ***carried*** unanimously.

6. REPORT OF SPECIAL COMMITTEES

None.

7. ANNOUNCEMENTS

None.

8. UNFINISHED BUSINESS

None.

9. NEW BUSINESS

None.

10. PRESIDENT'S COMMENTS

Mr. Scott Wester reported as follows:

The Joint Commission visited Memorial Regional Hospital and Joe DiMaggio Children's Hospital and were very impressed with the staff and resources. He thanked Ms. Justen for attending the Joint Commission meeting.

He reported on Memorial Hospital Pembroke's bariatric accreditation and Memorial Hospital West's successful Joint Commission Laboratory Survey.

Memorial's RPM (Remote Patient Monitoring) system enabled a patient to receive an immediate intervention and assistance, which resulted in an improvement to the patient's condition.

He gave details of the 27th Annual EMS Global Community Conference and the Paris Summer Olympics of 2024. He congratulated Jeremy Frank, M.D., Orthopedic Surgeon, who has been selected as the physician to the USA Wrestling Team at the Olympics.

The Memorial Cancer Institute is the first in Florida to treat a research patient with graft-versus-host disease with cellular therapy.

'Goldie' has joined Memorial's Pet Therapy Program and is undergoing training. The Program has benefited from a $500K donation from Mr. Craig Zinn and his family, and the Foundation has received a pledge of $250K for the Program from the Lewis family. He voiced his gratitude to the two families for their generosity.

He gave an update on the Near Site Health Center in Pembroke Pines.

He congratulated Mr. Vedner Guerrier, who has begun his tenure as the Chair of the Practice Quality Improvement Steering Group at the American Society of Clinical Oncology (ASCO). He also congratulated Dahlia Blake, M.D., Memorial Hospital West Intensivist, for her 'Recognition of Excellence' from the Governor General of Jamaica, for her significant contribution to Jamaica and the US communities in healthcare.

Memorial is the first in Florida to receive FEMA reimbursement. He thanked Mr. David Smith and his team for their hard work towards this.

He reported on various community visits, including members of the Miami Marlins baseball team, Florida Panthers ice hockey team, and Representative Sam Garrison to Joe DiMaggio Children's Hospital.

Joe DiMaggio Children's Hospital transformed its Child Life Zone into an Enchanted Forest to host a prom for its teenage patients who are unable to attend their own high school prom. He thanked Dunkin' Joy in Childhood Foundation and A Prom To Remember, who helped make this possible, and the Anthony Rizzo Family Foundation for donating raffle prizes and running the dessert station.

Lastly, he reported on the upcoming One City at a Time / Summer Health Fair Kickoff in Miramar.

11. CHAIRWOMAN'S COMMENTS

After allowing the other Board members to give their comments first, Ms. Justen confirmed that the Annual Board Meeting in July would be held at 3111 Stirling Road. She acknowledged the commitment of the Memorial staff, and thanked Mr. Alfredo Avalos, Senior Director of Security, and his team, for their inspiring skills.

12. COMMISSIONERS' COMMENTS

Dr. Orta recognized Mr. Avalos and his team for the dangerous job they do every day. He voiced his appreciation to Mr. Albert Garcia, Chief Nursing Officer of Memorial Hospital Miramar, for showing him around the hospital. He thanked Mr. David Smith and his finance team for their hard work, as always.

Mr. Basulto recognized the physicians who have worked for Memorial for a long time, in particular, Samuel Ostrower, M.D., Chief Physician of Pediatric Otolaryngology, and Blane Shatkin, M.D., Medical Director of the Wound Care Center, who have assisted him and his family over the years.

Mr. Friedman thanked Ms. Monica Puga, Senior Vice President and Chief Nurse Executive, Aharon Sareli, M.D., Executive Vice President and Chief Medical Officer of Memorial Healthcare System, and Dr. Neville, for their kindness in allowing his daughter to shadow them during their work. He had noticed in the corporate building lobby a case displaying awards which Memorial has won over the years and invited everyone to take a moment to look at them.

Mr. Harrison thanked everyone for attending the meeting and acknowledged the impact made every day by the staff. He thanked Dr. Neville for her professionalism. He thanked Mr. Avalos and his team for working to ensure that staff are safe at work. He reported that he replaced Mr. Avalos on the Board. He wished everyone a Happy July 4th.

Mr. Harvey also thanked Mr. Avalos and his team. He thanked all the staff for a phenomenal year and for setting the tone and the culture. He thanked Ms. Ivonne Diaz and Ms. Cheryl Yeo, Senior Executive Assistants to Mr. Wester, for looking after the Board members.

13. ADJOURNMENT

There being no further business to come before the Board, Ms. Justen declared the meeting adjourned at 7:06 p.m.

THE BOARD OF COMMISSIONERS OF THE SOUTH BROWARD HOSPITAL DISTRICT

BY: _____ **ATTEST:** _____
Elizabeth Justen, Chairwoman **Douglas Harrison, Secretary Treasurer**

Memorial Healthcare System

July 17, 2024

Ms. Elizabeth Justen
Chairwoman
Board of Commissioners
South Broward Hospital District

Dear Ms. Justen:

The Executive Committees of the Medical Staff met on these dates:

- Memorial Regional Hospital (MRH) and Joe DiMaggio Children's Hospital (JDCH) on July 17, 2024
- Memorial Hospital West (MHW) on July 8, 2024
- Memorial Hospital Pembroke (MHP) on July 15, 2024
- Memorial Hospital Miramar (MHM) on July 10, 2024

All committees made a recommendation to accept the report of the Credentials Committee as follows:

That the following applicants be approved for membership as indicated:

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Abull Perez, Tamara, APRN	Palliative Medicine (Dr. Ryan Sevel)	APP	Adult	X	X	X	X		1 year	Recommend one year initial appointment pending FPPE results.
Alvarado, Andrea Carolina, MD	Critical Care Medicine	Active	Adult	X	X	X	X		2 years	
Ambrosio-Slade, Victoria, APRN	Transplant Nephrology (Drs. Joseph Africa and Basit Javid	APP	Adult	X					2 years	
Bou Daher Rachwan, Daniela, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Casmartino Bondarenko, Ekaterina Franciscovna, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	
Cuenant, Lauren, DO	Physical Medicine and Rehabilitation	Active	Adult	X	X	X	X		2 years	
Cueto Clarke, Rachel, APRN	Neurosurgery (Drs. Noureldin Abdelhamid; George Diaz; Gaurav Kathuria; Sean Kenniff; Mohammed Qureshi & Fawad Yousuf.)	APP	Adult & Pediatrics	X	X	X	X		2 years	Intrathecal injection - First case must be proctored by MHS neurosurgeon.
DeSouza, Kelly Ughini, MD	Pain Medicine	Active	Adult	X					2 years	
Dombrowski, Jennifer Lynn, APRN	Neonatal Perinatal Medicine (Dr. Cherie Deon Foster)	APP	Pediatrics		X		X	X	2 years	
Dudaie, Ronen Shem, MD	Critical Care Medicine	Active	Adult	X	X	X	X		2 years	
Edelman, Daniel Scott, DO	Internal Medicine	Active	Adult	On staff	On staff	X	X		2 years	
Eldin, Sarah, MD	Emergency Medicine	Active	Adult	X	X	X			2 years	
Ellis, Sean, DO	Critical Care Medicine	Active	Adult	X	X	X	X		2 years	
Fernandez, Norly, APRN	Nephrology (Dr. Alejandro Pla)	APP	Adult	X	X	X	X		2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Fine, Matthew Samuel, MD	Urology	Active	Adult		On staff	X	On staff		2 years	
Garcia, David, MD	Anesthesiology	Active	Adult & Pediatrics	X	X	X	X	X	2 years	
Glaberson, Wendy Robin, MD	Pediatrics	Active	Pediatrics	X				X	2 years	
Gunczler Benaim, Ilana, MD	Pediatrics (Newborn Nursery Only)	Active	Pediatrics	X				X	2 years	Privileges limited to Normal Newborn Nursery. Requires observation period of 30 patient encounters with a credentialed member of the Medical Staff with pediatric newborn nursery privileges, who must verify competency.
Hadad, Elit, MD	Pediatric Emergency Medicine	Active	Pediatrics		X		X	X	2 years	
Herrero, Jose Ramon	Surgical Assistant	AHP	Adult & Pediatrics	X	X	X			2 years	
Hussain, Syeda Fatima, MD, MPH	Internal Medicine Primary Care (Ambulatory)	Active	Adult & Pediatrics	X		X			2 years	
Ivanov, Stanislav Asenov, MD, MPH	Oncology and Hematology	Active	Adult	X	X				2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Jalal, Ayesha Tamkinat, MD	Internal Medicine (Primary Care Ambulatory)	Active	Adult	X	X	X			2 years	
Kaner, Jeffrey Bruce, MD	Gastroenterology	Active	Adult	On staff	On staff	X			2 years	
Katz, Ronald L, DMD	Oral Maxillofacial Surgery	Active	Adult & Pediatrics	On staff				X	2 years	
Khouzam, Samir, MD	Hospice and Palliative Care	Active	Adult		X	X	X		2 years	
Losiniecki, Fergie Justine, MD	Electrophysiology	Active	Adult	X	X				2 years	1) Diagnostic Invasive – Five (5) cases per procedure must be proctored. 2) Interventional Procedures - Five (5) cases per procedure must be proctored. 3) Structural Heart Disease - Five (5) cases per procedure must be proctored. 4) Clinical Cardiac Electrophysiology - Five (5) cases per procedure must be proctored. 5) Insertion and management of central venous catheter (CVC) -

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										First 3 cases must be proctored. 6) Insertion and management of arterial line - First 3 cases must be proctored. 7) Insertion and management of pulmonary artery catheter - First 3 cases must be proctored. 8) Insertion and management of percutaneous hemodialysis catheter - First 3 cases must be proctored.
Moura, Rossana Martins, MD	Gastroenterology	Active	Adult			On staff	X		2 years	
Muminovic, Meri, MD	Oncology and Hematology	Active	Adult		X		X		2 years	
Nahmias, Javier Andres, MD	Ophthalmology	Active	Adult	X	X	X			2 years	
Narula, Paramjit Kaur, MD	Internal Medicine	Active	Adult	On staff	On staff	On staff	X		2 years	
Nguyen, Kimberly Quynh-Thanh, MD	Internal Medicine	Active	Adult	X	X	X	X		2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Ocampo-Chih, Claudia Giselle, MD	Neonatal Perinatal Medicine	Active	Pediatrics		X		X	X	2 years	
Paulino, Thamarre, APRN	Internal Medicine (Dr. Je-Anne Beaufort)	APP	Adult	X					2 years	
Pham, Tiffany Thienthao, MD	Plastic Surgery	Active	Adult & Pediatrics		X		X		2 years	
Ramsay, Michelle-Ann, MBBS	Family Medicine (Primary Care)	Active	Adult	X	X	X	X		2 years	
Razi, Syed Shahzad, MD	Thoracic Surgery	Active	Adult & Pediatrics	X	X	X	X	X	2 years	Recommend two year initial appointment. Additional proctoring of cases not required as recommended by Chief of Thoracic Surgery.
Reich, Shani Sylvia, MD	Ophthalmology	Active	Adult	X					2 years	
Rivera, Charlene, APRN	Gastroenterology (Dr. Howard Baikovitz)	APP	Adult		X				2 years	
Rivner, Harold Philip, MD	Electrophysiology	Active	Adult	X					2 years	Observation of five (5) cases per procedure: 1) Insertion of permanent pacemaker; 2) Insertion of Implantable

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										Cardioverter Defibrillator, including biventricular devices (ICD); 3) Electrophysiology diagnostic study with or without ablation; 4) Electrophysiology interventional ablation procedure requiring trans-septal puncture; 5) Noninvasive and invasive programmed stimulation and reprogramming of defibrillators.
Robison (Taskey), Taylor Gabrielle, DO	Pediatrics	Active	Pediatrics					X	2 years	
Rosero Basurto, Maria Fernanda, MD	Family Medicine	Active	Adult	X	X	X	X		2 years	
Salomon, Say Jr., MD	Internal Medicine	Active	Adult	X		On staff	On staff		2 years	
Santana Alcatara, Luis Enerio, MD	Family Medicine	Active	Adult	X	X	X	X		2 years	

New Applicant Name	Specialty (Sponsor)	Status	Adult & Pediatrics	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Visbal, Jhan Patrick, PA	Electrophysiology (Dr. Awais Humayun)	APP	Adult		X	X	X		2 years	
Waldron, Shervonne, MD	Internal Medicine	Active	Adult	X	X	X			2 years	
Wenzel, Serge Alexander, DO	Emergency Medicine	Active	Adult		X				2 years	Use of Ultrasound-25 cases must be proctored.
Yarimi, Jonathan Michael, MD	Pediatric Neurology	Active	Pediatrics	X			X	X	2 years	

That the following applicants for reappointment be approved as indicated:

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Abers PA, Kaitlin Nicole	Transplant Surgery and Trauma Surgery (Dr. Edson Franco and Dr. Andrew Rosenthal)	8/1/2024	Adult	APP					2 years	Recommend two year reappointment with additional privileges as follows: Prescribe/order controlled substances.
Adames PA, Jorge Alejandro	Oncology and Hematology (Drs. Atif Hussein; Brian Hunis; Matthew Salzberg; Michel Vulfovich; Frederick Wittlin; Jennifer Zikria & Jesus Mercado)	8/1/2024	Adult	APP	APP	APP	APP		2 years	Recommend two year reappointment with additional privileges as follows: Prescribe/order controlled substances.

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Aguirre MD, Maximo Raul	Pediatric Cardiology	8/1/2024	Pediatrics		Active		Active	Active	6 months	Recommend six months reappointment due to lack of reappointment criteria for: Interpretation of fetal echocardiogram, reporting 0 of 20 cases the past 2 years.
Ajayi MD, Folasade	Family Medicine	8/1/2024	Adult	Active		Active	Active		2 years	
Aji MD, Walif	Cardiovascular Disease	8/1/2024	Adult	Active	Active	Active	Active		2 years	Recommend two year reappointment with additional privileges for Use of Fluoroscopy.
Akar-Ghibril MD, Nicole Christine	Pediatric Allergy & Immunology	8/1/2024	Adult & Pediatrics	Active	Active		Active	Active	2 years	
Alterbaum MD, Robert Allan	Critical Care Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Alvarez APRN, Devon Hope	Pediatric Hospitalist (Drs. Scott Lazar; Robin Chaize & Angelica Parra)	8/1/2024	Pediatrics					APP	2 years	
Alvarez MD, Alden Rene	Family Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Antmen MD, Nilgun Ayse	Pediatric Emergency Medicine	8/1/2024	Pediatrics		Active		Active	Active	2 years	
Arango-Longo MD, Jenny	Obstetrics and Gynecology	8/1/2024	Adult				Active		2 years	Recommend two year reappointment with additional privileges for Use of Morcellator. First 3 cases must be proctored. Acessa privileges granted January 2023; proctoring of cases pending (1 of 3 cases).
Archilla MD, Alfredo Samuel	Otolaryngology/ Head and Neck Surgery	8/1/2024	Adult	Active					2 years	Recommend two year reappointment with a change from Active Staff to Consulting Staff status.
Avila APRN, Jessica	Oncology and Hematology (Drs. Alejandra Ergle; Adriana Naraine & Aurelio Castrellon)	8/1/2024	Adult	APP	APP				2 years	
Barrionuevo MD, Marcelo Jorge	Reproductive Endocrinology	8/1/2024	Adult	Active	Active				2 years	
Barros MD, Randy	Emergency Medicine	8/1/2024	Adult	Active					2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Batista MD, Gustavo Alberto	Infectious Disease	8/1/2024	Adult	Active	Active	Active			2 years	
Beltran MD, Sergio Alejandro	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Borgella MD, Jerald Daniel	Trauma Surgery	8/1/2024	Adult & Pediatrics	Active				Active	2 years	
Braffman MD, Bruce H	Diagnostic Radiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Bricio MD, Eugenio Medina	Cardiovascular Disease	8/1/2024	Adult	Active	Active	Active			2 years	
Brillante MD, Jacintha Anthony	Pediatrics	8/1/2024	Pediatrics		Active	Active		Active	2 years	
Bromberg MD, Romina J	Infectious Disease	8/1/2024	Adult	Active	Active		Active		2 years	
Cabrera MD, Marta De Jesus	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Caplan DO, Ariel Lindsey	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Castellon MD, Ignacio	Radiation Oncology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Chaudhari MD, Reena Singh	Anesthesiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Chen DO, Shirley	Neurocritical Care	8/1/2024	Adult	Active	Active	Active	Active		1 month	Recommend one month reappointment

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										pending completion of six (6) CME hours of stroke specific education to Care for a patient with acute stroke at MHW.
Coney APRN, Lakisha Denise	Cardiovascular Disease (Drs. Jose Guzman; Juan Carlos Brenes; Michael Entenberg; Julio Peguero Moreno; Ralph Levy; Vamsi Pavuluri; Ethan Siev; Selbourne Goode; Inbar Saporta; Joshua Saef; Kashmira Bhadha; Walif Aji; Howard Berlin; Alian Aguila; Paola Casanova; Chao-wen Lee; Alvaro Vargas; Jayant Nath & Minaba Wariboko.)	8/1/2024	Adult & Pediatrics	APP	APP	APP	APP		2 years	Recommend two year reappointment with additional privileges as follows: Prescribe/order controlled substances.
Davila MD, Susan	Obstetrics and Gynecology	8/1/2024	Adult	Active	Active				2 years	Privileges for repair of vesico-vaginal, vesico-uterine, and urethro-vaginal fistula were not approved for failure to meet reappointment criteria, reporting 0

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										out of 2 cases.
Davis APRN, Valen Verona	Family Medicine (Drs. Jennifer Goldman & Salvador Mora)	8/1/2024	Adult	APP	APP	APP			2 years	
Delgado CCP, Cesar Omar	Cardiac Surgery (Dr. Juan Plate)	8/1/2024	Adult & Pediatrics	AHP				AHP	2 years	
Domingo Cabreja MD, Gina Carolina	Palliative Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Drossner MD, David Mark	Pediatric Cardiology	8/1/2024	Pediatrics					Active	6 months	Recommend six months reappointment due to lack of reappointment criteria for: Interpretation of fetal echocardiogram, reporting 0 of 20 cases the past 2 years.
Edwards MD, Courtney Michelle	General Surgery	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Fabregas Cherenek MD, Hector Alberto	Family Medicine	8/1/2024	Adult				Active		2 years	
Fels PSYD, Robert Alan	Psychology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Fernandez Ruiz MD, Maria Cristina	Ophthalmology	8/1/2024	Adult & Pediatrics		Active		Active	Active	2 years	
Fine MD, Matthew Samuel	Urology	8/1/2024	Adult		Active		Active		2 years	
Frank MD, Jeremy Stephen	Pediatric Orthopedic Surgery	8/1/2024	Pediatrics	Active			Active	Active	2 years	
Ginsberg MD, Paul L	Neurology	8/1/2024	Adult	Active					2 years	
Glait MD, Sergio Alejandro	Orthopedic Surgery	8/1/2024	Adult		Active		Active		2 years	
Glogover MD, Philip	Anesthesiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	6 months	Recommend six months reappointment pending outcome of FL BOM Administrative Complaint.
Goluboff MD, Marcelo	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Gooden APRN, CRNA, Shelley Chen	Nurse Anesthetist (Dr. Cameron Howard)	8/1/2024	Adult & Pediatrics	APP	APP	APP	APP	APP	2 years	
Green DO, Melissa Joy	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Greenbaum MD, Shareen Mishal	Ophthalmology	8/1/2024	Adult	Active	Active				2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Grumberg MD, Beatrice Muriel	Internal Medicine	8/1/2024	Adult	Active					2 years	
Guvenli MD, Gokhan	Family Medicine	8/1/2024	Adult		Active	Active	Active		2 years	
Henry DO, Nicole	Obstetrics and Gynecology	8/1/2024	Adult & Pediatrics		Active		Active		2 years	
Hernandez DO, Nicolay F	Emergency Medicine	8/1/2024	Adult				Active		2 years	
Huaman PA, Gustavo Martin	Surgical Assistant (Dr. Farid Assouad)	8/1/2024	Adult & Pediatrics	APP	APP				2 years	
Jassir MD, David	Otolaryngology/Head and Neck Surgery	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	6 months	Recommend six month reappointment due to low pediatric patient encounters, reporting 6 out of 12 cases.
Johnstone MD, Scott Anthony II	Anesthesiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Joseph MD, Jessica	Pediatrics	8/1/2024	Pediatrics		Active		Active	Active	2 years	
Kaplan MD, Linda Joette	Ophthalmology	8/1/2024	Adult	Active					2 years	
Kazdan DO, Scott David	Orthopedic Surgery	8/1/2024	Adult		Active				2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Kent PA, Danielle	Pediatric Emergency Medicine (Dr. Heidi Cohen)	8/1/2024	Pediatrics		APP		APP	APP	3 months	Recommend three month reappointment pending CRM training.
Khazeni MD, Kristina Catherine	Surgery	8/1/2024	Adult	Active	Active	Active	Active		6 months	Recommend six months reappointment with additional privileges as follows: Fluoroscopy; Splenectomy, open; Adrenalectomy, open; Gastrectomy or other gastric procedures. Relinquishing privileges for: Moderate Sedation Liver resection privileges were not approved for failure to meet reappointment criteria, reporting 0 out of 5 cases.
Koshy DO, Sonia Mathai	Gynecology	8/1/2024	Adult	Active	Active		Active		2 years	
Lacey MD, Julian Keith	Pediatrics	8/1/2024	Pediatrics		Active		Active	Active	2 years	
Ladejobi MBBS, Adetola	Cardiovascular Disease	8/1/2024	Adult & Pediatrics	Active	Active	Active		Active	1 month	Recommend one month

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Oluwagbenga										reappointment pending completion of Moderate Sedation self-study.
Lau MD, Debra Ming-Wai	Diagnostic Radiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Lee MD, Francis F	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Leiba PA, Shawn Eric	Emergency Medicine (Dr. Michael Estreicher & Louis Jane)	8/1/2024	Adult	APP		APP			2 years	
Levin MD, Sheldon R	Ophthalmology	8/1/2024	Adult		Active				2 years	
Linzer MD, Dov Stephen	Cardiovascular Disease	8/1/2024	Adult	Active	Active	Active	Active		2 years	
MacKenzie MD, James Scott	Orthopedic Surgery	8/1/2024	Adult	Active	Active		Active		2 years	
Mark MD, Barry Jay	Allergy and Immunology	8/1/2024	Adult & Pediatrics		Active				2 years	
McKay MD, Jheanelle	Pediatric Emergency Medicine	8/1/2024	Pediatrics		Active		Active	Active	2 years	
Medina APRN, Kristina	Gynecologic Oncology & Gynecology (Drs. Emery Salom; Jonathan Black; Jacob Tangir & Taralyn Sowby)	8/1/2024	Adult	APP	APP		APP		2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Mendoza MD, Mari Sebastian Casanova	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		1 month	Recommend one month reappointment pending completion of six (6) CME hours of stroke specific education to Care for a patient with acute stroke at MHW.
Mignacca MD, Caroline Catherine	Obstetrics and Gynecology	8/1/2024	Adult & Pediatrics		Active				6 months	Recommend six months reappointment due to low robotic encounters, reporting 18 of 20 cases.
Milian MD, Nailim M	Obstetrics and Gynecology	8/1/2024	Adult & Pediatrics	Active				Active-GYN only	2 years	
Miller, Diana Lynn, APRN	Change in Specialty from Advanced Heart Failure & Transplant Cardiology to Cardiac Surgery (Drs. Juan Plate; Tae Song; John Melvan; Jose Garcia; John Dentel; Steven Bibevski, Michael Cortelli; Frank Scholl & I-wen Wang)	**9/1/2024**		APP	APP				2 years	Recommend two year reappointment with additional privileges as follows: 1) Management and removal of pleural tube 2) Thoracentesis 3) Ultrasound-guided Thoracentesis 4) Paracentesis 5) Ultrasound-guided Paracentesis

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										6) Function as surgical first assistant to the supervising physician(s) in a credentialed procedure 7) Management and removal of surgical drains 8) Superficial debridement 9) Superficial incision and drainage.
Minars MD, Todd Jonathan	Dermatology	8/1/2024	Adult	Active					2 years	
Mirrieles Miranda, Cesar Orlando	Surgical Assistant	8/1/2024	Adult & Pediatrics	AHP	AHP	AHP			2 years	
Nguyen MD, Nga Van	Internal Medicine	8/1/2024	Adult	Active					2 years	
Nunnelly PA, Heather Widman	Surgical Assistant (Dr. Farid Assouad)	8/1/2024	Adult & Pediatrics	AHP	AHP	AHP			2 years	
Okafor MD, Chukwudumebi Sandra	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		1 month	Recommend one month reappointment pending completion of six (6) CME hours of stroke specific education to Care for a patient

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										with acute stroke at MHW.
Owi, Enibokun Osayawe, APRN	Internal Medicine-Memorial Urgent Care (Dr. Marc Shapiro)	8/1/2024	Adult	APP					2 years	
Pages MD, Luz Marina	Pediatrics	8/1/2024	Pediatrics					Active	2 years	
Parra MD, Angelica Maria	Pediatric Hospitalist	8/1/2024	Pediatrics					Active	2 years	
Pastoriza DO, Sarah Michelle	Physical Medicine and Rehabilitation	8/1/2024	Adult	Active	Active				2 years	Recommend two year reappointment and relinquishment of Moderate Sedation privileges.
Patel MD, Anushil, S	Neurocritical Care	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active		2 years	
Peck MD, Jacquelin Elizabeth	Anesthesiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Perelman MD, Jason	Urology	8/1/2024	Adult		Active	Active			2 years	
Pico MD, Brian Anthony	Oncology and Hematology	8/1/2024	Adult	Active	Active				2 years	
Pines MD, Jack A	Urology	8/1/2024	Adult	Active	Active	Active			2 years	
Pitcher APRN, Diana Lynn Marinoff	Anesthesiology (Dr. Kiesha Raphael)	8/1/2024	Adult & Pediatrics	APP	APP	APP	APP	APP	2 years	Recommend two year reappointment with additional privileges as

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										follows: **Core Privileges for APRN – Anesthesiology:** 1. Evaluation of clinical status and implementation of treatment plan priorities based on the patient's diagnoses, with appropriate documentation. 2. Collaborate with anesthesiologists and surgical teams to develop individualized anesthesia plans based on patient's medical conditions, surgical procedures, and risk assessments. 3. Perform anesthesia-focused history and physical for pre-operative evaluation. 4. Perform, order, and interpret diagnostic tests. 5. Prescribe/order and monitor pharmacologic and

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										non-operative therapeutic interventions commonly associated with the medical specialty of the supervising physician(s) - excludes controlled substances. 6. Provide health teaching and counseling and initiate referrals as indicated. **Anesthesia Service Pain Management**: 1. Daily rounds on all pain service patients to include Patient Controlled Analgesia (PCA) pumps, continuous nerve block infusions, single shot nerve blocks and epidural infusions, with relevant documentation. 2. Initiate and modify the following analgesics for PCA,

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										continuous nerve block and epidural infusions after consultation with the anesthesiologist: Morphine, Dilaudid, Fentanyl, Bupivicaine, Ropivacaine, Nubain. Narcan-if life threatening (RR less than 10/minute), the ARNP may independently initiate therapy. 3. Initiate the PCA/Epidural orders using standard order set. 4. Initiate and modify non-controlled adjunct medications for patients on anesthesia pain service. 5. Discontinue infusion and remove epidural catheters. 6. Notify the anesthesiologist of any adverse reactions to analgesics or

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
										incidents that deviate from the protocol. 7. Make postoperative rounds on select patients after consultation with anesthesiologist.
Plesa-McCormack MD, Jocelyn Ann	Pediatric Emergency Medicine	8/1/2024	Pediatrics		Active		Active	Active	2 years	
Pollak MD, Wayne Marshall	Cardiovascular Disease	8/1/2024	Adult	Active	Active	Active			2 years	Recommend two year reappointment and relinquishment of Moderate Sedation privileges.
Preschel MD, Nelson	Ophthalmology	8/1/2024	Adult		Active		Active		2 years	
Pulido MD, Amy Klash	Anesthesiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Quintero MD, Christian Luis	Female Pelvic and Reconstructive Surgery	8/1/2024	Adult & Pediatrics	Active		Active		Active	2 years	Recommend two year reappointment and relinquishment of privileges as follows: 1) OB Core Privileges 2) Repair of vesico-vaginal, vesico-uterine and urethro-vaginal fistula.

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Raghunath MD, Neeraj Kumar	Pediatric Gastroenterology	8/1/2024	Pediatrics	Active	Active		Active	Active	2 years	
Reilly PA, Sarah	Hand Surgery (Dr. Harris Gellman)	8/1/2024					APP		2 years	
Rivera DPM, Michael A	Podiatry	8/1/2024	Adult	Active	Active				2 years	Recommend two year reappointment. Core Privileges in Pediatric Podiatry, Pediatric Podiatry-Advanced, and Pediatric Reconstructive Rearfoot and Ankle Surgery Procedures were not approved for failure to meet criteria.
Rivera-Rodriguez MD, Michael	Family Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Rodriguez MD, Joanna Mercedes	Nephrology	8/1/2024	Adult	Active	Active				2 years	
Rodriguez Zoppi MD, Eduardo	Vascular Surgery	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Roig-Cantisano MD, Ana M	Pediatric Emergency Medicine	8/1/2024	Pediatrics		Active		Active	Active	2 years	
Romeu MD, Jose Carlos	Internal Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Rosa MD, Cesar	Maternal Fetal Medicine	8/1/2024	Adult	Active	Active		Active		2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Rozenberg MD, Daniel	Diagnostic Radiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Salerno MD, James Anthony	Physical Medicine and Rehabilitation	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Santoro MD, Jose Esteban	Anesthesiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Sarroza DO, Joanne	Obstetrics and Gynecology	8/1/2024	Adult	Active					2 years	
Schmelzer DO, David Israel	Anesthesiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Siemon MD, John	Gynecologic Oncology	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Smith MD, Marvin Khalid	Orthopedic Surgery	8/1/2024	Adult & Pediatrics	Active					2 years	
Steinberg MD, Irwin Cary	Obstetrics and Gynecology	8/1/2024	Adult		Active				2 years	Recommend two year reappointment with relinquishment of privileges as follows: Repair of vesico-vaginal, vesico-uterine, and urethro-vaginal fistula.
Stone MD, Charles Barker	Internal Medicine	8/1/2024	Adult	Active	Active	Active			2 years	
Sturm MD, Jerome	Obstetrics and Gynecology	8/1/2024	Adult	Active		Active	Active		3 months	Recommend three months reappointment pending FPPE.

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Suarez APRN, Daniela	Transplant Nephrology & Transplant Surgery (Drs. Seyed Ghasemian; Edson Franco; Heather LaGuardia; Basit Javaid & Linda Chen)	8/1/2024	Adult	APP					2 years	
Sukenik MD, Mark A	Otolaryngology/Head and Neck Surgery	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Sullivan MD, Peter John	Diagnostic Radiology/ Neuroradiology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Szybinski MD, Stanley Thomas	Pediatric Sports Medicine	8/1/2024	Pediatrics	Active			Active	Active	6 months	Recommend six months reappointment due to low patient encounters, reporting 15 of 20.
Taboada MD, Martha V	Pediatric Endocrinology	8/1/2024	Pediatrics	Active	Active		Active	Active	2 years	
Talluri MD, Giridhar Sayee	Urology	8/1/2024	Adult	Active		Active			2 years	
Tannenbaum MD, Stephen	Urology	8/1/2024	Adult		Active				6 months	Recommend six months reappointment due to lack of robotic cases, reporting 5 of 20.
Tarrazzi MD, Francisco Antonio	General Surgery & Thoracic Surgery	8/1/2024	Adult	Active	Active	Active	Active		2 years	

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Van Ostran DO, Garrett James	Infectious Disease	8/1/2024	Adult & Pediatrics	Active	Active		Active		2 years	
Via y Rada PA, Nestor Gerardo	Surgery (Dr. Narciso Gomez)	8/1/2024	Adult		APP	APP	APP		1 month	Recommend one month reappointment pending sponsoring physician competency evaluation.
Wagner MD, Aaron Michael	Vascular Surgery	8/1/2024	Adult	Active	Active	Active	Active		2 years	Recommend two year reappointment with additional privileges as follows: Transcarotid artery revascularization (TCAR)- First 3 cases must be proctored by an open vascular surgeon with TCAR privileges.
Wegerif MD, Garrett Daniel	Plastic Surgery	8/1/2024	Adult & Pediatrics			Active			1 month	Recommend one month reappointment pending transfer to Community Affiliate staff status. Committee also accepted relinquishment of Moderate Sedation privileges.

Reappointment Applicant Name	Specialty (Sponsor)	Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Term	Action by Committee
Whitehouse MD, Jill Suzanne	Pediatric Surgery	8/1/2024	Pediatrics	Active	Active		Active	Active	2 years	
Widner MD, Matthew Ryan	Orthopedic Surgery	8/1/2024	Adult		Active		Active		2 years	
Wilkinson DO, Curtis Erwin	Family Medicine	8/1/2024	Adult	Active	Active	Active	Active		2 years	
Wilner CNIM, Jarrod Scott	Neurointraoperative Monitorist (Dr. Jason Soriano)	8/1/2024	Adult & Pediatrics	AHP	AHP	AHP		AHP	2 years	
Wilson DO, Kevin Anthony	Emergency Medicine	8/1/2024	Adult		Active				2 years	
Zampieri MD, Alejandro Jose	Pediatric Emergency Medicine	8/1/2024	Pediatrics		Active		Active	Active	2 years	
Zedan APRN, Tatiana	Pediatric Critical Care Medicine (Dr. Jason Adler)	8/1/2024	Pediatrics					APP	2 years	
Ziadie MD, Mandolin Summer	Anatomic and Clinical Pathology	8/1/2024	Adult & Pediatrics	Active	Active	Active	Active	Active	2 years	
Zide MD, Kenneth Mark	Cardiovascular Disease	8/1/2024	Adult	Active	Active				Denied	Discontinue membership and privileges for failing to meet patient encounter volume, as defined in the Joint Policies and Procedures.

That the following changes in privileges for lack of Crew Resource Management Training Course be approved:

Practitioners Name	Specialty (Sponsor)	Appointment Date	Expirable Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee

Practitioners Name	Specialty (Sponsor)	Appointment Date	Expirable Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Alperin, PA, Genna	Pediatric Critical Care Medicine (Dr. Allan Greissman)	12/20/2023	7/1/2024	Pediatrics					X	Discontinue invasive privileges pending completion of CRM training.
Arosemena, MD, Analisa	Ophthalmology	4/24/2024	7/1/2024	Adult & Pediatrics				X		Discontinue invasive privileges pending completion of CRM training.
Fernandez, MD, Vania	Pain Medicine	12/20/2023	7/1/2024	Adult	X	X	X	X		Discontinue invasive privileges pending completion of CRM training.
Gonzalez, MD, Christian	Pain Medicine	12/20/2023	7/1/2024	Adult	X	X	X	X		Discontinue invasive privileges pending completion of CRM training.
Martin, APRN, Laura	Gastroenterology (Dr. Katherine Kosche)	4/24/2024	7/1/2024	Adult		X				Discontinue invasive privileges pending completion of CRM training.
Smith, APRN, Joya	Pediatric General Surgery (Drs. Holly Neville, Jill Whitehouse, Tamar Levene, Oliver Lao,	4/24/2024	7/1/2024	Pediatrics	X				X	Discontinue invasive privileges pending completion of CRM training.

Practitioners Name	Specialty (Sponsor)	Appointment Date	Expirable Date	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
	Noor Kassira, YangYang Yu, and Moiz Mustafa)									
Wanis, DO, Sameh	Obstetrics and Gynecology	4/24/2024	7/1/2024	Adult		X		X		Discontinue invasive privileges pending completion of CRM training.

That the following requests for changes, additions or relinquishment of privileges be approved:

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Akam Venkata, Jyothsna, MD	Pediatric Cardiology	Additional	**Requesting privileges for:** Cardiac MRI	Pediatrics	X				X	Approved.
Cartin, Emily Maria, APRN	Pain Management (Dr. Nancy Erickson)	Additional	**Requesting privileges for:** Prescribe/order controlled substances (DEA required)	Adult	X	X	X	X		Approved.
Dauer, Marc Jonathan, MD	Vascular Surgery	Additional	Transcarotid artery re-vascularization (TCAR). First three cases must be proctored.	Adult & Pediatrics	X	X	On Staff	On Staff	On Staff	Approved. First three (3) TCAR cases must be proctored.

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
DuBois, Marie M., APRN	Family Medicine (Dr. Ana Kelegama)	Additional	**Requesting privileges for:** Prescribe/order controlled substances (DEA required)	Adult	X	X	X	X		Approved.
Fertel, Gabrielle Aryn, PA	Endocrinology, Diabetes and Metabolism (Dr. Amy Aronovitz)	Additional	**Requesting privileges for:** Prescribe/order controlled substances (DEA required)	Adult	X			X		Approved.
Gernaga, Kristi Esther, APRN	Vascular and Interventional Radiology (Dr. Federico Bengoa & Michael Cohn)	Additional	**Requesting privileges for:** 1. Fluoroscopic-guided lumbar puncture 2. Fluoroscopic-guided tunnel catheter placement 3. Image-guided bone marrow biopsy. 4. Function as surgical first assistant to the supervising physician(s) in credentialed procedure. 5. Insertion of	Adult & Pediatrics	X	X	X	X	X	Approved.

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
			pleural tube 6. Insertion/removal of suprapubic cystotomy tube 7. Lumbar puncture 8. Management and removal of pleural tube 9. Suprapubic bladder tap 10. Ultrasound-guided paracentesis 11. Ultrasound-guided Thoracentesis 12. Insertion of arterial line 13. Insertion of Central Venous Catheter (CVC) 14. Insertion of Peripherally Inserted Central Catheter (PICC) 15. Removal of venous or arterial sheath							
Najarian, Christina, APRN	Pediatric Oncology and Hematology	Change	**Requesting privileges for:** 1. Lumbar	Pediatrics	X				X	Approved.

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
	(Drs. Iftikhar Hanif; Brian Cauff; Haneen Abdella; Kerice Pinkney; Anne Schaefer; Carmen Ballestas & Deborah Kramer)		puncture 2. Administration of intrathecal chemotherapy 3. Bone marrow biopsy and aspiration. **Relinquishing privileges for:** 1. (Limited to Cardiovascular) : Provide care for patients with a mechanical circulatory support device & Management of external postoperative pacemaker. 2. (Limited to Cardiac Transplant): Clinical management of Advanced Heart Failure patients for inpatient and outpatient settings & Clinical management of							

Name	Specialty (Sponsor)	Request	Privilege	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
			Heart Transplant patients for inpatient and outpatient settings.							
Tamayo, Evelyn De Jesus, MD	Pediatrics	Change	**Requesting privileges for:** Neonatal Hospitalist	Pediatrics	X				X	Approved.
Tuerff, Sonya, MD	Vascular Surgery	Additional	Transcarotid artery re-vascularization (TCAR) First three cases must be proctored.	Adult & Pediatrics	X	X	On Staff	On Staff	On Staff	Approved. First three (3) TCAR cases must be proctored.

Please be advised that these applicants for appointment and reappointment were processed through the Board approved Credentialing Procedure that meets and exceeds the requirements of Florida Statute 395.011, and the standards of The Joint Commission.

The Executive Committees also accepted the following recommendations for changes in staff status as indicated:

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Alqaisi, Sura, MD	Internal Medicine	Automatic termination of membership and privileges. No longer providing services in MHS through TeamHealth effective 6/14/2024.	Adult	Active	Active	Active	Active		Automatic termination of membership and privileges. No longer providing services in MHS through TeamHealth effective 6/14/2024.
Brenes, Michelle PSYD	Psychology	Requested resignation at MRH only, effective 5/1/2024.	Adult & Pediatrics	Active				On staff	Accepted resignation at MRH only, effective 5/1/2024.
Browne, Janina Tandoc, PA	Internal Medicine (Drs. Christopher Ramsaran & Helen-Chukwu)	Automatic termination of membership and privileges. No longer providing services in MHS effective 5/29/2024.	Adult	APP		APP			Automatic termination of membership and privileges. No longer providing services in MHS effective 5/29/2024.
Bryant, Heather Nicole, PA	Vascular Interventional Neurology and Neurology (Drs. Brijesh Mehta; Norman Ajiboye; Haris Kamal; Mhd Tarek Zakaria; Sean Kenniff;	Automatic termination of membership and privileges. No longer providing services in MHS effective 5/25/2024.	Adult	APP	APP				Automatic termination of membership and privileges. No longer providing services in MHS effective 5/25/2024.

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
	Brandi Baker; Fawad Yousuf; Mohammed Qureshi; Noureldin Abdelhamid & Gaurav Kathuria)								
Contrucci, Robert B, DO	Otolaryngology/Head and Neck Surgery	Request transfer from Community Affiliate staff to Honorary Staff status at MHW.	Adult & Pediatrics		Inactive				Approved Honorary staff status at MHW.
Durham, Donna Marie, APRN	Neonatal Perinatal Medicine (Drs. Lester Mc Intyre: Bruce Schulman; Mesfin Afework; Yasser Al-Jebawi; Gianina Davila; Cristian Esquer; Vicki Johnston; Doron Kahn; Maria Pina-Rodrigues; Sharell Bindom; Mona Shehab; Flavio Soliz; Pablo Valencia; & Angela Leon Hernandez)	Automatic termination of membership and privileges due to failure to request reappointment effective 8/1/2024.	Pediatrics		APP		APP	APP	Automatic termination of membership and privileges for failing to request reappointment, effective 8/1/2024.
Flanders, Ximena Celedon, PSYD	Psychology	Requested resignation at MRH only, effective 5/1/2024.	Adult & Pediatrics	Active				On staff	Accepted resignation at MRH only, effective 5/1/2024.

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Fine, Jay B., MD	Plastic Surgery	Request resignation effective 10/1/2024, and Honorary/Honorary Emeritus Staff status at MHW and MHM.	Adult & Pediatrics		Active		Active		Accepted resignation effective 10/1/2024. Approved Honorary staff status at MHW effective 10/1/2024.
Grandez, Cesar, MD	Internal Medicine	Requested resignation effective 6/18/2024.	Adult	Active	Active	Active	Active		Accepted resignation effective 6/18/2024.
Grodin, Lauren Kimberly, PSYD	Psychology	Requested resignation at MRH only, effective 5/1/2024.	Adult & Pediatrics	Active				On staff	Accepted resignation at MRH only, effective 5/1/2024.
Jules, Helga Tina, PSYD	Psychology	Requested resignation at MRH only, effective 5/1/2024.	Adult & Pediatrics	Active				On staff	Accepted resignation at MRH only, effective 5/1/2024.
Martinez, Dario, MD	Internal Medicine	Automatic termination of membership and privileges. No longer providing services in MHS through TeamHealth effective 4/19/2024.	Adult	Active	Active	Active	Active		Automatic termination of membership and privileges. No longer providing services in MHS through TeamHealth effective 4/19/2024.

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Massucco, Johnnilynn, APRN, CRNA	Nurse Anesthetist (Drs. Richard Elf & Sandra Kaufmann)	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.	Adult & Pediatrics	APP	APP	APP	APP	APP	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.
Miller, Diana Lynn, APRN	Advanced Heart and Failure Transplant Cardiology (Drs. Priyanka Gosain; Iani Patsias & Miguel Castro)	Requested resignation at MHP & MHM only, effective 07/28/2024.	Adult	On staff	On Staff	APP	APP		Accepted resignation at MHP & MHM only, effective 7/28/2024.
Mudad, Raja A., MD	Oncology and Hematology	Requested resignation effective 5/30/2024.	Adult	Active					Accepted resignation effective 5/30/2024.
Ortega, Christina Joyce, PSYD	Neuropsychology	Requested resignation at MRH only, effective 5/1/2024.	Adult & Pediatrics	Active				On staff	Accepted resignation at MRH only, effective 5/1/2024.
Osawe, Efosa Osayande, MD	Internal Medicine	Requested resignation effective 7/1/2024.	Adult	Active	Active	Active	Active		Accepted resignation effective 7/1/2024.
Pantaleo, Amy Jo, APRN	Palliative Medicine (Drs. Jorge Luna & Ravi Samlal)	Automatic termination of membership and privileges. No longer providing	Adult	APP	APP	APP	APP		Automatic termination of membership and privileges. No longer

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
		services in MHS through Vitas Palliative Care effective 2/1/2024.							providing services in MHS through Vitas Palliative Care effective 2/1/2024.
Peralta, Edgar A PA	Surgical Assistant (Dr. Alvaro Garcia)	Requested resignation effective 07/31/2024.	Adult & Pediatrics		AHP				Accepted resignation effective 7/31/2024.
Piso, Michelle Andrea, APRN, CRNA	Nurse Anesthetist (Dr. Kiesha Raphael)	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.	Adult & Pediatrics	APP	APP	APP	APP	APP	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.
Rose, Jonathan David, MD	Emergency Medicine	Automatic termination of membership and privileges. No longer providing services in MHS through TeamHealth effective 5/29/2024.	Adult	Active	Active		Active		Automatic termination of membership and privileges. No longer providing services in MHS through TeamHealth effective 5/29/2024.

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
Roznowski, Adrian Maximilian, MD	Obstetrics and Gynecology	Automatic termination of membership and privileges for failing to request reappointment. No longer providing services in MHS effective 8/1/2024.	Adult	Active					Automatic termination of membership and privileges for failing to request reappointment. No longer providing services in MHS effective 8/1/2024.
Schwartz, Gary, MD	Hand Surgery	Request transfer to Honorary Staff status at MHW.	Adult & Pediatrics		Inactive				Approved Honorary staff status at MHW.
Soloway, Mark Stephen, MD	Urology	Automatic termination of membership and privileges. No longer providing services in MHS effective 5/31/2024.	Adult	Active					Automatic termination of membership and privileges. No longer providing services in MHS effective 5/31/2024.
Sturm, Jerome, MD	Obstetrics and Gynecology	Requested resignation at MHW only, effective 8/1/2024.	Adult	On staff	Active	On staff	On staff		Accepted resignation at MHW only, effective 8/1/2024.
Summerfield, Gary Allen, APRN	Emergency Medicine (Drs. Randy Katz & Heidi Cohen)	Automatic termination of membership and privileges. No longer providing services in MHS	Adult & Pediatrics	APP	APP	APP	APP	APP	Automatic termination of membership and privileges. No longer providing

Name	Specialty (Sponsor)	Topic	Age Category	MRH	MHW	MHP	MHM	JDCH	Action by Committee
		through TeamHealth effective 6/17/2024.							services in MHS through TeamHealth effective 6/17/2024.
Thorpe-Merritt, Joan Maud APRN, CRNA	Nurse Anesthetist (Dr. Karim Abouelenin)	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.	Adult & Pediatrics	APP	APP	APP	APP	APP	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.
Trkulja, Marko, AA	Anesthesiologist Assistant (Dr. Walter Diaz)	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.	Adult & Pediatrics	APP	APP	APP	APP	APP	Automatic termination of membership and privileges. No longer providing services in MHS through Envision effective 6/3/2024.

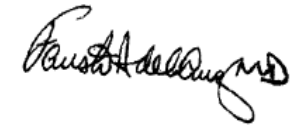
July 2024	MHS
New Physician Appointments	32
New AHP Appointments	9
Physician Reappointments	111
AHP Reappointments	22
Physician Resignations/Terminations	9

AHP Resignations/Terminations	10

Your approval of these recommendations is requested.

Sincerely,

Maria Pilar Gutierrez, MD
President
Memorial Regional Hospital
Joe DiMaggio Children's Hospital



Fausto A. De La Cruz, M.D.
Chief of Staff
Memorial Hospital West

Juan Villegas, M.D.
Chief of Staff
Memorial Hospital Miramar

Narendra R Upadhyaya, MD
Chief of Staff
Memorial Hospital Pembroke

MHS Infection Prevention and Control (IPC) Plan

Executive Summary of Plan Revisions CY 2024

MHS has Infection Prevention and Control (IPC) Plans at each main hospital site and a systemwide plan that encompasses all offsite locations. The Plans for CY 2024 were reviewed and updated by the System Infection Prevention Working Committee using Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS) required elements for IPC programs. This IPC Program, along with the collaboration with the Antimicrobial Stewardship Program, meets all the requirements in accordance with 42 CFR 482.42.

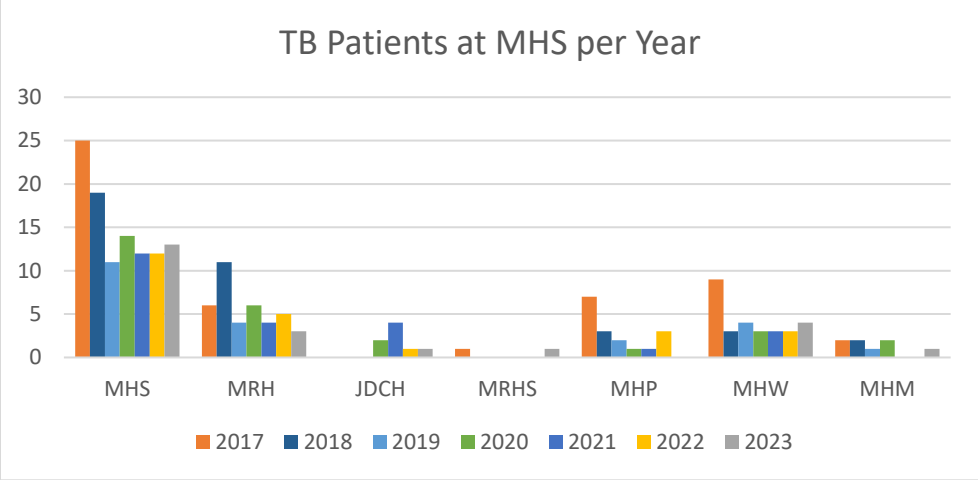
The **Plan** includes *Authority Statement* and a *Scope of Service* that is specific based on hospital location, populations served, and services provided. Annual revisions of each plan included:

- Added an Executive Summary page and Table of Contents page for organization.
- Updated locations of care, top ten diagnoses and top ten procedures at each site and system wide for CY 2023.
- Added Program Objectives and Program Management elements.
- Added a more thorough required section describing "Investigation of Outbreaks."
- Updated references.

The **Risk Assessment** uses a *Hazard Vulnerability* template in use by various MHS departments and was scored in 2024 Q1 based on CY 2023 actual data of risks. It was reviewed by the hospital's multidisciplinary Infection Control committee or working team. This year's (CY 2024) *Priorities, Goals, and Objectives* are identified using Pareto graphs to visually represent the top 20% of risks in four main areas: Hospital Associated Infections, Community Risks, Healthcare Worker Risks, and Environmental Risks. The top risks and goals include:

MHS Infection Prevention and Control (IPC) Plan

- MHS TB Risk Assessment for 2023 saw increased incidence nationally and the state for year 2022 (most update information). Broward county saw decrease but Miami-Dade increased. All hospitals remained **Low-Risk** classification for healthcare settings (MMWR 2005; 54 (No. RR-17).
- In 2023, the number of HCW conversions because of exposures were MHW-4, MRHS-0, MHP-0, MHM-0, MRH/JDCH-0. IC works with Employee Health. Annual TB education increased. EPIC orders updated to include airborne isolation with TB sputum orders.



The **Evaluation/Appraisal and Goals and Objectives** reviews and evaluates the previous year's CY 2023 hospital-specific goals and objectives by comparing the previous year's CY 2023 data for infections, hand hygiene, staff vaccination, and more. The goals and resultant data are clearly stated to compare performance in both 2022 and 2023, with a *Past Year's Summary of Action Items* undertaken in the past year, and specific, *Achievable Goal Metrics for 2024*. Annual goals and summary of actions related to:

- Continue monitoring and benchmarking HAI with 2-10% goal for reduction using SIR or internal rates. From 2022 to 2023, there was a:
  - **29% decrease** in system CLABSI SIR even with a 9.9% increase in central line days
  - **1.9% decrease** in system CAUTI SIR and 4.4% decrease in catheter days
  - **1.6% increase** in system MRSA bacteremia SIR with 6% increase in patient days
  - **19% decrease** in system CDI SIR even with 6% increase in patient days
  - **19% decrease** in system SSI Colon & Hyst SIR even with 23.5% increase in procedures
- Updated Hospital-specific HAI action plans with physician champions.
- Reviewed clusters, outbreaks, influx of infectious patients, highly infectious disease plans and emergency preparedness drills.
- Updated plans for increasing accuracy of hygiene compliance rates.
- Continue monitoring influenza and COVID-19 vaccination rates.
- Continue monitoring supply chain shortages and product substitutions.
- Updated multidisciplinary water management plans.

MHS Infection Prevention and Control (IPC) Plan

Approval Dates CY 2024

The hospital plans are annually reviewed by the Medical Executive Committee and taken to the MHS Board of Commissioners for approval. Please refer to meeting minutes for attendees and details.

Name of Hospital	Quality Care and Patient Safety Council *Meeting Date*	Medical Executive Committee *Meeting Date*	South Broward Hospital Board of Commissioners *Meeting Date*
Memorial Regional Hospital & Memorial Regional Hospital South	3/13/24	4/17/24	7/25/24
Joe DiMaggio Children's Hospital	6/7/24	6/19/24	7/25/24
Memorial Hospital Pembroke	3/1/24	4/11/24	7/25/24
Memorial Hospital West	5/28/24	7/8/24	7/25/24
Memorial Hospital Miramar	5/8/24	6/12/24	7/25/24

MRH

Evaluation of the Infection Prevention and Control Plan 2023 and Goals and Objectives 2024

This Program Evaluation is based in part on Annual Risk Assessment of top priorities ("vital few") as identified by Pareto Analysis and the outcomes achieved during calendar year 2023 (1/2023 to 12/2023). Outcomes are identified through review of performance measurement data, information resulting from our committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Memorial Regional Hospital and in collaboration with other Memorial Healthcare facilities. *The hospital evaluates the effectiveness of its infection prevention and control plan (IC.01.05.01)*

The purpose of this annual appraisal is to:

1. Evaluate the effectiveness of the Infection Control program of Memorial Regional Hospital in detection, identification, prevention, and control of hospital acquired and community acquired infections in patients, employees, physicians, licensed independent practitioners, volunteers, contract service workers and visitors while in the hospital.
2. Identify and assess the degree of risk factors for the acquisition and transmission of infectious diseases to reduce the incidence and eliminate their spread among persons in the hospital and in the community.
3. Identify opportunities for quality and performance improvement, loss prevention, cost containment and planning for the upcoming year.
4. Adhere to all local, state, and national regulatory guidelines for healthcare facilities.

The following top organizational risk priority targets were identified from the CY2022 Memorial Regional Hospital Infection Control Risk Assessment, 2023 Annual Plan and 2022 institutional data analysis. Targets were adopted from internal goals to reduce yearly harm by 10%, external reporting CMS/VBP/HAC and/or Leapfrog performance achievement thresholds, CDC/NHSN published progress reports and internal TAP reports, and community historical trends. *Based on institutional determined goals and identified risks (risk ≥20% on ICRA Pareto), the organization sets goals to minimize the possibility of transmitting infections (IC.01.04.01).*

1. Overall reduction of healthcare associated infections. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI) and catheter associated urinary tract infection (CAUTI). Minimize the risk of hospital acquired infections associated with invasive devices.	**2022 Performance**	**2023 Performance**	**2024 Goal** **10% reduction in rate or CMS or Leapfrog benchmark**
CLABSI Central Line Infections Central Line Days X 1000 = Rate per 1000 Central Line Days SIR = observed/predicted	**Total 28/ 15275** **Rate 1.83** (All units) **CMS Reportable 10/** **10 CLABSI** **SIR 0.650** (CMS reportable Units)	**Total 31/ 17206** **Rate 1.80** ↓ (All units) **(decreased by 1.63%)** **9 CLABSI** **SIR 0.527** ↓ (CMS reportable Units) GOAL MET **(decreased by 18.9%)**	0.00 Benchmark 0.760 Threshold
CAUTI Urinary Catheter Infections Urinary Catheter Days X 1000 = Rate per 1000 Urinary Catheter Days	**Total 34/ 10156** **Rate 3.35** (All units)	**Total 31/10218** **Rate 3.03** ↓ (All units) **(decreased by 9.28%)**	0.00 Benchmark 0.615 threshold

SIR = observed/predicted	**11 CAUTI** **SIR 0.929** (CMS reportable Units)	**8 CAUTI** **SIR 0.684↓** (CMS reportable Units) **(decreased by 26.37%)** Goal Not Met	

Analysis

- Infections are identified from prospective surveillance by the trained IP staff using NHSN definitions.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.

Effectiveness

- **CLABSI**
  - CLABSI threshold of 0.760 was **met** in CY 2023 as our SIR for CY 2023 was 0.527.
  - CLABSI SIR **decreased** from CY 2022 (0.650) to (0.527) in CY 2023, which yielded a decrease of **18.9%.**
  - In 2023 there were a total of 31 CLABSIs hospital wide that were identified with 17206 device days and a rate of **1.80.** In 2022 there was a total of 28 CLABSIs identified with 15275 device days which yielded a rate 1.83.
  - In CY 2023 we had 9 CMS reportable CLABSI one less than in CY 2022 where we had 10.
  - Our CLABSI rate identified a slight decreased in CY 2023 when compared to CY 2022 by **1.63%.**
  - We also saw device days increase by 1,931 in 2023 when compared to 2022, which is a 12.64% increase.

- **CLABSI Prevention initiatives**
  - Infection Preventionist rounding was utilized for bundle compliance with evidence based best practices as well as daily assessment of a central line including line necessity, discontinuation or an alternative to the central line, improved awareness and communication, opportunities with products in central line dressing kits, disinfectant caps on all central lines, daily chlorhexidine bath for patients with CVC lines was implemented facility wide, IP rounding included ongoing interventions; line necessity, education and line dressing surveillance.
  - Opportunities identified related to peripheral, blood culture collection and central line care were addressed in real time and follow up report to Nurse Manager, DON, Quality Leadership, and Nursing leadership.
  - Quality / Infection Control scheduled meeting to address blood culture contamination rate and CLABSI with Nursing unit leadership with monthly update to dashboard.
  - Education provided on Blood Culture Collection to include no blood cultures from central lines with Infection Preventionist providing unit specific education as well as attending scheduled Unit Departmental meeting to re-educate as well as partnering to identify any gaps in education or supply chain issues.
  - DONUT GIVE UP The sweetest journey to zero – Central Line Associated Bloodstream Infection Education, Rewards and Recognition to highlight and recognize those units that have been successful in preventing infections. All units given Educational Resource that hangs on their WOWS for quick reference on best practice initiative to prevent CLABSIs.
  - Infection Preventionist performs mini-RCA with drill down, timeline, and chart audit to ensure interventions were done. Meets with specific unit leadership on each event identified to determine any opportunities, for lessons learned to share with other units to prevent CLABSI and continue to strive for “Zero”. CLABSI Criteria is included in each event as a learning tool.

- Universal Decolonization was added to CLABSI Prevention Bundle during the Q4 2022. Nasal decolonization with Povidone iodine in Pre-Op and in Critical Care areas and Alcohol Nasal decolonization in all other units. With audits performed to ensure compliance as part of mini -RCA and on random units to ensure compliance.

- Vendor partnership for audits and staff education:

    - Stryker – 2% Chlorhexidine Gluconate (CHG) cloths / Comfort Warmer
    - 3 M – Tegaderm CHG Dressing

- IP will continue to monitor and communicate findings and report CLABSI Surveillance data and opportunities with the appropriate stakeholders by attending MRH Departmental meetings such as the MRH Critical Care Medical Staff Meeting, and Trauma Medical Staff meeting.

- Surveillance data presented during quarterly Infection Control and Prevention Committee.

- **CAUTI**
    - CAUTI achievement threshold of 0.615 was **not met** for CY 2023 as our SIR was 0.684.

    - CAUTI rates and SIR **decreased** overall in 2023 compared to 2022 in CMS reportable as well as Total hospital CAUTIs.

    - In 2023 there was a total of 31 CAUTIs identified with 10218 device days which yielded a rate of 3.03.

    - In 2022 there was a total of 34 CAUTIs identified with 10156 device days with a rate of 3.34.

    - The number of CMS reportable CAUTI d**ecreased** from 11 in CY 2022 to 8 in CY 2023.

    - The CAUTI rate **decreased** by **9.28%** from 2023 when compared to 2022.

    - The CAUTI SIR rate **decreased** by **26.37%** in 2023 compared to 2022.

    - There was an increase in Foley catheter days by 62 device days or 0.61% from 2023 (10218) to 2022 (10156).

- **CAUTI Prevention initiatives**

    - Infection Preventionist rounding was utilized for bundle compliance with evidence based best practices as well as daily assessment of a Foley Catheter including device necessity, discontinuation or an alternative to the Foley Catheters, improved awareness and communication, IP rounding included ongoing interventions, device necessity communication in real time, education, and Foley Maintenance surveillance.

    - Daily Foley catheter report reviewed to identify opportunities for removing indwelling catheters and/or replacing with external catheters, if indicated.

    - External Male and Female catheters are available, and staff have been educated to use ANI (advanced nursing Interventions) for early Foley removal as indicated.

    - Extensive education in place for Foley care and maintenance.

    - Communicated with nurse managers and administration during management huddle on lessons learned to prevent CAUTI.

    - Infection Preventionist performs mini-RCA with drill down, timeline, and chart audit to ensure interventions were done and meets with specific unit leadership on each event identified to determine any opportunities, for lessons learned to share with other units to prevent CAUTI and continue to strive for “Zero”. CAUTI Criteria is included in each event as a learning tool.

- DONUT GIVE UP The sweetest journey to zero – Catheter Associated Urinary Tract Infection Education, Rewards and Recognition to highlight and recognize those units that have been successful in preventing infections. All units given Educational Resource that hangs on their WOWS.
    - Urine Culture Collection Algorithm for Patient with Indwelling Foley Catheters
    - Foley Insertion Bundel Education
    - Daily Audit for CAUTI Prevention Education

- Vendor partnership for audits and staff education:

    - Bard – Foley Lifecyle Assessment
    - Stryker – 2% Chlorhexidine Gluconate (CHG) cloths / Comfort Warmer

- Universal Decolonization was added to CAUTI Prevention Bundle during the Q4 2022. Nasal decolonization with Povidone iodine in Pre-Op and in Critical Care areas and Alcohol Nasal decolonization in all other units.

- IP will continue to monitor and communicate findings and report CAUTI Surveillance data and opportunities with the appropriate stakeholders by attending MRH Departmental meetings such as the MRH Critical Care Medical Staff Meeting, and Trauma Medical Staff meeting.

- Surveillance data presented during quarterly Infection Control and Prevention Committee.

- Foley Free ED initiative reboots in April 2023 with ongoing education to Emergency Room Staff with tracking and trending with reports sent to ED leadership to share with their team.

2. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs), CRE, C auris, Resistant Acinetobacter baumannii Carbapenem-resistant Acinetobacter baumannii (CRAB) and *Clostridium difficile* (CDIFF)		**2022 Final**	**2023 Final**	**2024 Goal (10% reduction) from 2023**
CRE	# of patients with MDRO # of patient days x 1000 = MDRO rate	240/181333 **Rate 1.32**	200/ 181622 **Rate 1.10** ↓ **(decreased by 16.6%)** ***Goal met***	
C.auris		139/181333 **Rate 0.76**	52/181622 **Rate 0.29** ↓ **(decreased by 61.84%)** ***Goal met***	
Resistant Acinetobacter baumannii - Carbapenem-resistant Acinetobacter baumannii (CRAB)		10/181333 **Rate 0.055**	13/181622 **Rate 0.07** ↑ **(increased by 27.27%)** ***Goal not Met***	
CDIFF	# of patients with CDIFF # of patient days x 1000 = rate	65/181333 **Rate 0.358**	39/183165 **Rate 0.21**↓ **(decreased by 41.66%)** ***Goal met***	
MRSA bacteremia	# of patients with MRSA bacteremia	11/181333	7/186034	

	# of patient days x 1000 MRSA rate	**Rate 0.06**	**Rate 0.037** ↓ ***(decreased* by 38.3%)** ***Goal met***	
MRSA bacteremia SIR	SIR: observed predicted	SIR 1.038	SIR 0.641↓ ***(decreased* by 38.24%)** ***Goal met***	*0.747* *Threshold*
CDIFF SIR		SIR 0.59	SIR 0.35 ↓ ***(decreased* by 40.67%)** ***Goal met***	*0.423* *Threshold*

Analysis

- Infections are identified from prospective surveillance by the trained IP staff using NHSN definitions.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.

Effectiveness

- **MDRO, C auris & CRAB**
  - We **met** our goals in MDROs, as we saw decreases in MDROs of at least 10 % or the rates in CY 2022 in CY 2023.
  - There was a 16.67 % rate **decrease** in **CRE** rate overall from CY2022 to CY2023, in 2022 rate was 1.32 and decreased to 1.10 in 2023.
  - There was a 61.84% **decrease** in the **C auris** rate overall from CY 2022 to 2023.
  - **Resistant Acinetobacter baumannii -Carbapenem-resistant Acinetobacter baumannii (CRAB) increase** by 27.27% below the CY 2022 rate.

- **CDIFF & MRSA bacteremia**
  - We **met** our Achievement Threshold for Clostridium difficile infections for CY 2023.
  - There was a major **decrease** in **CDIFF** rate overall from CY2022 to 2023, from 0.36 in 2022 to 0.21 in 2023.
  - CDIFF SIR in CY 2022 was 0.59 and 0.35 in CY 2023 which represents a 41.6% **decrease.**
  - We **met** our Achievement Threshold for Methicillin-Resistant Staphylococcus aureus infections for CY 2023.
  - There was a **decrease** in **MRSA** bacteremia rate overall from CY 2022 when compared to 2023, from 0.61 in 2022 to 0.38 in 2023.
  - CY 2023 the MRSA SIR is 1.301 and 0.641 CY 2022 which is a 37.78% **decrease** from CY 2022.

- **Prevention initiatives**
  - Early identification of patients colonized or infected with resistant organisms or other infectious organisms and immediate transmission-based isolation of these patients reduced and prevented further transmission.

- IP performed daily surveillance of cultures from patients admitted with or developing infection.

- IP also monitored the high priority organism list and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the IP to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission-based precautions.

- Infection Control and Prevention department compile daily reports to ensure correct isolation precautions are in place and that patients are cohorted correctly to prevent infections such as:

    - Corhorting Patients with Droplet Precautions
    - Corhorting Patients with Contact & Enhanced Contact Precautions
    - GI Precautions Report
    - COVID-19 Convalescent Report

- The CDC isolation precautions are part of MHS policy and on the intranet website as a resource for all staff to have access to.

- We continued to implement GI Precautions, Enhanced Contact Precautions, Enhanced Respiratory Precautions in addition to CDC Transmissions-Based Precautions and Standard Precautions.

- Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Infection Prevention was a part of MDRO action plan.

- Continued active surveillance for CRE and C. auris for high-risk patients on admission, patients that meet the following criteria:

    - Long term Acute Care Patients
    - Patients requiring total assist/ Cannot perform basic ADLs.
    - Admitted with Tracheostomy
    - Direct admit form an ICU outside the USA
    - Patients with a chronic wound that has not healed for more than 6 months.

- Bioquell / mobile hydrogen peroxide vapor generator was used after Terminal cleaning Candida auris rooms to eliminate organism from exposed surfaces to prevent cross contamination and prevent patient harm.

- Partner with EVS leadership, implemented Enhanced Contact Precautions Terminal Cleaning Protocol along with EVS checklist to ensure patient safety and prevent cross contamination.

- Universal Decolonization was added to MRSA Prevention Bundle during the Q4 2022. Nasal decolonization with Povidone iodine in Pre-Op and in Critical Care areas and Alcohol Nasal decolonization in all other units.

- Blood culture collection education and opportunities identified.

- Surveillance rounds and lab monitoring are mechanisms in which information is gathered. Individual clusters were and will continue be analyzed and interventions will be determined at that time.

- Continued emphasis on hand hygiene and antimicrobial stewardship.

- Appropriate testing guidelines for C-diff disseminated to all medical staff.

- Continued use of Smart CDIFF order set that was implemented in November of 2022.

- Continue to educate on CDI algorithm as a method to identify patients in need of CDI testing.

- Collaboration with EVS team to implement additional prevention strategies as needed.

- Collaboration with antibiotic stewardship committee. Collaboration with EVS team to implement additional prevention strategies. This includes daily communication of patient rooms on GI precautions including rooms pending discharge targeted for Electrostatic bleach use. In addition, all discharges in Oncology Unit (regardless of Isolation status) are being treated with Electrostatic sprayer followed by bleach wipes.

3. Surgical Site Infections (SSI) Carry out systemic program surveillance and reporting of all Class I and II surgical site infections.	**Targeted Class**	**CY 2022 Performance**	**CY 2023 Performance**	**2024 Goal** **10% reduction in rate or CMS or Leapfrog benchmark**
Surgical Site Infections/ Surgical Procedures Completed X 100 = SSI Rate	**Class I Rate (All)**	33/5364 **0.62%**	30/ 5448 **0.55%** ↓ **(decrease of 11.29%)** **Goal Met**	
	Breast /Plastic SSI Rate	17/242 **7.02%**	14/261 ↓ **5.36%** **(decrease of 23.64%)** Goal met	
	Hysterectomy Rate	1/110 **0.87%**	0/127 ↓ **0.0%** **(decrease of 100%)** Goal met	
	Colon Rate	3/169 **1.77%**	5/194 ↑ **2.57%** **(increase of 45.19%)** Goal not met	
SIR: observed/predicted	**Colon SIR**	**0.585**	**0.809** ↑ **(increase of 38.29%)** Goal not met	**Benchmark 0.00** **Threshold 0.747**
	Hysterectomy SIR	**0.00** **SIR not calculated**	**0.0** Constant at zero Goal met	**Benchmark 0.00** **Threshold 0.763**

Analysis

- Infections are identified from prospective surveillance by the trained IP staff using NHSN definitions.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
    - Goal **met** for All Class I SSI, Breast Plastic Surgery SSI, and Hysterectomy SSI for CY 2023.

- Class I surgeries, surgery site infection rate **decreased** in CY 2023 (0.55) compared to CY 2022 (0.62), with represents an 11.29% decrease.
- Breast / plastic SSI rates **decreased** by 23.64% in CY 2023 (5.36%) from CY 2022 (7.02%).
- Colon SIR **increased** from 2023(0.809) to 2022 (0.585) by 38.29%.
- Hyst SIR was constant at zero, **benchmark of zero** was met.

Prevention initiatives

- Analysis of all SSI data reviewed at the NSQP and departmental meetings.
- Journey to ZERO Patient Harm task force for improving surgical Outcomes with focus on review and collaborative review of SSI for opportunities.
- Universal Decolonization implemented Q4 2022 with the addition of Nasal Decolonization with Povidone iodine 1 time for Pre op on all high-risk surgeries along with CHG treatment wipes initiative is ongoing.
- Intense analysis of colon and hysterectomy infections with Action Plan that includes all SSI prevention.
- Drill down on all SSI infections with an opportunity to discuss lessons learned with management and administration.
- Re-education was provided to clinical staff regarding pre-op chlorhexidine bathing; the antibiotic, time given and re-dosing.

Effectiveness

- Act as informed liaison between - Microbiology, Pharmacy, Utilization Review, and Nursing
- Monitor appropriate Antibiotic therapy. ICP participates in the SCIP program. Information presented quarterly to QCPSC, Department of OB, PIRM, Dept. of Pediatrics and Department of Surgery
- NSQP team including IP to work on SSI Reduction.
- In collaboration with Pharmacy team and Medical Staff, all MHS preoperative antibiotic prophylaxis order sets reviewed and updated to agree with current professional guidelines.
- Unscheduled C-sections receive azithromycin prophylaxis in addition to standard prophylaxis.
- Implemented use of Sage CHG wipes for surgical patients.
- Gap analysis and action plan regarding strategies supported by evidence-based medicine to reduce SSI which includes preoperative bathing with chlorhexidine, surgical site scrub with chlorhexidine, and weight based antibiotic dosing and appropriate antibiotic selection for patients.

- Surveillance of evidence based best practices as well as the improvement solutions remain on-going to maintain a downward trend with reducing colon surgery infections as well as class I SSI
- Infection Prevention participation and reporting during MRH Surgery Medical Staff Meeting and Plastic Surgery Medical Staff Meeting to report on SSIs.

4. Improve hand hygiene and standard precautions compliance. Improve employee knowledge of disease prevention and transmission.	2022 Rate	2023 Rate	2024 Goal
Hand Hygiene (iRound) compliance Number of observations/number of opportunities	**97.09 %**	**96.69%** Goal met	**>95%**
IP to perform PPE Just in time coaching and education for compliance during rounds.	**New for 2023**	**100%** Goal met	**>95%**
iRounds PPE used correctly	**New for 2023**	**99%** Goal met	**>95%**

Analysis

- iRound observed compliance of hand hygiene with:
    - Entering patient's room
    - Exiting patient's room
    - After glove removal
    - PPE used correctly

- Increase in audits performed in 2023 with 104,022 observations observed and documented in iRounds as compared with 83,658 observations in 2022.

Effectiveness

- Units complete monthly action plans for areas of opportunity.
- Discussed at staff meetings.
- Standardized training utilizing TJC education on observing compliance provided to unit observers.
- Infection Preventionist provides Hand Hygiene, Isolation Adherence to Isolation Precautions and Personal Protective Equipment during New Hire Orientation.
- Just in time education on Hand Hygiene, adherence to Isolation Precautions and Personal Protective Equipment during rounding to staff, as well as physician.
- Dr. Eckardt and Dr. Speir encourage physicians to adhere to our Hand Hygiene, Isolation Precautions and Personal Protective Equipment process and for incident reports to be completed for noncompliance by physician.

5. Reduction and mitigation of exposure to respiratory viruses including COVID-19. Reduction in delay or non-compliance with isolation precautions	2022	2023	2024 Goal
Patient COVID onset on day 14 or more	**160**	**86↓ (decrease of 46.25%)** Goal met	*10% decrease when compared to 2022*
Patients with active infections CY 2023 that were placed on Isolation Precautions on the same day infection was identified	**New for 2023**	**1587/2944 54%** **New for 2023**	

Analysis

- 86 patients tested positive for COVID on day 14 or more in CY 2023.
- 160 patients tested positive for COVID on day 14 or more in CY 2022 as compared to 86 patients in CY 2023, which is a 46.25% decrease

Effectiveness

- Semiprivate rooms at MRH posed challenges for roommate transmission of COVID
- COVID education and PPE donning and doffing education completed by IP team:
    - Monthly during New Hire Orientation
    - February 2023 COVID Specific Re-education
    - March 2023 COVID Specific Re-education
    - January 2024 COVID Exposure Bulletin
- Universal masking with medical grade masks on high-risk units or initiated with increased risk to the community or in the facility.
- Testing all patients on admission with respiratory symptoms as we are no longer testing every patient.
- Process for COVID-19 exposure:
    - Immediately place patient on Enhanced Respiratory Precautions
    - Move patient to private room
    - No further testing is required, but if tested as is positive for COVID, monitor patient for signs and symptoms of COVID for 7 days before removing from isolation.
    - If not tested, monitor patient for signs and symptoms of COVID for 10 days before removing from Isolation.
    - All Enhanced Respiratory Precautions rooms must be terminally cleaned by EVS upon patient discharged.
- COVID-19 intranet with continuously updated guidance documents along with updated CDC Covid-19 community transmission for Broward County (January 2024- Inf Broward County, Florida, the COVID -19 hospital admission level is low)
- Continue collaboration with Emergency Preparedness Committee and Employee Health to implement interventions that reduce exposure to and transmission of COVID-19; achieve zero nosocomial/hospital acquired transmission of infection.

- Tracking and trending on patients with active infections to ensure they are placed on Isolation on the same day infection was identified.

6. Reduction of risk of infection secondary to inadequate supplies, or failure to follow safety devices/sharps handling, personal protective equipment, handling of biohazardous waste.	2022	2023	2024 Goal
Frequency that IP consulted and responded with expert review in product substitutions and availability of supplies & front-line staff aware.	**100%**	**100%** Goal met	**100%**

Analysis

- Goal met Infection Prevention Team are consulted and respond to review products substitutions at MRH.

Effectiveness

- Provide input on issues of product selection and efficacy. Products evaluated as needed via MHS system wide VAT committees, chemical, cleaning agents and medications.
- IP team completed direct observation and return demonstration of PPE donning and doffing with staff.
- Hands on demonstrations and creation of education and visual aids in real time.
- Rounding on the floors to ensure staff has HAI initiative products available.
- Communication to unit leaders, DONs, and front-line staff with immediate response to any product or product substitution.
- Utilize CDC, APIC, SHEA and other professional society guidelines.
- Consultation and communication from supply chain, materials management, and clinical team for backorders, conservation activities, crisis, and contingency standards dependent on availability of medical equipment.
- Unit level in-services continued to be presented for dissemination of product information.
- Educational materials are created by the IP team, provided on the intranet, or printed and used to educate staff, patients, and families

7. Prevent unprotected exposure to pathogens (i.e., COVID-19, seasonal flu, pandemic flu, influx of infectious patients, active TB patients and patients with history of MDRO, unusual clusters of organisms or HAI, hemorrhagic fever diseases, emerging infectious diseases, other community acquired infection risks). Monitor the inpatient and outpatient traffic for any potential cases of active TB	2022	2023	2024 Goal

or increase in influx of infectious patient. Ensure PPE and education is provided to prevent outbreaks on affected units. Reduction in sharps injuries or blood borne pathogen exposures.			
MDRO trends/identification • TB	4 TB Cases / 181333	7 TB Cases/181622 **Sputum 2 cases** Tissue 2 cases Blood 1 case Abscess 1 case Urine 1 case	Ongoing monitoring and surveillance to ensure Airborne Isolation is initiated and followed to prevent patient and staff harm.
• Mycobacterium	6 Cases /181333 Blood 3 cases Tissue 2 cases Skin 1	14 Cases/ 181622 Abscess 3 cases Sputum 8 Cases Tissue 1 case Bronchial wash 2 cases	Ongoing monitoring and surveillance to look for trends or opportunities. Alert Leadership and physicians of trends & recommendations
Influx of other infectious patients • Monkeypox	29 cases	0 cases	Ongoing monitoring and surveillance to look for trends or opportunities

Analysis

- There were 471 COVID-19 positive employees, 5 TB exposures that involved 77 employees, 0 conversions, and 0 Varicella, 0 meningitis, 91 needle sticks, 2 sharps exposure, and 37 blood and body fluid exposures for CY 2023. Each exposure was followed by Employee Health. There were no conversions or nosocomial transmissions identified during post-exposure work-up.
- TB education updated in mandatory Annual Review.
- ICP Educate on TB during Monthly New Hire Orientation.
- The surveillance plan based on prioritized risk of transmission of diseases identified in our community and from the characteristics of the population served was developed and approved by the Quality Care Council.
- The surveillance plan is carried out by the IPs on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers, and visitors.
- The ESSENCE reporting system that identifies syndromic trends through the ER was used to coordinate surveillance with the Broward County Department of Health.
- MHS uses electronic case reporting (ECR) for COVID-19 reporting to the state.

Effectiveness:

- MRH will continue to actively track and trend admission of patients for any increase influx of patients and/or need to implement the Pandemic Plan.

- IP staff monitor the daily high priority organisms and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the IP nurse to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission-based precautions.
- All blood and body fluid exposures and TB exposures documented in CY 2023 were followed up by Employee Health and resulted in zero transmissions.
- Documents epidemiologically significant infections among employees.
- Monitors Employee Health (TB skin testing and Hepatitis B vaccination program, exposures to blood and body fluid during performance of work).
- Monitors tuberculosis program, updates TB Control Plan, provides educational programs on TB, reviews and updates mandatory written guide and employee self-education packet annually.
- Monitor compliance with OSHA Blood-borne Pathogen and Tuberculosis Standards.

8. Promote and improve seasonal flu and COVID immunization organization wide	**2021-2022**	**2022-2023**	**2023-2024 goal: >90%**
Employee Influenza immunization rate	92% all Healthcare workers	96% All Healthcare workers Goal met	**2023-2024 goal: >90%**
Employee COVID immunization rate		10/1/2022 to 3/26/2023 MRH compliance is 90% Goal met	**2023-2024 goal: >90%**

Analysis

- NHSN definitions are utilized for mandatory compliance reporting.
- Influenza vaccination became mandatory across MHS in 2021 driving an increase in compliance.
- Influenza vaccine program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs. Nursing offers vaccination to inpatient patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered in Employee Health during the entire flu season as well as times when mobile vaccination carts attend units and meetings.
- Infection Control and Prevention team participate by educating on Flu during the Safety Fair yearly.
- Mandatory influenza education is provided to all hospital staff via Annual Review.
- Individual counseling and encouragement for participation includes a video to watch for employees who decline vaccination.
- Declination forms are used to monitor the reasons given for declining the vaccine as well as the effect of educational interventions.

Effectiveness

- Flu and COVID vaccination information is available on Annual Review and is mandatory to complete for all staff.
- Administrative support by participated in campaigns for vaccination.
- Employees who take flu vaccine are incentivized with health insurance premiums.
- Influenza vaccine mandatory
- MHS System Human Resources and Employee Health will continue to explore methods to maintain the >90% rate of vaccination among health care workers.

9. Reduce risk of infection secondary to inadequate sterilization, high Level disinfection, low level disinfection, or environmental cleaning practices.	**2022**	**2023**	**2024 Goal**
Frequency that IP reviewed documentation and logs and conducted regular visual observations of reprocessing areas.	100%	100 % Goal met	100%

Analysis

- Infection Preventionist follow Center of Disease Control and Prevention (CDC) and Association for the Advancement of Medical Instrumentation (AAMI) guidelines.

Performance

- IP assisted with risk assessment and partnering with end users in following manufacturer's instructions, most up to date evidence-based guidelines.

Effectiveness / Actions taken:

- Annual competencies completed for OR terminal cleaning, BD Alaris pump, Ultrasound probe HLD.
- Review disinfectants annually and instructions for use.
- Review of new equipment and partner with end users in creating cleaning and disinfection process.
- Infection Prevention rounding in Surgical Services, and Sterile Processing Department and advocates the SPD personnel are responsible for ensuring that surgical instruments and other medical devices are properly sterilized and fee of harmful microorganism before use.
- Infection Prevention audits alongside of SPD leadership to ensure that instruments are not broken, damaged or malfunctioning.

10. Reduce risk of infection secondary to water management, Reduction of risk of infection secondary to hurricane or flood events.	2022	2023	2024 Goal
Frequency of IP participation in Water Management Committee meeting, review of documents.	100%	100% Goal met	100%
Frequency of IP participating in EOC rounds	100%	100% Goal met	100%
Frequency of IP participating in Emergency Management meeting, drills, tabletop exercises, and hurricane preparedness activities	100%	100 % Goal met	100%

Analysis

- Infection Preventionist reviewed national guidelines from the CDC, AAMI, APIC, SHEA, and other literature resources pertaining to water risks.

Performance/Effectiveness:

- Infection Preventionist partner with facilities, Sterile Processing, Emergency Preparedness, Emergency Department.

Actions taken:

- Continue to meet regularly and update plans as needed with interdisciplinary teams.
- Work with facilities and SPD Department to review temperature and humidity logs of sterile area after weather events and equipment failure.
- Ongoing monitoring and surveillance of environmental organisms.

11. Infection Prevention and Control Program Plan, Evaluation of the Plan, Risk Assessment, Policies and Procedures are reviewed and updated annually. Plans include policies and procedures for minimizing risk of transmitting infection associated with use of procedures, medical equipment, medical devices, and products.	2021 Target	20223 Final	2024 Goal
Program policies and procedures review completed	100%	100% Goal met	100%
Program has NHSN and APIC trained IPs with expertise ranging from MPH, RN, MT and CIC	100%	100% Goal met	100%
Medical Director, Board Certified Infectious Disease Physician	100%	100% Goal met	100%

Analysis

- ICP performs ongoing analysis of P.I. initiatives, participates in multi- disciplinary rounds and reports quarterly at QCPSC. COVID-19 infection control rounding, education, management of all patients and staff according to CDC and national best practice guidelines.

- Appropriate, clinical necessity and timeliness of support services are provided by the department during off hours through the nursing supervisor and/or designated personnel. The Infection Preventionist is available to address the needs of the facility via cell phone to provide a timely response.

- In the absence of the IP, another IP in the system availed him/herself to provide coverage.

- The Infectious Disease physician was available for consultation when necessary to assist with difficult cases.

- System Director of Epidemiology and Infection Prevention for support through system-wide initiatives, program goals, and infection control coverage.

- The Comprehensive Infection Control Risk Assessment for CY2023 was presented to a multidisciplinary group for review, recommendations, and approval.

- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Medical Council. The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified. The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.

- Memorial Regional Hospital's Infection Control Program, policies and procedures are developed based upon established professional guidelines and national, state, local, as well as regulatory requirements including CDC Guidelines, OSHA Regulations, CMS, HRS Regulations, Joint Commission Standards, APIC Guidelines, FDA guidelines. In the absence of professional guidelines, best practices and evidence-based literature and professional society consensus are utilized.

- Computer technology is utilized for analysis, trending and tracking of infection surveillance data.

- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.

- ICP performs ongoing analysis of P.I. initiatives, participates in multi- disciplinary rounds and reports quarterly at QCPSC. COVID-19 infection control rounding, education, management of all patients and staff according to CDC and national best practice guidelines.

Effectiveness

- The Infection Control Practitioner is an active member of the local APIC chapter and participates in educational opportunities. Additionally, many local educational offerings and teleconferences dealing with current infection control issues are attended monthly.

- All the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.

- The Infection Preventionists are members of the national and local chapter of their professional organization and receive education related to Epidemiology/ Infection Prevention and Control on an ongoing basis.

- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of data and surveillance over the calendar year. This has provided more accurate analysis to better prioritize our risks and set new goals for the coming calendar year.

- Infection control data is reported quarterly to Quality Care & Patient Safety Council and respective nursing units.

- Currently Infection Control Practitioner is involved in the following Hospital-wide and System-wide Performance Improvement activities.

- Patient Rights - Patients are treated preserving their confidentiality. Information obtained and actions taken as consequence of Infection Control Surveillance shall be confidential and protected.
- Patient Assessment - Risk of hospital acquired infections is monitored based upon patient diagnosis and health status. Rapid access of laboratory and pathology test results are available to practitioner. Outside reference labs are used as necessary.
- Care of the Patient - Care of patient at risk and with identified hospital acquired infection will be monitored on an ongoing basis. Interventions for prevention of transmission will be implemented.

For 2024:

- Continue emergency preparedness protocols, policies and procedures established in 2021 & 2022 to isolate and control the transmission of COVID-19 within the hospital.
- Continue MRSA screening process for select surgical procedures per policy.
- EOC/Infection control rounds in all hospital areas.
- Monitoring of construction projects for infection control compliance.
- Outpatient surgical surveillance selected surgical procedure surveillance.
- Maternity and newborn surveillance.
- Update on OSHA, HRS and CDC standards.
- Collect data on hospital acquired, community infections and outbreaks.
- Concurrent and retrospective chart review-establishes control measures as needed.
- Orientation for all new employees.
- Sit and advise on hospital committees including (QCPSC, Safety, Critical care, NICU, Pediatrics, Performance Improvement, VAT Team, Pharmacy and Therapeutics.
- Provide reports: Infection Control Report -quarterly, MOR monthly, board report monthly.
- Monitor for performance improvement on bloodstream infections, lower respiratory infections, and blood and body fluid exposures.
- Provide employee infection control educational programs based upon needs/problem identification, Hand Hygiene, OSHA and TB mandatory programs).
- Management of outbreaks based upon written policy.

CY 2024 Infection Prevention and Infection Control Plan

I. Executive Summary

Memorial Regional Hospital (MRH) is a healthcare facility associated with the Memorial Healthcare System (MHS) and maintains an individual Infection Prevention and Control (IPC) plan tailored to its scope of service, to meet the specific needs of its population, but also participates in a systemwide IP program that is used to assist in standardization and strategic vision, as well as creates a framework for systematic organization of the cohesive and growing IPC activities in both inpatient and ambulatory locations. This Infection Prevention and Control Program, along with the collaboration with the Antimicrobial Stewardship Program, meets all the requirements of a comprehensive program in accordance with Centers for Medicare and Medicaid (CMS) Conditions of Participation (CoP) for 42 CFR §482.42.

The annual **Plan** includes both an *Authority Statement* and a *Scope of Service* that is specifically based on hospital location, populations served, and services provided for last calendar year (CY 2023), including top diagnoses and top procedures by volume, and standard plan elements.

The annual **Risk Assessments** use a *Hazard Vulnerability* template (also used in MHS Emergency Management) and was scored in 2024 Q1 based on CY 2023 actual risks and then reviewed by the hospital's multidisciplinary Infection Control committee or working team. Using the actual risks from the previous year, this year's CY 2024 *Priorities, Goals, and Objectives* are identified using a Pareto graph to visually represent the top 20% of risks in four main areas: Hospital Acquired Infections, Community Risks, Healthcare Worker Risks, and Environmental Risks.

The annual **Evaluation/Appraisal of Goals and Objectives** reviews and evaluates the previous year's CY 2023 hospital-specific goals and objectives by comparing at least two years of performance for infections, hand hygiene, staff vaccination, and more. The goals and resultant data are clearly stated to track performance in both 2023 and 2023, with a *Past Year's Summary of Action Items* undertaken in the past year, and a specific, *Achievable Goal Metric for 2023*.

The oversight and support of this essential program at each facility includes at least one highly trained Manager, the system Director of Infection Prevention and Epidemiology for MHS, and the Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship for MHS.

The hospital plan is annually reviewed by the Quality Council, Medical Executive Committee and taken to the MHS Board of Commissioners for approval.

II. Table of Contents

III. Introduction

Mission: Heal the body, mind, and spirit of those we touch.

Vision: To be a premier clinically integrated delivery system providing access to exceptional patient-and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Commitment: Family Centered and Patient Focused Care

Purpose: To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases.

This plan will *define the scope of activities* and *provide a framework* for the systematic, organization wide approach for an effective infection control program.

IV. Authority Statement

Pursuant to the approval by the hospital's *Medical Executive Committee* (§482.42(c)(1,2)):

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).
2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.
3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

V. Scope of Service 2023-2024

Memorial Regional Hospital (MRH)

MRH is located at 3501 Johnson Street, Hollywood, in southeastern Broward County, Florida. This is a metropolitan area between Fort Lauderdale and Miami. Memorial Regional Hospital is the flagship facility of the healthcare system and is one of the largest hospitals in Florida.

MRH offers extensive and diverse health care services that include:

- Anesthesia
- Cardiology
- Cardiovascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Endocrinology
- Gastroenterology
- General Surgery
- Gynecology
- Hematology

- Hyperbaric Medicine
- Internal Medicine
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics
- Ophthalmology
- Oral/Maxillo-facial Surgery
- Orthopedics
- Otolaryngology
- Plastic Surgery
- Podiatry
- Psychiatry
- Pulmonary Medicine
- Radiology
- Thoracic Surgery
- Urology
- Vascular Surgery
- Transplant Program
    - **Memorial Transplant Institute**: Memorial Regional Hospital, 3501 Johnson Street, Hollywood.
    - Services:
        - Adult Heart
        - Adult Kidney
        - Adult Pancreas/Islet Cells
        - Ventricular Assist Device (VAD)

Acuity:

MRH has 863 total capacity- with 649 Bed Adult Acute Care Tertiary Care and Behavioral Health facility and houses the following additional Institutes:

- Level I Trauma Care
- Memorial Cardiac and Vascular Institute
- Memorial Cancer Institute
- Memorial Neuroscience Institute

Licensed Programs:

- Comprehensive Stroke Center
- Level 2 Adult Cardiovascular Services
- NICU Level IV

Class 1 Hospital Licensed Beds

- Acute care: 707
- Adult Psych: 54
- Child Psych: 12

- Comprehensive Med Rehab:6
- NICU :84
- Critical Care beds: 77
- Medical/Surgical/Stepdown/Telemetry/Oncology beds: 400
- Obstetrics/Gynecology beds (including high risk antepartum): 118
- Behavioral Health bed: 54
- Emergency Department beds: 84
- Surgical Suites: 19

Population served - Ages: 18 – End of Life for acute care, and age 5 to 18 (if still enrolled in high school) for child / adolescent psych unit.

MRH Top 10 Inpatient Procedures, 2023

1. Delivery of Products of Conception, External Approach
2. Performance of Urinary Filtration, Intermittent, less than 6 Hours Per Day
3. Measurement of Cardiac Sampling and Pressure, Bilateral, Percutaneous Approach
4. Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening
5. Introduction of Remdesivir Anti-infective into Peripheral Vein, Percutaneous Approach, New Technology Group 5
6. Drainage of Spinal Canal, Percutaneous Approach, Diagnostic
7. Drainage of Right Pleural Cavity, Percutaneous Approach
8. Drainage of Peritoneal Cavity, Percutaneous Approach
9. Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
10. Repair Scalp Skin, External Approach

MRH Top 10 Primary Diagnoses, 2023

1. Single liveborn infant, delivered vaginally
2. Single liveborn infant, delivered by cesarean
3. Sepsis, unspecified organism
4. Maternal care for low transverse scar from previous cesarean delivery
5. Major depressive disorder, recurrent severe without psychotic features
6. Post-term pregnancy
7. Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
8. Hypertensive heart disease with heart failure
9. Schizoaffective disorder, bipolar type
10. Non-ST elevation (NSTEMI) myocardial infarction

MRH Top 10 Outpatient Procedures, 2023

1. Parathyroidectomy or exploration of parathyroid(s)
2. Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C

3. Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
4. Total thyroid lobectomy, unilateral; with or without isthmectomy
5. Thyroidectomy, total or complete
6. Biopsy or excision of lymph node(s); open, deep axillary node(s)
7. Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
8. Arteriovenous anastomosis, open; direct, any site (e.g., Cimino type) (separate procedure)
9. Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
10. Laparoscopy, surgical; cholecystectomy

Off-Site Outpatient Facilities & Hospital Based Outpatient Facilities

- Memorial Home Infusion 9579 Premier Parkway, Miramar, Florida 33025
- Memorial Pathology Servies 9571 Premier Parkway, Miramar, Florida 33025
- Memorial Outpatient Behavioral Health Center, 5595 S University Dr, Davie, FL 33328
- U 18 Sports Medicine, 5830 Coral Ridge Dr Ste 120, Coral Springs, FL 33076
- Memorial Healthcare System Sickle Cell Medical Home, 3700 Johnson St Ste B, Hollywood, FL 33021
- Memorial Cancer Institute, 1150 North 35th Ave Ste 200, Hollywood, FL 33021
- Memorial Cancer Institute, 1150 North 35th Ave Ste 385, Hollywood, FL 33021
- Memorial Cancer Institute, 1150 North 35th Ave Ste 330, Hollywood, FL 33021
- Memorial Pediatric Kidney Transplant Program, 1005 Joe Dimaggio Dr, Hollywood, FL 33021
- U 18 Sports Medicine, 5830 Coral Ridge Dr Ste 110, Coral Springs, FL 33076
- Memorial Cancer Institute, 1150 North 35th Ave Ste 270, Hollywood, FL 33021
- Memorial Adult Kidney Transplant Program & Transplant Clinic, 1150 North 35th Ave Ste 390, Hollywood, FL 33021
- Memorial Primary Care - East Hollywood, 3700 Johnson Street, Hollywood, FL 33021
- Memorial Breast Cancer Center, 1150 N 35th Ave Suite 170, Hollywood, FL 33021
- Memorial Primary Care Center, 4105 Pembroke Rd, Hollywood, FL 33021
- Joe Dimaggio Children's Health Specialty Center At Wellington, 3377 S State Road 7 Ste 100, Wellington, FL 33449
- Memorial Regional Fitness & Rehab Center, 300 Hollywood Way, Hollywood, FL 33021
- Memorial Primary Care Center - Dania Beach, 140 S Federal Hwy, Dania, FL 33004
- Memorial Primary Care and Memorial Cancer Institute Hallandale, 1750 E Hallandale Beach Blvd, Hallandale Beach, FL 33009
- Pediatric Transplant Clinic, 1150 N 35th Ave Ste 445, Hollywood, FL 33021
- Mind Body Wellness Clinic at Outpatient Behavioral Health, 5595 S University Dr Ste A, Davie, FL 33328-5307

VI. Program Objectives

The system Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices at Memorial Healthcare System with the intent:

1. To create and implement an active, system-wide comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare

providers, employees, volunteers, and visitors from contracting or transmitting communicable infections and diseases.

2. To collaborate with all healthcare system departments including Antimicrobial Stewardship - Pharmacy, Quality, Clinical Effectiveness, and Performance Improvement to minimize the morbidity, mortality and economic burdens associated with healthcare associated infection (HAI) and multidrug resistant organisms (MDRO) through prevention and control efforts throughout all sites where care is delivered.
3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection, as well as
4. To collaborate with Emergency Preparedness to engender advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event.

VII. Program Management

A. <u>Program Administration and Resources</u>

1. IP Program led by designated, qualified healthcare Infection Preventionists (IPs), as identified in the Authority Statement and are responsible for the IP program. IP team has access to multiple resources and consultative support not limited to but including the Medical Director of Infection Control and Antimicrobial Stewardship, System Director of Epidemiology and Infection Prevention, as well as being able to communicate and collaborate with the entire group of MHS IPs as a system for a unified infection prevention team (§482.42 (a)(1), IC.01.01.01, IC.01.02.01).
    a. Ratification of <u>competency</u> of IPC team members by Medical Executive Committee and Board.
    b. Maintains membership in Association for Professionals in Infection Control or Florida Professionals in Infection Control.
    c. Attends one (1) educational seminar related to infection prevention and control per year.
    d. Job descriptions delineate the scope and responsibility for each Infection Prevention professional.
2. Staffing, Memorial Regional Hospital South:
    a. Director, Quality & Patient Safety
    b. Manager of Infection Prevention & Control/Rehab Quality
3. Staffing, Memorial Healthcare System (Oversight and Support):
    a. Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
    b. Physicians, Infectious Disease (MRH, MRHS)
    c. Director, Infection Prevention and Epidemiology, MHS
4. Leadership responsibilities (§482.42(c)(1), IC.05.01.01)
    a. Governing body of healthcare system approves annual IP Plan.
    b. System Medical Director presents program to Board Peer Review at least annually to ensure program is in place for accountability and monitoring and prevention of infections.

5. Hours of Operation: Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

B. Plan of Care and Practice for Infection Prevention and Control

1. Planning for management of infection control and prevention (IC & P) program. (IC.01.01.01)
2. Development of an infection prevention and control plan (IC.01.05.01) from utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus.
3. Plan is a written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection.
4. Plan reflects the scope and complexity of the services provided (§482.42(a)(4)).

C. Performance of Risk Assessments

1. Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing. (IC.01.03.01, IC.06.01.01)
2. A multidisciplinary team collaborates to review results of the hospital's infection risk assessment and are prioritized in order of level of probability and potential for harm.
3. Identification, prioritization, and documentation of risk assessment in order of probability and level of harm based on:
    a. Geographic location, community, and population served.
    b. Care, treatment, and services provided.
    c. Analysis of surveillance activities and aggregate IC data
4. Pareto Analysis used to identify the top risks and set goals for reducing the risks of infections that pose the greatest threat to patients and the community.

D. Goal Setting

1. Goal setting to reduce risk of infection to patients and community (IC.01.04.01) and lead to focused activities, based on relevant professional guidelines and sound scientific practices.
2. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
3. Written goals, based on identified risks, include (IC.06.01.01**)**:
    a. Addressing prioritized risks
    b. Limiting unprotected exposure to pathogens
    c. Limiting the transmission of infections associated with procedures.
    d. Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies.

E. Evaluation of Effectiveness and Appraisal of Infection Prevention and Control Plan and Program

1. Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01) based on:
    a. Plan's prioritized risks
    b. Plan's goals
    c. Program's efficacy
2. Communication of findings to patient safety program.
3. Include findings of evaluation when revising the plan.

F. Policy and Procedure Development (§482.42(a)(2))

1. For infection surveillance, prevention, and transmission control that are reviewed annually and reference and adhere to nationally recognized guidelines.
2. Implementation of Practice for Infection Prevention and Control
3. Prevention and control of transmission of healthcare associated infections (HAIs) and infectious disease among patients and staff.
4. Implementation and documentation of infection control plan, surveillance, prevention, and transmission control that adhere to nationally recognized guidelines.
5. Performance of activities based on relevant professional guidelines and scientific practices.

G. Implementation and Documentation of infection surveillance, prevention, and control (IC.02.03.01, IC.04.01.01)

1. Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues (§482.42(c)(1)(ii), §482.42(c)(2)(iii)).
    a. The Infection Control Practitioner reports to the Director of Quality who reports to the Chief Nursing Officer.
    b. The Infection Control Practitioner will report to the Medical Staff any trends within their departments.
2. Training and education of employees and medical staff on practical application of IC & P guidelines and P & Ps (**§482.42(c)(2)(iv)).**
3. Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (§482.42(c)(2)(v), IC.02.01.01).
4. Implementation of IC & P activities involving departments, employees, and medical staff
    a. Surveillance methodology utilizing CDC NHSN with sources for identification including:
        i. Microbiologic records
        ii. Reports from Information Systems including patient census/diagnosis.
        iii. EPIC and outside labs
        iv. Chart reviews and patient interviews
        v. Post-discharge surveillance

vi. Reporting of suspect/known infections or infection control issues from staff and units' multidisciplinary rounds

vii. Device day usage for urinary catheters, central line catheters, and ventilators

viii. Public health reporting of state mandated reportable infections.

ix. Microbiologic monitoring of water and dialysate

5. Provision of important IC & P information to patients, employees, medical staff, and visitors

a. Respiratory Hygiene Practices

b. Hand Hygiene

c. Implementation of standard and transmission-based precautions

d. Utilization of personal protective equipment (PPE)

e. Donning

f. Doffing

6. Storage and disposal of infectious waste

7. Investigation of outbreaks (IC.01.05.01) – MHS Policy and APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12.Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures for framework and guidelines conducting an outbreak investigation

a. Initiates outbreak investigation when an outbreak or cluster is suspected consistent with CDC Guidelines.

b. Institutes early control measures, prepares a preliminary case definition, and compares current incidence with usual or baseline data.

c. Develops case definition based on time, place, person.

d. Evaluates efficacy of the control measures.

e. Reports finding to Medical Director of Infectious Diseases, System Director of Infection Prevention, Quality Care and Patient Safety Committee, appropriate Medical Staff Departments and Florida Department of Health, if warranted.

f. Reporting of surveillance, prevention, and control information to appropriate staff within facility

8. The Infection Control Practitioner will report relevant findings to PIRM Committee, and Environment of Care Committee quarterly and a report will be submitted quarterly to the Quality Care and Patient Safety Council. The report is then submitted to the Medical Executive Committee, and to the Board of Commissioners.

9. Reporting of surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with laws and regulations.

10. Informing receiving organizations of patients requiring monitoring, treatment, and/or isolation

a. Upon transfer arrangement

b. After transfer, upon discovery

c. Upon receiving a patient and if notification had not occurred by the transferring facility

H. Reduction of risk of infection associated with environment, medical equipment, devices, and supplies. (§482.42(a)(3), IC.01.02.01)

1. Adherence to Spaulding Classification (CDC)
2. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
3. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
4. Disposal of medical equipment, devices, and supplies
5. Storage of medical equipment, devices, and supplies
6. Reprocessing single use devices consistent with regulatory and professional standards.
7. Availability of Manufacturer's Instructions for Use

I. Implementation of evidence-based practices to prevent healthcare associated infections (HAIs) due to the following: (IC.02.01.01, IC.02.05.01, IC.07.01.01)

1. Participation in CDC's National Healthcare Safety Network
2. Multidrug Resistant organisms (MDRO) and Emerging Infectious Diseases
    a. Candida auris
    b. MDR Acinetobacter baumannii
    c. MDR Carbapenem-resistant Enterobacteriaceae
    d. MRSA
    e. Pseudomonas aeruginosa
    f. Clostridiodes difficile
3. Central Line-associated bloodstream infections (CLABSI)
4. Catheter-associated urinary tract infections (CAUTI)
5. Ventilator Associated Event (VAE)
6. Surgical Site Infections (SSI)
7. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices
8. Participation in The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)
9. Protocols for high-consequence and emerging special pathogens and collaboration with Emergency Preparedness (IC.07.01.01).

J. Hand Hygiene

1. Improving compliance with the current CDC Hand Hygiene guidelines
2. iRound electronic audit tool for manual monitoring used since 2020
3. National Patient Safety Goal 7: Prevent infection by using hand cleaning guidelines from CDC or WHO.
4. Set goals to improve hand cleaning.
5. Report at Quality meetings by unit and type of employee.

K. Communication and collaboration with Emergency Preparedness (EP)

1. Preparation of response to influx of potentially infectious patients (IC.01.06.01)
2. Participation in interdisciplinary emergency management operations program: engagement in planning activities which includes identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.
3. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
4. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
5. Written plan delineating management of influx of infectious patients
6. MHS Highly Communicable Disease Preparedness and Response guidelines
7. COVID-19 guidelines continuously updated on intranet.

L. Communication and collaboration with Environment of Care (EOC)

1. Water Management Program (EC.02.05.02): Participation in an interdisciplinary water management program that addresses Legionella and other waterborne pathogens.
2. Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)
3. Infection Control Risk Assessment (ICRA)

M. Communication and collaboration with Employee Health (EH)

1. Vaccination against influenza of licensed independent practitioners and staff. (IC.02.04.01)
2. Annual influenza vaccination program that is offered to all licensed independent practitioners and staff.
3. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
4. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
5. Improvement of influenza vaccination rates
6. Written description of the methodology used to determine influenza vaccination rates
7. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually, and it's reported in PIRM
8. Improvement of vaccination rates according to established goals at least annually
9. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual
10. Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:

a. Hepatitis B
b. Covid-19
c. Tetanus, Diphtheria and Pertussis
d. Varicella

11. Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)

12. In collaboration with Medical Staff and Employee Health Services:
    a. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may be exposed to infections within the workplace
    b. Management of LIPs and employees who are suspected of or were occupationally exposed
    c. Management of patients who have been exposed to an infectious disease
    d. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
    e. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

N. **Communication and collaboration with Antimicrobial Stewardship Program (ASP)** (§482.42(d), §482.42(c)(2)(vi), §482.42(b), MM.09.01.01).

1. Please see addendum with ASP Plan and yearly documents.
2. IP has unified and integrated with ASP program as a system of multiple hospitals by sharing meetings and medical director.

O. Investigation of adverse events related to tissue use or donor infections.

1. Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices, and other implantable items.
2. Investigation of infections suspected of being directly related to the use of tissue.
3. Reporting of infection to tissue suppliers
4. Sequestering remaining tissue suspected of causing infection.
5. Notification of recipient of infectious agents that may have been transmitted through tissue.

VIII. References

1. Centers for Disease Control and Prevention (CDC). (2023).

    a. CDC. (2022). CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. Accessed from https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html

    b. CDC. (2015). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. Accessed from https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf

    c. CDC. Prevention Strategies for Seasonal Influenza in Healthcare Settings. Accessed from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm)

    d. Bolyard EA. Tablan OC, Williams WW, Pearson ML, Shapiro CN, Deitchmann SD. Guideline for Infection Control in Healthcare Personnel, 1998. Hospital Infection control Practices Advisory committee. Infect Control Hosp Epidemiol. 1998 Jun; 19(6):407-63. (Available at https://stacks.cdc.gov/view/cdc/7250.

    e. Boyce JM, Pittet D, Healthcare Infection control Practices Advisory Committee, Society for Healthcare Epidemiology of America, Association for Professionals in Infection control, Infectious Diseases Society of America, Hand Hygiene Task Force. Guideline for Hand Hygiene in Health-Care Settings: recommendation of the Healthcare Infection Control Practices Advisory committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Infect control Hosp Epidemiol. 2002 Dec 23(12 Suppl):S3-40. (Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm.

    f. Rutala WA, Weber DJ, Healthcare Infection Control Practices Advisory Committee. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Am J Infect Control.2013;41(5 Suppl):S67-71. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

    g. Sehulster L, Chin RY, Healthcare Infection Control Practices Advisory Committee. Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. MMWR Recomm Rep 2003 Jun 6:52(RR-10):1-42. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf

    h. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006. Am J Infect control, 2007 Dec 35 (10 Suppl 2):S165-93. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/mdro-guidelines.pdf [PDF – 75 Pages].)

    i. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission

of Infectious Agents in Healthcare Settings. Am J Infect Control. 2007 Dec 35(10 Suppl 2)S65-164. (Available at https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.)

2. Centers for Medicare and Medicaid Services. (2022 July 6). Conditions of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs. Accessed from https://www.cms.gov/files/document/qso-22-20-hospitals.pdf
3. Association for Professionals in Infection Control and Epidemiology (APIC). (2023). APIC Text accessed from https://apictext.org
4. Society for Healthcare Epidemiology of America (SHEA). (2023).
5. Joint Commission. (2024). Accessed from **https://e-dition.jcrinc.com/Frame.aspx**

I. Executive Summary

Memorial Regional Hospital South (MRHS) is a healthcare facility associated with the Memorial Healthcare System (MHS) and maintains an individual Infection Prevention and Control (IPC) plan tailored to its scope of service, to meet the specific needs of its population, but also participates in a systemwide IP program that is used to assist in standardization and strategic vision, as well as creates a framework for systematic organization of the cohesive and growing IPC activities in both inpatient and ambulatory locations. This Infection Prevention and Control Program, along with the collaboration with the Antimicrobial Stewardship Program, meets all the requirements of a comprehensive Program in accordance with 42 CFR 482.42.

The annual **Plan** includes both an *Authority Statement* and a *Scope of Service* that is specifically based on hospital location, populations served, and services provided for last calendar year (CY 2023), including top diagnoses and top procedures by volume, and standard plan elements.

The annual **Risk Assessments** use a *Hazard Vulnerability* template (also used in MHS Emergency Management) and was scored in 2024 Q1 based on CY 2023 actual risks and then reviewed by the hospital's multidisciplinary Infection Control committee or working team. Using the actual risks from the previous year, this year's CY 2024 *Priorities, Goals, and Objectives* are identified using a Pareto graph to visually represent the top 20% of risks in four main areas: Hospital Acquired Infections, Community Risks, Healthcare Worker Risks, and Environmental Risks.

The annual **Evaluation/Appraisal of Goals and Objectives** reviews and evaluates the previous year's CY 2023 hospital-specific goals and objectives by comparing at least two years of performance for infections, hand hygiene, staff vaccination, and more. The goals and resultant data are clearly stated to track performance in both 2022 and 2023, with a *Past Year's Summary of Action Items* undertaken in the past year, and a specific, *Achievable Goal Metric for 2024*.

The oversight and support of this essential program at each facility includes at least one highly trained Manager, the system Director of Infection Prevention and Epidemiology for MHS, and the Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship for MHS.

The hospital plan is annually reviewed by the Quality Council, Medical Executive Committee and taken to the MHS Board of Commissioners for approval.

II. Table of Contents

III. Introduction

Mission: Heal the body, mind, and spirit of those we touch.

Vision: To be a premier clinically integrated delivery system providing access to exceptional patient-and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Commitment: Family centered and patient focused care

Purpose: To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases.

This plan will *define the scope of activities* and *provide a framework* for the systematic, organization wide approach for an effective infection control program.

IV. Authority Statement

Pursuant to the approval by the hospital's *Medical Executive Committee* (§482.42(c)(1,2)):

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).
2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.
3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

V. Scope of Service 2023–2024

Memorial Regional Hospital South (MRHS)

MRHS is located at 3600 Washington Street in Hollywood, in southeastern Broward County, Florida. This is a metropolitan area between Fort Lauderdale and Miami. It is a 216-bed secondary acute care facility, and it houses the following specialty institute, Memorial Rehabilitation Institute.

MRHS offers the following services:

- 24 hrs. Emergency Care
- Adult Inpatient Rehabilitation
- Adult Outpatient Rehabilitation
- Adult Inpatient Acute Medical, Surgical and Telemetry Services
- Imagining Services
    - CT, MRI, US, Diagnostic Radiology and Nuclear Medicine

- Interventional Radiology
- Women's Imaging Services
- General Surgery
- Endoscopy

Acuity:

- 44 Medical Surgical/Telemetry/ Intermediate Critical Care beds
- 89 Inpatient Rehabilitation beds
- 12 Emergency Department beds
- 9 Surgical Suites

Population served:

- Emergency Care – 0 – End of Life
- Inpatient Services – 18 – End of Life
- Rehabilitation – 16 – End of Life
- Outpatient Services - 16 – End of Life

Top 10 Inpatient Primary Diagnoses, 2023

1. Unspecified abnormalities of gait and mobility
2. Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.
3. Critical illness myopathy
4. Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.
5. Other sequelae of cerebral infarction
6. Encounter for surgical aftercare following surgery on the circulatory system.
7. Encounter for orthopedic aftercare following surgical amputation.
8. Urinary tract infection, site not specified.
9. Chronic obstructive pulmonary disease with (acute) exacerbation
10. Aftercare following joint replacement surgery.

Top 10 Inpatient Primary Procedures, 2023

1. Performance of Urinary Filtration, Intermittent, less than 6 Hours Per Day
2. Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach
3. Excision of Stomach, Pylorus, Via Natural or Artificial Opening Endoscopic, Diagnostic
4. Resection of Uterus, Open Approach
5. Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach
6. Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach
7. Excision of Duodenum, Via Natural or Artificial Opening Endoscopic, Diagnostic
8. Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
9. Excision of Abdomen Subcutaneous Tissue and Fascia, Open Approach
10. Extraction of Back Subcutaneous Tissue and Fascia, Open Approach

Top 10 Outpatient Primary Procedures, 2023

1. Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
2. Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level.
3. Reduction mammaplasty
4. Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
5. Arthroplasty, knee, condyle, and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
6. Mammaplasty, augmentation; with prosthetic implant
7. Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
8. Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
9. Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
10. Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

Top 6 Rehabilitation Diagnosis:

1. Stroke
2. Traumatic Brain Injury
3. Amputee
4. Cancer
5. Spinal Cord Injury
6. Orthopedic/Trauma and Complex Medical

VI. Program Objectives

The system Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices at Memorial Healthcare System with the intent:

1. To create and implement an active, system-wide comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting or transmitting communicable infections and diseases.
2. To collaborate with all healthcare system departments including Antimicrobial Stewardship - Pharmacy, Quality, Clinical Effectiveness, and Performance Improvement to minimize the morbidity, mortality and economic burdens associated with healthcare associated infection (HAI) and multidrug resistant organisms (MDRO) through prevention and control efforts throughout all sites where care is delivered.
3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection, as well as
4. To collaborate with Emergency Preparedness to engender advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event.

VII. Program Management

A. <u>Program Administration and Resources</u>

1. IP Program led by designated, qualified healthcare Infection Preventionists (IPs), as identified in the Authority Statement and are responsible for the IP program. IP team has access to multiple resources and consultative support not limited to but including the Medical Director of Infection Control and Antimicrobial Stewardship, System Director of Epidemiology, and Infection Prevention, as well as being able to communicate and collaborate with the entire group of MHS IPs as a system for a unified infection prevention team (§482.42 (a), IC.01.01.01, IC.01.02.01).
    a. Ratification of <u>competency</u> of IPC team members.
    b. Maintains membership in Association for Professionals in Infection Control or Florida Professionals in Infection Control.
    c. Attends one (1) educational seminar related to infection prevention and control per year.
    d. Job descriptions delineate the scope and responsibility for each Infection Prevention professional.
2. Staffing, Memorial Regional Hospital South:
    a. Director, Quality & Patient Safety
    b. Manager of Infection Prevention & Control/Rehab Quality
    c. Infection Preventionist

3. Staffing, Memorial Healthcare System (Oversight and Support):
   a. Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
   b. Physicians, Infectious Disease (MRH, MRHS)
   c. Director, Infection Prevention and Epidemiology, MHS
4. Leadership responsibilities (§482.42(c)(1), IC.05.01.01)
   a. Governing body of healthcare system approves annual IP Plan.
   b. System Medical Director presents program to Board Peer Review at least annually to ensure program is in place for accountability and monitoring and prevention of infections.
5. Hours of Operation: Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

B. Plan of Care and Practice for Infection Prevention and Control

1. Planning for management of infection control and prevention (IC & P) program. (IC.01.01.01)
2. Development of an infection prevention and control plan (IC.01.05.01) from utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus.
3. Plan is a written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection (§482.42(a)(4)).

C. Performance of Risk Assessments

1. Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing. (IC.01.03.01, IC.06.01.01)
2. A multidisciplinary team collaborates to review results of the hospital's infection risk assessment and are prioritized in order of level of probability and potential for harm.
3. Identification, prioritization, and documentation of risk assessment in order of probability and level of harm based on:
   a. Geographic location, community, and population served.
   b. Care, treatment, and services provided.
   c. Analysis of surveillance activities and aggregate IC data
4. Pareto Analysis used to identify the top risks and set goals for reducing the risks of infections that pose the greatest threat to patients and the community.

D. Goal Setting

1. Goal setting to reduce risk of infection to patients and community (IC.01.04.01) and lead to focused activities, based on relevant professional guidelines and sound scientific practices.
2. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
3. Written goals, based on identified risks, include (IC.06.01.01):
    a. Addressing prioritized risks
    b. Limiting unprotected exposure to pathogens
    c. Limiting the transmission of infections associated with procedures.
    d. Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies.

E. Evaluation of Effectiveness and Appraisal of Infection Prevention and Control Plan and Program

1. Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01) based on:
    a. Plan's prioritized risks
    b. Plan's goals
    c. Program's efficacy
2. Communication of findings to patient safety program.
3. Include findings of evaluation when revising the plan.

F. Policy and Procedure Development (§482.42(a)(2))

1. For infection surveillance, prevention, and transmission control that are reviewed annually and reference and adhere to nationally recognized guidelines.
2. Implementation of Practice for Infection Prevention and Control
3. Prevention and control of transmission of healthcare associated infections (HAIs) and infectious disease among patients and staff.
4. Implementation and documentation of infection control plan, surveillance, prevention, and transmission control that adhere to nationally recognized guidelines.
5. Performance of activities based on relevant professional guidelines and scientific practices.

G. Development, implementation and documentation of infection surveillance, prevention, and control (IC.02.03.01, IC.04.01.01)

1. Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues (§482.42(c)(1)(ii), §482.42(c)(2)(iii)).
    a. The Infection Control Practitioner reports to the Director of Quality who reports to the Chief Nursing Officer.
    b. The Infection Control Practitioner will report to the Medical Staff any trends within their departments.
2. Training and education of employees and medical staff on practical application of IC & P guidelines and P & Ps (**§482.42(c)(2)(iv)).**
3. Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (§482.42(c)(2)(v), IC.02.01.01).
4. Implementation of IC & P activities involving departments, employees, and medical staff
    a. Surveillance methodology utilizing CDC NHSN with sources for identification including:
        i. Microbiologic records
        ii. Reports from Information Systems including patient census/diagnosis.
        iii. EPIC and outside labs
        iv. Chart reviews and patient interviews
        v. Post-discharge surveillance
        vi. Reporting of suspect/known infections or infection control issues from staff and units' multidisciplinary rounds
        vii. Device day usage for urinary catheters, central line catheters, and ventilators
        viii. Public health reporting of state mandated reportable infections.
        ix. Microbiologic monitoring of water and dialysate
5. Provision of important IC & P information to patients, employees, medical staff, and visitors
    a. Respiratory Hygiene Practices
    b. Hand Hygiene
    c. Implementation of standard and transmission-based precautions
    d. Utilization of personal protective equipment (PPE)
    e. Donning
    f. Doffing
6. Storage and disposal of infectious waste
7. Investigation of outbreaks (IC.01.05.01) – MHS Policy and APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12. Outbreak Investigations/

Epidemiology, Surveillance, Performance, and Patient Safety Measures for framework and guidelines conducting an outbreak investigation.

a. Initiates outbreak investigation when an outbreak or cluster is suspected consistent with CDC Guidelines.

b. Institutes early control measures, prepares a preliminary case definition, and compares current incidence with usual or baseline data.

c. Develops case definition based on time, place, person.

d. Evaluates efficacy of the control measures.

e. Reports finding to Medical Director of Infectious Diseases, System Director of Infection Prevention, Quality Care and Patient Safety Committee, appropriate Medical Staff Departments and Florida Department of Health, if warranted.

f. Reporting of surveillance, prevention, and control information to appropriate staff within facility

8. The Infection Control Practitioner will report relevant findings to PIRM Committee, and Environment of Care Committee quarterly and a report will be submitted quarterly to the Quality Care and Patient Safety Council. The report is then submitted to the Medical Executive Committee, and to the Board of Commissioners.

9. Reporting of surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with laws and regulations.

10. Informing receiving organizations of patients requiring monitoring, treatment, and/or isolation

a. Upon transfer arrangement

b. After transfer, upon discovery

c. Upon receiving a patient and if notification had not occurred by the transferring facility

H. <u>Reduction of risk of infection associated with environment, medical equipment, devices, and supplies. (§482.42(a)(3), IC.01.02.01)</u>

1. Adherence to Spaulding Classification (CDC)

2. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)

3. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies

4. Disposal of medical equipment, devices, and supplies

5. Storage of medical equipment, devices, and supplies

6. Reprocessing single use devices consistent with regulatory and professional standards.

7. Availability of Manufacturer's Instructions for Use

I. Implementation of evidence-based practices to prevent healthcare associated infections (HAIs) due to the following: (IC.02.01.01, IC.02.05.01, IC.07.01.01)

1. Participation in CDC's National Healthcare Safety Network
2. Multidrug Resistant organisms (MDRO) and Emerging Infectious Diseases
    a. Candida auris
    b. MDR Acinetobacter baumannii
    c. MDR Carbapenem-resistant enterobateriaceae
    d. MRSA
    e. Pseudomonas aeruginosa
    f. Clostridiodes difficile
3. Central Line-associated bloodstream infections (CLABSI)
4. Catheter-associated urinary tract infections (CAUTI)
5. Ventilator Associated Event (VAE)
6. Surgical Site Infections (SSI)
7. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices.
8. Participation in The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)
9. Protocols for high-consequence and emerging special pathogens and collaboration with Emergency Preparedness (IC.07.01.01).

J. Hand Hygiene

1. Improving compliance with the current CDC Hand Hygiene guidelines
2. iRound electronic audit tool for manual monitoring used in 2020 and 2021.
3. Discontinuation of the Electronic Monitoring System in March of 2023 due reliability and validity concerns to properly collect HH observations.
4. Continuation of the use of iRound electronic Audit tool to monitor HH.
5. National Patient Safety Goal 7: Prevent infection by using hand cleaning guidelines from CDC or WHO.
6. Set goals to improve hand cleaning.
7. Report Data by unit and healthcare worker type to quality and leadership.

K. Communication and collaboration with Emergency Preparedness (EP)

1. Preparation of response to influx of potentially infectious patients (IC.01.06.01)
2. Participation in interdisciplinary emergency management operations program: engagement in planning activities which includes identifying risks, prioritizing likely

emergencies, attempting to mitigate them when possible, and considering potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.

3. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients.
4. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.
5. Written plan delineating management of influx of infectious patients
6. MHS Highly Communicable Disease Preparedness and Response guidelines

L. Communication and collaboration with Environment of Care (EOC)

1. Water Management Program (EC.02.05.02): Participation in an interdisciplinary water management program that addresses Legionella and other waterborne pathogens.
2. Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)
3. Infection Control Risk Assessment (ICRA)

M. Communication and collaboration with Employee Health (EH)

1. Vaccination against influenza of licensed independent practitioners and staff. (IC.02.04.01)
2. Annual influenza vaccination program that is offered to all licensed independent practitioners and staff.
3. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
4. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
5. Improvement of influenza vaccination rates
6. Written description of the methodology used to determine influenza vaccination rates.
7. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually, and it's reported in PIRM.

8. Improvement of vaccination rates according to established goals at least annually

9. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual.

10. Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:

   a. Hepatitis B
   b. Covid-19
   c. Tetanus, Diphtheria and Pertussis
   d. Varicella

11. Prevention of transmission of infectious disease among patients, licensed independent practitioners, and staff (IC.02.03.01)

12. In collaboration with Medical Staff and Employee Health Services:

   a. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may be exposed to infections within the workplace.
   b. Management of LIPs and employees who are suspected of or were occupationally exposed.
   c. Management of patients who have been exposed to an infectious disease.
   d. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
   e. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

N. **Communication and collaboration with Antimicrobial Stewardship Program (ASP)** (§482.42(d), §482.42(c)(2)(vi), §482.42(b), MM.09.01.01).

1. Please see addendum with ASP Plan and yearly documents.
2. IP has unified and integrated with ASP program as a system of multiple hospitals by sharing meetings and medical director.

VIII. References

1. Centers for Disease Control and Prevention (CDC). (2023).

    a. CDC. (2022). CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. Accessed from https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html

    b. CDC. (2015). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. Accessed from https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf

    c. CDC. Prevention Strategies for Seasonal Influenza in Healthcare Settings. Accessed from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm)

    d. Bolyard EA. Tablan OC, Williams WW, Pearson ML, Shapiro CN, Deitchmann SD. Guideline for Infection Control in Healthcare Personnel, 1998. Hospital Infection control Practices Advisory committee. Infect Control Hosp Epidemiol. 1998 Jun; 19(6):407-63. (Available at https://stacks.cdc.gov/view/cdc/7250.

    e. Boyce JM, Pittet D, Healthcare Infection control Practices Advisory Committee, Society for Healthcare Epidemiology of America, Association for Professionals in Infection control, Infectious Diseases Society of America, Hand Hygiene Task Force. Guideline for Hand Hygiene in Health-Care Settings: recommendation of the Healthcare Infection Control Practices Advisory committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Infect control Hosp Epidemiol. 2002 Dec 23(12 Suppl): S3-40. (Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm.

    f. Rutala WA, Weber DJ, Healthcare Infection Control Practices Advisory Committee. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Am J Infect Control.2013;41(5 Suppl): S67-71. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

    g. Sehulster L, Chin RY, Healthcare Infection Control Practices Advisory Committee. Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. MMWR Recomm Rep 2003 Jun 6:52(RR-10):1-42. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf

    h. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006. Am J Infect control, 2007 Dec 35 (10 Suppl 2): S165-93. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/mdro-guidelines.pdf [PDF – 75 Pages].)

    i. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Am J Infect Control. 2007 Dec 35(10 Suppl 2)

S65-164. (Available at https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.)

2. Centers for Medicare and Medicaid Services. (2022 July 6). Conditions of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs. Accessed from https://www.cms.gov/files/document/qso-22-20-hospitals.pdf
3. Association for Professionals in Infection Control and Epidemiology (APIC). (2023). APIC Text accessed from https://apictext.org
4. Society for Healthcare Epidemiology of America (SHEA). (2023).
5. Joint Commission. (2024). Accessed from **https://e-dition.jcrinc.com/Frame.aspx**

Evaluation of the Infection Prevention and Control Plan 2023
And
Goals and Objectives 2024

This Program Evaluation is based in part on the annual Risk Assessment of top priorities ("vital few") as identified by the Pareto Analysis and the outcomes achieved during calendar year 2023. Outcomes are identified through review of performance measurement data, information resulting from our committees, team meetings and multidisciplinary rounds, as well as interviews and discussions conducted with staff and leaders throughout Memorial Regional Hospital South and in collaboration with other Memorial Healthcare facilities. *The hospital evaluates the effectiveness of its infection prevention and control plan (IC.01.05.01)*

The purpose of this annual appraisal is to:

1. Evaluate the effectiveness of the Infection Control program of Memorial Regional Hospital South in detection, identification, prevention, and control of hospital acquired and community acquired infections in patients, employees, physicians, licensed independent practitioners, volunteers, contract service workers and visitors while in the hospital.
2. Identify and assess the degree of risk factors for the acquisition and transmission of infectious diseases to reduce the incidence and eliminate their spread among persons in the hospital and in the community.
3. Identify opportunities for quality and performance improvement, loss prevention, cost containment and planning for the upcoming year.
4. Adhere to all local, state, and national regulatory guidelines for healthcare facilities.

The following top organizational risk priority targets were identified from the CY2024 Memorial Regional Hospital South Infection Control Risk Assessment, 2024 Annual Plan and 2023 institutional data analysis. Targets were adopted from internal goals to reduce yearly harm by 2%, external reporting CMS/VBP/HAC and/or Leapfrog performance achievement thresholds, CDC/NHSN published progress reports and internal TAP reports, and community historical trends. *Based on institutional determined goals and identified risks (risk ≥20% on ICRA Pareto), the organization sets goals to minimize the possibility of transmitting infections (IC.01.04.01).*

1. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and *Clostridium difficile* (CDIFF)		**2022 Performance**	**2023 Performance**	**2024 Goal (2% reduction)**
Candida Auris	# of patients with MDRO on day 4+ # of patient days x 1000	0 (rehab units) 0 (acute units)	0 (rehab units) 0 (acute units)	0 0
MRSA bacteremia Rate	# of patients with MRSA bac on day 4+ # of patient days x 10,000	0 (rehab units) 0 (acute unit)	0 (rehab units) 0 (acute unit)	0 0
CDIFF Rate	# of patients with CDIFF on day 4+ # of patient days x 1000	0.22 (rehab units) 0 (acute units)	0.20 ↓ (rehab units) 1.50 ↑ (acute units)	0.19 1.47

MRSA bacteremia SIR	SIR: Observed Predicted	N/A (rehab unit) 0 (acute unit)	N/A (rehab unit) 0 (acute unit)	0.793 VBP
CDIFF SIR		0.40 (rehab unit) 0 (acute unit)	0.37 (rehab unit) 0.51 (acute unit)	0.423 VBP

Performance/Effectiveness:

- **Rehab Units:**
  - Goals for Candida Auris **was met.**
    - There were no healthcare-acquired Candida Auris cases in 2023 or 2022.
  - Goal for MRSA **was met.**
    - There were no cases of healthcare-acquired –MRSA in 2023 or 2022
  - Goal for CDI was **met.**
    - In 2023, there were a total of 5 HO-CDI cases for a rate of 0.20 representing a decrease from the previous year.
    - In 2022, there were 6 cases of HA-CDI for a rate of 0.22.
- **Acute Care Unit:**
  - Goals for Candida Auris **was met.**
    - There were no Candida Auris cases in 2023 or 2022.
  - Goal for MRSA **was met.**
    - There were no MRSA cases in 2023 or 2022.
  - Goal for CDI **was not met.**
    - There was 1 HO-CDI case in 2023 for a rate of 1.50 representing an increase from the previous year.
    - There were no HO-CDI cases in 2022.

Actions Taken (Rehab and Acute):

Candida Auris and CR organisms:

- Continue active surveillance on admitted high risk patients by screening for CRE and C. Auris.
- IP continues to perform daily surveillance of cultures from patients admitted with infections.
- IP monitors high priority organism lists and isolations.
  - These measures assist with identifying previously colonized or infected patients with resistant organisms and allow the IP to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission-based precautions.
- Continue to implement Contact Precautions, GI Precautions, Enhanced Contact Precautions, Enhanced Respiratory Precautions in addition to CDC Transmissions-Based Precautions and Standard Precautions.
- Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical/nursing departments and Infection Prevention continue to be practiced.

CDIFF:

- C Diff education including isolation, testing protocol, hand hygiene and low-level disinfection is facilitated to all clinical staff working in inpatient units at least annually as part of our C Diff Action Plan; additional education is provided as needed.
- Continue to use the Smart CDIFF order set which includes the CDI algorithm as a method to identify patients in need of CDI testing.
- Reinforce the immediate implementation of isolation precautions for patients suspected of C diff colonization.
- Monitor and support proper use of PPE and hand washing practices while caring for C Diff patients.
- Continue to emphasize the use of Clorox Bleach Germicide for low level disinfection and cleaning of C Diff patients-associated medical equipment and environment.
- Collaboration with EVS team to implement additional prevention strategies.
- Collaboration with antibiotic stewardship committee.
- Work closely with the Pharmacy Department in terms of ASP guidance to clinicians on de-escalation and appropriate antibiotic treatment for patients presenting with diarrhea and patients being transferred to our hospital.

- Continued emphasis on Hand Hygiene and Antimicrobial Stewardship programs.

MDRO:

- Education on Isolation Precautions, Hand Hygiene and proper use of PPE is provided to all clinical staff working in inpatient units at least annually; additional education is provided as needed.
- Ensure Contact precautions are initiated on patients that require isolation by following the CDC's isolation precaution guidelines.
- Promote hand hygiene and proper use of PPE while interacting with all patients including suspected and confirmed MRSA patients.
- Modified isolation precautions for MRSA and VRE have been discontinued except for uncontained draining wounds, uncontained bodily fluids, and purulent sputum production with a positive MRSA isolate. Select group of high-risk patients screened using molecular test, including pre-op patients and patients with soft skin and tissue infections such as cellulitis. Positive patients are subsequently initiated on decolonization protocol.

2. Overall reduction of healthcare associated infections. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI) and catheter associated urinary tract infection (CAUTI). Minimize the risk of hospital acquired infections associated with invasive devices.	**2022 Performance**	**2023 Performance**	**2024 Goal** **2% reduction in rate or CMS or Leapfrog benchmark**
CLABSI Central Line Infections Central Line Days X 1000 = Rate per 1000 Central Line Days SIR = observed/predicted	**0.27 (rehab units)** (1/3749) x 1000 **1.78 (acute care unit)** (1/562) x 1000 n/a (Rehab) 1.16 (Acute)	0.26 ↓ **(rehab units)** (1/3832) x 1000 **0** ↓ **(acute care unit)** (0/347) x 1000 n/a (Rehab) 0 (Acute)	0.25 0.760 VBP threshold 0
CAUTI Urinary Catheter Infections Urinary Catheter Days X 1000 = Rate per 1000 Urinary Catheter Days SIR = observed/predicted	**2.21 (rehab units)** (4/1813) x 1000 **2.31 (acute care unit)** (1/433) x 1000 1.62 (Rehab) 2.60 (Acute)	**4.68**↑ **(rehab units)** (7/1497) x 1000 **0** ↓ **(acute care unit)** (0/278) x 1000 3.08 (Rehab) 0 (Acute)	3.28 (30% reduction*) 0.615 VBP threshold 0

Analysis

- Infections are identified from prospective surveillance by the trained IP staff using NHSN definitions.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.

CLABSI

- **Performance/Effectiveness:**
  - Rehab Units:
    - CLABSI goal for 2023 **was met.**
    - In 2023, there was 1 CLABSI case per 3832 central line days for a rate of 0.26 per 1000 line days. This represented a slight decrease compared to 2022.
    - There was 1 CLABSI cases in 2022 per 3749 central line days for a rate of 0.27 per 1000 line

days.
    - Acute Care Unit:
        - CLABSI goal for 2023 **was met**.
        - In 2023, there were no CLABSI cases; there were 347 central line days for a rate of 0.
        - In 2022, there was 1 CLABSI case per 562 central line days for a rate of 1.78.
        - There was a 38% decrease in line days in 2023 (347) compared to 2022 (562).
- **Actions Taken (Rehab and Acute):**
    - IC conducts Visual Assessment of CLs
    - Daily report of all CLs (reason for line continuation and removal date) by each unit during morning Safety Huddle
    - Continue to practice immediate removal of unnecessary central lines whenever possible.
    - CHG dressing are used on all central lines.
    - CHG treatments are ordered and administered to all inpatients with CLs.
    - Audit conducted daily on all patients with CLs through the iRound tool.
    - Each CLABSI is reviewed by IC, nurse manager and leadership team. A detailed drill down is shared with appropriate leadership teams.
    - Near missed or any other cases where an opportunity is identified by IC is reviewed and a detailed report is shared with appropriate department.

CAUTI

- **Performance/Effectiveness:**
    - Rehab Units:
        - CAUTI goal for 2023 **was not met.**
        - In 2023, there were 7 CAUTI cases per 1497 Foley days, for a rate of 4.68 per 1000 Foley days. This is a significant increase compared to the previous year.
        - In 2022, there were 4 CAUTI cases per 1813 Foley days, for a rate of 2.21 per 1000 Foley days.
        - There was a 17% decrease in catheter days in 2023 (1497) compared to 2022 (1813).
    - Acute Care Unit:
        - CAUTI goal for 2023 **was met.**
        - In 2023, there were no CAUTI cases; there were 278 Foley days, for a rate of 0 per 1000 Foley days.
        - In 2022, there was 1 CAUTI cases per 433 Foley days, for a rate of 2.31 per 1000 Foley days.
        - There was a 36% decrease in catheter days in 2023 (278) compared to the 2022 (433).
- **Actions Taken (Rehab and Acute):**
    - IC conducts Visual Assessment of CLs
    - Daily report of all CLs (reason for line continuation and removal date) by each unit during morning Safety Huddle
    - Continue the process of removing Foleys when not clinically indicated.
    - Foley discontinued by day 2 on surgical patients unless reason not to discontinue is documented. Nursing is empowered by an ANI to discontinue.
    - Audit conducted daily on all patients with Foley catheters through the iRound tool.
    - Each CAUTI is reviewed by IC, nurse manager and leadership team. A detailed drill down is shared with appropriate leadership teams.
    - Near missed or any other cases where an opportunity is identified by IC is reviewed and a detailed report is shared with appropriate department

3. Surgical Site Infections (SSI) Carry out systemic program surveillance and reporting of epidemiologically important Class I and II surgical site infections.	**Targeted Class**	**CY 2022 Performance**	**CY 2023 Performance**	**2024 Goal** **2% reduction in rate or CMS or Leapfrog benchmark**
Surgical Site Infections	Class I Rate	0.39	0.37↓	0.36

Performance/Effectiveness: • SSI goal for 2023 **was met.** • In 2023, there were 14 Class I & II SSI cases and 3804 surgical procedures, representing an 8% increase in volume compared to 2022 (3596 surgeries). The rate of infection for 2023 was 0.37. • In 2022, there were 14 Class I & II SSI cases and 3596 surgical procedures, The rate of infection for 2022 was 0.39. **Actions Taken:** • Monthly meetings with the SSI Task Force (Surgical Director, Quality, IC and NSQIP) to review cases and actions are conducted. • Drill down on all SSI infections is completed by IC and reviewed and discussed with Quality and Surgical leadership team. Opportunities and lessons learned are shared with leadership. • Ensure only hospital-laundered scrubs are worn in restricted and semi-restricted areas. • Ensure appropriate timing of antibiotic administration (within 1 hour prior to incision) • Ensure appropriate hair removal (where indicated) is practiced. • Monitor proper CHG bathing and skin prep practices. • Monitor environmental cleaning; ensure cleaning is performed with the correct surface and floor disinfectant. • Ensure the sterile field is kept intact during surgical procedures through monitoring and implementation of proper infection control practices. • Monitor Sterilization practices and sterile techniques. • RCA performed on all SSIs, NSQIP taskforce utilized. • Proper use of irrigation fluids • Ensure surface (Oxivir1) and floor disinfectants (Virex Plus) are used for turning of the rooms and terminal cleaning. • IC performs Initial and Annual Competency Checks on each EVS staff completing Terminal Cleaning in the OR and SPD areas. • Collaboration with Pharmacy team and Medical Staff, all MHS preoperative antibiotic prophylaxis order sets are reviewed. • Implementation of nasal decolonization of all patients with an ASA score of 2 or above. Additionally, at least 1 surgeon is requesting for all his patients to have nasal decolonization.				

4. Use Standard Precautions to prevent unprotected exposure to pathogens (i.e., symptomatic patients, respiratory virus-like COVID-19, seasonal flu, pandemic flu, influx of infectious patients, active TB patients and patients with history of MDRO, unusual clusters of organisms or HAI, outbreaks, etc.). Monitor for any potential cases of active TB or increase in influx of infectious patients.	**2022**	**2023**	**2024 Goal**
PPE Trends/identification	n/a	n/a	0 occurrences
MDRO trends/identification	0 Cluster. Continued to monitor and intervene as necessary.	1 Clusters. Provided Standard precautions to clinical staff	0 Clusters. Ongoing monitoring, surveillance, and implementation of interventions as needed.
Outbreaks, clusters, or transmission			
Influx of other infectious patients & emergency preparedness			
Performance/Effectiveness: • MRHS continues to be at low risk for M-TB. • No MDR-TB cases in 2023. • No cases of respiratory M-TB in 2023 and 0 case of respiratory M-TB in 2022. • There were no conversions in healthcare workers as the result of exposures in 2023.			

Actions taken:

- Standard precautions and PPE education during Skills Fairs, New Employee Orientation, Just-in-Time training, Rehab Residents in-service, and staff IC education.
- Attended National Security training on HIDs at the Homeland security center in Aniston, Alabama.
- In 2023, a new isolation gown was trialed at all MHS facilities. After review by clinicians and staff feedback, gown was removed and substituted by a better one.
- Continue to educate new and current employees on standard precautions and essential IC practices including, but not limited to HH, Proper Use of PPE, and Low-level Disinfection of our environment.
- MHS system leadership conducting safety rounds with increased awareness for incident reporting of safety events.
- Monitoring of trends and potential HO infections by utilizing the EPIC-Outbreak Tool
- MHS uses electronic case reporting for COVID-19 reporting to the state.
- For Laboratory personnel: Minimizing exposure to infectious agents by use of OSHA guidelines, establishing standard operating procedures, requirements for personal protective equipment, engineering controls (e.g., chemical fume hoods, air handlers, etc.) and waste disposal procedures.
- MRHS will continue to actively track and trend admission of patients for any increase influx of patients and/or need to implement the Pandemic Plan.
- MRHS has been implementing continual education via simulation drills and desktop learning, planning and emergency notification.
- MRHS has participated in Emergency Preparedness exercises and activities, HID PPE in-service to ICPs.
- MRHS has implemented key IC practices and measures to mitigate the effect of respiratory viral season in our hospital. These practices have been directed by national (CDC). These have also been monitored, assessed, and adjusted as the situation in our community has changed.

5. Improve Hand Hygiene Compliance **Monitor hand hygiene compliance.**	**2022 Performance**	**2023 Performance**	**2024 Goal**
Number of observations/number of opportunities	**98.1%**	**98.8% ↑**	**98.9%**

Performance/Effectiveness:

- Goal for 2023 was met.
- In 2023, the hand hygiene compliance was 98.8% with a total of 22314 observations.
- This represents an 8% increase in the number of collected observations compared to 2022 (20731)
- The hand hygiene compliance for 2022 was 98.1%.

Actions Taken:

- Continue unit-based education/coaching on hand hygiene with all staff.
- Monthly HH data is presented to quarterly Quality care and Patient Safety Council Meetings, Employee Skills Fairs, New Employee Orientation, and specific department in-services and presentations.
- Support the use of hospital-approved alternative hand hygiene products for those employees that have allergies or sensitivities.
- Provide education and support to the patient safety champions to collect accurate hand hygiene observations.
- Continue routine observations of appropriate hand hygiene (handwashing and the use of alcohol-based sanitizers)
- Continuation with the utilization of the iRound HH tool to collect HH observations.

6. Reduction of risk of infection secondary to inadequate supplies, failure to follow safety devices and personal protective equipment.	**2022**	**2023**	**2024 Goal**
Frequency that IP consulted and responded with expert review on product substitutions and availability of supplies & made front line staff aware.	**100%**	**100%**	**100%**
Frequency that IP was consulted on protocols related to safety	**100%**	**100%**	**100%**

devices and equipment			

Performance/Effectiveness:

- All shortages and alternative products are shared with IC and monitored by IC.

Actions taken:

- Communication from supply chain, materials management, and clinical team for backorders, conservation activities, crisis, and contingency standards dependent on availability of medical equipment.
- Unit level in-services continued to be presented for dissemination of alternate product information.
- Educational materials are created by the IP team, printed, and used to educate staff, patients, and families.
- Demonstrate/observe proper implementation and usage of new and alternative products by end-users.
- Education on alternative products is conducted each time a new product is brought to MRHS.
- IC monitors, keeps tracks and communicates shortages and new products.

7. Reduction of risk of infection secondary to improper equipment sterilization. High level disinfection, low level disinfection or environmental cleaning.	**2022**	**2023**	**2024 Goal**
Frequency that IP reviews documentation, logs, and conducted visual observations of reprocessing areas	100%	100%	100%

Performance/Effectiveness:

- Assisting in risk assessment and partnering with end users in following manufacturer's instructions for use, most up-to-date guidelines

Actions taken:

- Initial and annual Competency Checks on: OR-Terminal Cleaning, Alaris Pumps Cleaning, Disinfecting and Handling, US Vaginal probes HLD Process.
- Review instructions for use for disinfectants being used.
- Review new equipment and partner with end users in creating cleaning and disinfection process.
- Monitoring compliance of cleaning and disinfection practices.

8. Reduction and mitigation of community exposure to respiratory viruses including COVID-19, Influenza, and others. Promote and improve seasonal flu and COVID immunization organization wide.	**2022**	**2023**	**2024 Goal**
Number of clusters of COVID-19 staff or patients.	**0**	**1**	**0**
Employee Influenza immunization rate	96%	93.05	95%
Employee COVID immunization rate	96%	87.52	90%

Performance/Effectiveness:

Clusters:

- In 2023, there was 1 identified cluster of COVID-19 in the Rehab units.
  - Number of patients involved: 8.
  - Severity of symptoms: mild.
- In 2022, no cluster of COVID-19 were identified.
- Immediate containment using contact tracing and prevalence testing of all patients and staff was implemented each time.
- Additional actions included but not limited to universal masking of HCHs while providing direct patient care, terminal cleaning of unit, testing follow up of patients and staff and continues communication with leadership, reinforcement of proper standard precautions practices.
- Universal masking of HCWs was promptly lifted 14 days from initial test of last identified COVID patient.

Vaccination:

- Goal for Influenza Immunization was not met.
  - In 2023, MRHS had an Influenza Immunization rate of 93.05%
  - In 2022, MRHS had an Influenza Immunization rate of 96%

- Goal for COVID Immunization was not met.??
    - In 2023, MRHS had a COVID Immunization rate of 87.52%
    - In 2022, MRHS had a COVID Immunization rate of 96%

Actions Taken:

- Staying up to date with guidelines from the CDC, FDOH and other community partners.
- Continue to monitor each HO case of COVID 19 which leads to additional review and tracing and if applicable identification of additional cases.
- Use of standard precautions and early isolation to minimize transmission.
- Continue to educate staff on IC practices as it relates to emerging diseases including COVID 19.
- Continue collaboration with Employee Health to monitor staff trends of Covid 19.
- NHSN definitions are utilized for mandatory compliance reporting of vaccination.
- Influenza vaccination is still mandatory for all MHS staff members.
- Mandatory influenza education is provided to all hospital staff via Annual Review.
- Continued education at employee orientation, employee skills fair, and presentations at Department Leaders on Influenza Vaccination rate.
- Email alerts/reminders during influenza season are sent to employees and flyers are posted throughout the facility.
- Influenza Vaccine Program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs.
- Nursing offers vaccination to patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered by Employee Health during the entire flu season; at times, mobile vaccination carts attend units and meetings.
- Administrative Officers support by participating in campaigns for vaccination.
- Employees who take the flu vaccine are incentivized through credits that affect the cost of the health insurance premiums.

9. Reduction of risk of infection secondary to water management. Reduction of risk of infection secondary to hurricane or flood events.	**2022**	**2023**	**2024 Goal**
Frequency of IP participation on Water Management meetings and program document review.	**100%**	**100%**	**100%**
Frequency of IP participation on EOC Rounds	**100%**	**100%**	**100%**
Frequency of IP participation on Emergency Management drills and table-top exercises and hurricane preparedness activities.	**100%**	**100%**	**100%**

Performance/Effectiveness:

- IP reviewed of national guidelines from CDC, AAMI, AORN, APIC, SHEA, and other literature sources pertaining to water risks.
- IP partnered with facilities, sterile processing, emergency preparedness, and emergency department.

Actions Taken:

- Continue to meet regularly and update plans as needed.
- Review temp and humidity logs of sterile areas after weather events and equipment failure
- Ongoing monitoring, surveillance, and reporting of environmental organism

10. Infection Prevention and Control Program Plan, Evaluation of the Plan, Risk Assessment, Policies and Procedures are reviewed and updated annually. Plans include policies and procedures for minimizing risk of transmitting infection associated with use of procedures, medical equipment, medical devices, and	**2022**	**2023**	**2024 Goal**

products.			
Program policies and procedures review completed	100%	100%	100%
Program has an APIC trained IP	100%	100%	100%
Medical Director, Board Certified Infectious Disease Physician	100%	100%	100%

Performance/Effectiveness:

- The Comprehensive Infection Control Risk Assessment for CY2024 was presented to a multidisciplinary group for review, recommendations, and approval.
- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Quality and Patient Safety Committee.
- The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified.
- The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- Computer technology is utilized for analysis, trending and tracking of infection surveillance data.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.

Actions Taken:

- All the prioritized risks were reviewed and evaluated.
- Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- The Infection Preventionists are members of the national and local chapters of their professional organization and receive education related to Epidemiology/ Infection Prevention and Control on an ongoing basis.
- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of data and surveillance over the calendar year. This has provided more accurate analysis to better prioritize our risks and set new goals for the coming calendar year.

Joe DiMaggio Children's Hospital

Infection Prevention and Control Plan 2024

I. Executive Summary

Joe DiMaggio Children's Hospital (JDCH) is the pediatric specialty healthcare facility associated with the Memorial Healthcare System (MHS) and maintains an individual Infection Prevention and Control (IPC) plan tailored to its scope of service, to meet the specific needs of its population, but also participates in a systemwide IP program that is used to assist in standardization and strategic vision, as well as creates a framework for systematic organization of the cohesive and growing IPC activities in both inpatient and ambulatory locations. This Infection Prevention and Control Program, along with the collaboration with the Antimicrobial Stewardship Program, meets all the requirements of a comprehensive Program in accordance with 42 CFR 482.42.

The annual **Plan** includes both an *Authority Statement* and a *Scope of Service* that is specifically based on hospital location, populations served, and services provided for last calendar year (CY 2023), including top diagnoses and top procedures by volume, and standard plan elements.

The annual **Risk Assessments** use a *Hazard Vulnerability* template (also used in MHS Emergency Management) and was scored in 2024 Q1 based on CY 2023 actual risks and then reviewed by the hospital's multidisciplinary Infection Control committee or working team. Using the actual risks from the previous year, this year's CY 2024 *Priorities, Goals, and Objectives* are identified using a Pareto graph to visually represent the top 20% of risks in four main areas: Hospital Acquired Infections, Community Risks, Healthcare Worker Risks, and Environmental Risks.

The annual **Evaluation/Appraisal of Goals and Objectives** reviews and evaluates the previous year's CY 2023 hospital-specific goals and objectives by comparing at least two years of performance for infections, hand hygiene, staff vaccination, and more. The goals and resultant data are clearly stated to track performance in both 2022 and 2023, with a *Past Year's Summary of Action Items* undertaken in the past year, and a specific, *Achievable Goal Metric for 2024*.

The oversight and support of this essential program at each facility includes at least one highly trained Manager, the specialty pediatric Infectious Disease Medical Directors, the system Director of Infection Prevention and Epidemiology for MHS, and the Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship for MHS.

The hospital plan is annually reviewed by the Quality Council, Medical Executive Committee and taken to the MHS Board of Commissioners for approval.

Joe DiMaggio Children's Hospital

Infection Prevention and Control Plan 2024

II. Table of Contents

III. Introduction

Our Mission: Heal the body, mind, and spirit of those we touch.

Our Vision: To be a premier clinically integrated delivery system providing access to exceptional patient-and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Our Commitment: Family Centered and Patient Focused Care

Purpose: To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases

This plan will *define the scope of activities* and *provide a framework* for the systematic, organization wide approach for an effective infection control program.

IV. Authority Statement

Pursuant to the approval by the hospital's *Medical Executive Committee* (§482.42(c)(1,2)):

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).
2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.
3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

V. Scope of Service 2023–2024

Joe DiMaggio Children's **Hospital (JDCH)** is located at 1005 Joe DiMaggio Drive Hollywood, is a 216-bed full-service pediatric hospital that offers the following services:

(Receiving facility for patients with high acuity – and requiring specialty services)

JDCH offers the following services:

- Level I Trauma Care
- Emergency Services
- Cardiac and Vascular Services
- Cardiovascular Surgery

- Neurology
    - Epilepsy Monitoring Unit
- Cancer Care
- Neonatal Intensive Care (Level IV)
- Endocrinology
- General Surgical Services
- Sports and Dance Medicine
- Orthopedics
- Behavioral Health (inpatient, outpatient and emergency)
- Dialysis, Inpatient and Outpatient
- Inpatient Rehabilitation Services
- Neurosurgery
- Palliative Care/Hospice
- Ophthalmology
- Immunology/Genetics
- Hematology
- Ear, Nose and Throat (ENT)
- Cystic Fibrosis
- Gastrointestinal Services
- Transplant Services

Acuity:

- 46 Critical Care beds
- 84 Neonatal ICU (Level II/III) beds
- 68 Medical/Surgical/Telemetry/Stepdown/Oncology beds
- 12 Behavioral Health beds
- 6 Rehabilitation beds
- 37 Emergency beds
- 9 Surgical Suites
- 4 Cardiac Surgical Procedure/Hybrid Suites

Population served: Ages 0 – 21 years

Top Surgical Procedures:

- Dental Procedures (i.e., multiple caries)
- Myringotomy w/Tube insertions
- Ear, Nose and Throat (ENT) (Tonsillectomy and Adenoidectomy)
- General Surgery (i.e., laparoscopic appendectomy)
- Orchiopexy, circumcision

Top 4 Medical Diagnosis:

- Abdominal pain (Nausea, Vomiting, Diarrhea)
- Viral Respiratory Illness
- Asthma and Bronchiolitis
- Neurology (Epilepsy and Seizure Monitoring)

Top 4 Outpatient Procedures:

- Procedural Sedation (Lumbar Punctures, Chemotherapy, Imaging Studies)
- Renal Biopsies
- Incision and Drainage
- Minor Outpatient Procedures (Circumcision, Botox, Auditory Brainstem Response)

Outpatient Rehabilitation Centers

- Joe DiMaggio Children's Rehabilitation Center - 5830 Coral Ridge Drive, Coral Springs
  - Pediatric MRI Services
  - Feeding Therapy
  - Occupational and Physical Therapy
  - Speech Therapy
  - Pediatric ENT
  - Pediatric Pulmonology
  - Concussion Clinic
  - U-18 Sports Medicine
- Joe DiMaggio Children's Health Specialty Center – 3377 S. State Road 7, Wellington
  - Imaging Services
  - Rehabilitative Services
    - Physical and Occupational Therapy
    - Speech Therapy
    - Feeding Therapy
    - U-18 Sports Medicine Rehabilitation

VI. Program Objectives

The system Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices at Memorial Healthcare System with the intent:

1. To create and implement an active, system-wide comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting or transmitting communicable infections and diseases.
2. To collaborate with all healthcare system departments including Antimicrobial Stewardship - Pharmacy, Quality, Clinical Effectiveness, and Performance Improvement to minimize the morbidity, mortality and economic burdens associated with healthcare

associated infection (HAI) and multidrug resistant organisms (MDRO) through prevention and control efforts throughout all sites where care is delivered.

3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection, as well as
4. To collaborate with Emergency Preparedness to engender advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event.

VII. Program Management

A. <u>Program Administration and Resources</u>

1. IP Program led by designated, qualified healthcare Infection Preventionists (IPs), as identified in the Authority Statement and are responsible for the IP program. IP team has access to multiple resources and consultative support not limited to but including the Medical Director of Infection Control and Antimicrobial Stewardship, System Director of Epidemiology, and Infection Prevention, as well as being able to communicate and collaborate with the entire group of MHS IPs as a system for a unified infection prevention team (§482.42 (a), IC.01.01.01, IC.01.02.01).
    a. Ratification of <u>competency</u> of IPC team members.
    b. Maintains membership in Association for Professionals in Infection Control or Florida Professionals in Infection Control.
    c. Attends one (1) educational seminar related to infection prevention and control per year.
    d. Job descriptions delineate the scope and responsibility for each Infection Prevention professional.
2. Staffing, Joe DiMaggio Children's Hospital:
    a. Director, Quality & Patient Safety
    b. 1 Manager of Infection Prevention & Control
    c. 2 Infection Preventionists
    i. 2 Physician Co-Directors of Pediatric Infectious Disease
3. Staffing, Memorial Healthcare System (Oversight and Support):
    a. Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
    b. Physicians, Infectious Disease (MRH, MRHS)
    c. Director, Infection Prevention and Epidemiology, MHS
4. Leadership responsibilities (§482.42(c)(1), IC.05.01.01)

a. Governing body of healthcare system approves annual IP Plan.
b. System Medical Director presents program to Board Peer Review at least annually to ensure program is in place for accountability and monitoring and prevention of infections.

5. Hours of Operation: Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

B. Plan of Care and Practice for Infection Prevention and Control

1. Planning for management of infection control and prevention (IC & P) program. (IC.01.01.01)
2. Development of an infection prevention and control plan (IC.01.05.01) from utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus.
3. Plan is a written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection (§482.42(a)(4)).

C. Performance of Risk Assessments

1. Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing. (IC.01.03.01, IC.06.01.01)
2. A multidisciplinary team collaborates to review results of the hospital's infection risk assessment and are prioritized in order of level of probability and potential for harm.
3. Identification, prioritization, and documentation of risk assessment in order of probability and level of harm based on:
    a. Geographic location, community, and population served.
    b. Care, treatment, and services provided.
    c. Analysis of surveillance activities and aggregate IC data
4. Pareto Analysis used to identify the top risks and set goals for reducing the risks of infections that pose the greatest threat to patients and the community.

D. Goal Setting

1. Goal setting to reduce risk of infection to patients and community (IC.01.04.01) and lead to focused activities, based on relevant professional guidelines and sound scientific practices.

2. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
3. Written goals, based on identified risks, include (IC.06.01.01):
    a. Addressing prioritized risks
    b. Limiting unprotected exposure to pathogens
    c. Limiting the transmission of infections associated with procedures.
    d. Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies.

E. Evaluation of Effectiveness and Appraisal of Infection Prevention and Control Plan and Program

1. Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01) based on:
    a. Plan's prioritized risks
    b. Plan's goals
    c. Program's efficacy
2. Communication of findings to patient safety program.
3. Include findings of evaluation when revising the plan.

F. Policy and Procedure Development (§482.42(a)(2))

1. For infection surveillance, prevention, and transmission control that are reviewed annually and reference and adhere to nationally recognized guidelines.
2. Implementation of Practice for Infection Prevention and Control
3. Prevention and control of transmission of healthcare associated infections (HAIs) and infectious disease among patients and staff.
4. Implementation and documentation of infection control plan, surveillance, prevention, and transmission control that adhere to nationally recognized guidelines.
5. Performance of activities based on relevant professional guidelines and scientific practices.

G. Development, implementation and documentation of infection surveillance, prevention, and control (IC.02.03.01, IC.04.01.01)

1. Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues (§482.42(c)(1)(ii), §482.42(c)(2)(iii)).
    a. The Infection Control Practitioner reports to the Director of Quality who reports to the Chief Nursing Officer.
    b. The Infection Control Practitioner will report to the Medical Staff any trends within their departments.
2. Training and education of employees and medical staff on practical application of IC & P guidelines and P & Ps (**§482.42(c)(2)(iv)).**
3. Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (§482.42(c)(2)(v), IC.02.01.01).
4. Implementation of IC & P activities involving departments, employees, and medical staff
    a. Surveillance methodology utilizing CDC NHSN with sources for identification including:
        i. Microbiologic records
        ii. Reports from Information Systems including patient census/diagnosis.
        iii. EPIC and outside labs
        iv. Chart reviews and patient interviews
        v. Post-discharge surveillance
        vi. Reporting of suspect/known infections or infection control issues from staff and units' multidisciplinary rounds
        vii. Device day usage for urinary catheters, central line catheters, and ventilators
        viii. Public health reporting of state mandated reportable infections.
        ix. Microbiologic monitoring of water and dialysate
5. Provision of important IC & P information to patients, employees, medical staff, and visitors
    a. Respiratory Hygiene Practices
    b. Hand Hygiene
    c. Implementation of standard and transmission-based precautions
    d. Utilization of personal protective equipment (PPE)
    e. Donning

f. Doffing

6. Storage and disposal of infectious waste
7. Investigation of outbreaks (IC.01.05.01) – MHS Policy and APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12. Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures for framework and guidelines conducting an outbreak investigation.
    a. Initiates outbreak investigation when an outbreak or cluster is suspected consistent with CDC Guidelines.
    b. Institutes early control measures, prepares a preliminary case definition, and compares current incidence with usual or baseline data.
    c. Develops case definition based on time, place, person.
    d. Evaluates efficacy of the control measures.
    e. Reports finding to Medical Director of Infectious Diseases, System Director of Infection Prevention, Quality Care and Patient Safety Committee, appropriate Medical Staff Departments and Florida Department of Health, if warranted.
    f. Reporting of surveillance, prevention, and control information to appropriate staff within facility
8. The Infection Control Practitioner will report relevant findings to PIRM Committee, and Environment of Care Committee quarterly and a report will be submitted quarterly to the Quality Care and Patient Safety Council. The report is then submitted to the Medical Executive Committee, and to the Board of Commissioners.
9. Reporting of surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with laws and regulations.
10. Informing receiving organizations of patients requiring monitoring, treatment, and/or isolation
    a. Upon transfer arrangement
    b. After transfer, upon discovery
    c. Upon receiving a patient and if notification had not occurred by the transferring facility

H. <u>Reduction of risk of infection associated with environment, medical equipment, devices, and supplies. (§482.42(a)(3), IC.01.02.01)</u>

1. Adherence to Spaulding Classification (CDC)

2. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
3. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
4. Disposal of medical equipment, devices, and supplies
5. Storage of medical equipment, devices, and supplies
6. Reprocessing single use devices consistent with regulatory and professional standards.
7. Availability of Manufacturer's Instructions for Use

I. <u>Implementation of evidence-based practices to prevent healthcare associated infections (HAIs) due to the following: (IC.02.01.01, IC.02.05.01, IC.07.01.01)</u>

1. Participation in CDC's National Healthcare Safety Network
2. Multidrug Resistant organisms (MDRO) and Emerging Infectious Diseases
    a. MRSA
    b. MDR Carbapenem-resistant enterobaterales
    c. *Clostridiodes difficile*
    d. *Candida auris*
    e. MDR *Acinetobacter baumannii, Pseudomonas aeruginosa*
3. Central Line-associated bloodstream infections (CLABSI)
4. Catheter-associated urinary tract infections (CAUTI)
5. Ventilator Associated Event (VAE)
6. Surgical Site Infections (SSI)
7. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices.
8. Participation in The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)
9. Protocols for high-consequence and emerging special pathogens and collaboration with Emergency Preparedness (IC.07.01.01).

J. <u>Hand Hygiene</u>

1. Improving compliance with the current World Health Organization (WHO) <u>Hand Hygiene guidelines</u>
2. iRound electronic audit tool for manual monitoring used in 2020 and 2021.
3. Discontinuation of the Electronic Monitoring System in March of 2022 due reliability and validity concerns to properly collect HH observations.

4. Continuation of the use of iRound electronic Audit tool to monitor HH.
5. National Patient Safety Goal 7: Prevent infection by using hand cleaning guidelines from CDC or WHO.
6. Set goals to improve hand cleaning.
7. Report Data by unit and healthcare worker type to quality and leadership.

K. Transplant Safety

1. Investigation of adverse events related to tissue use or donor infections.
    a. Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices and other implantable.
    b. Investigation of infections suspected of being directly related to the use of tissue
    c. Reporting of infection to tissue supplies
    d. Sequestering tissue suspected of causing infection
    e. Notification of recipient of infectious agents that may have been transmitted through tissue

L. Communication and collaboration with Emergency Preparedness (EP)

1. Preparation of response to influx of potentially infectious patients (IC.01.06.01)
2. Participation in interdisciplinary emergency management operations program: engagement in planning activities which includes identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.
3. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients.
4. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.
5. Written plan delineating management of influx of infectious patients
6. MHS Highly Communicable Disease Preparedness and Response guidelines

M. Communication and collaboration with Environment of Care (EOC)

1. Water Management Program (EC.02.05.02): Participation in an interdisciplinary water management program that addresses Legionella and other waterborne pathogens.
2. Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)
3. Infection Control Risk Assessment (ICRA)

N. Communication and collaboration with Employee Health (EH)

1. Vaccination against influenza of licensed independent practitioners and staff. (IC.02.04.01)
2. Annual influenza vaccination program that is offered to all licensed independent practitioners and staff.
3. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
4. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
5. Improvement of influenza vaccination rates
6. Written description of the methodology used to determine influenza vaccination rates.
7. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually, and it's reported in PIRM.
8. Improvement of vaccination rates according to established goals at least annually
9. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual.
10. Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:
    a. Hepatitis B
    b. Covid-19
    c. Tetanus, Diphtheria and Pertussis
    d. Varicella
11. Prevention of transmission of infectious disease among patients, licensed independent practitioners, and staff (IC.02.03.01)
12. In collaboration with Medical Staff and Employee Health Services:

a. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may be exposed to infections within the workplace.
b. Management of LIPs and employees who are suspected of or were occupationally exposed.
c. Management of patients who have been exposed to an infectious disease.
d. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
e. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

O. **Communication and collaboration with Antimicrobial Stewardship Program (ASP)** (§482.42(d), §482.42(c)(2)(vi), §482.42(b), MM.09.01.01).

1. Please see addendum with ASP Plan and yearly documents.
2. IP has unified and integrated with ASP program as a system of multiple hospitals by sharing meetings and medical director.

VIII. References

1. Centers for Disease Control and Prevention (CDC). (2023).

    a. CDC. (2022). CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. Accessed from https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html

    b. CDC. (2015). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. Accessed from https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf

    c. CDC. Prevention Strategies for Seasonal Influenza in Healthcare Settings. Accessed from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm)

    d. Bolyard EA. Tablan OC, Williams WW, Pearson ML, Shapiro CN, Deitchmann SD. Guideline for Infection Control in Healthcare Personnel, 1998. Hospital Infection control Practices Advisory committee. Infect Control Hosp Epidemiol. 1998 Jun; 19(6):407-63. (Available at https://stacks.cdc.gov/view/cdc/7250.

    e. Boyce JM, Pittet D, Healthcare Infection control Practices Advisory Committee, Society for Healthcare Epidemiology of America, Association for Professionals in Infection control, Infectious Diseases Society of America, Hand Hygiene Task Force. Guideline for Hand Hygiene in Health-Care Settings: recommendation of the Healthcare Infection Control Practices Advisory committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Infect control Hosp Epidemiol. 2002 Dec 23(12 Suppl): S3-40. (Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm.

    f. Rutala WA, Weber DJ, Healthcare Infection Control Practices Advisory Committee. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Am J Infect Control.2013;41(5 Suppl): S67-71. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

    g. Sehulster L, Chin RY, Healthcare Infection Control Practices Advisory Committee. Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. MMWR Recomm Rep 2003 Jun 6:52(RR-10):1-42. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf

    h. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006. Am J Infect control, 2007 Dec 35 (10 Suppl 2): S165-93. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/mdro-guidelines.pdf [PDF – 75 Pages].)

i. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Am J Infect Control. 2007 Dec 35(10 Suppl 2) S65-164. (Available at https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.)

2. Centers for Medicare and Medicaid Services. (2022 July 6). Conditions of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs. Accessed from https://www.cms.gov/files/document/qso-22-20-hospitals.pdf
3. Association for Professionals in Infection Control and Epidemiology (APIC). (2023). APIC Text accessed from https://apictext.org
4. Society for Healthcare Epidemiology of America (SHEA). (2023).
5. Joint Commission. (2024). Accessed from **https://e-dition.jcrinc.com/Frame.aspx**

Evaluation of the Infection Prevention and Control Plan 2023
And
Goals and Objectives 2024

This Program Evaluation is based in part on annual risk assessment of top priorities ("vital few") as identified by Pareto Analysis and the outcomes achieved during calendar year 2023 (1/2023 to 12/2023). Outcomes are identified through review of performance measurement data, information resulting from our committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Joe DiMaggio Children's Hospital and in collaboration with other Memorial Healthcare facilities. *The hospital evaluates the effectiveness of its infection prevention and control plan (IC.01.05.01)*

The purpose of this annual appraisal is to:

1. Evaluate the effectiveness of the Infection Control program of Joe DiMaggio Children's Hospital in detection, identification, prevention, and control of hospital acquired and community acquired infections in patients, employees, physicians, licensed independent practitioners, volunteers, contract service workers and visitors while in the hospital.
2. Identify and assess the degree of risk factors for the acquisition and transmission of infectious diseases to reduce the incidence and eliminate their spread among persons in the hospital and in the community.
3. Identify opportunities for quality and performance improvement, loss prevention, cost containment and planning for the upcoming year.
4. Adhere to all local, state, and national regulatory guidelines for healthcare facilities.

The following top organizational risk priority targets were identified from the CY2024 Joe DiMaggio Children's Hospital Infection Control Risk Assessment, 2024 Annual Plan and 2023 institutional data analysis. Targets were adopted from internal goal to reduce yearly harm by 10%, external reporting CMS/VBP/HAC and/or Leapfrog NDNQI and SPS performance achievement thresholds, CDC/NHSN published progress reports and internal TAP reports, and community historical trends. *Based on institutional determined goals and identified risks (risk ≥20% on ICRA Pareto), the organization sets goals to minimize the possibility of transmitting infections (IC.01.04.01).*

1. Overall reduction of healthcare associated infections. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI) and catheter associated urinary tract infection (CAUTI). Minimize the risk of hospital acquired infections associated with invasive devices.	**CY 2022 Performance**	**CY 2023 Performance**	**2024 Goal** **10% reduction in rate or CMS or Leapfrog benchmark**
CLABSI Central Line Infections Central Line Days X 1000 = Rate per 1000 Central Line Days SIR = observed/predicted	19/17155= ↑ 1.1 ↑ 0.717 (All units)	17/17855 ↓0.95 ↓0.655 (All units)	0.855 **0.760 VBP** threshold
CAUTI Urinary Catheter Infections Urinary Catheter Days X 1000 = Rate per 1000 Urinary Catheter Days SIR = observed/predicted	0/1118 = ↓0 ↓0 (All units except NICU)	2/1450= ↑ 1.38 ↑0.929 (All units except NICU)	1.24 **0.615 VBP** threshold

VAP Ventilator Associated Pneumonia Infections Ventilator Days X 1000 = Rate per 1000 Ventilator Days	11/7642= ↑1.4	15/8556= ↑1.75	1.575

Analysis

- Infections are identified from prospective surveillance by the trained IP staff using NHSN definitions.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.

Effectiveness

- **CLABSI**
  - House-wide CLABSI rate decreased from 2022 to 2023. House-wide SIR also decreased overall in 2023 compared to 2022.
  - CLABSI total raw infections increased in NICU and in the Critical Care areas. The Hematology/Oncology unit saw a decrease in total CLABSI while the Medical Surgical unit saw a CLABSI in 2023.
  - CY 2023 SIR was above VBP threshold.
  - While we saw an increase in total central line days (raw data), the SUR has dropped from 0.808 (2022) to 0.770 (2023) for the second consecutive year.
  - While in 2022 the objective was to standardize the tracking and trending of the bundle compliance using RedCAP, this year there was focus on consistent rounding with a consistent team. This team rounded weekly to assess the assessment of a central line including line necessity, discontinuation, or an alternative to the central line.
  - Solutions for Patient Safety(SPS) Hospital Acquired Committee continues to meet monthly to discuss:
    - CLABSI cases
    - Bundle reliability
    - Education to include partnership with medical providers, patient and family partners and ancillary partners.
    - Standardization of central line practices
  - NICU implemented monthly meeting to complement the SPS meeting, **Wipeout Wednesday.** This meeting provided a forum for staff to voice concerns, ideas and participate in the NICU HAI intensive reviews. Opportunities identified related to central line care:
    - Inconsistencies in disinfection of the end cap, “scrub the hub”
    - Supply chain shortages (i.e., auto substitutions for skin disinfectant, end cap disinfectant)
    - Hand Hygiene opportunities
  - Robust plan implemented to address CHG treatment to be done daily for ALL patients with central lines, and central line care.
  - Each CLABSI included a detailed drill down for any event identified to determine any opportunities for improvement.
  - Communication established with nurse managers and administration during management huddle on lessons learned to prevent CLABSI.
  - Strive for “zero”
  - IP will continue to monitor and communicate findings with the appropriate stakeholders.
- **CAUTI**
  - CAUTI rates and SIR increased overall in 2023 compared to 2022.
  - CAUTI totals for 2023 were 2
  - CY 2023 SIR was above VBP threshold.
  - We saw an increase in total foley catheter days (raw data) but saw a drop in the SUR from 0.602 (2022) to 0.529 (2023).
  - Daily Foley catheter report reviewed to identify opportunities for removing indwelling catheters and/or replacing with external catheters, if indicated.
  - External Male and Female catheters are available, and staff have been educated to use ANI (advanced nursing Interventions) for early foley removal as indicated.
  - Communicated with nurse managers and administration during management huddle on lessons learned to prevent CAUTI.
  - IP will continue to monitor trends associated with CAUTI
- **VAP**
  - VAP rates continue to increase overall in 2023 compared to 2022. Ventilator days are steady when compared to previous year.
  - VAP raw infections decreased in the Critical Care areas but increased in NICU.
  - Solution for Patient Safety VAP/UE Hospital Acquired Committee meet to discuss the following:
    - All unplanned extubations
    - All ventilator associated pneumonia (VAP) trends

- VAP bundle compliance
- Collaboration with Respiratory, Nursing, Physician leadership.
  - Opportunities identified:
    - lack of bundle compliance
    - deviation in practice with the management of ventilated patient and ensuring care of the respiratory equipment is consistent among the Respiratory Therapist.
    - Need to implement formal VAP rounds

2. Surgical Site Infections (SSI) Carry out systemic program surveillance and reporting of all Class I and II surgical site infections.	**Targeted Class**	**CY 2022 Performance**	**CY 2023 Performance**	**2024 Goal** **10% reduction in rate or CMS or Leapfrog benchmark or SPS Goal**
Surgical Site Infections/ Surgical Procedures Completed X 100 = SSI Rate	Class I and II Rate	15/8544= 0.18	20/9076 0.22↑	*10 % Reduction in 12 month rate per SPS*
	VP Shunt	4/57= 7↑	6/61 9.8↑	
	Spinal Fusion	0/74= 0	1/80 1.25↑	
	Cardiothoracic	0/135= 0	2/98 2.04↑	

Analysis

- Class I and II surgery volumes increased by 0.5% as well as the surgical site infections. There was an increase in SSI rates from CY 2022 compared to 2023 by 15%
- Analysis of surgical site infections reported to SPS SSI HAC reviewed.
  - Cardiac, VP Shunt and Spinal fusion SSIs are reported and reviewed
  - Noted an increase in SSI infection rates in all three disciplines with a significant increase in the VP shunt surgeries
  - SSI subcommittee created in the summer of 2023 to investigate any trends/opportunities that may be attributed to the increase in trends.
- 100% compliance with reliability reporting to SPS SSI HAC (VP Shunts, Spinal fusion and cardiothoracic surgeries).
- Analysis of all SSI data reviewed that are captured in the NSQIP database. Data shared in departmental meetings.
- Drill down on all SSI infections with an opportunity to discuss lessons learned with management and administration
- Opportunities Identified:
  - Pre-op baths are being missed when patient arrives from ED and goes directly to OR
  - Pre-op bath documentation can be documented in various locations in the EMR
- Re-education was provided to clinical staff RE: pre-op chlorhexidine bathing, antibiotic, time given and re-dosing
- Traffic addressed and monitored as well as post-op practices (i.e. post-op education and follow-up)

Effectiveness

- In collaboration with Pharmacy team and Medical Staff, all MHS preoperative antibiotic prophylaxis order sets reviewed and updated to agree with current professional guidelines.
- JDCH Quality Department launched Back to Basic Campaign in the fall 2023 with emphasis on several topics one being the reeducation of CHG treatment prior to surgery
- Gap analysis and action plan regarding strategies supported by evidence-based medicine to reduce SSI which includes preoperative bathing with chlorhexidine, surgical site scrub with chlorhexidine, and weight based antibiotic dosing and appropriate antibiotic selection for patients.
- Surveillance of evidence based best practices as well as the improvement solutions remain on-going to reestablish the downward trend with reducing VP Shunt infections, Spinal Fusion and Cardiothoracic (per SPS) infections as well as class I and II SSI.

3. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and *Clostridium difficile* (CDIFF)		2022 Final	2023 Final	2024 Goal (10% reduction), VBP threshold or SPS goal
CRPA	# of patients with MDRO # of patient days x 10000 = MDRO rate	4/54720= 0.73	22/59302= 3.7↑	
C.*auris*	# of patients with MDRO # of patient days x 10000 = MDRO rate			Currently no recommendation for active surveillance for C.*auris* in the pediatric population
CDIFF (HO-CDI)	# of patients with MDRO # of patient days x 10000 = MDRO rate	4/28154= 1.42	10/30836 3.24↑	
MRSA bacteremia (HO-MRSA)	# of patients with MRSA bacteremia # of patient days x 10,000 MRSA rate	2/54720= 0.37	3/59302 0.51↑	
MRSA bacteremia SIR	SIR: observed / predicted	0.916	1.25↑	0.793 VBP
CDIFF SIR		0.339	0.797↑	0.423 VBP

Analysis

- Significant increase in CDIFF rate overall from CY2022 to 2023 AND a significant increase in SIR and compared to VBP benchmark.
- ~40% increase in MRSA bacteremia rate from CY 2022 to 2023 AND significant increase in SIR and compared to VBP benchmark.
- Opportunities identified related to CDIFF: updated the CDI order set, use of laxatives, pt not meeting s/s criteria and untimely collection of the specimen.
- Early identification of patients colonized or infected with resistant organisms or other infectious organisms and immediate transmission-based isolation of these patients reduced and prevented further transmission.
- IP also monitored the high priority organism list and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the IP to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission-based precautions.
- The CDC isolation precautions are part of MHS policy and on the intranet website as a resource for all staff to have access to.
- We continued to implement Modified Contact Precautions, GI Precautions, Enhanced Contact Precautions, Enhanced Respiratory Precautions in addition to CDC Transmissions-Based Precautions and Standard Precautions.
- Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Infection Prevention was a part of MDRO action plan.
- Continued active surveillance for CRPA for high-risk patients on admission.

Effectiveness

- Surveillance rounds and lab monitoring are mechanisms in which information is gathered. Individual clusters were and will continue to be analyzed and interventions will be determined at that time.
- Continued emphasis on hand hygiene and antimicrobial stewardship.
- Appropriate testing guidelines for C-diff disseminated to all medical staff and the clinical nurse.
- Collaboration with antibiotic stewardship committee. Collaboration with EVS team to implement additional prevention strategies. This includes daily communication of patient rooms on GI precautions including rooms pending discharge targeted for Electrostatic bleach use. In addition all discharges in Oncology Unit (regardless of Isolation status) are being treated with Electrostatic sprayer followed by bleach wipes.

4. Improve Hand Hygiene Compliance	2022 Rate	2023 Rate	2024 Goal
	44%	100%↑	70%

- JDCH utilized as pilot site for electronic hand hygiene monitoring system at MHS
  - Hand Hygiene Intelligent Observation Electronic Monitoring
- Number of observations/number of opportunities
- Door sensors in place that monitor all healthcare workers for entrance and exit compliance
- Hand hygiene with alcohol-based hand sanitizer as well as compliance with soap and water hand washing for >15 seconds monitored

Analysis/Effectiveness

- Marked increase in data points since Intelligent Observation electronic observation system implemented.
- Units complete monthly action plans for areas of opportunity.
- Discussed at staff meetings.
- March 2023, JDCH removed the electronic monitoring device due to inconsistent data and reliability issues with the sensors.
- JDCH moved to direct observation receiving ~200 audits a month per respective units with 100% hand hygiene compliance
- JDCH Quality Department launched Back to Basic Campaign in the fall 2023 with emphasis on several topics one being the reeducation of the 5 Moments of Hand Hygiene

5. Prevent unprotected exposure to pathogens (i.e. COVID-19, seasonal flu, pandemic flu, influx of infectious patients, active TB patients and patients with history of MDRO, unusual clusters of organisms or HAI). Monitor the inpatient and outpatient traffic for any potential cases of active TB or increase in influx of infectious patients.	2021	2022	2023 Goal
MDRO trends/identification COVID-19 inpatient clusters or transmission Influx of other infectious patients	Zero. Monitored for any trends of MDRO and COVID transmission.	Zero. Continued to monitor and intervene as necessary.	Zero. Ongoing monitoring and surveillance and will intervene as necessary.

Analysis

- There were 508 COVID-19 positive employees, 0 TB exposures and 0 conversions, and 0 Varicella, 32 meningitis, 7 needle sticks, 4 sharps exposure, and 5 blood and body fluid exposures for CY 2022. Each exposure was followed by Employee Health. There were no conversions or nosocomial transmissions identified during post-exposure work-up.
- No unusual clusters of organisms or HAI.
- The surveillance plan based on prioritized risk of transmission of diseases identified in our community and from the characteristics of the population served was developed and approved by the Quality Care Council.
- The surveillance plan is carried out by the IPs on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers, and visitors.
- The ESSENCE reporting system that identifies syndromic trends through the ER was used to coordinate surveillance with the Broward County Department of Health.
- MHS uses electronic case reporting for COVID-19 reporting to the state.

Performance/Effectiveness:

- JDCH will continue to actively track and trend admission of patients for any increase influx of patients and/or need to implement the Pandemic Plan.
- IP staff monitor the daily high priority organisms and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the Epidemiology nurse to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission-based precautions.
- All blood and body fluid exposures and TB exposures documented in CY 2021 were followed up by Employee Health and resulted in zero transmissions.

6. Reduction of risk of infection secondary to employee knowledge deficit of disease transmission or prevention, inadequate supplies, safety devices and personal protective equipment.	2021	2022	2023 Goal
Frequency that IP consulted and responded with expert review in employee knowledge deficit of disease transmission and prevention, product substitutions and availability of supplies & front-line staff aware.	**100%**	**100%**	**100%**

- Isolation rounds conducted by IPs.
- Provide input on issues of product selection and efficacy. Products evaluated as needed via
- MHS system wide VAT committees, chemical, cleaning agents and medications.
- IP team completed direct observation and return demonstration of PPE donning and doffing with staff.
- Hands on demonstrations and creation of education and visual aids in real time.
- Rounding on the floors.
- Communication to unit leaders, DONs, and front-line staff with immediate response.

Analysis/Effectiveness

- Utilize CDC, APIC, SHEA and other professional society guidelines.
- Consultation and communication from supply chain, materials management, and clinical team for backorders, conservation activities, with crisis and contingency standards dependent on availability of medical equipment.
- Unit level in-services continued to be presented for dissemination of product information.
- Educational materials are created by the IP team, provided on the intranet or printed and used to educate staff, patients and families.

7. Promote and improve seasonal flu and COVID immunization organization wide	2022-2023	2023-2024	2024-2025 goal: >90%
Employee Influenza immunization rate	10/1/22 to 3/31/23, the compliance at JDCH is: 1495/1584 = 94.4%	10/01/23 to 03/31/24 the compliance at JDCH is: 1650/1728= 95.49%	
Employee COVID immunization rate	10/1/2022 to 3/26/2023 JDCH compliance is 1208/1297 = 93.3%	No longer tracking per Employee Health	

Analysis

- NHSN definitions are utilized for mandatory compliance reporting.
- Influenza vaccination became mandatory across MHS in 2021 driving an increase in compliance.
- Influenza vaccine program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs. Nursing offers vaccination to inpatient patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered in Employee Health during the entire flu season as well as times when mobile vaccination carts attend units and meetings.
- Mandatory influenza education is provided to all hospital staff via Annual Review.
- Individual counseling and encouragement for participation includes a video to watch for employees who decline vaccination.
- Declination forms are used to monitor the reasons given for declining the vaccine as well as the effect of educational interventions.

Performance/Effectiveness

- Flu and COVID vaccination information is available on Annual Review and is mandatory to complete for all staff.
- Administrative support by participated in campaigns for vaccination.
- Employees who take flu vaccine are incentivized with health insurance premiums.
- Influenza vaccine mandatory/

- MHS System Human Resources and Employee Health will continue to explore methods to maintain the >90% rate of vaccination among health care workers.

8. **Infection Prevention and Control Program Plan, Evaluation of the Plan, Risk Assessment, Policies and Procedures are reviewed and updated annually. Plans include policies and procedures for minimizing risk of transmitting infection associated with use of procedures, medical equipment, medical devices, and products.**	**2022 Target**	**2023 Final**	**2024 Goal**
Program policies and procedures review completed	100%	100%	100%
Program has a CIC trained IP and NHSN trained?	100%	100%	100%
Medical Director, Board Certified Infectious Disease Physician	100%	100%	100%

Analysis

- The Comprehensive Infection Control Risk Assessment for CY2022 was presented to a multidisciplinary group for review, recommendations and approval.
- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Medical Council. The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified. The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- Computer technology is utilized for analysis, trending and tracking of infection surveillance data.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.

Performance/Effectiveness

- All of the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- The Infection Preventionists are members of the national and local chapter of their professional organization and receive education related to Epidemiology/ Infection Prevention and Control on an ongoing basis.
- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of data and surveillance over the calendar year. This has provided more accurate analysis to better prioritize our risks and set new goals for the coming calendar year.

Memorial Hospital Pembroke

CY 2024 Infection Prevention and Infection Control Plan

I. Executive Summary

Memorial Hospital Pembroke (MHP) is a healthcare facility associated with the Memorial Healthcare System (MHS) and maintains an individual Infection Prevention and Control (IPC) plan tailored to its scope of service, to meet the specific needs of its population, but also participates in a systemwide IP program that is used to assist in standardization and strategic vision, as well as creates a framework for systematic organization of the cohesive and growing IPC activities in both inpatient and ambulatory locations. This Infection Prevention and Control Program, along with the collaboration with the Antimicrobial Stewardship Program, meets all the requirements of a comprehensive program in accordance with Centers for Medicare and Medicaid (CMS) Conditions of Participation (CoP) for 42 CFR §482.42.

The annual **Plan** includes both an *Authority Statement* and a *Scope of Service* that is specifically based on hospital location, populations served, and services provided for last calendar year (CY 2023), including top diagnoses and top procedures by volume, and standard plan elements.

The annual **Risk Assessments** use a *Hazard Vulnerability* template (also used in MHS Emergency Management) and was scored in 2024 Q1 based on CY 2023 actual risks and then reviewed by the hospital's multidisciplinary Infection Control committee or working team. Using the actual risks from the previous year, this year's CY 2024 *Priorities, Goals, and Objectives* are identified using a Pareto graph to visually represent the top 20% of risks in four main areas: Hospital Acquired Infections, Community Risks, Healthcare Worker Risks, and Environmental Risks.

The annual **Evaluation/Appraisal of Goals and Objectives** reviews and evaluates the previous year's CY 2023 hospital-specific goals and objectives by comparing at least two years of performance for infections, hand hygiene, staff vaccination, and more. The goals and resultant data are clearly stated to track performance in both 2023 and 2023, with a *Past Year's Summary of Action Items* undertaken in the past year, and a specific, *Achievable Goal Metric for 2023*.

The oversight and support of this essential program at each facility includes at least one highly trained Manager, the system Director of Infection Prevention and Epidemiology for MHS, and the Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship for MHS.

The hospital plan is annually reviewed by the Quality Council, Medical Executive Committee and taken to the MHS Board of Commissioners for approval.

II. Table of Contents

III. Introduction

Mission: Heal the body, mind, and spirit of those we touch.

Vision: To be a premier clinically integrated delivery system providing access to exceptional patient-and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Commitment: Family Centered and Patient Focused Care

Purpose: To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases.

This plan will *define the scope of activities* and *provide a framework* for the systematic, organization wide approach for an effective infection control program.

IV. Authority Statement

Pursuant to the approval by the hospital's *Medical Executive Committee* (§482.42(c)(1,2)):

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).
2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.
3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

V. Scope of Service 2023-2024

Memorial Hospital Pembroke (MHP)

MHP is located at 7800 Sheridan Street, Pembroke Pines, in south central Broward County, Florida. This is a suburban area and communities served includes north Miami-Dade County. Memorial Hospital Pembroke is one facility of the healthcare system. There is also an off-site 24/7 Care Center and Primary Care Clinics.

MHP offers extensive and diverse health care services that include:

- Anesthesia
- Bariatric Surgery
- Colon & Rectal Surgery
- Urology
- Emergency Medicine
- Hyperbaric Wound Therapy
- Gastroenterology
- General Surgery
- Internal Medicine
- Nephrology
- Neurology
- Podiatry
- Pulmonary Medicine
- Radiology
- Vascular Surgery
- Inpatient Rehabilitation
- Dialysis

Acuity:

MHP has 229 beds, total capacity: 301 beds

Licensed Programs:

- Primary Stroke Center
- Center of Excellence in Hernia Surgery accredited by SRC
- MBSAQIP Bariatric Accreditation
- Geriatric Emergency Department Accreditation

Class 1 Hospital Licensed Beds

- Critical Care beds: 12
- Medical/Surgical/Stepdown/Telemetry beds: 189
- Emergency Department beds: 28
- Surgical Suites: 8

Population served - Ages: 18 – End of Life for acute care.

MHP Top Inpatient Diagnoses, 2023

1. Sepsis, unspecified organisms

2. Morbid (severe) obesity due to excess calories
3. Urinary tract infection, site not specified
4. Pneumonia, unspecified organism
5. COVID-19
6. Acute kidney failure, unspecified
7. Hypertensive heart and chronic kidney disease with heart failure and stage 1-4 CKD
8. Type 2 diabetes mellitus with other specified complications
9. Chronic obstructive pulmonary disease with (acute) exacerbation
10. Hypertensive heart disease with heart failure

MHP Top 10 Inpatient Procedures, 2023

1. Performance of urinary filtration, intermittent
2. Excision of stomach, percutaneous endoscopic approach
3. Insertion of infusion device into superior vena cava
4. Resection of gallbladder, percutaneous endoscopic approach
5. Bypass stomach to jejunum, percutaneous endoscopic approach
6. Resection of appendix, percutaneous endoscopic approach
7. Insertion of tunneled vascular access device into
8. Dilation of right ureter with intraluminal device
9. Respiratory ventilation, greater than 96 consecutive hours
10. Extirpation of matter from left ureter, via natural

MHP Top 10 Outpatient Procedures, 2023

1. Laparoscopy, surgical repair initial inguinal hernia
2. Laparoscopy surgical cholecystectomy
3. Lithotripsy, extracorporeal shock wave
4. Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft
5. Transurethral electrosurgical resection of prostate, including control of post-op bleeding, complete
6. Cystourethroscopy, with ureteroscopy and or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent
7. Biopsy, prostate; needle or punch
8. Laser enucleation of the prostate with morcellation
9. Laparoscopy, surgical, repair of paraoesophageal hernia, includes fundoplasty, when performed
10. Cystourethroscopy, with insertion of indwelling ureteral stent

Off-Site Locations:

- 24/7 Care Center – 801 South Douglas Road, Pembroke Pines, FL 33025
- Memorial Primary Care Clinic – Pembroke Pines – 2217 N. University Drive, Pembroke Pines, FL 33024

VI. Program Objectives

The MHP Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices at Memorial Healthcare System with the intent:

1. To create and implement an active, system-wide comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting or transmitting communicable infections and diseases.
2. To collaborate with all healthcare system departments including Antimicrobial Stewardship - Pharmacy, Quality, Clinical Effectiveness, and Performance Improvement to minimize the morbidity, mortality and economic burdens associated with healthcare associated infection (HAI) and multidrug resistant organisms (MDRO) through prevention and control efforts throughout all sites where care is delivered.
3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection, as well as
4. To collaborate with Emergency Preparedness to engender advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event.

VII. Program Management

A. Program Administration and Resources

1. IP Program led by designated, qualified healthcare Infection Preventionist (IP), as identified in the Authority Statement and are responsible for the IP program. IP team has access to multiple resources and consultative support not limited to but including the Medical Director of Infection Control and Antimicrobial Stewardship, System Director of Epidemiology and Infection Prevention, as well as being able to communicate and collaborate with the entire group of MHS IPs as a system for a unified infection prevention team (§482.42 (a)(1), IC.01.01.01, IC.01.02.01).

   a. Ratification of competency of IPC team members by Medical Executive Committee and Board.
   b. Maintains membership in Association for Professionals in Infection Control or Florida Professionals in Infection Control.
   c. Attends one (1) educational seminar related to infection prevention and control per year.
   d. Job descriptions delineate the scope and responsibility for each Infection Prevention professional.
2. Staffing, Memorial Hospital Pembroke:
   a. Director, Quality & Patient Safety
   b. Manager of Infection Prevention & Control
3. Staffing, Memorial Healthcare System (Oversight and Support):
   a. Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
   b. Physicians, Infectious Disease (MRH, MRHS)
   a. Director, Infection Prevention and Epidemiology, MHS
4. Leadership responsibilities (§482.42(c)(1), IC.05.01.01)
   a. Governing body of healthcare system approves annual IP Plan.
   b. System Medical Director presents program to Board Peer Review at least annually to ensure program is in place for accountability and monitoring and prevention of infections.
5. Hours of Operation: Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

B. Plan of Care and Practice for Infection Prevention and Control

1. Planning for management of infection control and prevention (IC & P) program. (IC.01.01.01)
2. Development of an infection prevention and control plan (IC.01.05.01) from utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus.
3. Plan is a written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection.
4. Plan reflects the scope and complexity of the services provided (§482.42(a)(4)).

C. Performance of Risk Assessments

1. Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing. (IC.01.03.01, IC.06.01.01)
2. A multidisciplinary team collaborates to review results of the hospital's infection risk assessment and are prioritized in order of level of probability and potential for harm.
3. Identification, prioritization, and documentation of risk assessment in order of probability and level of harm based on:
    a. Geographic location, community, and population served.
    b. Care, treatment, and services provided.
    c. Analysis of surveillance activities and aggregate IC data
4. Pareto Analysis used to identify the top risks and set goals for reducing the risks of infections that pose the greatest threat to patients and the community.

D. Goal Setting

1. Goal setting to reduce risk of infection to patients and community (IC.01.04.01) and lead to focused activities, based on relevant professional guidelines and sound scientific practices.
2. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
3. Written goals, based on identified risks, include (IC.06.01.01):
    a. Addressing prioritized risks
    a. Limiting unprotected exposure to pathogens
    b. Limiting the transmission of infections associated with procedures.
    c. Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies.

E. Evaluation of Effectiveness and Appraisal of Infection Prevention and Control Plan and Program

1. Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01) based on:
    a. Plan's prioritized risks
    b. Plan's goals
    c. Program's efficacy
2. Communication of findings to patient safety program.
3. Include findings of evaluation when revising the plan.

F. **Policy and Procedure Development** (§482.42(a)(2))

1. For infection surveillance, prevention, and transmission control that are reviewed annually and reference and adhere to nationally recognized guidelines.
2. Implementation of Practice for Infection Prevention and Control
3. Prevention and control of transmission of healthcare associated infections (HAIs) and infectious disease among patients and staff.
4. Implementation and documentation of infection control plan, surveillance, prevention, and transmission control that adhere to nationally recognized guidelines.
5. Performance of activities based on relevant professional guidelines and scientific practices.

G. **Implementation and Documentation of infection surveillance, prevention, and control** (IC.02.03.01, IC.04.01.01)

1. Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues (§482.42(c)(1)(ii), §482.42(c)(2)(iii)).
    a. The Infection Control Practitioner reports to the Director of Quality who reports to the Chief Nursing Officer.
    b. The Infection Control Practitioner will report to the Medical Staff any trends within their departments.
2. Training and education of employees and medical staff on practical application of IC & P guidelines and P & Ps (§482.42(c)(2)(iv)).
3. Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (§482.42(c)(2)(v), IC.02.01.01).
4. Implementation of IC & P activities involving departments, employees, and medical staff
    a. Surveillance methodology utilizing CDC NHSN with sources for identification including:
        i. Microbiologic records
        ii. Reports from Information Systems including patient census/diagnosis.
        iii. EPIC and outside labs
        iv. Chart reviews and patient interviews
        v. Post-discharge surveillance

vi. Reporting of suspect/known infections or infection control issues from staff and units' multidisciplinary rounds
vii. Device day usage for urinary catheters, central line catheters, and ventilators
viii. Public health reporting of state mandated reportable infections.
ix. Microbiologic monitoring of water and dialysate

5. Provision of important IC & P information to patients, employees, medical staff, and visitors
    a. Respiratory Hygiene Practices
    b. Hand Hygiene
    c. Implementation of standard and transmission-based precautions
    d. Utilization of personal protective equipment (PPE)
    e. Donning
    f. Doffing
6. Storage and disposal of infectious waste
7. Investigation of outbreaks (IC.01.05.01) – MHS Policy and APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12. Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures for framework and guidelines conducting an outbreak investigation
    a. Initiates outbreak investigation when an outbreak or cluster is suspected consistent with CDC Guidelines.
    b. Institutes early control measures, prepares a preliminary case definition, and compares current incidence with usual or baseline data.
    c. Develops case definition based on time, place, person.
    d. Evaluates efficacy of the control measures.
    e. Reports finding to Medical Director of Infectious Diseases, System Director of Infection Prevention, Quality Care and Patient Safety Committee, appropriate Medical Staff Departments and Florida Department of Health, if warranted.
    f. Reporting of surveillance, prevention, and control information to appropriate staff within facility
8. The Infection Control Practitioner will report relevant findings to PIRM Committee, and Environment of Care Committee quarterly and a report will be submitted quarterly to the Quality Care and Patient Safety Council. The report is then submitted to the Medical Executive Committee, and to the Board of Commissioners.
9. Reporting of surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with laws and regulations.

10. Informing receiving organizations of patients requiring monitoring, treatment, and/or isolation
    a. Upon transfer arrangement
    b. After transfer, upon discovery
    c. Upon receiving a patient and if notification had not occurred by the transferring facility

H. **Reduction of risk of infection associated with environment, medical equipment, devices, and supplies.** (§482.42(a)(3), IC.01.02.01)

1. Adherence to Spaulding Classification (CDC)
2. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
3. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
4. Disposal of medical equipment, devices, and supplies
5. Storage of medical equipment, devices, and supplies
6. Reprocessing single use devices consistent with regulatory and professional standards.
7. Availability of Manufacturer's Instructions for Use

I. **Implementation of evidence-based practices to prevent healthcare associated infections (HAIs) due to the following:** (IC.02.01.01, IC.02.05.01, IC.07.01.01)

1. Participation in CDC's National Healthcare Safety Network
2. Multidrug Resistant organisms (MDRO) and Emerging Infectious Diseases
    a. Candida auris
    b. MDR Acinetobacter baumannii
    c. MDR Carbapenem-resistant Enterobacteriaceae
    d. MRSA
    e. Pseudomonas aeruginosa
    f. Clostridiodes difficile
3. Central Line-associated bloodstream infections (CLABSI)
4. Catheter-associated urinary tract infections (CAUTI)
5. Ventilator Associated Event (VAE)
6. Surgical Site Infections (SSI)
7. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices

8. Participation in The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)
9. Protocols for high-consequence and emerging special pathogens and collaboration with Emergency Preparedness (IC.07.01.01).

J. Hand Hygiene

1. Improving compliance with the current CDC Hand Hygiene guidelines
2. iRound electronic audit tool for manual monitoring used since 2020
3. National Patient Safety Goal 7: Prevent infection by using hand cleaning guidelines from CDC or WHO.
4. Set goals to improve hand cleaning.
5. Report at Quality meetings by unit and type of employee.

K. Communication and collaboration with Emergency Preparedness (EP)

1. Preparation of response to influx of potentially infectious patients (IC.01.06.01)
2. Participation in interdisciplinary emergency management operations program: engagement in planning activities which includes identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.
3. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
4. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
5. Written plan delineating management of influx of infectious patients
6. MHS Highly Communicable Disease Preparedness and Response guidelines
7. COVID-19 guidelines continuously updated on intranet.

L. Communication and collaboration with Environment of Care (EOC)

1. Water Management Program (EC.02.05.02): Participation in an interdisciplinary water management program that addresses Legionella and other waterborne pathogens.
2. Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)

3. Infection Control Risk Assessment (ICRA)

M. Communication and collaboration with Employee Health (EH)

1. Vaccination against influenza of licensed independent practitioners and staff. (IC.02.04.01)
2. Annual influenza vaccination program that is offered to all licensed independent practitioners and staff.
3. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
4. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
5. Improvement of influenza vaccination rates
6. Written description of the methodology used to determine influenza vaccination rates
7. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually, and it's reported in PIRM
8. Improvement of vaccination rates according to established goals at least annually
9. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual
10. Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:
    a. Hepatitis B
    b. Covid-19
    c. Tetanus, Diphtheria and Pertussis
    d. Varicella
11. Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)
12. In collaboration with Medical Staff and Employee Health Services:
    a. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may be exposed to infections within the workplace
    b. Management of LIPs and employees who are suspected of or were occupationally exposed
    c. Management of patients who have been exposed to an infectious disease

d. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
e. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

N. **Communication and collaboration with Antimicrobial Stewardship Program (ASP)** (§482.42(d), §482.42(c)(2)(vi), §482.42(b), MM.09.01.01)

1. Please see addendum with ASP Plan and yearly documents.
2. IP has unified and integrated with ASP program as a system of multiple hospitals by sharing meetings and medical director.

O. Investigation of adverse events related to tissue use or donor infections.

1. Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices, and other implantable items.
2. Investigation of infections suspected of being directly related to the use of tissue.
3. Reporting of infection to tissue suppliers
4. Sequestering remaining tissue suspected of causing infection.
5. Notification of recipient of infectious agents that may have been transmitted through tissue.

VIII. References

1. Centers for Disease Control and Prevention (CDC). (2023).
    a. CDC. (2022). CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. Accessed from https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html
    b. CDC. (2015). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. Accessed from https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf
    c. CDC. Prevention Strategies for Seasonal Influenza in Healthcare Settings. Accessed from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm)
    d. Bolyard EA. Tablan OC, Williams WW, Pearson ML, Shapiro CN, Deitchmann SD. Guideline for Infection Control in Healthcare Personnel, 1998. Hospital Infection control Practices Advisory committee. Infect Control Hosp Epidemiol. 1998 Jun; 19(6):407-63. (Available at https://stacks.cdc.gov/view/cdc/7250.
    e. Boyce JM, Pittet D, Healthcare Infection control Practices Advisory Committee, Society for Healthcare Epidemiology of America, Association for Professionals in Infection control, Infectious Diseases Society of America, Hand Hygiene Task Force. Guideline for Hand Hygiene in Health-Care Settings: recommendation of the Healthcare Infection Control Practices Advisory committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Infect control Hosp Epidemiol. 2002 Dec 23(12 Suppl):S3-40. (Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm.
    f. Rutala WA, Weber DJ, Healthcare Infection Control Practices Advisory Committee. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Am J Infect Control.2013;41(5 Suppl):S67-71. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf
    g. Sehulster L, Chin RY, Healthcare Infection Control Practices Advisory Committee. Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC and the Healthcare Infection Control Practices

Advisory Committee. MMWR Recomm Rep 2003 Jun 6:52(RR-10):1-42. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf

h. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006. Am J Infect control, 2007 Dec 35 (10 Suppl 2):S165-93. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/mdro-guidelines.pdf [PDF – 75 Pages].)

i. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Am J Infect Control. 2007 Dec 35(10 Suppl 2)S65-164. (Available at https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.)

2. Centers for Medicare and Medicaid Services. (2022 July 6). Conditions of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs. Accessed from https://www.cms.gov/files/document/qso-22-20-hospitals.pdf

3. Association for Professionals in Infection Control and Epidemiology (APIC). (2023). APIC Text accessed from https://apictext.org

4. Society for Healthcare Epidemiology of America (SHEA). (2023).

5. Joint Commission. (2024). Accessed from **https://e-dition.jcrinc.com/Frame.aspx**

Evaluation of the Infection Prevention and Control Plan 2023
And
Goals and Objectives 2024

This Program Evaluation is based in part on the annual Risk Assessment of top priorities ("vital few") as identified by the Pareto Analysis and the outcomes achieved during calendar year 2023. Outcomes are identified through review of performance measurement data, information resulting from our committees, team meetings and multidisciplinary rounds, as well as interviews and discussions conducted with staff and leaders throughout Memorial Hospital Pembroke and in collaboration with other Memorial Healthcare facilities. *The hospital evaluates the effectiveness of its infection prevention and control plan (IC.01.05.01)*

The purpose of this annual appraisal is to:

1. Evaluate the effectiveness of the Infection Control program of Memorial Hospital Pembroke in detection, identification, prevention, and control of hospital acquired and community acquired infections in patients, employees, physicians, licensed independent practitioners, volunteers, contract service workers and visitors while in the hospital.
2. Identify and assess the degree of risk factors for the acquisition and transmission of infectious diseases to reduce the incidence and eliminate their spread among persons in the hospital and in the community.
3. Identify opportunities for quality and performance improvement, loss prevention, cost containment and planning for the upcoming year.
4. Adhere to all local, state, and national regulatory guidelines for healthcare facilities.

The following top organizational risk priority targets were identified from the CY2023 Memorial Hospital Pembroke Infection Control Risk Assessment, 2023 Annual Plan and 2023 institutional data analysis. Targets were adopted from internal goals to reduce yearly harm to rate of 0.30 or less, external reporting CMS/VBP/HAC and/or Leapfrog performance achievement thresholds, CDC/NHSN published progress reports and internal TAP reports, and community historical trends. *Based on institutional determined goals and identified risks (risk ≥30% on ICRA Pareto), the organization sets goals to minimize the possibility of transmitting infections (IC.01.04.01).*

1. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and *Clostridium difficile* (CDIFF)		**2022 Final**	**2023 Final**	**2024 Goal 10% reduction or CMS benchmark**
Candida Auris	# of patients with MDRO on day 4+ # of patient days x 1000	**0**	**0**	**0.00**
Carbapenem resistant organisms (CRO)	# of patients with MDRO on day 4+ # of patient days x 1000	**0**	**0**	**0.00**
MRSA bacteremia Rate	# of patients with MRSA bac on day 4+ # of patient days x 10,000	**0.54**	**0.83** ↑	**0.75**
CDIFF Rate	# of patients with CDIFF on day 4+ # of patient days x 1000	**0.46**	**0.37** ↓	**0.33**
MRSA bacteremia SIR	SIR: Observed / Predicted	**1.476**	**2.114** ↑	**0.793**
CDIFF SIR		**0.677**	**0.614** ↓	**0.423**

Performance/Effectiveness:

- Goal for Candida Auris was met
  - There were no HA-Candida Auris cases in 2023 or 2022
- Goal for MRSA bacteremia was not met, to decrease HA-MRSA bacteremia rate to 0%. There was a 54% increase.
  - There were 4 HA-MRSA bacteremia cases in 2023 compared to 2 cases in 2022.
- Goal for CDI was met, to decrease HA-Cdiff rate by 5%. There was a 19.6 % reduction.
  - There were 18 CDI cases in 2023 compared to 17 cases in 2022.

Actions Taken (Acute):

- IP monitors high priority organism lists and isolations.
  - These measures assist with identifying previously colonized or infected patients with resistant organisms and allow the IP to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission based precautions.
- Continue active surveillance for CRE and C. Auris for high risk patients on admission.
- The CDC isolation precautions are part of MHS policy and on the intranet as a resource for all staff to have access to.
- We continue to implement Contact Precautions, GI Precautions, Enhanced Contact Precautions, Enhanced Respiratory Precautions in addition to CDC Transmissions-Based Precautions and Standard Precautions.
- Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical/nursing departments and Infection Prevention continue to be practiced.
- Blood culture collection education and opportunities identified.

CDIFF:

- We continue to utilize the CDI algorithm as a method to identify patients in need of CDI testing.
- Appropriate testing guidelines for C-diff was disseminated to all medical staff.
- Reinforce the immediate implementation of isolation precautions for patients suspected of C diff colonization.
- Monitor and support proper use of PPE and hand washing practices while caring for C Diff patients.
- Continue to emphasize the use of Clorox Bleach Germicide for low level disinfection and cleaning of C Diff patients-associated medical equipment and environment.
- Ensure proper use of the CDI algorithm and EPIC smart orderset
- Use of laxatives, and multiple use of antibiotics were identified as opportunities, so culture stewardship was undertaken as initiative.
- Collaboration with EVS team to implement additional prevention strategies.
- Continued emphasis on Hand Hygiene and Antimicrobial Stewardship programs.

MRSA:

- Ensure Contact precautions are initiated on all patients with "significant" multidrug resistant organisms as deemed by Infection Control.
- Promote hand hygiene and proper use of PPE while interacting with all patients including suspected and confirmed MRSA patients.
- Modified isolation precautions for MRSA and VRE have been discontinued with the exception of: uncontained draining wounds, uncontained bodily fluids, and purulent sputum production with a positive MRSA isolate. Select group of high risk patients screened using molecular test, including pre-op patients and patients with soft skin and tissue infections such as cellulitis. Positive patients are subsequently initiated on decolonization protocol.

2. Overall reduction of healthcare associated infections. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI) and catheter associated urinary tract infection (CAUTI). Minimize the risk of hospital acquired infections associated with invasive devices.	**2022 Performance**	**2023 Performance**	**2024 Goal 10% reduction in rate or CMS benchmark**
CLABSI Central Line Infections Central Line Days X 1000 = Rate per 1000 Central Line Days SIR = observed/predicted	**0.87** (3/3447) X 1000 **1.055**	**0.81** ↓ (3/3694) x 1000 **0.976** ↓	**0.73** **0.760**
CAUTI Urinary Catheter Infections Urinary Catheter Days X 1000 = Rate per 1000 Urinary Catheter Days SIR = observed/predicted	**0.75** (2/2678) x 1000 **0.863**	**0.36** ↓ (1/2799) x 1000 **0.415** ↓	**0.32** **0.615**
Analysis			

- Infections are identified from prospective surveillance by the trained IP staff using NHSN definitions.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.

CLABSI

- **Performance/Effectiveness:**
  - Acute Care Unit:
    - CLABSI goal for 2023 was not met, to decrease rate to 0.30 and utilization rate to 22%
    - In 2023, there was 3 reportable CLABSI cases per 3694 central line days for a rate of 0.81.
    - For the prior year (2022), there were 3 reportable CLABSI cases per 3447-line days for a rate of.0.87.
    - There was a slight increase (7.2%) in line days in 2023 (3694) compared to the 2022 (3447).
- **Actions Taken (Acute):**
  - Review/monitor patients with CLs daily during bed huddle and rounds.
  - Immediate removal of unnecessary central lines whenever possible.
  - Random "Line Lunas" (Monday) audits to ensure compliance infection control recommendations and evidence-based best practices.
  - Identification of high risk patients and use of alternative methods of medication delivery that may allow for downgrade of IV access.
  - Adherence to the Central line bundle and daily CHG treatments. Non-compliance and infections are reported to the nurse manager after daily surveillance.
  - CHG impregnated dressing are used on all CVCs & PICCs.
  - Audit conducted daily on all patients with CLs through the iRound tool
  - Results from the iRound tool audits provided monthly to nurse managers for staff review and education.

CAUTI

- **Performance/Effectiveness:**
  - Acute Care Unit:
    - CAUTI goal for 2023 was not met, to decrease rate to 0.30 and utilization rate to 13%
    - In 2023, there was 1 reportable CAUTI case per 2799 Foley days, for a rate of 0.36.
    - There were 2 reportable CAUTI cases in 2022 per 2678 Foley days for a rate of 0.75.
    - There was a slight increase (4.5%) in catheter days in 2023 (2799) compared to the 2022 (2678).
- **Actions Taken (Acute):**
  - Review/monitor patients with Foley catheters daily during bed huddle and rounds.
  - Continue the process of removing Foleys when not clinically indicated.
  - Random "Foley Friday" audits to ensure compliance infection control recommendations and evidence-based best practices.
  - Foley should be discontinued by day 2 on surgical patients unless reason not to discontinue is documented. Nursing is empowered by an ANI to discontinue.
  - Audit conducted daily on all patients with Foley catheters through the iRound tool
  - Results from the iRound tool audits provided monthly to nurse managers for staff review and education.

3. Surgical Site Infections (SSI) Carry out systemic program surveillance and reporting of epidemiologically important Class I and II surgical site infections.	**Targeted Class**	**CY 2022 Performance**	**CY 2023 Performance**	**2024 Goal 10% reduction in rate or CMS benchmark**
Surgical Site Infections	**COLO** SIR	**0.51** **0.817**	**0.39**↓ **0.523**↓	**0.35** **0.747**
	HYST SIR	**0.00**	**0.00**	**0.00** **0.763**

Performance/Effectiveness:

- SSI goal for 2023 was met, to decrease SSI rate to 0.40.
- In 2023, there were 67 COLO surgical procedures, representing a 2% increase in volume compared to 2022 (49 surgeries). The rate of infection for 2023 was 0.39 which is a 24% reduction compared with the previous year.
- In 2022, there was 1 COLO SSI case and 49 surgical procedures. The rate of infection for 2022 was 0.51.

Actions Taken:

- Bimonthly meetings with the SSI Task Force (Surgical Director, Quality, IC and NSQIP) to review cases and actions are conducted.
- These cases are discussed at the hospital Sepsis-Infection Control-Antibiotic Stewardship (SIPAS) Committee.
- Drill down on all SSI infections with an opportunity to discuss lessons learned with leadership.

- Additional surveillance is done by our NSQIP reviewer. This focus has provided different opportunities to improve our pt. outcomes.
- Ensure only hospital-laundered scrubs are worn in restricted and semi-restricted areas.
- Ensure appropriate timing of antibiotic administration (within 1 hour prior to incision)
- Ensure appropriate hair removal (where indicated) is practiced
- Monitor proper CHG bathing and skin prep practices
- Monitor environmental cleaning; ensure cleaning is performed with the correct surface and floor disinfectant.
- Ensure the sterile field is kept intact during surgical procedures through monitoring and implementation of proper infection control practices.
- Review post op instructions including SSI prevention at home
- Monitor Sterilization practices and sterile techniques.
- Ensure surface (Oxivir1) and floor disinfectants (Virex Plus) are used for turning of the rooms and terminal cleaning.
- Collaboration with Pharmacy team and Medical Staff, all MHS preoperative antibiotic prophylaxis order sets are reviewed
- Use of Sage CHG wipes for surgical patients.
- Implementation of nasal decolonization of all patients with an ASA score of 2 or above.

4. **Improve and monitor Hand Hygiene Compliance**	**2022 Rate**	**2023 Rate**	**2024 Goal**
Number of observations/number of opportunities	**97.7%**	**97.7%**	**98%**

Performance/Effectiveness:

- Goal for 2023 was to decrease noncompliance by 5% which was met with 2.3% reduction.
- In 2023, the hand hygiene compliance was 97.7% with a total of 5164 observations.
- This represents a 15% decrease in the number of collected observations compared to 2022 (4970); however, the % of compliance was the same as the previous year (97.7%).

Actions Taken:

- Continue unit-based education/coaching on hand hygiene with all staff.
- Quarterly HH data is presented to Patient Safety Quality Care Council.
- HH data/information is also presented during PIRM, Employee Skills Fairs, New Employee Orientation, and specific department in-services and presentations.
- Support the use of hospital-approved alternative hand hygiene products for those employees that have allergies or sensitivities.
- Provide education and support to the patient safety champions to collect accurate hand hygiene observations.
- Continue routine observations of appropriate hand hygiene (handwashing and the use of alcohol-based sanitizers)
- Continuation with the utilization of the iRound HH tool to collect HH observations.
- Mealtime patient Hand Hygiene program continues.

5. **Reduction of risk of infection secondary to inadequate supplies, failure to follow safety devices and personal protective equipment.**	**2022**	**2023**	**2024 Goal**
Frequency that IP consulted and responded with expert review on product substitutions and availability of supplies & made front line staff aware.	**100%**	**100%**	**100%**
Frequency that IP was consulted on protocols related safety devices and equipment.	**100%**	**100%**	**100%**

Performance/Effectiveness:

- All shortages and alternative products are shared with IC and monitored by IC.

Actions taken:

- Communication from supply chain, materials management, and clinical team for backorders, conservation activities, crisis and contingency standards dependent on availability of medical equipment.
- Unit level in-services continued to be presented for dissemination of alternate product information.
- Educational materials are created by the IP team, printed and used to educate staff, patients and families.
- Demonstrate/observe proper implementation and usage of new and alternative products by end-users.
- Education on alternative products is conducted each time a new product is brought to MHP.
- IC collaborates with supply chains to monitor, keeps track and communicate shortages and new products.
- Timeline of these shortages is kept and shared during monthly Clinical Leadership meetings.

6. Reduction and mitigation of community exposure to respiratory viruses including COVID-19, influenza, and others. Promote and improve seasonal influenza and COVID vaccination systemwide.	2022	2023	2024 Goal
Number of clusters of COVID-19 staff or patients.	**0**	**0**	**0**
Employee Influenza immunization rate	**89%**	**94%**	**95%**
Employee COVID immunization rate	**90%**	**93%**	**NA**

Performance/Effectiveness:

- In 2023, there were no identified cluster of COVID-19 in any of the units.
- Immediate containment using contact tracing and prevalence testing of all patients and staff was implemented each time.
- Additional actions included but not limited to terminal cleaning of unit, testing follow up of patients and staff and continues communication with leadership.
- Reinforcement of proper Standard Precautions was highly stressed in 2023.
- Goal for Influenza Immunization was met.
    - In 2023, MHP had an Influenza Immunization rate of 94%
    - In 2022, MHP had an Influenza Immunization rate of 89%
- Goal for COVID Immunization was met.
    - In 2023, MHP had a COVID Immunization rate of 94% (preliminary)
    - In 2022, MHP had a COVID Immunization rate of 90%

Actions Taken:

- Staying up-to –date with guidelines from the CDC, FDOH and other community partners.
- Continue to monitor each HO case of COVID 19 which leads to additional review and tracing and if applicable identification of additional cases.
- Use of standard precautions and early isolation to minimize transmission.
- Continue to educate staff on IC practices as it relates to emerging diseases including COVID 19.
- Continue collaboration Employee Health to monitor staff trends of COVID-19.
- NHSN definitions are utilized for mandatory compliance reporting of vaccinations.
- Influenza vaccination remains mandatory for all MHS staff members.
- Mandatory influenza education is provided to all hospital staff via Annual Review.
- Continued education at employee orientation, employee skills fair, and presentations at Department Leaders on Influenza Vaccination rate.
- Email alerts/reminders during influenza season are sent to employees and flyers are posted throughout the facility.
- Influenza Vaccine Program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs.
- Nursing offers vaccination to patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered by Employee Health during the entire flu season; at times, mobile vaccination carts attend units and meetings.
- Administrative Officers support by participating in campaigns for vaccination.
- Employees who take the flu vaccine are incentivized through credits that affect the cost of the health insurance premiums.

7. Infection Prevention and Control Program Plan, Evaluation of the Plan, Risk Assessment, Policies and Procedures are reviewed and updated annually. Plans include policies and procedures for minimizing risk of transmitting infection associated with use of procedures, medical equipment, medical devices, and products.	2022	2023	2024 Goal
Program policies and procedures review completed	**100%**	**100%**	**100%**
Program has an APIC trained IP	**100%**	**100%**	**100%**
Medical Director, Board Certified Infectious Disease Physician	**100%**	**100%**	**100%**

Performance/Effectiveness:

- The Comprehensive Infection Control Risk Assessment for CY2023 was presented to a multidisciplinary group for review, recommendations and approval.
- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Quality and Patient Safety Committee.
- The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified.
- The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- Computer technology is utilized for analysis, trending and tracking of infection surveillance data.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.

Actions Taken:

- All the prioritized risks were reviewed and evaluated.
- Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- The Infection Preventionists are members of the national and local chapters of their professional organization and receive education related to Epidemiology/ Infection Prevention and Control on an ongoing basis.
- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of data and surveillance over the calendar year. This has provided more accurate analysis to better prioritize our risks and set new goals for the coming calendar year.

IP-IC Scope of Service

Infection Prevention and Infection Control Plan 2024

Our Mission: Heal the body, mind, and spirit of those we touch.

Our Vision: To be a premier clinically integrated delivery system providing access to exceptional patient- and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Our Commitment: Family Centered and Patient Focused Care

Purpose: The purpose of the Memorial Hospital West Infection Prevention and Control Plan is to define the scope of activities and to provide a framework for the systematic organization wide approach to create an effective infection control program. The Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices with the intent:

1. To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases
2. To collaborate with the Emergency Preparedness Committee by engendering advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event
3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection
4. To collaborate with all departments and services to minimize the morbidity, mortality and economic burdens associated with infection through prevention and control efforts throughout the facilities and in the well and ill populations

Authority Statement

Pursuant to the approval by the Medical Executive Committee:

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).

2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.

3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

Scope of Service 2023 – 2024

Memorial Hospital West (MHW) is located at 703 N. Flamingo Road, Pembroke Pines, Florida 33028, and serves the population of Southwest Broward County and Northwest Broward County. MHW is the second largest member hospital of the South Broward Hospital System, DBA: Memorial Healthcare System. MHW is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a teaching facility.

(Receiving facility for patients with high acuity – and requiring specialty services)

MHW is a 486 Bed Adult Acute Care Tertiary Care facility and offers the following services:

Population served - Ages: 18 – End of Life, unless pediatric services are designated:

1. Emergency Care for Adults
2. Emergency Care for Children, birth – 17 years (Joe DiMaggio Children's Hospital)
3. Cancer Care
    a. Bone Marrow Transplant Unit
4. Cardiac and Vascular Care
5. Joint Replacement
6. Neurology
7. Neurosurgery
8. Bariatrics
9. Family Birthplace
    a. Level III Neonatal Intensive Care Unit (NICU)
10. Nutrition
11. Stroke Treatment
12. Surgery
13. Women's Services
14. Inpatient Dialysis
15. Outpatient Rehabilitation Services
16. Outpatient Rehabilitation Services for Children, birth – 17 years (Joe DiMaggio Children's Hospital)

Acuity:

- 32 Critical Care beds
- 412 Medical/Surgical/Stepdown/Telemetry/Oncology beds (69 Oncology inpatient beds and 7 Oncology Outpatient BMT beds)
- 44 Obstetrics/Gynecology beds
- 20 Level III NICU beds
- 50 Adult ED and 16 Peds ED
- 16 Surgical Suites

Top 10 Inpatient Medical Diagnosis:

1. Single liveborn infant, delivered vaginally
2. Single liveborn infant, delivered by cesarean
3. Sepsis
4. Hypertensive heart and chronic kidney disease with heart failure and stage 1-4 CKD
5. Hypertensive heart disease with heart failure
6. Maternal care for low transverse scar from previous cesarean delivery
7. Non-ST-elevation (NSTEMI) myocardial infarction
8. COVID-19
9. Post-term pregnancy
10. Pneumonia

Top 5 Inpatient Primary Procedures:

1. Measurement of cardiac sampling and pressure, bilateral, percutaneous approach
2. Measurement of cardiac sampling and pressure, right heart, percutaneous approach
3. Insertion of endotracheal airway
4. Drainage of peritoneal cavity, percutaneous approach
5. Insertion of tunneled vascular access device into chest subcutaneous tissue and fascia, percutaneous

Top 5 Out-Patient Procedures:

1. Hysteroscopy, sampling of endometrium and/or polypectomy, with or without D&C
2. Laparoscopy, total hysterectomy fur uterus <250 g
3. Total knee arthroplasty
4. Laparoscopy, repair inguinal hernia
5. Laparoscopy, cholecystectomy

Additional Sites of Service:

Cardiac & Pulmonary Rehabilitation, Memorial Fitness & Rehab
701 North Flamingo Road, Pembroke Pines FL, 33028

Memorial Cancer Institute at Memorial Hospital West
12235 Pines Boulevard, Pembroke Pines, FL 33026

Memorial Hospital West
703 North Flamingo Road, Pembroke Pines FL, 33028

Memorial Hospital West – Outpatient Imaging
603 North Flamingo Road, Suite 306, Pembroke Pines FL, 33028

Memorial Primary Care – Silver Lakes
17786 SW 2nd Street, Pembroke Pines FL, 33029

Memorial Primary Care – West Miramar
10910 Pembroke Road, Miramar FL, 32305

Memorial Primary Care – Monarch Lakes
12781 Miramar Parkway, Suite 1-202, Miramar FL, 33027

Plan of Care and Practice for Infection Prevention and Control

The following activities are within the scope of care and practice of the infection prevention, infection control and epidemiology professionals:

Planning for management of infection control and prevention (IC & P) program (IC.01.01.01)

1. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent

healthcare associated infections in patients, healthcare providers, and visitors.

2. A multidisciplinary team collaborates to develop a comprehensive written plan

Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing

1. Identification, prioritization, and documentation of risk assessment based in order of probabilityand level of harm based on (IC.01.03.01)
    a. Geographic location, community, and population served
    b. Care, treatment, and services provided
    c. Analysis of surveillance activities and aggregate IC data
        i. Pareto Analysis

Goal setting to reduce risk of infection to patients and community (IC.01.04.01)

1. Written goals, based on identified risks, include
    a. Addressing prioritized risks
    b. Limiting unprotected exposure to pathogens
    c. Limiting the transmission of infections associated with procedures
    d. Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies

Development of an IC & P Plan (IC.01.05.01)

1. Utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, inabsence of such guidelines, expert consensus
2. Written description of activities, including surveillance, to reduce or eliminate risk ofinfection

Performance of activities based on relevant professional guidelines and scientific practices

Development, implementation and documentation of infection surveillance, prevention, and control P & Ps that adhere to nationally recognized guidelines

Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues

Training and education of employees and medical staff on practical application of IC & P guidelines and P&Ps

Prevention and control of healthcare associated infections, including audit of adherence to IC & P P&Ps by hospital employees and medical staff (IC.02.01.01)

1. Implementation of IC & P activities involving departments, employees, and medical staff
2. Provision of important IC & P information to patients, employees, medical staff, and visitors
    a. Respiratory Hygiene Practices
    b. Hand Hygiene
3. Implementation of standard and transmission-based precautions
4. Utilization of personal protective equipment (PPE)

   a. Donning
   b. Doffing
   c. Disposal
   d. Storage
   e. Reprocessing (in rare circumstances of necessity due to lack of supplies in epidemic emergencies)
5. Implementation of surveillance
6. Storage and disposal of infectious waste
7. Investigation of outbreaks (IC.01.05.01)
8. Reporting of surveillance, prevention, and control information to appropriate staff within facility
9. Reporting of surveillance, prevention, and control information to local, state, and federal publichealth authorities
10. Informing receiving organizations of patients of patient requiring monitoring, treatment, and/or isolation
    a. Upon transfer arrangement
    b. After transfer, upon discovery
    c. Upon receiving such patient and not having been notified by transferring facility

Investigation of outbreaks (IC.01.05.01)

MHS utilizes a standard process for investigating outbreaks of infectious disease based on resources from local and state health department, CDC, APIC and SHEA. The series of steps outlined are performed simultaneously while being extremely time-sensitive due to nature of containing an outbreak, stopping spread, and preventing further infection. Activities like literature review and research cannot be overlooked and are important to review historical investigations and outbreaks. Healthcare outbreaks also must be sensitive to alerting key stakeholders, administrators, as well as contacting local health department to assist in investigation. The following written process is the basic guideline for investigating outbreaks of infectious disease at MHS:

1. Recognizing outbreak or cluster based on surveillance activity or notification of event
2. Confirming presence of an outbreak by comparing historical surveillance data
3. Verify diagnosis and establish case definition
4. Case finding and abstracting health records into a line list
5. Analyzing commonalities for descriptive epidemiology (person, place, time) and creating an epi curve

6. Field research in rounding and observing practices that may identify cause of outbreak and hypothesizing causes
7. Implementing interventions to prevent and control infections
8. Communicating findings, after-action reports, and health promotion and education materials

Preparation of response to an influx of potentially infectious patients (IC.01.06.01)

The results of the hospital's infection risk assessment are prioritized in order of level of probability and potential for harm by a multidisciplinary team of stakeholders. Goals for reducing the risks of the

infections that pose the greatest threat to patients and the community are defined. These goals lead to focused activities, based on relevant professional guidelines and sound scientific practices.

Reduction of risk of infections associated with medical equipment, devices, and supplies (IC.01.02.01)

1. Implementation of IC &P activities
2. Adherence to Spaulding Classification (CDC)
3. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
4. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
5. Disposal of medical equipment, devices, and supplies
6. Storage of medical equipment, devices, and supplies
7. Reprocessing single use devices
8. Availability of Manufacturer's Instructions for Use

Prevention of transmission of infectious disease among patients, licensed independent practitioners and staff (IC.02.03.01)

In collaboration with Medical Staff and Employee Health Services:

1. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may encounter infections in the workplace
2. Management of LIPs and employees who are suspected of or were occupationally exposed
3. Management of patients who have been exposed to an infectious disease
4. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
5. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

Vaccination against influenza to licensed independent practitioners and staff. (IC.02.04.01)

1. Annual influenza vaccination program that is offered to licensed independent practitioners and staff.
2. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
3. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
4. Improvement of influenza vaccination rates
5. Written description of the methodology used to determine influenza vaccination rates
6. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually
7. Improvement of vaccination rates according to established goals at least annually
8. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual
9. Collaboration with Employee Health Department, utilizing above process, to provide

additional vaccination against:

a. Hepatitis B
b. Covid-19
c. Tetanus, Diphtheria and Pertussis
d. Varicella

Implementation of evidence-based practices to prevent healthcare associated infections due to the following: (IC.02.05.01)

1. Multidrug Resistant organisms (MDRO)
    a. *Candida auris*
    b. *MDR Acinetobacter baumannii*
    c. *MDR Carbapenem-resistant enterobacteriaceae*
    d. *MRSA*
    e. *MDR Pseudomonas aeruginosa*
2. Central Line-associated bloodstream infections (CLABSI)
    a. Participation in CDC's National Healthcare Safety Network
3. Catheter-associated urinary tract infections (CAUTI)
    a. Participation in CDC's National Healthcare Safety Network
4. Ventilator Associated Event (VAE)
    a. Participation in CDC's National Healthcare Safety Network
5. Emerging Infectious Diseases
6. *Clostridioides difficile*
    a. Participation in CDC's National Healthcare Safety Network
7. Surgical Site Infections (SSI)
    a. For these:
    b. Development and implementation of P & P based on evidence-based practice,aimed at reduction
    c. Periodic risk assessments and surveillance, aimed at reduction
    d. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices
    e. Participation The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)

Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01)

1. Plan's prioritized risks
2. Plan's goals
3. Program's efficacy
    - Communication of findings to patient safety program
    - Include findings of evaluation when revising the plan

Communication and collaboration with Antimicrobial Stewardship Program (ASP) (MM.09.01.01)

Ratification of competency of Infection Control and Prevention team members

Preparation of response to an influx of potentially infectious patients, emergency preparedness (IC.01.06.01)

1. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients
2. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients
3. Written plan delineating management of influx of infectious patients

Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)

- Infection Control Risk Assessment (ICRA)

National Patient Safety Goal (NPSG.07.01.01)

Compliance with either WHO or the current CDC hand hygiene guidelines

Transplant Safety (TS.03.03.01)

Investigation of adverse events related to tissue use or donor infections

1. Compliance with P&P for identifying, tracking, storing, and handling tissues, medical devices and other implantables.
2. Investigation of infections suspected of being directly related to the use of tissue
3. Reporting of infection to tissue supplies
4. Sequestering tissue suspected of causing infection
5. Notification of recipient of infectious agents that may have been transmitted through tissue

Water Management Program (EC.02.05.02)

Participation in interdisciplinary water management program that addresses Legionella and other waterborne pathogens.

Emergency Management Operations Program (EM.09.09.01)

Participation in interdisciplinary emergency management operations program: engagement in planning activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.

Staffing:

Memorial Hospital West

- Director, Quality & Patient Safety
- Manager, Infection Control
- 4 Infection Preventionists
- 1 Board Certified Internal Medicine and Infectious Disease Physician/Medical director

Job descriptions delineate the scope and responsibility for each Infection Prevention Professional

Memorial Healthcare System (Oversight and Support)

- Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
- Physicians, Infectious Disease (MHW)
- Director, Infection Prevention and Epidemiology, MHS

Hours of Operation:

Monday – Friday 7:30 am – 4:30 pm; other times immediate availability by cell phone.

References:

APIC Text of Infection Control and Epidemiology; April 7, 2020

APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12. *Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures* for framework and guidelines conducting an outbreak investigation

Campbell, E. A., Eichhorn, C. L., Outbreak Investigations. In Boston K.M., et al, eds. APIC Text. 2020. Available at https://text.apic.org/toc/epidemiology-surveillance-performance-and-patient-safety-measures/outbreak-investigations. Links to an external site. Accessed January 17, 2023.

Centers for Disease Control and Prevention. Outbreak investigations in healthcare settings. Healthcare-Associated Infections (HAIs). Available at https://www.cdc.gov/hai/outbreaks/index.html Links to an external site.. Reviewed June 14, 2021. Accessed January 17, 2023.

https://e-dition.jcrinc.com/Frame.aspx January 1, 2022

Evaluation of the Infection Prevention and Control Plan 2023
and
Goals and Objectives 2024

This Program Evaluation is based in part on annual risk assessment of top priorities ("vital few") as identified by Pareto Analysis and the outcomes achieved during the 2023 calendar year. Outcomes are identified through review of performance measurement data, information resulting from our committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Memorial Hospital West and in collaboration with other Memorial Healthcare facilities. *The hospital evaluates the effectiveness of its infection prevention and control plan (IC.01.05.01)*

The purpose of this annual appraisal is to:

1. Evaluate the effectiveness of the Infection Control program of Memorial Hospital West in detection, identification, prevention, and control of hospital acquired and community acquired infections in patients, employees, physicians, licensed independent practitioners, volunteers, contract service workers and visitors while in the hospital.
2. Identify and assess the degree of risk factors for the acquisition and transmission of infectious diseases to reduce the incidence and eliminate their spread among persons in the hospital and in the community.
3. Identify opportunities for quality and performance improvement, loss prevention, cost containment and planning for the upcoming year.
4. Adhere to all local, state, and national regulatory guidelines for healthcare facilities.

The following top organizational risk priority targets were identified from the CY2024 Memorial Hospital West Infection Control Risk Assessment, 2024 Annual Plan and 2023 institutional data analysis. Targets were adopted from internal goal to reduce yearly harm by 10%, external reporting CMS/VBP/HAC and/or Leapfrog performance achievement thresholds, CDC/NHSN published progress reports and internal TAP reports, and community historical trends. *Based on institutional determined goals and identified risks (risk ≥20% on ICRA Pareto), the organization sets goals to minimize the possibility of transmitting infections (IC.01.04.01).*

1. Overall reduction of healthcare associated infections. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI) and catheter associated urinary tract infection (CAUTI). Minimize the risk of hospital acquired infections associated with invasive devices.	**2022 Performance**	**2023 Performance**	**2024 Goal** **10% reduction in rate or CMS or Leapfrog benchmark**
CLABSI Central Line Infections Central Line Days X 1000 = Rate per 1000 Central Line Days SIR = observed/predicted	**1.1** ↓ **1.073** ↓ **(all units)**	**0.6** ↓ **0.57** ↓ **(all units)**	0.5 0.760 Achievement Threshold
CAUTI Urinary Catheter Infections Urinary Catheter Days X 1000 = Rate per 1000 Urinary Catheter Days SIR = observed/predicted	**1.3** ↓ **0.991** ↓ **(all units)**	**1.0** ↓ **0.864** ↓ **(all units)**	0.9 0.615 Achievement Threshold
Analysis • Infections are identified from prospective surveillance by trained IP staff using NHSN definitions. • Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.			

CLABSI

- **Performance/Effectiveness**
  - CLABSI goal for 2023 was met
  - CLABSI rate and SIR decreased significantly overall in 2023 compared to 2022
  - In 2023, there were 25 CLABSIs from 41887 central line days; 0.6 rate per 1000 central line days. This was a significant decrease compared to 2022.
  - In 2022, there were 45 CLABSIs from 39215 central line days; 1.1 rate per 1000 central line days.
  - There was an increase in the central line days in 2023 (41887) compared to 2022 (39215).
  - CLABSIs in the ICUs decreased in 2023 (n=2) compared to 2022 (n=6).
  - CLABSIs in patients with Dialysis lines decreased in 2023 (n=3) compared to 2022 (n=17).
- **Actions**
  - Central Line data reported daily to Nursing Leaders at the morning bed huddle. This information is also provided monthly at the HAI Taskforce meeting.
  - Central Line orders, necessity, and discontinuation are addressed during unit Interdisciplinary Rounds, Central Line rounds, and Infection Control rounds.
  - Concerns regarding central lines are also communicated to the Care Team via EPIC chat.
  - Central Line rounds, using the iRound tool, are performed to evaluate line necessity, discontinuation or an alternative to the central line, improved awareness and communication, opportunities with products in central line dressing kits, and caps on all central lines.
  - Continuous CLABSI prevention education provided at nursing/pca skills fairs, unit staff meetings, unit daily huddles, and at the point of care. CLABSI education was also provided to the Dialysis unit multiple times throughout the year.
  - Infection Control regularly observes blood culture collections providing real time staff education as well as dissemination of findings to unit leadership. 2023 included the initiation of the observation of line access for apheresis procedures.
  - Ensure adherence to the Central Line bundle: daily CHG treatment baths for all inpatients, twice daily nasal decolonization (ICU), and Central Line care. Non-compliance reported to nurse manager as opportunities are identified.
  - Education is provided immediately on new products or on replacement products that are in-place due to shortages or backorders.
  - Invited CHG Dressing and CHG wipes vendors to audit and educate the entire facility for compliance and education.
  - Each CLABSI included a mini-RCA drill down to determine opportunities for improvement. Findings are communicated with nurse managers and administration during management huddle on lessons learned to prevent CLABSI. CLABSIs are also discussed at HAI department meetings where the opportunities are shared across units for review.

CAUTI

- **Performance/Effectiveness**
  - CAUTI goal for 2023 was met
  - CAUTI rate and SIR decreased overall in 2023 compared to 2022
  - In 2023, there were 14 CAUTIs from 13890 urinary catheter days; 1.0 rate per 1000 urinary catheter days. This was a significant decrease compared to 2022.
  - In 2022, there were 21 CAUTIs from 16125 urinary catheter days; 1.3 rate per 1000 urinary catheter days.
  - There was a significant decrease in urinary catheter days in 2023 (13890) compared to 2022 (16125).
  - CAUTIs in the ICUs decreased slightly in 2023 (n=4) compared to 2022 (n=5).
- **Actions**
  - Urinary catheter data is reported daily to Nursing Leaders at the morning bed huddle. This information is also provided monthly at the HAI Taskforce meeting.
  - Daily urinary catheter report reviewed by Infection Control to identify opportunities for removing indwelling catheters and/or replacing with external catheters, if indicated. Communication is initiated during Interdisciplinary Rounds as well as EPIC chats with the Care Team.
  - iRound bundle compliance documentation with evidence based best practices as well as continuing improvement solutions to reduce CAUTI.
  - External Male and Female catheters are available, and staff have been educated to use ANI (advanced nursing Interventions) for early Foley removal as indicated. Extensive education in place for Foley care and maintenance.
  - Each CAUTI results in a mini-RCA drill down to determine opportunities for improvement. Findings are communicated with nurse managers and administration during management huddle. CAUTIs are discussed at HAI department meetings to share opportunities across the units.
  - Infection control will continue to monitor trends associated with CAUTIs and communicate findings with appropriate stakeholders.

2. Surgical Site Infections (SSI) Carry out systemic program surveillance and reporting of epidemiologically important Class I and II surgical site infections.	Targeted Class	CY 2022 Performance	CY 2023 Performance	2024 Goal 10% reduction in rate or CMS or Leapfrog benchmark
Surgical Site Infections/ Surgical Procedures Completed X 100 = SSI Rate	Class I & II Rate	0.73 ↓	0.58 ↓	0.52
	C-Section Rate	0.36 ↓	0.30 ↓	0.27
	Hysterectomy Rate	2.92 ↑	1.60 ↓	1.44
	Colon Rate	2.75 ↓	2.10 ↓	1.89
SIR: observed/predicted	Colon SIR	1.024 ↓	0.590 ↓	0.747 Achievement Threshold
	Hysterectomy SIR	3.214 ↓	2.912 ↓	0.763 Achievement Threshold

Performance/Effectiveness

- All SSIs goals were met: Class I & II surgeries, C-section, Hysterectomy, and Colon
- In 2023, there were 50 Class I & II SSIs and 8607 surgical procedures; 0.58 rate per 100 surgical procedures. This was a significant decrease compared to 2022.
- In 2022, there were 55 Class I & II SSIs and 8257 surgical procedures; 0.73 rate per 100 surgical procedures.
- The number of Class I & II surgical procedures increased in 2023 (n=8607) compared to 2022 (n=8257).
- Large decrease observed in Colon and Hysterectomy Rates and SIRs. Colon SIR fell below the VBP threshold for 2023.

Actions

- Each SSI results in a mini-RCA drill down to determine opportunities for improvement. Findings are communicated with OR leadership, Quality, Pharmacy, the Surgeon, and Anesthesia. Analysis of all SSI data reviewed at the NSQIP and Departmental meetings.
- In response to an increase in Hysterectomy SSIs in 2022, Flagyl was prescribed, in addition to standard prophylaxis, for all Hysterectomy procedures. This trial was extended throughout 2023.
- Infection Control continues to monitor compliance with unscheduled C-sections receiving azithromycin prophylaxis in addition to standard prophylaxis for all SSIs.
- Ensure components of surgical prep are followed: CHG treatment bathing the day of and the night before the procedure, mechanical and oral bowel prep, pre-op Chin-to-Toes Sage CHG wipes, povidone-iodine nasal decolonization for high-risk surgeries, etc. Non-compliance is documented for every SSI and opportunities are discussed with stakeholders.
- Increased focus on antibiotic administration timing and patient normothermia intra-op.
- Education on wound classification provided to OR staff. Additional information posted via visible signage to ensure the proper wound class is documented post-op. Wound class also discussed at Surgical Department meetings. Misclassified surgical procedures are directed to the Director of Surgical Services for review.
- Multiple education sessions provided by vendor to OR teams to ensure surgical instruments are being cared for properly intra-op and post-op at bedside. This education included wiping down instruments, flushing lumens, and keeping instruments organized and moist.
- Increased focus on OR teams properly identifying when a surgical instruments is safe to use. All nursing staff have undergone training to help them identify these instruments via visual inspection, indicators, etc. All staff have been trained on when and how to properly reject a surgical instrument from use in a case including documentation of that activity.
- The Department of Health was invited to the facility multiple times to audit and educate our OR and EVS teams on proper OR turnover and terminal cleaning procedures.
- Data collection including post-discharge surveillance with dedicated NSQIP case reviewer, surgical wound infection report based on patient readmissions, EPIC Possible SSI reports, and review of wound/body fluid cultures in EPIC.
- Continued education provided to clinical staff regarding pre-op chlorhexidine bathing and nasal decolonization. Nasal decolonization vendor and the CHG treatment bath vendor both provided education to pre-op staff.
- Continued surveillance of evidence-based best practices is an ongoing process to ensure reductions across all SSIs.
- Surgical Care Improvement Taskforce was created as a multidisciplinary approach to ensuring the optimum care for surgical patients. This includes pre-op optimization for blood sugar, antibiotics, CHG bathing. Actions included adjusting the approach to antibiotic prophylaxis to ensure timing is correct.

3. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and *Clostridioides difficile* (CDIFF)		2022 Final	2023 Final	2024 Goal (10% reduction)
Candida auris	(# of patients with Candida auris on Day 4+) / (# of patient days) x 1000	0.004 ↑ (inf only)	0.018 ↑	0.016
Carbapenem-resistant Organisms (CRO)	(# of patients with CRO on Day 4+) / (# of patient days) x 1000	0.007 ↓ (CRE only)	0.13 ↑	0.12
MRSA Bacteremia Rate	(# of patients with MRSA Bact on Day 4+) / (# of patients days) x 10000	0.4 ↓	0.5 ↑	0.45
CDIFF Rate	(# of patients with CDIFF on Day 4+) / (# of patients days) x 10000	4.1 ↓	3.8 ↓	3.4
MRSA bacteremia SIR	SIR: observed / predicted	0.717 ↓	1.023 ↑	0.793 Achievement Threshold
CDIFF SIR		0.594 ↓	0.503 ↓	0.423 Achievement Threshold

Performance/Effectiveness

- Goals for Candida auris were not met. There were missed opportunities to screen specific patients upon admission based on high-risk screening decision tree.
- CRE was changed to CRO, and now additional organisms are tracked (i.e., CR-Pseudomonas aeruginosa). The result from 2022 is not comparable to 2023.
- HO-MRSA bacteremia rate and SIR goals were not met. There was a slight increase in the MRSA rate. 2023 had 8 HO-MRSA infections identified compared to 6 identified in 2022. Most patients with HO-MRSA bacteremia infection in 2023 were admitted with MRSA isolated in another body site.
- 25% increase in HO-MRSA bacteremia rate from CY 2022 to CY 2023 AND 42.6% increase in SIR.
- CDIFF rate goal was met. The number of HO CDIFF reported in 2023 (n=56) was not significantly different than the number reported in 2022 (n=57). However, the rate is improved due to an increase in patient days from 138874 in 2022 to 148530 in 2023.
- 7.3% decrease in CDIFF rate overall from CY 2022 to CY 2023 AND 15.3% decrease in SIR. The CDIFF SIR did meet goal for 2023 by falling below the VBP benchmark.

Actions

- New BPA created to ensure patients with history of Candida auris and/or CRO are promptly isolated on admission.
- New BPA created to ensure patients with positive 'Recent Exposure' screen on admission have correct tests ordered and isolations placed promptly.
- Increased collaboration with the EPIC team to create BPAs, Patient Chart Advisories, and increased banner prompts to increase early identification of Candida auris and CROs.
- Infection control has increased education regarding Candida auris and CRO prevention at bed huddle, unit staff meetings, and skills fairs. Education focused on proper PPE and disinfection protocols as well as how to navigate the electronic components in EPIC to prevent transmission.
- Inpatient and Emergency Room staff re-educated on properly screening patients on admission to determine if they meet criteria for Candida auris and/or CRE screening.
- Infection Control follows-up with the departments that have missed opportunities to promptly screen and isolate patients for Candida auris and/or CROs.
- Early identification of patients colonized or infected with resistant organisms or other infectious organisms and immediate transmission-based isolation of these patients reduced and prevented further transmission.
- Infection control monitored the high priority organism list and isolation log. This allows prompt identification of previously colonized or infected patients with resistant organisms. This, in turn, limited unprotected exposure to pathogens by thorough immediate action with appropriate transmission-based precautions.
- The CDC isolation precautions are part of MHS policy and are readily available via the MHS intranet. Infection control educated staff on the availability of these documents on the intranet and continued to provide real-time education.
- We continued to implement Droplet Precautions, Contact Precautions, GI Precautions, Enhanced Contact Precautions, Enhanced Respiratory Precautions, and Airborne Precautions in addition to CDC Transmissions-Based Precautions and Standard Precautions.
- Hand Hygiene education, PPE selection education, MDRO/CRO admission alerts, antimicrobial stewardship and frequent communication between clinical/nursing departments and Infection Prevention was part of MDRO/CRO action plan.
- Blood culture collection education conducted house wide. Infection Control observes blood culture collections and opportunities are communicated to the staff at the point-of-care and to the leadership.

- Surveillance rounds and lab monitoring are mechanisms in which information is gathered. Individual clusters were and will continue to be analyzed and appropriate interventions will be determined at that time.
- MRSA isolation education provided to ensure patients are properly isolated. Changes in isolation protocols were made and this required house-wide re-education.
- Opportunities identified related to CDIFF; missing opportunities to collect stool on admission, incomplete documentation of stool in the flowsheet, and inappropriate CDIFF orders on day 4 and beyond.
- Increased collaboration with the EPIC team to promote compliance with the MHS CDIFF algorithm via order sets. Including requiring attestations prior to order placement regarding laxative use, presence of loose stools, and the presence of additional symptoms or epidemiologic criteria in addition to loose stools.
- Infection Control follows-up daily with all CDIFF or GPP orders to ensure the order is appropriate. Opportunities are communicated to the care team for resolution (i.e., order placement, removal, etc.).
- HO-CDIFF infections result in mini-RCA drill down to determine opportunities for improvement. Findings are communicated with nurse managers and administration during management huddle. HO-CDIFFs are discussed at HAI department meetings to share opportunities across the units. Pharmacy Antibiotic Stewardship is also included in all mini-RCAs.
- Appropriate testing guidelines for CDIFF disseminated to all medical staff. The testing algorithm has also been embedded within the orderset for additional notice. The CDIFF algorithm is also presented at all Departmental Meetings for additional communication to medical staff and nursing leadership.
- Collaboration with antibiotic stewardship committee to review all CDIFF infections for opportunities.
- Collaboration with EVS team to implement additional prevention strategies. This includes daily communication of patient rooms on GI precautions as well as rooms pending discharge targeted for Electrostatic bleach sprayer use. In addition, all discharges in Oncology Units (regardless of Isolation status) are being treated with Electrostatic bleach sprayer after terminal cleaning.
- Collaborated with EVS to revamp the terminal cleaning process. This includes reworking the flow and creating a flowchart/checklist for the staff. Infection Control also partnered with EVS to create a Terminal Cleaning validation form. Terminal cleaning observations performed by Infection Control.

4. Use standard and transmission-based precautions to prevent unprotected exposure to pathogens (i.e., COVID-19, seasonal flu, pandemic flu, influx of infectious patients, active TB patients, patients with history of MDRO and/or CRO, unusual clusters of organisms or HAI, etc.).	**2022**	**2023**	**2024 Goal**
Isolation and PPE Compliance trends	N/A	0	0 occurrences
MDRO/CRO trends/identification	Zero. Ongoing monitoring and surveillance and intervention as needed.	Zero. Ongoing monitoring and surveillance and intervention as needed.	Zero. Ongoing monitoring and surveillance and intervention as needed.
Outbreaks, clusters, or transmission			
Influx of other infectious patients & Emergency Preparedness			

Performance/Effectiveness:

- There were 8 TB exposures and 8 Varicella exposures in CY 2023. This is an increase from the 4 TB exposures and 6 Varicella exposures documented in CY 2022.
- There were 4 TB conversions in CY 2023 identified during post-exposure work-up.
- All blood and body fluid exposures, TB exposures, and Varicella exposures documented in CY 2023 were followed up by Employee Health.

Actions:

- Isolation Precautions, PPE Education, and MDRO/CRO/*Candida auris* Education was provided to all clinical staff via skills fairs, staff meetings, and daily huddles.
- Educated staff on importance of Standard & Transmission-based precautions especially in Emergency Room Triage areas.
- Isolation rounds are conducted to ensure patients are properly isolated: order is in EPIC, signage is on the door, PPE is readily available, and the staff are using PPE appropriately. This also includes ensuring staff are performing low-level disinfection with the proper chemicals.
- MDRO and CROs are tracked and analyzed by Infection Control to detect and trends or patterns. No trends or patterns were identified in CY 2023.
- *Candida auris* was identified in CY 2023 and containment measures were completed including point prevalence testing of nearby patients as directed by Infection Control Medical Director and the Department of Health. Local health department was notified in each case. No additional cases identified beyond the primary case to signify spread.
- No unusual clusters of organisms or HAIs were detected in CY 2023.

- The surveillance plan based on the prioritized disease transmission risk in the community was updated for CY 2023 and was disseminated across hospital committees.
- The surveillance plan is carried out by the IPs on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers, and visitors.
- The ESSENCE reporting system that identifies syndromic trends through the ER was used to coordinate surveillance with the Broward County Department of Health.
- MHS uses electronic case reporting for COVID-19 reporting to the state.
- Provided real time education and rounding in response to Monkeypox cases in CY 2023. This ensured rapid identification of high-risk patients, prompt placement of isolation precautions, and continued adherence to proper isolation protocols.
- For Laboratory personnel: Minimizing exposure to infectious agents by use of OSHA guidelines, establishing standard operating procedures, requirements for personal protective equipment, engineering controls (e.g., chemical fume hoods, air handlers, etc.) and waste disposal procedures.
- MHW continues to actively track and trend admission of patients due to any increase influx of patients and/or need to implement the Pandemic Plan.
- MHW has been implementing continual education via simulation drills and desktop learning, planning and emergency notification.
- MHW has participated in Emergency Preparedness meetings and activities, including review of PPE donning and doffing for Ebola.
- MHW has implemented key Infection Control practices and measures to mitigate the effect of respiratory viral season in our hospital. These practices have been directed by national (CDC) guidelines. These have also been monitored, assessed, and adjusted as the situation in our community has changed.
- IP perform daily review of high priority organisms and ensure proper isolation and reporting to the local health department. These measures assist with identification of previously colonized or infected patients with resistant organisms and allowed staff to limit unprotected exposure to pathogens with prompt placement of appropriate transmission-based precautions.

5. Monitor and Improve Hand Hygiene Compliance	**2022 Rate**	**2023 Rate**	**2024 Goal**
Hand Hygiene (iRound) compliance Number of observations/number of opportunities	99.4%	99.4%	99.6%

Performance/Effectiveness:

- Goal for 2023 was not met; fell short of the goal of 100% compliance.
- iRound observed compliance of hand hygiene rate for CY 2023 (99.4%) was the same as the rate for CY 2022 (99.4%).
- Number of observations documented in CY 2023 (n=93028); this is a decrease from the number documented in CY 2022 (n=101045).
- 7.9% decrease in iRound observations from CY 2022 to CY 2023.

Analysis

- Hand Hygiene Observer training was conducted house wide in 2023. Education provided to ensure observers are evaluating hand hygiene observations correctly and uniformly.
- Increased focus on observation quality impacted number of observations as more time has been put into each observation.
- Hand Hygiene Dashboards were created that track all MHW hand hygiene metrics: number of observations, different disciplines observed, weekend/weekday split, AM/PM split, exiting and entering compliance, and overall compliance.
- Hand Hygiene Dashboards are updated monthly, and units post this information on their PI boards for staff awareness and accountability.
- Units not meeting the Hand Hygiene goals are required to submit an Action Plan.
- Hand Hygiene compliance is discussed at Departmental Meetings, staff huddles, daily huddles, etc.
- Continuation with the utilization of the iRound HH tool to collect HH observations.
- Standardized training utilizing TJC education on observing compliance provided to unit observers.

6. Reduction of risk of infection secondary to inadequate supplies, failure to follow safety devices and personal protective equipment.	2022	2023	2024 Goal
Frequency that IP consulted and responded with expert review in product substitutions and availability of supplies & front-line staff aware.	100%	100%	100%
Frequency that IP was consulted on protocols related to safety devices and equipment.	100%	100%	100%

Performance/Effectiveness:

- All shortages and potential alternatives products were communicated to Infection Control.
- Notification provided to all the appropriate stakeholders when shortages and temporary alternatives and/or new products become available.
- Infection Control was consulted by multiple departments for new devices and/or equipment to proper use and cleaning/disinfection.

Actions:

- Appropriate units are educated on replacement products at daily bed huddles, staff meetings, and impromptu sessions to ensure all areas are properly informed of how to use replacement products.
- Unit level in-services continued to be presented for dissemination of product information. Units were rounded to ensure new products are available and to ensure their proper use.
- Consultation and communication from supply chain, materials management, and clinical team for backorders, conservation activities, crisis, and contingency standards dependent on availability of medical equipment.
- Educational materials are created by the Infection Control team, provided on the intranet, and/or printed and used to educate staff, patients, and families in real time.
- Demonstrate/observe proper implementation and usage of new and alternative products by end-users.
- Education on alternative products is conducted each time a new product is brought to MHW.
- Infection Control monitors, keeps tracks and communicates shortages and new products.
- Using CDC, APIC, SHEA and other professional society guidelines, Infection Control provides direct observations with return demonstration of proper PPE donning and doffing with staff.

7. Reduction of risk of infection secondary to improper equipment sterilization, high level disinfection, low level disinfection, or environmental cleaning.	2022	2023	2024 Goal
Frequency that IP reviewed documentation and logs and conducted regular visual observations of reprocessing areas.	100%	100%	100%

Performance/Effectiveness:

- Direct observations and rounding conducted in reprocessing areas.
- Infection Control rounds conducted in reprocessing areas utilizing sterilization, high-level disinfection, and low-level disinfection.
- Collaboration between Infection Control and end users on creating Risk Assessments to ensure compliance with manufacturer's instructions for use, and other up-to-date evidence-based guidelines.

Actions:

- Collaborated with EVS to create Operating room terminal cleaning and Inpatient room terminal cleaning competencies. Processes are regularly observed by Infection Control to ensure practices are in-place and followed.
- Invited the Florida Department of Health to audit and educate our Operating room EVS teams on terminal cleaning and the Operating room staff on between case turnover cleaning.
- Completed the Ultrasound probe High-level disinfection Risk assessment. Infection Control ensured relevant units are aware of the level of disinfection required for probes used and are using the proper method to provide that disinfection.
- Collaborated with Sterile Processing to ensure flexible endoscopes are reprocessed per manufacturer's instructions including competencies for staff. Sterile Processing is rounded regularly by Infection Control in-person to observe reprocessing on instruments and scopes.
- Cleaning validation is a joint effort between Infection Control and the end users to verify cleanliness. Clean Trace ATP testing is used to validate Operating room, Inpatient room, surgical instruments, and flexible endoscopes cleanliness. Data is tracked and trended with reports communicated to end users for discussion of opportunities.
- Review of current and new equipment to partner with end users to create cleaning and disinfection processes.

8. Reduction and mitigation of exposure to respiratory viruses including COVID-19, influenza, and others. Promote and improve seasonal influenza and COVID vaccination compliance.	2022	2023	2024 Goal
Employee Influenza immunization rate	3524/3727 = 94.6%	3992/4261 = 93.6%	Remain >90%
Employee COVID immunization rate	2908/3159 = 92.0%	3388/3749 = 90.3%	Remain >90%

Performance/Effectiveness:

- Slight decrease in the Employee Influenza immunization rate; one percentage point decrease in 2023 from 2022. Rate remains above the 90% goal.
- Slight decrease in the Employee COVID immunization rate; almost two percentage point decrease in 2023 from 2022. Rate remains above the 90% goal.

Actions:

- Continued education at new employee orientation, employee skills fair, and presentations to Department Leaders on Influenza Vaccination rate by Employee Health.
- Email alerts/reminders during influenza season are sent to employees and flyers are posted throughout the facility.
- Influenza Vaccine Program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs.
- Nursing offers vaccination to patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered by Employee Health during the entire flu season; at times, mobile vaccination carts attend units and meetings.
- Employees who take the influenza vaccine are incentivized through credits that affect the cost of the health insurance premiums.
- COVID patients are communicated in the morning daily bed huddle and are rounded on isolation protocols including PPE donning and doffing by Infection Control.
- Positive COVID results are investigated daily by Infection Control to ensure patients are isolated properly. Any issues found are communicated to the nursing unit.
- COVID intranet documents were updated multiple times throughout the year as community rates changed. Infection Control continued to educate staff on changes to COVID guidelines regarding testing, isolation protocols, discontinuation of isolation, and visitation protocols.
- COVID patients are regularly reviewed by Infection Control prior to discontinuation of isolation when appropriate.
- Continued collaboration with Emergency Preparedness Committee and Employee Health to implement interventions that reduce exposure to and transmission of COVID-19; achieve zero hospital acquired transmission of infection.
- Continued notification of COVID positive employees and possible COVID exposures to Employee Health in a timely fashion.

9. Reduction of risk of infection secondary to water management. Reduction of risk of infection secondary to hurricane or flood events.	2022	2023	2024 Goal
Frequency of Infection Control participation in water management meetings, review of documents.	100%	100%	100%
Frequency of Infection Control participation in EOC rounds.	100%	100%	100%
Frequency of Infection Control participation in Emergency Management drills, tabletop exercises, and hurricane preparedness activities.	100%	100%	100%

Performance/Effectiveness:

- Infection Control attends all water management meetings and document reviews. EOC rounds and Emergency Management meetings are also attended by Infection Control.

Actions:

- Reviewed national guidelines from CDC, AAMI, AORN, APIC, SHEA, and other literature resources pertaining to water risks and management.
- Collaborated with Regulatory, Facilities, Sterile Processing, Emergency Preparedness, and the Emergency Department.
- Infection Control will continue to attend all Water management, EOC rounds and meetings, and Emergency management meetings to include any impromptu/emergent sessions.
- Review of temperature and humidity logs of sterile areas after weather events and equipment failure will continue. Ongoing monitoring and surveillance of environmental organisms.

10. **Infection Prevention and Control Program Plan, Evaluation of the Plan, Risk Assessment, Policies and Procedures are reviewed and updated annually. Plans include policies and procedures for minimizing risk of transmitting infection associated with use of procedures, medical equipment, medical devices, and products.**	**2023 Target**	**2023 Final**	**2024 Goal**
Program policies and procedures review completed	100%	100%	100%
Program has a CIC/APIC/CDC trained IP	66% (CIC only)	80%	100%
Medical Director, Board Certified Infectious Disease Physician	100%	100%	100%

Performance/Effectiveness

- All Infection Control policies are reviewed and/or revised annually. New policies may also be created as a group to ensure all aspects are covered.
- The Comprehensive Infection Control Risk Assessment for CY 2023 was presented to a multidisciplinary group for review, recommendations, and approval.
- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Medical Council and the Quality and Patient Safety Committee.
- The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified.
- The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- Information technology is utilized for analysis, trending and tracking of infection surveillance data.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.

Actions:

- All the prioritized risks were reviewed and evaluated.
- Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- The Infection Preventionists are members of the national and local chapter of their professional organization and receive education related to Epidemiology/Infection Prevention and Control on an ongoing basis in the form of webinars, conferences, and speakers.
- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of information technology and report creation over CY 2023. This provided deeper analyses resulting in improved prioritization of risks and the ability to set applicable goals for the upcoming year.

I. Executive Summary

Memorial Hospital Miramar (MHM) is a healthcare facility associated with the Memorial Healthcare System (MHS) and maintains an individual Infection Prevention and Control (IPC) plan tailored to its scope of service, to meet the specific needs of its population, but also participates in a systemwide IP program that is used to assist in standardization and strategic vision, as well as creates a framework for systematic organization of the cohesive and growing IPC activities in both inpatient and ambulatory locations. This Infection Prevention and Control Program, along with the collaboration with the Antimicrobial Stewardship Program, meets all the requirements of a comprehensive Program in accordance with 42 CFR 482.42.

The annual **Plan** includes both an *Authority Statement* and a *Scope of Service* that is specifically based on hospital location, populations served, and services provided for last calendar year (CY 2023), including top diagnoses and top procedures by volume, and standard plan elements.

The annual **Risk Assessments** use a *Hazard Vulnerability* template (also used in MHS Emergency Management) and was scored in 2024 Q1 based on CY 2023 actual risks and then reviewed by the hospital's multidisciplinary Infection Control committee or working team. Using the actual risks from the previous year, this year's CY 2024 *Priorities, Goals, and Objectives* are identified using a Pareto graph to visually represent the top 20% of risks in four main areas: Hospital Acquired Infections, Community Risks, Healthcare Worker Risks, and Environmental Risks.

The annual **Evaluation/Appraisal of Goals and Objectives** reviews and evaluates the previous year's CY 2023 hospital-specific goals and objectives by comparing at least two years of performance for infections, hand hygiene, staff vaccination, and more. The goals and resultant data are clearly stated to track performance in both 2022 and 2023, with a *Past Year's Summary of Action Items* undertaken in the past year, and a specific, *Achievable Goal Metric for 2024*.

The oversight and support of this essential program at each facility includes at least one highly trained Manager, the system Director of Infection Prevention and Epidemiology for MHS, and the Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship for MHS.

The hospital plan is annually reviewed by the Quality Council, Medical Executive Committee and taken to the MHS Board of Commissioners for approval.

II. Table of Contents

III. Introduction

Mission: Heal the body, mind, and spirit of those we touch.

Vision: To be a premier clinically integrated delivery system providing access to exceptional patient-and family-centered care, medical education, research, and innovation for the benefit of the community we serve.

Commitment: Family centered and patient focused care

Purpose: To create and implement a comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting/and or transmitting infections and diseases.

This plan will *define the scope of activities* and *provide a framework* for the systematic, organization wide approach for an effective infection control program.

IV. Authority Statement

Pursuant to the approval by the hospital's *Medical Executive Committee* (§482.42(c)(1,2)):

1. The Infection Preventionist (IP) or designee has the authority to obtain cultures as needed to ascertain if someone has a hospital acquired infection (HAI).
2. The IP or designee has the authority to enact measures deemed appropriate to prevent the transmission of communicable diseases.
3. Depending on the severity of the measures required for the containment of the causative pathogen, collaboration with the Medical Director and/or MHS's Infectious Disease consultants will be initiated.

V. Scope of Service 2023–2024

Memorial Hospital Miramar (MHM)

Memorial Hospital Miramar (MHM) is located at 1901 SW 172nd Avenue, Miramar, FL 33029 and serves the population of Southwest Broward County and Northwest Miami-Dade County. MHM is the newest hospital of the South Broward Hospital System, DBA: Memorial Healthcare System. MHM is an acute care setting with a broad range of diagnosis groups and serves newborn to end of life including labor and delivery.

MHM is a 178 Acute Care Tertiary Care facility and offers the following services:

MHM offers the following services - Ages: 18 – End of Life, unless pediatric services are designated:

1. Emergency Care for Adults
2. Emergency Care for Children, birth – 17 years (Joe DiMaggio Children's Hospital)
3. Cancer Care
4. Vascular and Interventional Radiology Care
5. Neurology
6. Family Birthplace Labor and Delivery
7. Family Birthplace Mother Baby

8. Level II & III Neonatal Intensive Care Unit (NICU)
9. Well -Baby Nursery
10. Nutrition
11. Stroke Treatment
12. Surgery
13. Women's Services
14. Outpatient Laboratory Services
15. Inpatient Dialysis
16. Outpatient Rehabilitation Services
17. Outpatient Rehabilitation Services for Children, birth – 17 years (Joe Di Maggio children's Hospital)
18. Medical Office Building II

Acuity:

- 18 Critical Care beds
- 94 Medical/Surgical/Stepdown/Telemetry
- 50 Obstetrics/Gynecology beds
- 16 Level II and III NICU beds
- 26 Adult Emergency Department beds
- 11 Pediatric Emergency Department beds
- 9 Obstetric Emergency Department beds
- 8 Surgical Suites – Main OR
- 4 Surgical Suites in Memorial Surgical Center (MSC)
- 3 Surgical Suites in Obstetrics

Top 10 Inpatient Primary Diagnoses, 2023

1. Single liveborn infant, delivered vaginally
2. Single liveborn infant, delivered by cesarean
3. Maternal care for low transverse scar from previous cesarean delivery
4. Post-term pregnancy
5. Sepsis
6. Full-term premature rupture of membranes
7. Pneumonia
8. Gestational pregnancy induced hypertension without significant proteinuria, complicating childbirth
9. Labor and delivery complicated by cord around neck, without compression
10. Hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 CKD

Top 10 Inpatient Primary Procedures, 2023

1. Delivery of products of conception, external approach
2. Insertion of infusion device into superior vena cava, percutaneous approach
3. Extraction of products of conception, vacuum
4. Resection of prepuce, external approach

5. Resection of gallbladder, percutaneous endoscopic approach
6. Excision of stomach, via natural or artificial opening endoscopic, diagnostic
7. Drainage of peritoneal cavity, percutaneous approach
8. Drainage of right pleural cavity, percutaneous approach
9. Resection of uterus, open approach
10. Inspection of lower intestinal tract, via natural or artificial opening endoscopic

Top 10 Outpatient Primary Procedures, 2023

1. Hysteroscopy, surgical with sampling biopsy of endometrium and/or polypectomy with or without D&C
2. Laparoscopy total hysterectomy for uterus <250 g
3. Laparoscopy total hysterectomy for uterus >250 g
4. Tonsillectomy and adenoidectomy, younger than age 12
5. Laparoscopy removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
6. Laparoscopy cholecystectomy
7. Laparoscopy myomectomy excision
8. Laparoscopy repair initial inguinal hernia
9. Tympanostomy requiring insertion of ventilation tube
10. Hysteroscopy surgical with removal of leiomyomata

Additional Sites of Service:

1. Medical Office Building
   1951 SW 172nd Avenue
   Miramar, FL 33029

2. Medical Office Building 2: Memorial Surgery Center and Women's Center
   1971 SW 172nd Avenue
   Miramar, FL 33029

VI. Program Objectives

The system Infection Prevention and Infection Control Plan integrates all departments, patient care sites and practices at Memorial Healthcare System with the intent:

1. To create and implement an active, system-wide comprehensive infection control, prevention and epidemiology program aimed at protecting patients, healthcare providers, employees, volunteers, and visitors from contracting or transmitting communicable infections and diseases.
2. To collaborate with all healthcare system departments including Antimicrobial Stewardship - Pharmacy, Quality, Clinical Effectiveness, and Performance Improvement to minimize the morbidity, mortality and economic burdens associated with healthcare associated infection (HAI) and multidrug resistant organisms (MDRO) through prevention and control efforts throughout all sites where care is delivered.
3. To collaborate with the local and state Health Departments to monitor incidence of infections, identify potential outbreaks, and implement actions to mitigate and control the spread of infection, as well as
4. To collaborate with Emergency Preparedness to engender advance planning and preparedness critical to help mitigate the impact of an epidemic or pandemic event.

VII. Program Management

A. Program Administration and Resources

1. IP Program led by designated, qualified healthcare Infection Preventionists (IPs), as identified in the Authority Statement and are responsible for the IP program. IP team has access to multiple resources and consultative support not limited to but including the Medical Director of Infection Control and Antimicrobial Stewardship, System Director of Epidemiology, and Infection Prevention, as well as being able to communicate and collaborate with the entire group of MHS IPs as a system for a unified infection prevention team (§482.42 (a), IC.01.01.01, IC.01.02.01).
    a. Ratification of competency of IPC team members.
    b. Maintains membership in Association for Professionals in Infection Control or Florida Professionals in Infection Control.
    c. Attends one (1) educational seminar related to infection prevention and control per year.
    d. Job descriptions delineate the scope and responsibility for each Infection Prevention professional.
2. Staffing, Memorial Hospital Miramar:
    a. Director, Quality & Patient Safety
    b. Manager of Infection Prevention & Control
    c. Infection Preventionist
3. Staffing, Memorial Healthcare System (Oversight and Support):
    a. Chief Physician, Division of Infectious Diseases and Medical Director of Infection Control and Antimicrobial Stewardship, MHS
    b. Physicians, Infectious Disease (MRH, MHM)
    c. Director, Infection Prevention and Epidemiology, MHS

4. Leadership responsibilities (§482.42(c)(1), IC.05.01.01)
    a. Governing body of healthcare system approves annual IP Plan.
    b. System Medical Director presents program to Board Peer Review at least annually to ensure program is in place for accountability and monitoring and prevention of infections.
5. Hours of Operation: Monday – Friday 8:00 am – 5:00 pm; other times immediate availability by cell phone.

B. Plan of Care and Practice for Infection Prevention and Control

1. Planning for management of infection control and prevention (IC & P) program. (IC.01.01.01)
2. Development of an infection prevention and control plan (IC.01.05.01) from utilization of evidence-based guidelines such as APIC, SHEA, CDC, HICPAC, OSHA etc. or, in absence of such guidelines, expert consensus.
3. Plan is a written description of activities, including surveillance, to minimize, reduce or eliminate risk of infection (§482.42(a)(4)).

C. Performance of Risk Assessments

1. Performance of risk assessments at least annually and whenever significant changes occur, at a minimum inclusion of IP's, medical staff, leadership, and nursing. (IC.01.03.01, IC.06.01.01)
2. A multidisciplinary team collaborates to review results of the hospital's infection risk assessment and are prioritized in order of level of probability and potential for harm.
3. Identification, prioritization, and documentation of risk assessment in order of probability and level of harm based on:
    a. Geographic location, community, and population served.
    b. Care, treatment, and services provided.
    c. Analysis of surveillance activities and aggregate IC data
4. Pareto Analysis used to identify the top risks and set goals for reducing the risks of infections that pose the greatest threat to patients and the community.

D. Goal Setting

1. Goal setting to reduce risk of infection to patients and community (IC.01.04.01) and lead to focused activities, based on relevant professional guidelines and sound scientific practices.
2. The goal of the Infection Prevention, Infection Control and Epidemiology program is to prevent healthcare associated infections in patients, healthcare providers, and visitors.
3. Written goals, based on identified risks, include (IC.06.01.01):
    a. Addressing prioritized risks
    b. Limiting unprotected exposure to pathogens
    c. Limiting the transmission of infections associated with procedures.

d. Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies.

E. Evaluation of Effectiveness and Appraisal of Infection Prevention and Control Plan and Program

1. Evaluation of effectiveness of infection prevention and control plan and program (IC.03.01.01) based on:
   a. Plan's prioritized risks
   b. Plan's goals
   c. Program's efficacy
2. Communication of findings to patient safety program.
3. Include findings of evaluation when revising the plan.

F. Policy and Procedure Development (§482.42(a)(2))

1. For infection surveillance, prevention, and transmission control that are reviewed annually and reference and adhere to nationally recognized guidelines.
2. Implementation of Practice for Infection Prevention and Control
3. Prevention and control of transmission of healthcare associated infections (HAIs) and infectious disease among patients and staff.
4. Implementation and documentation of infection control plan, surveillance, prevention, and transmission control that adhere to nationally recognized guidelines.
5. Performance of activities based on relevant professional guidelines and scientific practices.

G. Development, implementation and documentation of infection surveillance, prevention, and control (IC.02.03.01, IC.04.01.01)

1. Communication and collaboration with quality assessment and performance improvement program (QAPI) and Risk Management on IC & P issues (§482.42(c)(1)(ii), §482.42(c)(2)(iii)).
   a. The Infection Control Practitioner reports to the Director of Quality who reports to the Chief Nursing Officer.
   b. The Infection Control Practitioner will report to the Medical Staff any trends within their departments.
2. Training and education of employees and medical staff on practical application of IC & P guidelines and P & Ps (**§482.42(c)(2)(iv)).**
3. Prevention and control of healthcare associated infections, including audit of adherence to IC & P & P by hospital employees and medical staff (§482.42(c)(2)(v), IC.02.01.01).
4. Implementation of IC & P activities involving departments, employees, and medical staff
   a. Surveillance methodology utilizing CDC NHSN with sources for identification including:
      i. Microbiologic records
      ii. Reports from Information Systems including patient census/diagnosis.
      iii. EPIC and outside labs

iv. Chart reviews and patient interviews
v. Post-discharge surveillance
vi. Reporting of suspect/known infections or infection control issues from staff and units' multidisciplinary rounds
vii. Device day usage for urinary catheters, central line catheters, and ventilators
viii. Public health reporting of state mandated reportable infections.
ix. Microbiologic monitoring of water and dialysate

5. Provision of important IC & P information to patients, employees, medical staff, and visitors
   a. Respiratory Hygiene Practices
   b. Hand Hygiene
   c. Implementation of standard and transmission-based precautions
   d. Utilization of personal protective equipment (PPE)
   e. Donning
   f. Doffing
6. Storage and disposal of infectious waste
7. Investigation of outbreaks (IC.01.05.01) – MHS Policy and APIC Text of Infection Control and Epidemiology; April 7, 2020. Chapter 12. Outbreak Investigations/ Epidemiology, Surveillance, Performance, and Patient Safety Measures for framework and guidelines conducting an outbreak investigation.
   a. Initiates outbreak investigation when an outbreak or cluster is suspected consistent with CDC Guidelines.
   b. Institutes early control measures, prepares a preliminary case definition, and compares current incidence with usual or baseline data.
   c. Develops case definition based on time, place, person.
   d. Evaluates efficacy of the control measures.
   e. Reports finding to Medical Director of Infectious Diseases, System Director of Infection Prevention, Quality Care and Patient Safety Committee, appropriate Medical Staff Departments and Florida Department of Health, if warranted.
   f. Reporting of surveillance, prevention, and control information to appropriate staff within facility
8. The Infection Control Practitioner will report relevant findings to PIRM Committee, and Environment of Care Committee quarterly and a report will be submitted quarterly to the Quality Care and Patient Safety Council. The report is then submitted to the Medical Executive Committee, and to the Board of Commissioners.
9. Reporting of surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with laws and regulations.
10. Informing receiving organizations of patients requiring monitoring, treatment, and/or isolation
   a. Upon transfer arrangement
   b. After transfer, upon discovery
   c. Upon receiving a patient and if notification had not occurred by the transferring facility

H. Reduction of risk of infection associated with environment, medical equipment, devices, and supplies. (§482.42(a)(3), IC.01.02.01)

1. Adherence to Spaulding Classification (CDC)
2. Cleaning and performing low level disinfection of medical equipment, devices and supplies consistent with Manufacturer's Instruction for Use (IFUs)
3. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies
4. Disposal of medical equipment, devices, and supplies
5. Storage of medical equipment, devices, and supplies
6. Reprocessing single use devices consistent with regulatory and professional standards.
7. Availability of Manufacturer's Instructions for Use

I. Implementation of evidence-based practices to prevent healthcare associated infections (HAIs) due to the following: (IC.02.01.01, IC.02.05.01, IC.07.01.01)

1. Participation in CDC's National Healthcare Safety Network
2. Multidrug Resistant organisms (MDRO) and Emerging Infectious Diseases
    a. Candida auris
    b. MDR Acinetobacter baumannii
    c. MDR Carbapenem-resistant enterobateriaceae
    d. MRSA
    e. Pseudomonas aeruginosa
    f. Clostridiodes difficile
3. Central Line-associated bloodstream infections (CLABSI)
4. Catheter-associated urinary tract infections (CAUTI)
5. Ventilator Associated Event (VAE)
6. Surgical Site Infections (SSI)
7. Measurement and monitoring of infection prevention processes, outcomes, and compliance using evidence-based guidelines or best practices.
8. Participation in The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)
9. Protocols for high-consequence and emerging special pathogens and collaboration with Emergency Preparedness (IC.07.01.01).

J. Hand Hygiene

1. Improving compliance with the current CDC Hand Hygiene guidelines
2. iRound electronic audit tool for manual monitoring used in 2020 and 2021.
3. Discontinuation of the Electronic Monitoring System in March of 2023 due reliability and validity concerns to properly collect HH observations.
4. Continuation of the use of iRound electronic Audit tool to monitor HH.
5. National Patient Safety Goal 7: Prevent infection by using hand cleaning guidelines from CDC or WHO.

6. Set goals to improve hand cleaning.
7. Report Data by unit and healthcare worker type to quality and leadership.

K. Communication and collaboration with Emergency Preparedness (EP)

1. Preparation of response to influx of potentially infectious patients (IC.01.06.01)
2. Participation in interdisciplinary emergency management operations program: engagement in planning activities which includes identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering potential emergencies in developing strategies for preparedness, with a focus on infection control and prevention. This includes, where possible, collaboration with relevant parties in the community.
3. Monitoring and evaluation of current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients.
4. Communication of critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.
5. Written plan delineating management of influx of infectious patients
6. MHS Highly Communicable Disease Preparedness and Response guidelines

L. Communication and collaboration with Environment of Care (EOC)

1. Water Management Program (EC.02.05.02): Participation in an interdisciplinary water management program that addresses Legionella and other waterborne pathogens.
2. Management of Environment during demolition, renovation, or new construction to reduce risk of infection (EC.02.06.05)
3. Infection Control Risk Assessment (ICRA)

M. Communication and collaboration with Employee Health (EH)

1. Vaccination against influenza of licensed independent practitioners and staff. (IC.02.04.01)
2. Annual influenza vaccination program that is offered to all licensed independent practitioners and staff.
3. Education of licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.
4. Provision of influenza vaccination at sites and times accessible to licensed independent practitioners and staff.
5. Improvement of influenza vaccination rates
6. Written description of the methodology used to determine influenza vaccination rates.
7. Evaluation of the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually, and it's reported in PIRM.
8. Improvement of vaccination rates according to established goals at least annually

9. Provision of influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annual.
10. Collaboration with Employee Health Department, utilizing above process, to provide additional vaccination against:
    a. Hepatitis B
    b. Covid-19
    c. Tetanus, Diphtheria and Pertussis
    d. Varicella
11. Prevention of transmission of infectious disease among patients, licensed independent practitioners, and staff (IC.02.03.01)
12. In collaboration with Medical Staff and Employee Health Services:
    a. Screening for exposure and/or immunity to infectious diseases available to LIPs and employees who may be exposed to infections within the workplace.
    b. Management of LIPs and employees who are suspected of or were occupationally exposed.
    c. Management of patients who have been exposed to an infectious disease.
    d. Assessing compliance with and confirming proper use of optimal personal protective equipment (PPE)
    e. Assessing compliance with and confirming proper implementation of isolation guidelines and Hand Hygiene

N. **Communication and collaboration with Antimicrobial Stewardship Program (ASP)** (§482.42(d), §482.42(c)(2)(vi), §482.42(b), MM.09.01.01).

1. Please see addendum with ASP Plan and yearly documents.
2. IP has unified and integrated with ASP program as a system of multiple hospitals by sharing meetings and medical director.

VIII. References

1. Centers for Disease Control and Prevention (CDC). (2023).

    a. CDC. (2022). CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. Accessed from https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html

    b. CDC. (2015). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. Accessed from https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf

    c. CDC. Prevention Strategies for Seasonal Influenza in Healthcare Settings. Accessed from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm)

    d. Bolyard EA. Tablan OC, Williams WW, Pearson ML, Shapiro CN, Deitchmann SD. Guideline for Infection Control in Healthcare Personnel, 1998. Hospital Infection control Practices Advisory committee. Infect Control Hosp Epidemiol. 1998 Jun; 19(6):407-63. (Available at https://stacks.cdc.gov/view/cdc/7250.

    e. Boyce JM, Pittet D, Healthcare Infection control Practices Advisory Committee, Society for Healthcare Epidemiology of America, Association for Professionals in Infection control, Infectious Diseases Society of America, Hand Hygiene Task Force. Guideline for Hand Hygiene in Health-Care Settings: recommendation of the Healthcare Infection Control Practices Advisory committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Infect control Hosp Epidemiol. 2002 Dec 23(12 Suppl): S3-40. (Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm.

    f. Rutala WA, Weber DJ, Healthcare Infection Control Practices Advisory Committee. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Am J Infect Control.2013;41(5 Suppl): S67-71. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

    g. Sehulster L, Chin RY, Healthcare Infection Control Practices Advisory Committee. Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. MMWR Recomm Rep 2003 Jun 6:52(RR-10):1-42. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf

    h. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006. Am J Infect control, 2007 Dec 35 (10 Suppl 2): S165-93. (Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/mdro-guidelines.pdf [PDF – 75 Pages].)

    i. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Am J Infect Control. 2007 Dec 35(10 Suppl 2)

S65-164. (Available at https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.)

2. Centers for Medicare and Medicaid Services. (2022 July 6). Conditions of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs. Accessed from https://www.cms.gov/files/document/qso-22-20-hospitals.pdf
3. Association for Professionals in Infection Control and Epidemiology (APIC). (2023). APIC Text accessed from https://apictext.org
4. Society for Healthcare Epidemiology of America (SHEA). (2023).
5. Joint Commission. (2024). Accessed from **https://e-dition.jcrinc.com/Frame.aspx**

Evaluation of the Infection Prevention and Control Plan 2023
and
Goals and Objectives 2024

This Program Evaluation is based in part on annual risk assessment of top priorities ("vital few") as identified by Pareto Analysis and the outcomes achieved during calendar year 2023 (1/2023 to 12/2023). Outcomes are identified through review of performance measurement data, information resulting from our committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Memorial Hospital Miramar and in collaboration with other Memorial Healthcare facilities. *The hospital evaluates the effectiveness of its infection prevention and control plan (IC.01.05.01)*

The purpose of this annual appraisal is to:

1. Evaluate the effectiveness of the Infection Control program of Memorial Hospital Miramar in detection, identification, prevention and control of hospital acquired and community acquired infections in patients, employees, physicians, licensed independent practitioners, volunteers, contract service workers and visitors while in the hospital.
2. Identify and assess the degree of risk factors for the acquisition and transmission of infectious diseases to reduce the incidence and eliminate their spread among persons in the hospital and in the community.
3. Identify opportunities for quality and performance improvement, loss prevention, cost containment and planning for the upcoming year.
4. Adhere to all local, state, and national regulatory guidelines for healthcare facilities.

The following top organizational risk priority targets were identified from the CY2024 Memorial Hospital Miramar Infection Control Risk Assessment, 2024 Annual Plan and 2023 institutional data analysis. Targets were adopted from internal goal to reduce yearly harm by 10%, external reporting CMS/VBP/HAC and/or Leapfrog performance achievement thresholds, CDC/NHSN published progress reports and internal TAP reports, and community historical trends. *Based on institutional determined goals and identified risks (risk ≥20% on ICRA Pareto), the organization sets goals to minimize the possibility of transmitting infections (IC.01.04.01).*

1. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and Clostridium difficile (CDIFF)		**2022 Final**	**2023 Final**	**2024 Goal (10% reduction)**
CRO	# of patients with MDRO / # of patient days x 1000 = MDRO rate	**0.00**	**↑4.19**	**3.77**
C. auris		**0.00**	**0.00**	**0.00**
CDIFF		**2.19**	**↑2.48**	**2.32**
MRSA bacteremia	# of patients with MRSA bacteremia / # of patient days x 10,000 = MRSA rate	**0.00**	**0.00**	**0.00**
MRSA bacteremia SIR	SIR: observed / predicted	**0.00**	**0.00**	**0.793 VBP**
CDIFF SIR		**0.313**	**↑0.366**	**0.423 VBP**
	Analysis • There was an increase in CDIFF rate overall from CY2022 to 2023 and increase in SIR and it was below VBP benchmark.			

	• There MRSA bacteremia rate stayed the same from CY 2022 to 2023 and the SIR was the same that is below VBP benchmark. • There was an increase in CRO rate overall from CY2022 to 2023 • C. auris rate stayed the same from CY 2022 to 2023. • Opportunities identified related to CDIFF order set, Use of laxatives, multiple use of antibiotics so culture stewardship undertaken as initiative. • Early identification of patients colonized or infected with resistant organisms or other infectious organisms and immediate transmission-based isolation of these patients reduced and prevented further transmission. • IP performed daily surveillance of cultures from patients admitted with or developing infection. • IP runs reports for early identification of patient who are suspicious or confirmed for specific organism or pathogen. • IP also monitored the high priority organism list and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the IP to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission-based precautions. • The CDC isolation precautions are part of MHS policy and on the intranet website as a resource for all staff to have access to. • We continued to implement GI Precautions, Enhanced Contact Precautions, Enhanced Respiratory Precautions in addition to CDC Transmissions-Based Precautions and Standard Precautions. • Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Infection Prevention was a part of MDRO action plan. • Continued active surveillance for CRE and C. auris for high-risk patients on admission. **Actions Taken:** Candida Auris and CR organisms: • Continue active surveillance on admitted high risk patients by screening for CRE and C. Auris. • IP continues to perform daily surveillance of cultures from patients admitted with infections. • IP monitors high priority organism lists and isolations. o These measures assist with identifying previously colonized or infected patients with resistant organisms and allow the IP to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission-based precautions. • Continue to implement Contact Precautions, GI Precautions, Enhanced Contact Precautions, Enhanced Respiratory Precautions in addition to CDC Transmissions-Based Precautions and Standard Precautions. • Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical/nursing departments and Infection Prevention continue to be practiced. CDIFF: • C Diff education including isolation, testing protocol, hand hygiene and low-level disinfection is facilitated to all clinical staff working in inpatient units at least annually as part of our C Diff Action Plan; additional education is provided as needed. • Continue to use the Smart CDIFF order set which includes the CDI algorithm as a method to identify patients in need of CDI testing. • Reinforce the immediate implementation of isolation precautions for patients suspected of C diff colonization. • Monitor and support proper use of PPE and hand washing practices while caring for C Diff patients.

	• Continue to emphasize the use of Clorox Bleach Germicide for low level disinfection and cleaning of C Diff patients-associated medical equipment and environment. • Collaboration with EVS team to implement additional prevention strategies. • Collaboration with antibiotic stewardship committee. • Work closely with the Pharmacy Department in terms of ASP guidance to clinicians on de-escalation and appropriate antibiotic treatment for patients presenting with diarrhea and patients being transferred to our hospital. • Continued emphasis on Hand Hygiene and Antimicrobial Stewardship programs. MDRO: • Education on Isolation Precautions, Hand Hygiene and proper use of PPE is provided to all clinical staff working in inpatient units at least annually; additional education is provided as needed. • Ensure Contact precautions are initiated on patients that require isolation by following the CDC's isolation precaution guidelines. • Promote hand hygiene and proper use of PPE while interacting with all patients including suspected and confirmed MRSA patients. • Modified isolation precautions for MRSA and VRE have been discontinued except for uncontained draining wounds, uncontained bodily fluids, and purulent sputum production with a positive MRSA isolate. Select group of high-risk patients screened using molecular test, including pre-op patients and patients with soft skin and tissue infections such as cellulitis. Positive patients are subsequently initiated on decolonization protocol. **Effectiveness** • Blood culture collection education and opportunities identified. • Surveillance rounds and lab monitoring are mechanisms in which information is gathered. • Individual clusters were and will continue to be analyzed and interventions will be determined at that time. • Continued emphasis on hand hygiene and antimicrobial stewardship. • Appropriate testing guidelines for C-diff disseminated to all medical staff, regarding the CDI testing algorithm criteria. • Collaboration with antibiotic stewardship committee. • Collaboration with EVS team to implement additional prevention strategies. This includes daily communication of patient rooms on GI precautions including rooms pending discharge targeted for Electrostatic bleach use.

2. Overall reduction of healthcare associated infections. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI) and catheter associated urinary tract infection (CAUTI). Minimize the risk of hospital acquired infections associated with invasive devices.	**2022 Performance**	**2023 Performance**	**2024 Goal** **10% reduction in rate or CMS or Leapfrog benchmark**
CLABSI <u>Central Line Infections</u> Central Line Days X 1000 = Rate/1000 Central Line Days	**5/6143 = 0.814**	**4/5298=↓0.755**	**0.679**
SIR = observed/predicted	**5/2.003 = 2.49 (all units)**	**4/2.122=↓ 1.88 (all units)**	**0.760 VBP threshold**

CAUTI Urinary Catheter Infections Urinary Catheter Days X 1000 = Rate/1000 Urinary Catheter Days SIR = observed/predicted	**0/3310=0.00** **0.00 (all units)**	**0/2770=0.00** **↓ 0.00 (all units)**	**0.00** **0.615 VBP threshold**

Analysis

- Infections are identified from prospective surveillance by the trained IP staff using NHSN definitions.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.

Effectiveness

- **CLABSI**
  - CLABSI rates decreased from 2022 to 2023. SIR decreased from CY 2022 to 2023
  - There were 4 CLABSI on all units, but there were 2 CMS reportable CLABSI's for 2023.
  - CY 2023 SIR was above the VBP threshold.
  - There was a decrease in central line days from 2022 (6143) to 2023 (5298).
  - iRound was utilized for bundle compliance with evidence based best practices as well as daily assessment of a central line including line necessity, discontinuation or an alternative to the central line, improved awareness and communication, opportunities with products in central line dressing kits, alcohol impregnated caps on all central lines, daily chlorhexidine bath for all patients was implemented facility wide, IP rounding included ongoing interventions, nasal decolonization with Povidone-Iodine among the ICU population, minimize blood culture collection on patient that do not meet criteria for testing, dedicated central line dressing change day, education and line dressing surveillance.
  - Opportunities identified related to peripheral and central line blood culture collection and central line care.
  - Robust plan implemented to address blood culture contamination, CHG bathing, and central line care.
  - No blood cultures from central line practice adopted.
  - Each CLABSI included mini-RCA dill down for any event identified to determine any opportunities for improvement.
  - Communicated with nurse managers and administration during management huddle on lessons learned to prevent CLABSI.
  - Strive for "zero"
  - IP will continue to monitor and communicate findings with the appropriate stakeholders.
- **CAUTI**
  - CAUTI rates and SIR stayed the same in 2022 compared to 2023.
  - CAUTI raw infections stayed the same overall.
  - CY 2023 SIR was below VBP threshold.
  - There was a decrease in catheter days from 2022 (3310) to 2023 (2770).
  - iRound bundle compliance documentation with evidence based best practices as well as continuing improvement solutions to reduce CAUTI.
  - Daily Foley catheter report reviewed to identify opportunities for removing indwelling catheters and/or replacing with external catheters, if indicated.
  - External Male and Female catheters are available, and staff have been educated to use ANI (advanced nursing Interventions) for early Foley removal as indicated.
  - Daily CHG bathing and perineal care for all patients and minimize the collection of urine cultures for only the patients who meet indication for urine culture collection.

	o Extensive education in place for Foley care and maintenance. o Communicated with nurse managers and administration during management huddle on lessons learned to prevent CAUTI. o IP will continue to monitor trends associated with CAUTI and communicate findings with appropriate stakeholders. o Strive for "zero"

3. Surgical Site Infections (SSI) Carry out systemic program surveillance and reporting of all Class I and II surgical site infections.	**Targeted Class**	**CY 2022 Performance**	**CY 2023 Performance**	**2024 Goal** **10% reduction in rate or CMS or Leapfrog benchmark**
Surgical Site Infections/ Surgical Procedures Completed X 100 = SSI Rate	***Class I Rate (All)***	***0.380***	***↓ 0.180***	***0.162***
	Class II Rate (All)	***0.330***	***↓ 0.320***	***0.288***
	C-Section Rate	***0.150***	***↑ 0.540***	***0.486***
	Hysterectomy Rate	***0.630***	***↑ 0.980***	***0.882***
	Colon Rate	***3.770***	***↑ 4.690***	***4.221***
SIR: observed/predicted	**Colon SIR**	**1.280**	**↓0.472**	**0.747**
	Hysterectomy SIR	**0.857**	**↑1.440**	**0.763**

Analysis

- Class I surgeries decreased from CY 2023 compared to 2022.
- Class II surgeries decreased from CY 2023 compared to 2022.
- C-section rates increased from CY 2023 compared to 2022.
- Colon SIR decreased from 2023 compared to 2022 and was below VBP threshold.
- Hysterectomy SIR increased from 2022 to 2023 and was above VBP threshold.
- Analysis of all SSI data reviewed at the NSQIP and departmental meetings.
- Intense analysis of colon and hysterectomy infections with Action Plan that includes all SSI prevention.
- Drill down on all SSI infections with an opportunity to discuss lessons learned with management and administration.
- Re-education was provided to clinical staff regarding pre-op chlorhexidine bathing; the antibiotic, time given and re-dosing, nasal decolonization for high-risk surgeries, intraop temperature monitoring, and CHG treatment wipes being done in preop.

Effectiveness

- Act as informed liaison between - Microbiology, Pharmacy, Utilization Review, and Nursing,
- Monitor appropriate Antibiotic therapy. ICP participates in the SCIP program. Information presented at all departmental meetings with data specific to the physician group.
- NSQIP team including IP to work on SSI Reduction.
- In collaboration with Pharmacy team and Medical Staff, all MHS preoperative antibiotic prophylaxis order sets reviewed and updated to agree with current professional guidelines.
- Unscheduled C-sections receive azithromycin prophylaxis in addition to standard prophylaxis.
- Implemented use of CHG treatment wipes for surgical patients.
- Gap analysis and action plan regarding strategies supported by evidence-based medicine to reduce SSI which includes preoperative bathing with chlorhexidine, surgical site scrub with chlorhexidine, and weight based antibiotic dosing, appropriate antibiotic selection for patients, and intraoperative temperature at or above core temp.

	• Surveillance of evidence based best practices as well as the improvement solutions remain on-going to maintain a downward trend with reducing Hysterectomy and colon surgery infections as well as class I and II SSI

4. Use Standard Precautions to prevent unprotected exposure to pathogens (i.e., symptomatic patients, respiratory virus-like COVID-19, seasonal flu, pandemic flu, influx of infectious patients, active TB patients and patients with history of MDRO, unusual clusters of organisms or HAI, outbreaks, etc.). Monitor for any potential cases of active TB or increase in influx of infectious patients.	**2022**	**2023**	**2024 Goal**
PPE Trends/identification	**n/a**	**n/a**	**0 occurrences**
MDRO trends/identification Outbreaks, clusters, or transmission Influx of other infectious patients & emergency preparedness	**0 Cluster. Continued to monitor and intervene as necessary.**	**0 Clusters. Continued to monitor and intervene as necessary.**	**0 Clusters. Ongoing monitoring, surveillance, and implementation of interventions as needed.**

Performance/Effectiveness:

- MHM continues to be at low risk for M-TB.
- No MDR-TB cases in 2023.
- No cases of respiratory M-TB in 2022 and 2023.
- There were no conversions in healthcare workers as the result of exposures in 2023.

Actions taken:

- Standard precautions and PPE education during Skills Fairs, New Employee Orientation, Just-in-Time training, Rehab outpatient services, and staff IC education.
- In 2023, a new isolation gown was trialed at all MHS facilities. After review by clinicians and staff feedback, gown was removed and substituted by a better one.
- Continue to educate new and current employees on standard precautions and essential IC practices including, but not limited to HH, Proper Use of PPE, and Low-level Disinfection of our environment.
- MHS system leadership conducting safety rounds with increased awareness for incident reporting of safety events.
- Monitoring of trends and potential HO infections by utilizing the EPIC-Outbreak Tool
- MHS uses electronic case reporting for COVID-19 reporting to the state.
- For Laboratory personnel: Minimizing exposure to infectious agents by use of OSHA guidelines, establishing standard operating procedures, requirements for personal protective equipment, engineering controls (e.g., chemical fume hoods, air handlers, etc.) and waste disposal procedures.
- MHM will continue to actively track and trend admission of patients for any increase influx of patients and/or need to implement the Pandemic Plan.
- MHM has been implementing continual education via simulation drills and desktop learning, planning and emergency notification.
- MHM has participated in Emergency Preparedness exercises and activities, HID PPE in-service to ICPs.
- MHM has implemented key IC practices and measures to mitigate the effect of respiratory viral season in our hospital. These practices have been directed by national (CDC). These have also been monitored, assessed, and adjusted as the situation in our community has changed.

5. Improve Hand Hygiene Compliance **Monitor hand hygiene compliance.**	**2022 Performance**	**2023 Performance**	**2024 Goal**
Number of observations/number of opportunities	**99%**	**↓98%**	**90%**
Performance/Effectiveness:			

- Goal for 2023 was met.
- In 2023, the hand hygiene compliance was 98% with a total of 55,573 observations.
- This represents an 54% increase in the number of collected observations compared to 2022 (36,082)
- The hand hygiene compliance for 2022 was 99%.

Actions Taken:

- Continue unit-based education/coaching on hand hygiene with all staff.
- Monthly HH data is presented to quarterly Quality care and Patient Safety Council Meetings, Employee Skills Fairs, New Employee Orientation, and specific department in-services and presentations.
- Support the use of hospital-approved alternative hand hygiene products for those employees that have allergies or sensitivities.
- Provide education and support to the patient safety champions to collect accurate hand hygiene observations.
- Continue routine observations of appropriate hand hygiene (handwashing and the use of alcohol-based sanitizers)
- Continuation with the utilization of the iRound HH tool to collect HH observations.

6. Reduction of risk of infection secondary to inadequate supplies, failure to follow safety devices and personal protective equipment.	**2022**	**2023**	**2024 Goal**
Frequency that IP consulted and responded with expert review on product substitutions and availability of supplies & made front line staff aware.	**100%**	**100%**	**100%**
Frequency that IP was consulted on protocols related to safety devices and equipment	**100%**	**100%**	**100%**

Performance/Effectiveness:

- All shortages and alternative products are shared with IC and monitored by IC.

Actions taken:

- Communication from supply chain, materials management, and clinical team for backorders, conservation activities, crisis, and contingency standards dependent on availability of medical equipment.
- Unit level in-services continued to be presented for dissemination of alternate product information.
- Educational materials are created by the IP team, printed, and used to educate staff, patients, and families.
- Demonstrate/observe proper implementation and usage of new and alternative products by end-users.
- Education on alternative products is conducted each time a new product is brought to MHM.
- IC monitors, keeps tracks and communicates shortages and new products.

7. Reduction of risk of infection secondary to improper equipment sterilization. High level disinfection, low level disinfection or environmental cleaning.	**2022**	**2023**	**2024 Goal**
Frequency that IP reviews documentation, logs, and conducted visual observations of reprocessing areas	100%	100%	100%

Performance/Effectiveness:

- Assisting in risk assessment and partnering with end users in following manufacturer's instructions for use, most up-to-date guidelines

Actions taken:

- Initial and annual Competency Checks on: OR-Terminal Cleaning, Alaris Pumps Cleaning, Disinfecting and Handling, US Vaginal probes HLD Process.
- Review instructions for use for disinfectants being used.
- Review new equipment and partner with end users in creating cleaning and disinfection process.
- Monitoring compliance of cleaning and disinfection practices.

8. Reduction of risk of infection secondary to water management. Reduction of risk of infection secondary to hurricane or flood events.	2022	2023	2024 Goal
Frequency of IP participation on Water Management meetings and program document review.	**100%**	**100%**	**100%**
Frequency of IP participation on EOC Rounds	**100%**	**100%**	**100%**
Frequency of IP participation on Emergency Management drills and table-top exercises and hurricane preparedness activities.	**100%**	**100%**	**100%**

Performance/Effectiveness:

- IP reviewed of national guidelines from CDC, AAMI, AORN, APIC, SHEA, and other literature sources pertaining to water risks.
- IP partnered with facilities, sterile processing, emergency preparedness, and emergency department.

Actions Taken:

- Continue to meet regularly and update plans as needed.
- Review temp and humidity logs of sterile areas after weather events and equipment failure
- Ongoing monitoring, surveillance, and reporting of environmental organism

9. Reduction and mitigation of community exposure to respiratory viruses including COVID-19, Influenza, and others. Promote and improve seasonal flu and COVID immunization organization wide.	2022	2023	2024 Goal
Number of clusters of COVID-19 staff or patients.	**0**	**0**	**0**
Employee Influenza immunization rate	**89%**	**95%**	**95%**
Employee COVID immunization rate	**88%**	**93%**	**90%**

Performance/Effectiveness:

Clusters:

- In 2022 and 2023, no cluster of COVID-19 were identified.

Vaccination:

- Goal for Influenza Immunization
  - In 2023, MHM had an Influenza Immunization rate of 89% and goal was not met.
  - In 2022, MHM had an Influenza Immunization rate of 95% and goal was met.
- Goal for COVID Immunization was not met.??
  - In 2023, MHM had a COVID Immunization rate of 92.6% and goal was met.
  - In 2022, MHM had a COVID Immunization rate of 88.1% and goal was not met.

Actions Taken:

- Staying up to date with guidelines from the CDC, FDOH and other community partners.
- Continue to monitor each HO case of COVID 19 which leads to additional review and tracing and if applicable identification of additional cases.
- Use of standard precautions and early isolation to minimize transmission.
- Continue to educate staff on IC practices as it relates to emerging diseases including COVID 19.
- Continue collaboration with Employee Health to monitor staff trends of Covid 19.
- NHSN definitions are utilized for mandatory compliance reporting of vaccination.
- Influenza vaccination is still mandatory for all MHS staff members.
- Mandatory influenza education is provided to all hospital staff via Annual Review.
- Continued education at employee orientation, employee skills fair, and presentations at Department Leaders on Influenza Vaccination rate.
- Email alerts/reminders during influenza season are sent to employees and flyers are posted throughout the facility.
- Influenza Vaccine Program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs.

- Nursing offers vaccination to patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered by Employee Health during the entire flu season; at times, mobile vaccination carts attend units and meetings.
- Administrative Officers support by participating in campaigns for vaccination.
- Employees who take the flu vaccine are incentivized through credits that affect the cost of the health insurance premiums.

10. Infection Prevention and Control Program Plan, Evaluation of the Plan, Risk Assessment, Policies and Procedures are reviewed and updated annually. Plans include policies and procedures for minimizing risk of transmitting infection associated with use of procedures, medical equipment, medical devices, and products.	**2022 Target**	**2023 Final**	**2024 Goal**
Program policies and procedures review completed	**100%**	**100%**	**100%**
Program has an NHSN and APIC trained IP with Masters of Science in Nursing (MSN) and Bachelor of Science (BSN) and Associates of Medical Laboratory Technology (MT)	**100%**	**100%**	**100%**
Medical Director, Board Certified Infectious Disease Physician	**100%**	**100%**	**100%**

Analysis

- ICP performs ongoing analysis of P.I. initiatives, participates in multi- disciplinary rounds and reports quarterly at QCPSC. COVID-19 infection control rounding, education, management of all patients and staff according to CDC and national best practice guidelines.
- Appropriate, clinical necessity and timeliness of support services are provided by the department during off hours through the nursing supervisor and/or designated personnel. The Infection Preventionist is available to address the needs of the facility via cell phone to provide a timely response.
- In the absence of the IP, another IP in the system availed him/herself to provide coverage.
- The Infectious Disease physician was available for consultation when necessary to assist with difficult cases.
- System Director of Epidemiology and Infection Prevention for support through system-wide initiatives, program goals, and infection control coverage.
- The Comprehensive Infection Control Risk Assessment for CY2023 was presented to a multidisciplinary group for review, recommendations and approval.
- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Medical Council. The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified. The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- Memorial Hospital Miramar's Infection Control Program, policies and procedures are developed based upon established professional guidelines and national, state, local, as well as regulatory requirements including CDC Guidelines, OSHA Regulations, CMS, HRS Regulations, Joint Commission Standards, APIC Guidelines, FDA guidelines. In the absence of professional guidelines, best practices and evidence based literature and professional society consensus are utilized.
- Computer technology is utilized for analysis, trending and tracking of infection surveillance data.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.
- ICP performs ongoing analysis of P.I. initiatives, participates in multi- disciplinary rounds and reports quarterly at QCPSC. COVID-19 infection control rounding, education, management of all patients and staff according to CDC and national best practice guidelines.

Performance/Effectiveness

- Memorial Hospital Miramar provided sufficient staffing and resources to meet the requirements for the Infection Prevention Program
- The Infection Control Practitioner is an active member of the local APIC chapter and participates in educational opportunities. Additionally, many local educational offerings and teleconferences dealing with current infection control issues are attended monthly.
- All of the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- The Infection Preventionists are members of the national and local chapter of their professional organization and receive education related to Epidemiology/ Infection Prevention and Control on an ongoing basis.
- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of data and surveillance over the calendar year. This has provided more accurate analysis to better prioritize our risks and set new goals for the coming calendar year.
- Infection control data is reported quarterly to Quality Care & Patient Safety Council and respective nursing units.
- Currently Infection Control Practitioner is involved in the following Hospital-wide and System-wide Performance Improvement activities.
- Patient Rights - Patients are treated preserving their confidentiality. Information obtained and actions taken as consequence of Infection Control Surveillance shall be confidential and protected.
- Patient Assessment - Risk of hospital acquired infections is monitored based upon patient diagnosis and health status. Rapid access of laboratory and pathology test results are available to practitioner. Outside reference labs are used as necessary.
- Care of the Patient - Care of patient at risk and with identified hospital acquired infection will be monitored on an ongoing basis. Interventions for prevention of transmission will be implemented.
- Patient Education - Patient will receive education on the prevention and control of infection by nursing staff and practitioners as necessary.

- Improving Organizational Performance
    - Attends performance improvement meetings as needed.
    - Provides statistics and reports to PI Committee and QCPSC.
    - Assists And interacts with all departments on Performance Improvement projects using an interdisciplinary approach.
    - Shares information hospital wide disseminating this information with healthcare providers who directly affect patient outcomes.
- Leadership- Infection Control will:
    - Provides orientation and continuing education of all personnel regarding infection control and infection prevention.
    - Acts as consultant to hospital and physicians.
    - Participate in the development of guidelines for surveillance, prevention and control of infections.
    - Provide information and statistical reports regarding surveillance activity.
    - Provide information on an ongoing basis regarding new regulations and guidelines.

- Management of Environment of Care
    - Prevalence rounds will be performed annually and as needed on all departments to ensure compliance and facilitate any corrective actions
    - Monitor and update Biomedical waste policies and procedures.
- Management of Information
    - Infection Control acts as hospital resource for data collection, interpretation and analysis.
    - Reports of surveillance activities are shared with all departments involved in prevention of infection.
    - Information from Infection Control activities is shared with all Patient Care departments to improve the quality of patient care.
- MHM IP completes multidisciplinary rounds, sits on VAT teams, and participates in System IP meetings, and System Infection Prevention and Control Committee with the following interdisciplinary departments.

Multidisciplinary rounds	Infection Control, Case Management, Pharmacy, Dietary, Physical Therapy, Medical Staff, Quality, Facilities Management, EVS.
MHS VAT Teams	MHS ICPs, MHS RNs, MHS Directors
MHS Infection Control Practitioners' Meeting	Infection Control team, Laboratory, Infection Control Medical Director
MHS System Infection Prevention and Control Committee	System CMO, System Safety and Quality, System Chief Nurse Executive, Hospital Chief Physicians, Executives, Infection Control, Laboratory, Emergency Preparedness, Facilities and Engineering, Employee Health

For 2023:

- Continue emergency preparedness protocols, policies and procedures established in 2020 & 2021 to isolate and control the transmission of COVID-19 within the hospital.
- Continue multidisciplinary unit rounds.
- Continue MRSA screening process for select surgical procedures per policy.
- EOC/Infection control rounds in all hospital areas.
- Monitoring of construction projects for infection control compliance.
- Outpatient surgical surveillance, selected surgical procedure surveillance.
- Maternity and newborn surveillance.
- Update on OSHA, HRS and CDC standards.
- Collect data on hospital acquired, community infections and outbreaks.
- Concurrent and retrospective chart review-establishes control measures as needed.
- Orientation for all new employees.
- Sit and advise on hospital committees including (QCPSC, Safety, Critical care, NICU, Pediatrics, Performance Improvement, VAT Team, Pharmacy and Therapeutics.
- Provide reports: Infection Control Report -quarterly, MOR monthly, board report monthly.
- Monitor for performance improvement on bloodstream infections, lower respiratory infections, and blood and body fluid exposures.

- Provide employee infection control educational programs based upon needs/problem identification, Hand Hygiene, OSHA and TB mandatory programs).
- Management of outbreaks based upon written policy.

Memorial Healthcare System

Financial Reports for June 2024

July 24, 2024
Board Meeting

Memorial Healthcare System - Executive Summary - MTD June 2024

- Inpatient Revenue was above budget due to 2.7% higher admissions and 4.1% higher patient days

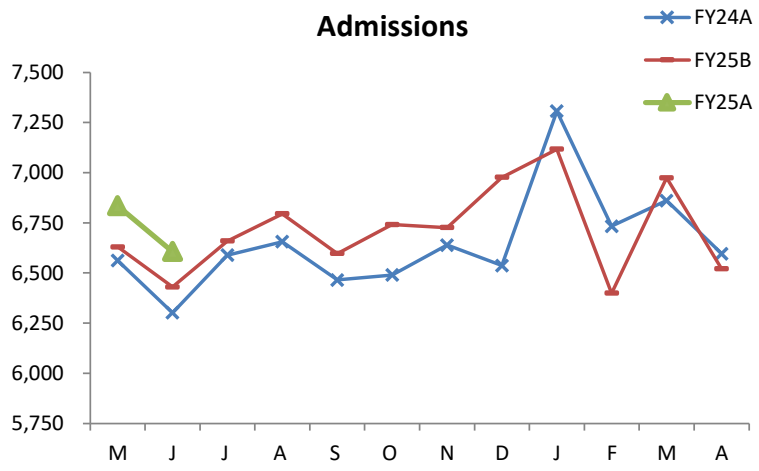
- Outpatient Revenue below budget due to (2.1%) lower outpatient visits, (4.4%) lower observation discharges, and (6.2%) lower outpatient surgeries

- Net Revenue of $274.9M was above the budget of $266.3M, and Income from Operations of $11.8M was higher than the budget of $6.5M

- Excess of Revenues over Expenses was $73.0M, including FEMA reimbursement of $40.4M, and an unrealized gain of $14.6M, compared with the budgeted Excess of Revenues over Expenses of $10.8M

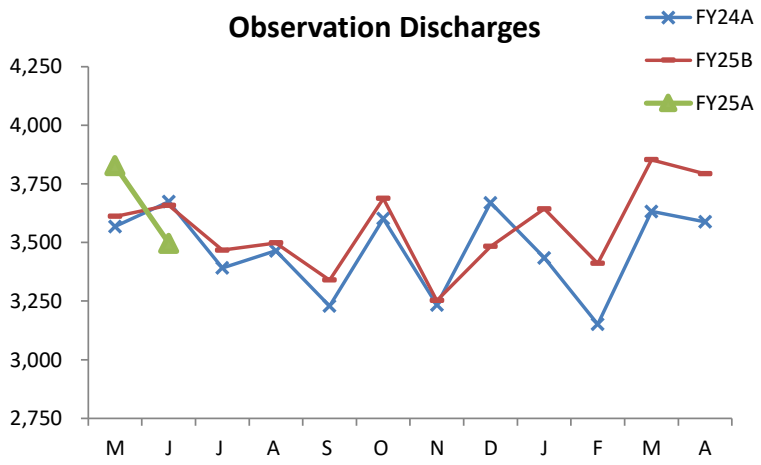
Memorial Healthcare System - Consolidated Volumes and Payor Mix - June 2024

Admissions



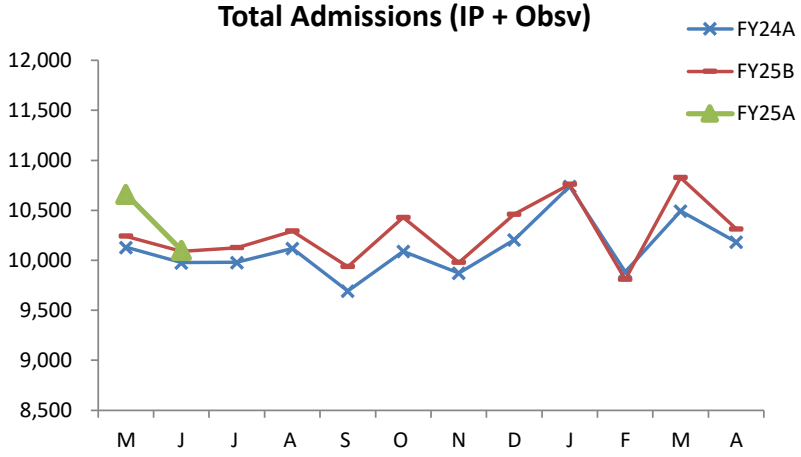
	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	6,607	6,430	6,302	2.7%	4.8%
YTD:	13,442	13,060	12,864	2.9%	4.5%

Observation Discharges



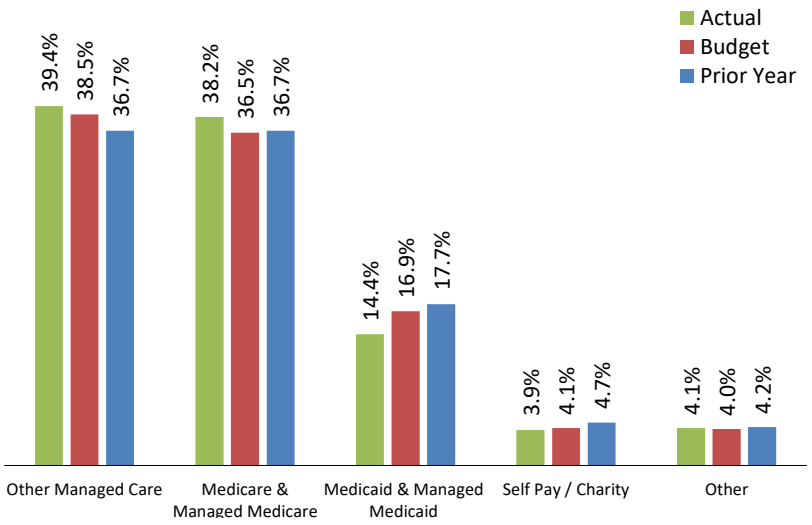
	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	3,496	3,658	3,674	-4.4%	-4.8%
YTD:	7,323	7,269	7,242	0.7%	1.1%

Total Admissions (IP + Obsv)



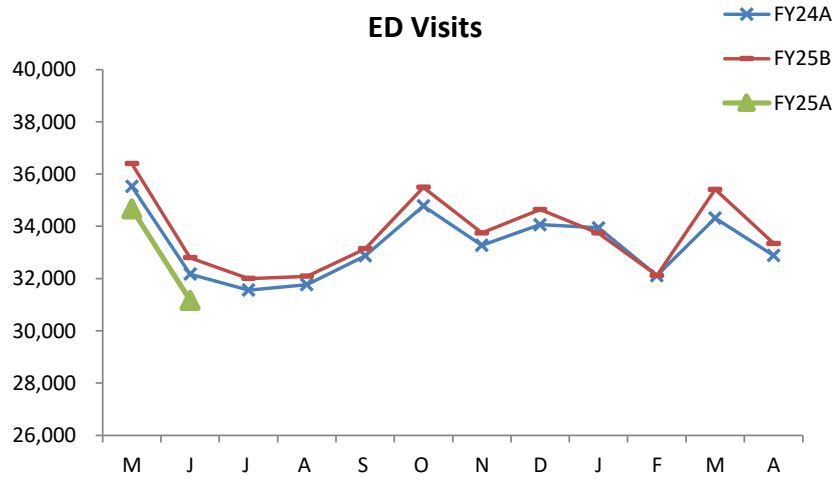
	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	10,103	10,088	9,976	0.1%	1.3%
YTD:	20,765	20,328	20,106	2.1%	3.3%

Payor Mix (Gross Revenue) - YTD FY2025



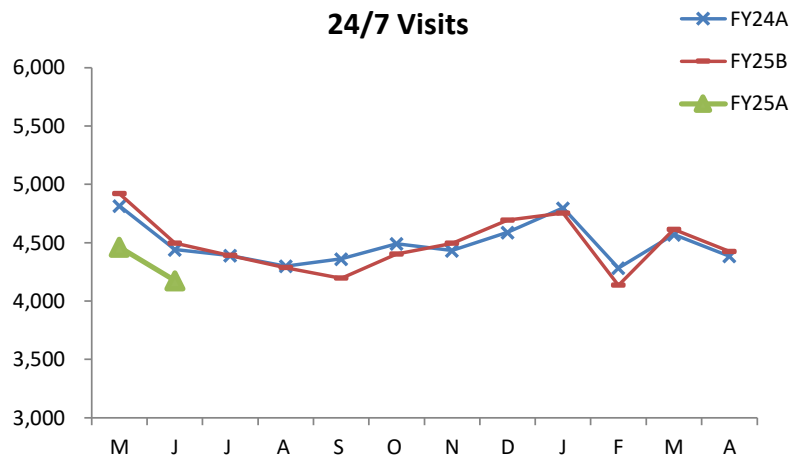
Memorial Healthcare System - Consolidated Volumes - June 2024

ED Visits



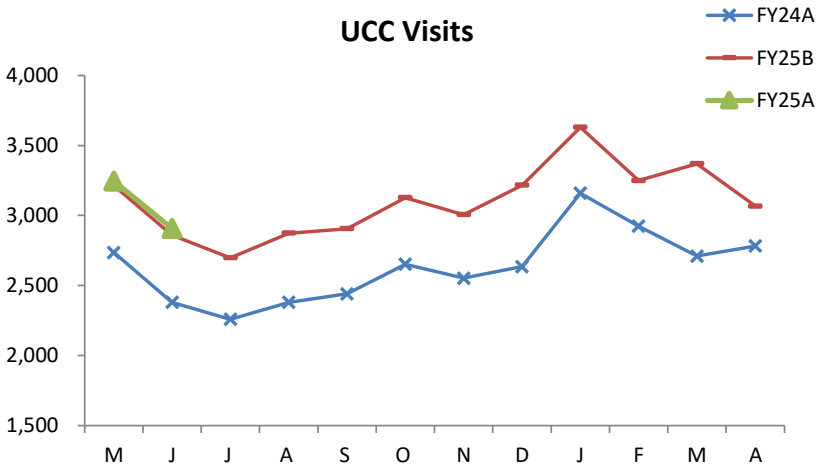
	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	31,157	32,790	32,169	-5.0%	-3.1%
YTD:	65,824	69,185	67,703	-4.9%	-2.8%

24/7 Visits



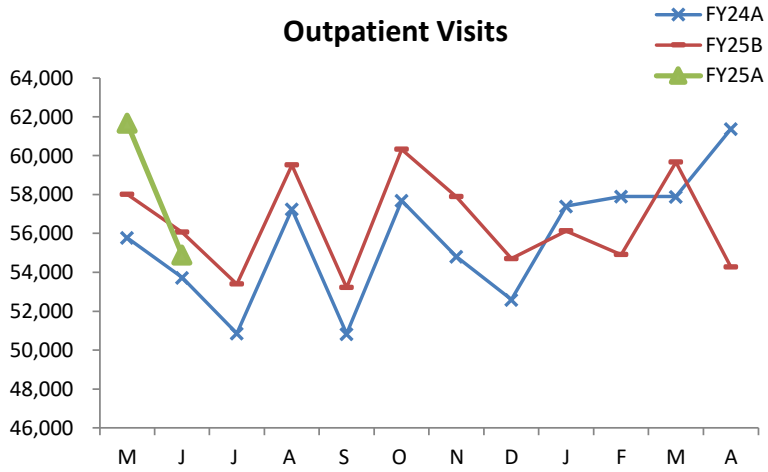
	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	4,176	4,496	4,441	-7.1%	-6.0%
YTD:	8,639	9,416	9,256	-8.3%	-6.7%

UCC Visits



	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	2,906	2,859	2,380	1.7%	22.1%
YTD:	6,151	6,073	5,115	1.3%	20.3%

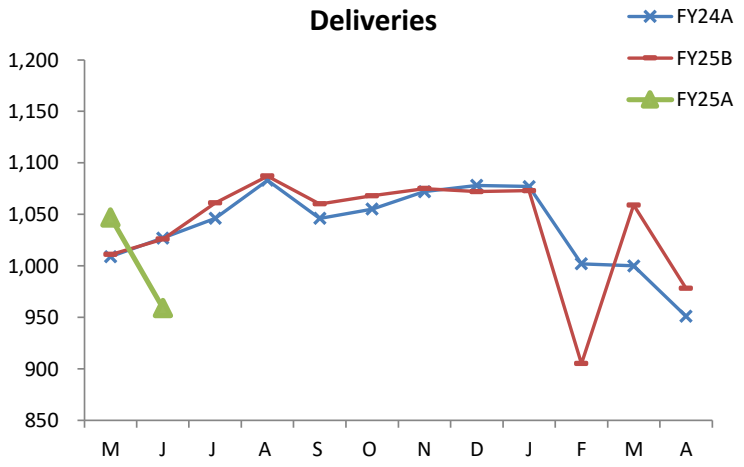
Outpatient Visits



	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	54,896	56,065	53,733	-2.1%	2.2%
YTD:	116,578	114,073	109,508	2.2%	6.5%

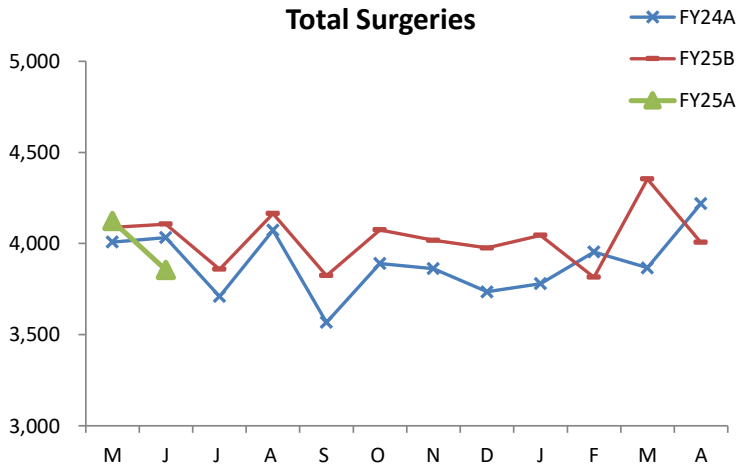
Memorial Healthcare System - Consolidated Volumes - June 2024

Deliveries



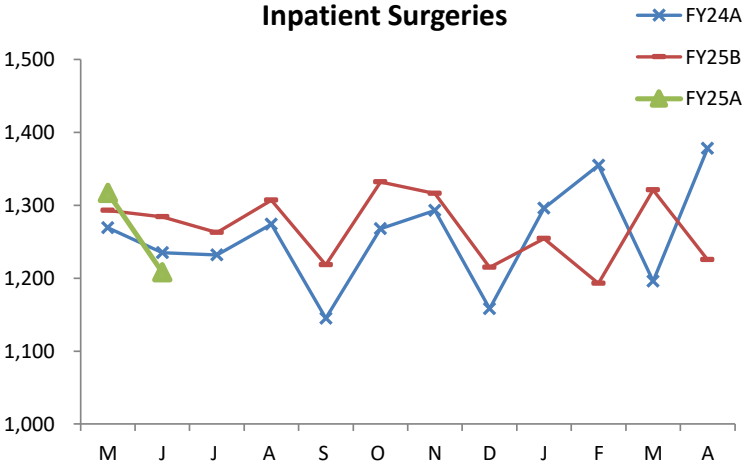
	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	959	1,026	1,027	-6.5%	-6.6%
YTD:	2,006	2,037	2,036	-1.5%	-1.5%

Total Surgeries



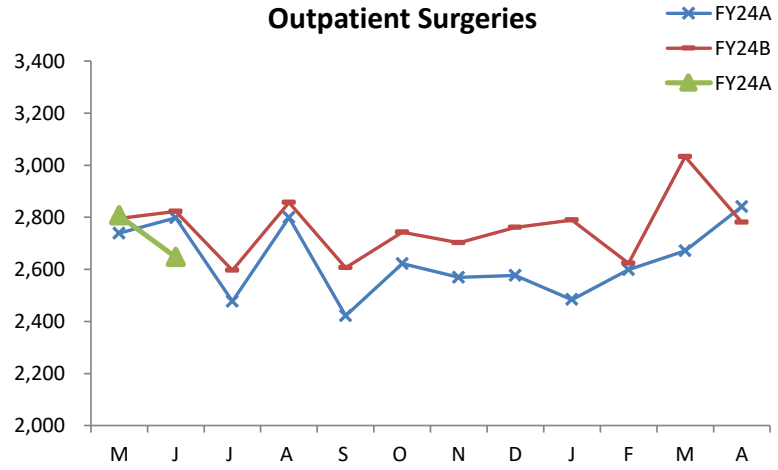
	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	3,855	4,107	4,033	-6.1%	-4.4%
YTD:	7,979	8,195	8,041	-2.6%	-0.8%

Inpatient Surgeries



	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	1,208	1,284	1,235	-5.9%	-2.2%
YTD:	2,525	2,577	2,504	-2.0%	0.8%

Outpatient Surgeries



	FY25A	FY25B	FY24A	vs FY25B	vs FY24
MTD:	2,647	2,823	2,798	-6.2%	-5.4%
YTD:	5,454	5,618	5,537	-2.9%	-1.5%

Memorial Healthcare System - Operating Statement - June 2024

	Variance		Month to Date			$ thousands	Year to Date			Variance	
	vs PY	vs Budget	Prior Year	Budget	Actual		Actual	Budget	Prior Year	vs Budget	vs PY
A	13.5%	3.3%	824,214	906,087	935,894	Inpatient Revenue	1,891,467	1,832,088	1,704,164	3.2%	11.0%
B	7.2%	(5.8%)	807,979	920,127	866,508	Outpatient Revenue	1,827,608	1,847,571	1,609,873	(1.1%)	13.5%
C	**10.4%**	**(1.3%)**	**1,632,193**	**1,826,214**	**1,802,402**	**Total Patient Revenue**	**3,719,075**	**3,679,658**	**3,314,037**	**1.1%**	**12.2%**
D	9.2%	(4.2%)	1,331,348	1,517,535	1,454,310	Contractual Allowances	3,027,512	3,051,447	2,712,412	(0.8%)	11.6%
E	31.3%	23.5%	53,785	57,166	70,601	Charity Care	136,931	115,108	111,390	19.0%	22.9%
F	43.8%	>100%	17,483	7,769	25,149	Provision for Bad Debt	43,051	15,593	30,290	>100%	42.1%
G	**10.5%**	**(2.0%)**	**1,402,616**	**1,582,470**	**1,550,060**	**Total Deductions**	**3,207,493**	**3,182,147**	**2,854,092**	**0.8%**	**12.4%**
H	**9.9%**	**3.5%**	**229,577**	**243,744**	**252,342**	**Net Patient Revenue**	**511,582**	**497,512**	**459,945**	**2.8%**	**11.2%**
I	<(100%)	<(100%)	10,616	4,857	(1,097)	Disproportionate Share Distributions	(400)	9,715	15,268	<(100%)	<(100%)
J	59.4%	33.6%	14,833	17,691	23,641	Other Operating Revenue	45,488	35,379	31,489	28.6%	44.5%
K	**(11.4%)**	**0.0%**	**25,448**	**22,549**	**22,544**	**Total Other Operating Revenue**	**45,088**	**45,094**	**46,758**	**0.0%**	**(3.6%)**
L	**7.8%**	**3.2%**	**255,026**	**266,293**	**274,886**	**Net Revenue**	**556,670**	**542,606**	**506,702**	**2.6%**	**9.9%**
M	9.8%	3.0%	119,112	126,983	130,738	Salaries & Wages	265,556	258,860	240,098	2.6%	10.6%
N	(1.3%)	(4.5%)	19,649	20,309	19,393	Employee Benefits	42,586	44,910	39,386	(5.2%)	8.1%
O	2.2%	(6.5%)	6,915	7,559	7,065	Professional Fees	14,392	15,144	13,042	(5.0%)	10.4%
P	8.8%	4.9%	53,003	54,946	57,649	Supplies Expense	114,602	110,041	106,701	4.1%	7.4%
Q	(20.2%)	(1.1%)	23,152	18,692	18,478	Purchased Services	37,687	37,699	46,692	0.0%	(19.3%)
R	2.5%	(12.6%)	7,506	8,804	7,692	Facilities Expense	14,504	17,722	14,041	(18.2%)	3.3%
S	36.1%	1.5%	9,673	12,970	13,163	Depreciation & Amortization	25,976	25,967	19,316	0.0%	34.5%
T	8.7%	(6.4%)	8,169	9,491	8,881	Other Operating Expense	18,072	19,063	16,150	(5.2%)	11.9%
V	**6.4%**	**1.3%**	**247,179**	**259,754**	**263,059**	**Total Expenses**	**533,375**	**529,406**	**495,426**	**0.7%**	**7.7%**
W	**50.7%**	**80.9%**	**7,847**	**6,539**	**11,827**	**Income/(Loss) from Operations**	**23,295**	**13,200**	**11,276**	**76.5%**	**>100%**
X	100.0%	N/A	(4)	-	-	Tax Revenue	-	-	-	N/A	N/A
Y	(5.9%)	(1.8%)	(2,731)	(2,843)	(2,893)	Interest Expense	(5,648)	(5,689)	(5,357)	0.7%	(5.4%)
Z	>100%	N/A	5,408	-	14,630	Unrealized Gain/(Loss)	40,588	-	(23,775)	N/A	>100%
AA	>100%	>100%	6,268	7,067	49,330	Investment & Other	92,452	14,140	14,380	>100%	>100%
AB	**>100%**	**>100%**	**8,675**	**4,279**	**61,125**	**Total Non Operating Revenue/(Loss)**	**127,510**	**8,564**	**(15,230)**	**>100%**	**>100%**
AC	**>100%**	**>100%**	**$16,521**	**$10,818**	**$72,952**	**Excess/(Deficit) of Revenues over Expenses**	**$150,805**	**$21,763**	**($3,953)**	**>100%**	**>100%**
AD	**>100%**	**>100%**	**$23,528**	**$26,709**	**$74,389**	**EBITDA**	**$141,863**	**$53,575**	**$44,517**	**>100%**	**>100%**
AE	**>100%**	**>100%**	**$21,912**	**$22,522**	**$69,602**	**Normalized EBITDA (GASB 96 and GASB 87 Impacts Removed)**	**$132,589**	**$45,199**	**$41,276**	**>100%**	**>100%**

Memorial Healthcare System - Operating Statement - MTD June 2024

	$ thousands	Month to Date		Variance	Variance %	
		Actual	Budget	vs Budget		
A	Inpatient Revenue	935,894	906,087	29,807	3.3%	Higher admissions and patient days
B	Outpatient Revenue	866,508	920,127	(53,620)	-5.8%	Lower outpatient visits, observation discharges, and outpatient surgeries
C	**Total Patient Revenue**	**1,802,402**	**1,826,214**	**(23,812)**	-1.3%	
D	Total Deductions	1,550,060	1,582,470	(32,410)	-2.0%	
E	**Net Patient Revenue**	**252,342**	**243,744**	**8,598**	3.5%	Improved payments and favorable payor mix
F	**Total Other Operating Revenue**	**22,544**	**22,549**	**(5)**	0.0%	
G	**Net Revenue**	**274,886**	**266,293**	**8,593**	3.2%	
H	Salaries and Wages	130,738	126,983	3,755	3.0%	Higher labor costs from staffing to higher inpatient volumes
I	Employee Benefits	19,393	20,309	(916)	-4.5%	Lower employee drug costs, partially offset by higher FICA
J	Professional Fees	7,065	7,559	(493)	-6.5%	Lower physician and consulting fees
K	Supplies Expense	57,649	54,946	2,703	4.9%	Higher drugs and organ acquisition expenses
L	Purchased Services	18,478	18,692	(214)	-1.1%	Timing of audits and care coordination project expenses
M	Facilities Expense	7,692	8,804	(1,112)	-12.6%	Lower repairs and maintenance expenses due to timing
N	Depreciation and Amortization	13,163	12,970	193	1.5%	
O	Other Operating Expense	8,882	9,491	(609)	-6.4%	Lower corporate partnership expenses and advertising
P	**Total Expenses**	**263,059**	**259,754**	**3,305**	1.3%	
Q	**Income/(Loss) from Operations**	**11,827**	**6,539**	**5,288**	80.9%	
R	**Operating EBITDA**	**24,990**	**19,575**	**5,414**	27.7%	
S	Operating EBITDA Margin	9.09%	7.35%			
T	Non Operating Revenue/Expense	61,125	4,279	56,846	1328.4%	FEMA reimbursement and unrealized investment gains
U	**Excess/(Deficit) of Revenues over Expenses**	**72,952**	**10,818**	**62,134**	574.37%	
V	**EBITDA**	**74,389**	**26,709**	**47,680**	178.52%	
W	EBITDA Margin	27.06%	10.03%			

Memorial Healthcare System - Operating Statement - YTD June 2024

	$ thousands	Year to Date		Variance	Variance %	
		Actual	Budget	vs Budget		
A	Inpatient Revenue	1,891,467	1,832,088	59,379	3.2%	Higher admissions and patient days
B	Outpatient Revenue	1,827,608	1,847,571	(19,963)	-1.1%	Lower outpatient surgeries
C	**Total Patient Revenue**	**3,719,075**	**3,679,658**	**39,417**	1.1%	
D	Total Deductions	3,207,493	3,182,147	25,346	0.8%	
E	**Net Patient Revenue**	**511,582**	**497,512**	**14,070**	2.8%	Higher gross revenue impact from higher volumes and favorable payor mix
F	**Total Other Operating Revenue**	**45,088**	**45,094**	**(6)**	0.0%	
G	**Net Revenue**	**556,670**	**542,606**	**14,064**	2.6%	
H	Salaries & Wages	265,556	258,860	6,696	2.6%	Higher labor costs from staffing to higher inpatient volumes
I	Employee Benefits	42,586	44,910	(2,324)	-5.2%	Lower employee drug cost, lower pension expense due to increase in pension asset value, and lower FICA
J	Professional Fees	14,392	15,144	(751)	-5.0%	Lower physician fees and consulting fees
K	Supplies Expense	114,602	110,041	4,561	4.1%	Higher drugs, organ acquisition expenses, and instrument purchases
L	Purchased Services	37,687	37,699	(12)	0.0%	
M	Facilities Expense	14,504	17,722	(3,218)	-18.2%	Lower repairs and maintenance expenses due to timing, and lower electricity
N	Depreciation & Amortization	25,976	25,967	9	0.0%	
O	Other Operating Expense	18,072	19,064	(992)	-5.2%	Lower corporate partnership expenses and shared savings distributions
P	**Total Expenses**	**533,375**	**529,406**	**3,969**	0.7%	
Q	**Income/(Loss) from Operations**	**23,295**	**13,199**	**10,095**	76.5%	
R	**Operating EBITDA**	**49,271**	**39,300**	**9,971**	25.4%	
S	Operating EBITDA Margin	8.85%	7.24%			
T	Total Non Operating Revenue/(Loss)	127,510	8,564	118,947	1389.0%	FEMA reimbursement and unrealized investment gains
U	**Excess/(Deficit) of Revenues over Expenses**	**150,805**	**21,763**	**129,042**	592.94%	
V	**EBITDA**	**141,863**	**53,575**	**88,288**	164.79%	
W	EBITDA Margin	25.48%	9.87%			

Memorial Healthcare System - Consolidated Balance Sheet and Key Indicators - June 2024

	$ thousands	06/30/2024	05/31/2024	4/30/2024
A	CASH AND INVESTMENTS	$ 2,665,425	$ 2,623,474	$ 2,617,560
B	PATIENT ACCOUNTS RECEIVABLE (NET)	402,229	385,132	361,946
C	RESTRICTED ASSETS AND ASSETS WHOSE USE IS LIMITED	83,681	83,309	111,156
D	CAPITAL ASSETS (NET)	1,421,154	1,411,625	1,429,281
E	OTHER ASSETS AND DEFERRED OUTFLOWS	626,859	589,767	486,752
F	TOTAL ASSETS AND DEFERRED OUTFLOWS	$ 5,199,348	$ 5,093,307	$ 5,006,695
G	CURRENT LIABILITIES	$ 659,428	$ 632,085	$ 657,224
H	LONG TERM DEBT	863,167	863,349	881,811
I	ESTIMATED CLAIMS LIABILITY	28,254	27,767	27,487
J	OTHER NON-CURRENT LIABILITIES AND DEFERRED INFLOWS	356,738	351,366	299,286
K	TOTAL LIABILITIES AND DEFERRED INFLOWS	1,907,587	1,874,567	1,865,808
L	NET POSITION	3,291,760	3,218,740	3,140,887
M	LIABILITIES, NET POSITION AND DEFERRED INFLOWS	$ 5,199,348	$ 5,093,307	$ 5,006,695
N	DAYS CASH ON HAND	326.4	322.6	323.9
O	CASH TO DEBT (%)	274.1	270.5	264.8
P	NET DAYS IN AR	45.9	43.2	38.4
Q	DEBT TO NET POSITION RATIO	0.30	0.30	0.32
R	DEBT TO CAPITALIZATION	0.23	0.23	0.24
S	DEBT TO CASH FLOW	1.97	2.18	2.47
T	MADS* COVERAGE	6.24	5.64	5.09

* MAXIMUM ANNUAL DEBT SERVICE

FROM: David Smith, Executive Vice President and Chief Financial Officer, MHS

TO: K. Scott Wester, President and Chief Executive Officer, MHS

CC: Frank P. Rainer, Senior Vice President and General Counsel, MHS

DATE: July 17, 2024

SUBJECT: **SOUTH BROWARD HOSPITAL DISTRICT PROPOSED TAX MILLAGE RATE FOR FISCAL YEAR 2025**

We have received the 2024 Broward County Property Appraiser's Certification of Taxable Value, totaling $90,903,111,392 for property in the South Broward Hospital District (District). Compared with last year's assessed valuation of $83,270,352,539 this year's valuation is an increase of $7,632,758,853 or 9.2%. This change amounts to an increase of $6,686,075,573 or 8.0% related to previously existing property and an increase of $946,683,280 or 1.1% related to new construction.

At the July 24 Board Meeting, the District Board of Commissioners (Board) will adopt a "Proposed Millage Rate" based on these new, assessed values. The Board also shall establish the date, time, and place of the first required public hearing of the tentative tax budget. Such a hearing is required to be held between September 3 and September 18 and is not to conflict with the County Commission or School Board public hearing dates. The School Board meetings are scheduled for July 30 and September 10, while the County Commission meetings are scheduled for September 5 and 17. The District's final public hearing is required to be held within 15 days of the first public hearing.

When establishing millage rates for the current fiscal year, the Board must take into consideration previously enacted tax relief legislation. Key to the various calculations continues to be the Rolled-Back Rate (RBR), which is the millage rate that would raise the same amount of revenue as last year when applied to the current year's assessed value, less the value of any new construction and the dedicated increment values of the Community Redevelopment Agencies (CRAs).

The following is a summary of the voting requirements and the millage rates per requirement:

- Simple Majority vote 0.0000 to 2.2378 mils

  The maximum millage rate allowed by a Simple Majority vote of the Board is equal to the rate that would raise the same amount of revenue as last year's simple majority rate (excluding new construction and CRA dedicated increment values), adjusted by the change in per capita Florida personal income.

- Two-Thirds vote: 2.2379 to 2.4616 mils (110% of the maximum millage rate allowed by Simple Majority vote)

- Unanimous vote or Referendum of the voters: 2.4617 to 2.5000 mils (statutory maximum millage)

The millage rate proposed at the July board meeting can be reduced at the Preliminary Tax Hearing, but any increase would be extremely difficult to accomplish, due to notice requirements. After the Preliminary Hearing, a reduction can be made but there can be no increase.

In order to assist in the determination of a Proposed Millage Rate, I have enclosed a schedule showing several alternative millage rates for the current year, including the Rolled-Back Rate. Also attached is the proposed September calendar, which is in compliance with the Statutory Timetable.

Should you have any questions regarding these matters, please contact me at your convenience.

SOUTH BROWARD HOSPITAL DISTRICT
TAX FUND BUDGET - SENSITIVITY ANALYSIS
FY 2025

		PRIOR YEAR'S RATE	BREAK EVEN RATE	ROLLED-BACK RATE (RBR)	BUDGET BOOK	
	ROLLED-BACK RATE IS 0.0869	**FY2025**	**FY2025**	**FY2025**	**FY2025**	**FY2024**
		A	B	C		
		NO CHANGE	**6.5% INCREASE**	**7.3% DECREASE**	**PROJECTED BUDGET**	**ACTUAL**
1	**ASSESSED VALUATIONS (In thousands)**	$ 90,903,111	$ 90,903,111	$ 90,903,111	$ 90,668,440	$ 83,270,353
2	**MILLAGE RATE**	**0.0937**	**0.0998**	**0.0869**	**0.0885**	**0.0937**
3	*% Change from Rolled-Back Rate*	*7.83%*	*14.84%*	*0.00%*	*1.84%*	*2.18%*
4	% Change from Prior Year Rate	0.00%	6.51%	-7.26%	-5.55%	-7.23%
5	**GROSS TAXES LEVIED**	$ 8,518,000	$ 9,073,000	$ 7,899,000	$ 8,024,000	$ 7,802,000
a	Difference from Prior Year Actual	$ 716,000	$ 1,271,000	$ 97,000	$ 222,000	$ 267,237
b	Variance from Prior Year Actual	9.18%	16.29%	1.24%	2.85%	3.43%
	TAX FUND REVENUE					
5	Gross Taxes Levied	$ 8,518,000	$ 9,073,000	$ 7,899,000	$ 8,024,000	$ 7,802,000
6	Less:					
a	Discounts on Taxes	40,000	43,000	37,000	67,000	37,000
b	Uncollectible Taxes	0	0	0	1,000	0
7	**TAXES PAID BY DISTRICT RESIDENTS**	$ 8,478,000	$ 9,030,000	$ 7,862,000	$ 7,956,000	$ 7,765,000
a	Difference from Prior Year Actual	$ 713,000	$ 1,265,000	$ 97,000	$ 191,000	$ 475,770
b	Variance from Prior Year Actual	9.18%	16.29%	1.25%	2.46%	6.13%
8	Revenue Collection Fees	170,000	181,000	157,000	159,000	155,000
9	**DISTRICT TAX RECEIPTS**	$ 8,308,000	$ 8,849,000	$ 7,705,000	$ 7,797,000	$ 7,610,000
a	Difference from Prior Year Actual	$ 698,000	$ 1,239,000	$ 95,000	$ 187,000	$ 475,770
b	Variance from Prior Year Actual	9.17%	16.28%	1.25%	2.46%	6.25%
	Other Deductions from Tax Revenue:					
10	Property Appraiser's Fee	46,000	46,000	46,000	48,000	48,000
11	Community Redevelopment Agencies	382,000	394,000	369,000	365,000	361,000
12	Medicaid Match	8,409,000	8,409,000	8,409,000	7,384,000	7,201,000
	Total Other Deductions from Tax Revenue	$ 8,837,000	$ 8,849,000	$ 8,824,000	$ 7,797,000	$ 7,610,000
13	**NET TAX REVENUE/(EXPENSE)**	$ (529,000)	$ -	$ (1,119,000)	$ -	$ -
14	TAX RECEIPTS FROM PRIOR TAX YEARS AND OTHER ADJUSTMENTS	-	-	-	-	-
15	**TOTAL NET TAX REVENUE/(EXPENSE)**	$ (529,000)	$ -	$ (1,119,000)	$ -	$ -
a	Difference from Prior Year Actual	$ (529,000)	$ -	$ (1,119,000)	$ -	$ -
	TAX FUND PATIENT CARE EXPENDITURES					
16	Memorial Primary Care	-	-	-	-	-
17	Other SBHD Charity Care	-	-	-	-	-
18	Other SBHD Operating Fund Flow**	(529,000)	-	(1,119,000)	-	-
	TOTAL TAX FUND PATIENT CARE EXPENDITURES	$ (529,000)	$ -	$ (1,119,000)	$ -	$ -

** Negative amount indicates that operations had to cover some or all of the Tax Fund obligations.

DESCRIPTION OF TAX FUND COMPONENTS

1 **ASSESSED VALUATIONS (IN THOUSANDS)**
These values (illustrated in thousands) are provided by Broward County on the Certification of Taxable Value (form DR-420).

2 **MILLAGE RATE**
The millage rate is multiplied by the Assessed Valuation (In Thousands) to derive the gross taxes levied. Per statutory guidelines, the District's maximum allowed millage rate is 2.5000.

3 **% CHANGE FROM ROLLED-BACK RATE**
The percentage change in the millage rate from the year's rolled-back rate. The rolled-back rate is the rate that would generate the same tax revenues as the prior year, less allowances for new construction, additions, rehabilitative improvements increasing assessed value by at least 100%, annexations and deletions.

4 **% CHANGE FROM PRIOR YEAR RATE**
The percentage change in the millage rate from the prior year millage rate.

5 **GROSS TAXES LEVIED**
Total taxes levied on the assessed valuations per the given millage rate.

a **Difference from Prior Year Actual**
The dollar difference in gross taxes levied per the given millage rate versus those levied in the prior year.

b **Variance from Prior Year Actual**
The percentage change in gross taxes levied per the given millage rate versus those levied in the prior year.

6 **LESS:**

a **Discounts on Taxes**
The discounts that taxpayers receive by paying their property taxes prior to the due date.

b **Uncollectible Taxes**
The taxes that are not collected from taxpayers (bad debt).

7 **TAXES PAID BY DISTRICT RESIDENTS**
Total amount of ad valorem taxes paid to the District for the given year.

a **Difference from Prior Year Actual**
The dollar difference in taxes paid by District residents versus those paid in the prior year.

b **Variance from Prior Year Actual**
The percentage change in taxes paid by District residents versus those paid in the prior year.

8 **REVENUE COLLECTION FEES**
Represents collection fees charged by the Broward County Tax Collector. This is 2.0% of collected funds (i.e., 2.0% of taxes paid).

9 **DISTRICT TAX RECEIPTS**
Total amount of tax revenue actually received by the District for the given year.

a **Difference from Prior Year Actual**
The dollar difference in tax revenue received by the District versus that received in the prior year.

b **Variance from Prior Year Actual**
The percentage change in tax revenue received by the District versus that received in the prior year.

10 **PROPERTY APPRAISER'S FEE**

Fees charged by Broward County Property Appraiser's Office.

11 **COMMUNITY REDEVELOPMENT AGENCIES**

The portion of taxes that must be remitted to the cities of Hollywood, Hallandale Beach and Davie for their community redevelopment agency programs.

12 **MEDICAID MATCH**

The State of Florida has determined an amount due from each county. That amount is allocated to all counties based on a blend of each county's total Medicaid expenditures and number of Medicaid eligible enrollees per county. The District's share is 27.4% of the amount allocated to Broward County, based on historical hospital inpatient utilization.

13 **NET TAX REVENUE/(EXPENSE)**

Total net tax revenue for the given year available for patient care; i.e., gross taxes levied less discounts on taxes, uncollectable taxes, revenue collection fees, Property Appraiser's fee, community redevelopment agency assessments, and Medicaid match.

14 **TAX RECEIPTS FROM PRIOR TAX YEARS AND OTHER ADJUSTMENTS**

Collections and adjustments related to prior tax years.

15 **TOTAL NET TAX REVENUE/(EXPENSE)**

Total net tax revenue (for all years), received in the given year, available for patient care.

a **Difference from Prior Year Actual**

The dollar difference in total net tax revenue per the given millage rate versus those in the prior year.

16 **MEMORIAL PRIMARY CARE**

Funding for the clinics and programs offered by Memorial Primary Care.

17 **OTHER SBHD CHARITY CARE**

Tax funds allocated to offset charges for services rendered at District hospitals to patients qualifying as "indigent" under the District's indigent care policy guidelines. The annual income test currently used by the District corresponds to 200% of the Federal Poverty Guidelines.

18 **OTHER SBHD OPERATING FUND FLOW**

Non-tax, District operating funds needed to cover expenditures not otherwise provided by the Tax Fund.

TAX EFFECT ON A SAMPLE HOME

SOUTH BROWARD HOSPITAL DISTRICT
TAX FUND BUDGET
FISCAL YEAR 2025

	FISCAL YEAR	OPERATING MILLAGE RATE	TAXABLE VALUE BEFORE HOMESTEAD EXEMPTION	TAXABLE VALUE AFTER HOMESTEAD EXEMPTION	TAX ON HOME ASSESSED AT $310,000 THIS YEAR	ANNUAL DOLLAR CHANGE	ANNUAL PERCENT CHANGE
PRIOR YEAR	2024-2025	0.0937	$310,000	$260,000	$24.36	$0.93	4.0%
BREAK EVEN	2024-2025	0.0998	$310,000	$260,000	$25.95	$2.52	10.8%
ROLLED BACK	2024-2025	0.0869	$310,000	$260,000	$22.59	($0.84)	-3.6%
PRIOR YEAR	2023-2024	0.0937	$300,000	$250,000	$23.43	$0.00	0.0%
	2022-2023	0.1010	$282,000	$232,000	$23.43	($1.05)	-4.3%
	2021-2022	0.1144	$264,000	$214,000	$24.48	($0.70)	-2.8%
	2020-2021	0.1199	$260,000	$210,000	$25.18	($0.51)	-2.0%
	2019-2020	0.1260	$254,000	$204,000	$25.69	($2.45)	-8.7%
	2018-2019	0.1414	$249,000	$199,000	$28.14	($0.36)	-1.3%
	2017-2018	0.1469	$244,000	$194,000	$28.50	($2.02)	-6.6%
	2016-2017	0.1615	$239,000	$189,000	$30.52	($1.96)	-6.0%
	2015-2016	0.1737	$237,000	$187,000	$32.48	($1.99)	-5.8%
	2014-2015	0.1863	$235,000	$185,000	$34.47	($38.33)	-52.7%
	2013-2014	0.4000	$232,000	$182,000	$72.80	($34.00)	-31.8%
	2012-2013	0.6000	$228,000	$178,000	$106.80	($21.45)	-16.7%

Comparing various millage rate scenarios with prior year for a sample home valued at $310,000 with homestead exemption

Break-Even Rate

Sources & Uses of Tax Funds Based on Millage Rate of 0.0998

Sources of Funds		Funds	Millage Breakout	% Breakout
Gross Taxes Levied by SBHD		$ 9,073,000	0.0998	100.0%
Total Sources		**$ 9,073,000**	**0.0998**	**100.0%**
Uses of Funds				
Medicaid Match		$ 8,409,000	0.0925	92.7%
Community Redevelopment Agencies		$ 394,000	0.0043	4.3%
Hallandale Beach	200,000			
Hollywood Downtown	117,000			
Davie	77,000			
Uncollected Taxes		$ 43,000	0.0005	0.5%
Discounts on Taxes	43,000			
Uncollectible Taxes	-			
Broward County Revenue Collector's Fees		$ 181,000	0.0020	2.0%
Property Appraiser's Fee		$ 46,000	0.0005	0.5%
Memorial Primary Care		$ -	-	0.0%
Total Uses		**$ 9,073,000**	**0.0998**	**100.0%**

Proposed MHS FY2024-2025 Tax Budget Hearing Calendar

September

S	M	T	W	T	F	S
1	~~2~~	3	4	~~5~~	6	7
8	9	~~10~~	11	12	13	14
15	16	~~17~~	18	19	20	21
22	23	24	25	26	27	28
29	30					

Key Dates and Deadlines

11	**First/Tentative Tax Hearing (meetings must be held b/n Sept 3 to 18); alternate days 9/12, 9/13 and 9/16, in-person quorum**
25	**Final Tax Hearing & Board Meeting (must be held within 15 days of First Tax Hearing)**
27	Deadline for Property Appraiser to receive final resolutions of adopted millage (3 days after final tax hearing)
~~2~~	Rosh Hashanah 10/2 - 10/4
~~5~~	Yom Kippur 10/11 - 10/12
~~10~~	School Board Second Public Hearing
~~5, 17~~	Broward County Commission First & Second Public Hearing

Memorial Healthcare System

GRID OF OPTIONS FOR MOTIONS TO ADOPT A MILLAGE RATE

	A	B	C	D
MOTION #1				
PROPOSED MILLAGE RATE	**0.0937**	**0.0998**	**0.0869**	**0.6764**
% DIFFERENCE VS ROLLED-BACK	**7.83%**	**14.84%**	**0.00%**	**678.37%**
ROLLED-BACK MILLAGE RATE	**0.0869**	**0.0869**	**0.0869**	**0.0869**

NOTE:
ONLY DECREASES TO SELECTED RATE CAN BE ACHIEVED AT SUBSEQUENT HEARINGS.

MOTION #2

TAX HEARING DATES:

FIRST	Wednesday, September 11, 2024 at 5:30 PM
FINAL	Wednesday, September 25, 2024 at 5:30 PM

MEMORIAL HEALTHCARE SYSTEM
RISK MANAGEMENT PLAN

I. Board and Administrative Endorsement and Oversight

The Board of Commissioners of Memorial Healthcare System (MHS) is committed to promoting the safety of all patients, visitors, employees, medical staff, volunteers, and other individuals involved in organization operations. The Risk Management Plan is a System-wide planned, comprehensive and ongoing effort to achieve safety and excellence in structures, processes, and outcomes. The purpose of the Plan is fulfillment of the intent of the Mission, Vision, and Seven Pillars of Excellence. The objectives of the Risk Management Plan align with the Performance Improvement Program to a) implement well-planned and designed processes that sustain improvement over time, b) monitor for undesirable patterns or trends, c) sustain excellent performance, and d) enhance performance improvement, safety and customer satisfaction over time. The Board tasks, through the President and CEO, MHS's leadership and management teams with the responsibility for implementing performance improvement and risk management strategies.

The Board of Commissioners, administration, leadership staff, and medical staff work collaboratively to establish, maintain, and support the Risk Management Plan. Each seeks to establish effective mechanisms for assessing and responding to risk related findings.

The Corporate Director of Risk Management is appointed as the Risk Manager for MHS. The Risk Manager, under the direction of the Senior Vice President/General Counsel, is responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating and reporting actual or potential professional or general liability claims or lawsuits to the excess insurance carrier. The Risk Manager may delegate any of his/her duties to the Assistant Director of Risk Management, or to any of the Risk Managers/Designees at any of the MHS facilities.

Guiding Principles

The Risk Management Plan is an overarching, conceptual framework for developing a program for risk management and patient safety initiatives and activities.

The Risk Management Plan supports MHS's philosophy that patient safety and risk management is everyone's responsibility. Teamwork and participation are essential for an efficient and effective patient safety and risk management program.

MHS supports the establishment of a just culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. Through the Just Culture principles and algorithm, there is a shift of focus from errors and outcomes to system design and behavioral choices. In a just culture, unsafe conditions and hazards are readily and proactively identified, errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. This level of transparency in reporting and evaluation supports the overall Risk Management philosophy of the organization. Individuals are accountable for compliance with patient safety and risk management practices. (See Standard Practice entitled, Just Culture.)

The MHS Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks. The Plan provides the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management;
- Complaint resolution;
- Confidentiality and release of information;
- Event, investigation, root-cause analysis, and follow-up;
- Failure mode and effects analysis;
- Provider and staff education, competency validation, and credentialing requirements;
- Reporting and management of adverse events and near misses; and
- Trend analysis of events, near misses, and claims.

II. Plan Mission & Vision

A. Mission Statement

Impacting our community by Making Healthcare Safer.

B. Vision Statement

We will lead the organization in exceptional safety and quality for our patients, staff and community by integrating the principles of Enterprise Risk Management with a trusted comprehensive approach.

III. Goals & Objectives

A. Overarching Goals & Objectives: Consistent with MHS's Pillars of Excellence and with MHS's mission and vision, the goals & objectives of the Risk Management Plan are to:

- Continuously improve the timely, accurate, coordinated, and safe delivery of health care services, and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to potential harm through proactive risk management and activities consistent with the Culture of Safety;

- Facilitate prompt identification and response to patient safety and risk issues; Encourage an organizational culture of patient safety and transparency;

- Decrease the frequency and severity of any adverse events, and reduce financial losses associated with claims by proactively identifying, analyzing, preventing, and controlling actual and potential clinical, business, and operational risks, including risks to intangible resources (e.g., reputation);

- Comply with Chapter 395, Florida Statutes, and other applicable State, Federal, and regulatory requirements; and

- Provide oversight to safeguard and maintain the confidentiality of all documents that are part of risk management proceedings, reports, and records as defined by State and Federal law.

- Seek ways to incorporate consideration and acceptance/transfer/mitigation of risk into strategic planning.

- Continue to integrate Risk Management oversight into the MPG program.

- Support leaders to improve risk reduction, decrease waste, and streamline processes to increase safety and decrease harm.

- Partner with IT to identify opportunities for technological solutions to increase safety and efficacy

- Support leaders to facilitate transparency and the prompt disclosure of unanticipated outcomes.

- Facilitate communication between department leaders and frontline staff regarding incidents and safety-related changes

* Components of the organizational Culture of Patient Safety are articulated in the Standard Practice entitled, Patient Safety Plan.

IV. Mechanisms for Plan Coordination

The Risk Management Plan focuses on integrating the general corporate mission of achieving high quality and cost-effective operations and outcomes with initiatives aimed at patient safety, risk reduction, and risk prevention. Integration with the organization-wide performance improvement/clinical effectiveness program shall be accomplished through strategic planning and on-going risk-related activities of the Risk Management department and organizational leaders. Additionally, partnerships in risk control and patient safety are formed and maintained across departments, including without limitation:

- Patient & Family Centered Care representatives
- Nursing leaders and clinical department managers
- Medical department chairs and leaders
- Physician and allied health providers
- Multidisciplinary and nursing care providers
- Information Technology leaders
- Clinical educators
- Performance Improvement project leaders
- Clinical Effectiveness staff (including Case Management/Utilization Review)
- Credentialing coordinators/medical staff secretaries
- Infection control practitioners

- Housekeeping and dietary staff
- Clinical Engineering staff
- Compliance officers and corporate legal counsel
- Other staff providing direct or indirect patient services, including volunteers

The cross-functional and interdepartmental collaboration facilitates an enterprise-wide risk management approach which includes, without limitation, the following activities:

a) Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies, as well as the organization's chosen Patient Safety Organization.

b) Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events. Proactive risk assessment may include failure mode and effects analysis, system analysis, and other tools.

c) Providing feedback to providers and staff, and facilitating systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis may be used to identify causes and contributing factors in the occurrence of such events.

d) Identifying and assisting in the development of patient safety initiatives such as medication safety systems, falls prevention programs, initiatives to reduce clinical alarm fatigue, etc.

e) Facilitating educational programs to enhance patient safety and risk management.

f) Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution. Performing safety culture surveys and assessments on a regular basis.

g) Proactively communicating to the organization strategies to reduce unsafe situations and improve the overall safety of patients, visitors, staff, and volunteers.

h) Creating systems to reduce the probability of events that may result in losses to the physical plant and equipment (e.g., biomedical equipment maintenance, fire prevention).

i) Establishing measures to prevent and minimize the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization. Decreasing the likelihood of claims and lawsuits by enhancing communication with patients and families. This includes monitoring the disclosure of unanticipated outcomes with a plan to manage any adverse effects or complications.

j) Effectively managing claims, and investigating and assisting in claim resolution to minimize financial exposure

k) Reporting claims and Potentially Compensable Events (PCEs) to third parties and/or excess insurance carriers in accordance with the requirements of the insurance policy/contract.

l) Supporting quality assessment and improvement programs throughout the organization

m) Implementing programs that fulfill regulatory, legal, and accreditation requirements.

n) Reviewing information from committees providing oversight of quality and safety.

o) Monitoring the effectiveness and performance of risk management and patient safety actions. Data reviewed may include: incident, complaint, and claim trends, culture of safety surveys, risk assessment information, customer service surveys, clinical effectiveness data, insurance/finance evaluations, audits of processes aimed to improve the quality of care.

Risk Management/Safety, Medical Staff Department Quality, and Clinical Effectiveness Interfaces

Findings, conclusions, actions, and recommendations are relayed by linkage between the multiple departments and committee channels including those noted below.

A. Hospital-Based Committees

Existing in each Hospital (Memorial Regional Hospital/Memorial Regional Hospital South, Joe DiMaggio Children's Hospital, Memorial Hospital West, Memorial Hospital Pembroke, and Memorial Hospital Miramar) are the following forums for communication of pertinent findings:

1. **Performance Improvement/Risk Management (Pl/RM):** Risk Management information, quarterly improvement reports, patient care statistics, infection control statistics, and house-wide surveillance reports are presented to the Committee for review and recommendations. A Risk Management representative presents statistics to the Committee on a quarterly basis. Information flows to the Quality Care & Patient Safety Council. Memorial Manor has a counterpart to this Committee in the form of the Quality Assurance/Risk Management (QA/RM) meeting.

2. **Environment of Care:** The Safety Tours findings, a summary of actions taken resulting from manufacturer's alerts, and employee incidents related to safety or equipment issues are reviewed by the Committee. Risk Management is represented on this Committee. Information flows to the Pl/RM Committee.

3. **Quality Care & Patient Safety Council (QCPSC):** The QCPSC supports the ongoing direction, coordination, and evaluation of the performance improvement/clinical effectiveness, risk management and patient safety programs. The agenda includes physician and non-physician activities related to the reduction of morbidity and mortality and improvement of patient safety. The council Coordinates quality, risk, and patient safety programs in the facility, oversees departmental reporting on an aggregate basis, and reviews significant events and their corrective actions. The QCPSC cooperates with the Medical Staff Credentialing Committee in resolving multidisciplinary problems in patient care delivery, and also reports on activities to the Board of

Commissioners. The Risk Manager is a member and presents Root Cause actions to the Committee on a quarterly basis. Information flows to the Medical Executive Committee and to the Board of Commissioners. The QCPSC meeting at Memorial Regional Hospital includes information from Memorial Regional Hospital South.

4. **Clinical Leadership Meeting:** The Clinical Leadership Meeting meets generally monthly. The Risk Manager or designee uses this opportunity to address with the Directors of Nursing/Nurse Managers any Risk Management concerns that need to be shared at unit staff meetings.

5. **Huddles:** Risk Management staff located at each Hospital are able to easily disseminate information rapidly via daily huddles or staff meetings as needed.

*CNO Meeting at MRHS

B. System Based Committees:

1. **MHS Quality & Patient Safety Committee (MHS QPSC**): The MHS QPSC meets on a regular basis to address, coordinate and communicate quality and safety initiatives system-wide. Quality and/or Safety issues from any of the hospitals are brought to the Committee for review and standardization of actions on a district wide level. The Risk Manager is a member and presents applicable issues of concern requiring district review and corrective actions. Root cause analysis actions are also presented to the Committee for final review and dissemination throughout the District. Additionally, any safety related matters or noted trends of a patient safety nature are brought to the MHS Quality & Patient Safety Committee for review and recommendation. Additional functions performed by the MHS QPSC are a) assigning teams to projects that focus on meeting the assessed needs of patients, families, employees, the community and regulatory compliance; b) ensuring adequate resources for team activities; c) monitoring the team's progress; and d) redirecting the team's focus when corrective actions do not yield the desired results. The QPSC is co-chaired by the Chief Quality and Patient Safety Officer, MHS and the Chief Nursing Executive, MHS.

2. **Medical Affairs/Risk Management Committee:** The Medical Affairs/Risk Management Committee meets regularly to review physician related risk management information. Medical Staff actions taken in response to the Risk Management review process or to complaints that involve staff physicians are reviewed and evaluated for appropriate follow-up. Additional review or action is initiated as deemed appropriate by the Committee members. The Risk Manager/designee, Senior Vice President/Chief Medical Officer/MHS, Chief Medical; Officers from each Hospital, Chief Quality & Patient Safety Officer, and Administrative Director of Clinical Effectiveness are members.

3. **Summary Reports to the Board:** A summary report of Quality, Risk and Patient Safety Information is provided to the Board of Commissioners on a quarterly basis.

V. Communicating with Patients about Safety

A goal of the Risk Management Program is to foster effective and transparent patient and family communication, including patient involvement in treatment planning, informed consent and/or informed refusal, and disclosure of unanticipated outcomes.

It is the philosophy of MHS to maintain honesty and integrity in all organizational functions as per the procedures outlined in the Standard Practice entitled Disclosure of Unanticipated Outcomes.

VI. Staff Education: Safety Related Knowledge and Practice

Patient safety and risk management education is provided in established ongoing organization-wide formats, and is also conveyed in other venues, including, without limitation, staff meetings, huddles, and clinical leadership meetings.

VII. Risk Identification, Assessment, and Analysis

A. Data Sources

Data sources to identify organizational risks shall include, without limitation, the following:

- Incidents, adverse events, complications, and claims
- Patient grievances
- Patient satisfaction surveys
- Global Trigger Tool
- Incident investigation and root cause analysis
- External survey deficiencies
- Internal risk surveys and assessments
- Pharmacy Reports
- Infection control and environmental surveillance
- Departmental Huddles
- Educational clinical case conferences
- Risk and quality indicator monitoring and audits
- Quality screens, near miss events, FMEA, RCA
- Employee and physician surveys and informal feedback
- Outside sources such as TJC Sentinel Event Alerts

B. Incident Reporting

The Risk Management Program encourages risk identification through a systematic incident reporting process, along with other proactive and collaborative procedures. See Standard Practice entitled, Incident Report.

The Risk Management department staff conducts an initial review of all incidents, assigns a severity level, responds immediately as needed, and oversees the completion of follow-up action plans with managers and directors as appropriate. Incidents are also reviewed to assess for external reporting as per State, Federal, or other regulatory requirements. Incidents are trended, analyzed, and reported at least quarterly to appropriate committees in order to improve the safety and quality of care and reduce risk-related morbidity and mortality. Strategies for loss prevention and loss reduction are integrated into the organization's performance improvement processes in a manner consistent with the corporate vision, mission, and strategic objectives.

C. Critical Incident Management

A Critical Incident is an event that results in an undesirable and unexpected patient outcome, unrelated to the natural course of the patient's underlying condition that involves the actual or potential loss of life limb, or function. Risk Management supports staff and leaders involved in a potential critical incident 24/7. All Critical Incidents will be managed, documented, appropriately communicated and investigated promptly in a consistent and non-accusatory manner. See Standard Practice entitled, Critical Incident Management.

Improvement processes including, without limitation, Root Cause Analyses, will be applied to identify the underlying causes and the opportunities for improvements to the systems and processes that will reduce the probability recurrence.

D. Potentially Compensable Events (PCE)

Within the organization, and in conjunction with patient care providers and facility leaders, the Risk Management staff identifies unexpected or unanticipated risk exposures or events that have loss potential. Various data sources may be reviewed to identify PCEs (e.g., complaints, staff feedback, incident reports, and screen failures). In responding to a PCE, the risk manager/designee may gather information about the event, and obtain and sequester physical and documentary evidence related to the occurrence.

The Risk Manager, in coordination with involved key directors, managers, and medical staff reviews potentially compensable events, addresses them immediately as necessary, and refers them for further review to any applicable committee and professional liability carrier as appropriate.

Risk reduction strategies are additionally identified which may include referral to peer review, root cause analysis, or development of an action plan by the appropriate manager(s) or director(s).
Sentinel events shall be managed as per the Standard Practice entitled, Sentinel Event Policy.

VIII. Risk Control

Strategies in the phase of risk control (reactive and proactive) shall include, without limitation, the following:

A. Reactive Risk Control

- Critical event response, including complaints
- Incident investigation
- Debriefing and disclosure
- Internal claims management and litigation support

Claims Management

The Risk Management department maintains records of professional and general liability claims. Aggregate and claim-specific data is analyzed by the Corporate Director of Risk Management to identify trends and patterns, and to implement risk reduction strategies that can improve the quality of patient care and reduce morbidity and mortality. Information pertinent to risk trends and recurring high-risk processes and outcomes is communicated to appropriate managers, directors, performance improvement coordinators, administration, medical staff, and the Board of Directors.

Reserves

A reserve is a figure that represents an estimate as to the total indemnity and defense cost of an actual or potential claim. Reserves are established for accounting purposes, to ensure the stability of the Hospital's self-insurance medical malpractice and general liability insurance funds.

The present maximum reserve figure is $200,000.00 per claim, $300,000.00 per occurrence, in addition to defense reserves. [1] Exposures over statutory limitations are estimated, as well as the exposures of co-defendants. Reserves are estimated with the concurrent approval of the Senior Vice President/General Counsel, the Risk Manager, and the Risk Management Paralegal. Outside Defense Counsel provides supplemental reserve recommendations for cases that they are handling.

All reserve figures are reviewed semi-annually by the Reserve Review Committee, and adjusted to meet any change in circumstance.

B. Proactive Risk Control/Transfer

The Risk Management Plan incorporates a variety of means with which to proactively address risk concerns through risk transfer and risk mitigation, including, without limitation:

- Obtaining insurance coverage and risk financing
- Contract review
- Facilitating regulatory compliance
- Providing risk consultation to all organizational levels serving as liaison to federal and state agencies and regulatory bodies
- Crew Resource Management techniques
- Medication error reduction procedures
- Evidence-based clinical protocol development
- Adequate staffing levels and mix
- FMEA
- Other techniques as described in the Risk Management Plan

[1] For incidents occurring prior to October 1, 2011, the statutory cap for limits of liability are $100,000 per claim, $200,000 per occurrence. Therefore, for incidents occurring prior to that date, the maximum reserve figure will be $100,000 per claim, $200,000 per occurrence, in addition to defense reserves.

IX. Risk and Patient Safety Monitoring, Evaluation, and Reporting

The Risk Management Plan involves continuous monitoring and evaluation of risk issues and outcomes. Toward this end, measurable indicators are strategically defined, efficient and reliable data collection is accomplished, basic statistical principles in data analysis and reporting are utilized, and involvement of appropriate providers is encouraged in monitoring occurrences, recognizing hazardous situations, and striving for improvements.

MHS supports the following activities in the phase of risk monitoring and evaluation which include, without limitation, the following:

- Aggregate occurrence analysis and claims analysis and trending
- Patient satisfaction surveys and trending of complaint type and severity
- Practitioner performance trending
- Compliance audits of redesigned safety procedures and clinical practice protocols
- Regulatory compliance monitoring regarding patient safety
- Summary patient safety reports to the governing body, department leaders, and providers
- Required reporting to external agencies

The Risk Management Plan may be amended at any time with the written concurrence of the President/CEO, Senior Vice President/General Counsel, and Corporate Director of Risk Management.

X Confidentiality Statement

All records, data, and information collected and then maintained by the Risk Management department are confidential to the fullest extent of applicable law. Memorial Healthcare System has partnered with ECRI Patient Safety Organization (PSO) as of May 1, 2014. Any documents earmarked "Patient Safety Work Product" are intended for submission to the PSO and as such are privileged and protected from disclosure to the fullest extent of applicable law. No one shall have access to or the right to release documents collected or prepared by the risk management staff without authorization from the General Counsel.

Signatures of Acceptance and Approval

Chair, Board of Commissioners	Date
President/CEO	Date
Senior VP/General Counsel	Date
Corporate Director of Risk Management	Date

Group:	S.B.H.D. Finance Committee	**Date:**	July 15, 2024
Chairwoman:	Ms. Elizabeth Justen	**Time:**	1:00 p.m.
Vice Chairman:	Mr. Steven Harvey		
Location:	Executive Conference Room, 3111 Stirling Road, Hollywood, Florida, 33312		

In Attendance: Ms. Elizabeth Justen, Mr. Steven Harvey, Mr. Brad Friedman, Mr. Scott Wester, Mr. David Smith, Ms. Leah Carpenter, Ms. Margie Vargas, Mr. Frank Rainer, Mr. Irfan Mirza (via WebEx), Mr. Veda Rampat (via WebEx), Mr. Saul Kredi, Mr. Richard Holcomb, Mr. Richard Probert, Mr. Gary Wyniemko (NEPC), Mr. David Moore (NEPC), Ms. Deirdre Robert (NEPC) (via WebEx), and Mr. Jacob Pollack (NEPC)

SUBJECT: **Call to Order / Public Meeting Notice Certification**

Ms. Justen called the meeting to order at 1:07 p.m., after which Mr. Rainer certified the meeting was properly noticed.

No action is required by the Board of Commissioners.

SUBJECT: **Market Update**

Mr. Wyniemko provided an overview of the market update for June 2024 to the Finance Committee. Stocks showed a second consecutive monthly increase, bolstered by robust economic reports released in June, indicating sustained healthy growth trends. Lower long-term interest rates contributed to higher returns on both investment-grade and high-yield bonds. Inflation also displayed improvement in June, with a slower growth rate observed across major inflation indicators.

The market update was presented for informational purposes only.

No action is required by the Board of Commissioners.

SUBJECT: **Operating Funds Monthly Flash Report**

Mr. Wyniemko reviewed the Monthly Flash Performance Report for the Operating Funds for the month ended June 30, 2024. The portfolio returned 0.9% for the month and 2.2% for the fiscal year-to-date, compared to Policy benchmark returns of 0.8% and 2.1%, respectively. The assets in the operating funds were reported at $2.63 billion.

The monthly flash report was presented for informational purposes only.

No action is required by the Board of Commissioners.

SUBJECT: **Retirement Plan Monthly Flash Report**

Mr. Wyniemko reviewed the Monthly Flash Performance Report for the Retirement Plan for the month ended June 30, 2024. The plan returned 1.0% for the month and 3.9% fiscal year-to-date, versus Policy benchmark returns of 1.7% and 4.6%, respectively. Total assets in the Retirement Plan were reported at $1.03 billion.

The monthly flash report was presented for informational purposes only.

No action is required by the Board of Commissioners.

SUBJECT: **Defined Contribution Plans Monthly Flash Report**

Ms. Robert reviewed the Monthly Flash Performance Report for Defined Contribution Plans. As of June 30, 2024, plan assets totaled $1.62 billion, with the largest concentration in JPMorgan blend target date funds at 62.3%.

The monthly flash report was presented for informational purposes only.

No action is required by the Board of Commissioners.

SUBJECT: **Investment Workplan Detail**

Mr. Wyniemko discussed a detailed investment workplan with the committee, outlining a tentative path to a modified portfolio. The work plan is structured in four phases to provide a clear roadmap for potential allocation changes, ensure committee education and support for each step, and remain flexible to adjustments as progress is made. Phase 1, which includes Enterprise Risk Management and adjustments to Fixed Income Guidelines further is expanded on below.

No action is required by the Board of Commissioners.

SUBJECT: **Enterprise Risk Management (ERM) Review**

The NEPC team (Mr. Moore, Mr. Pollack and Mr. Wyniemko) provided the committee with an overview and online demonstration of NEPC's SKYAN ERM application. SKYAN is an analytical tool being used for investment risk scenario analysis across the Operating portfolio, utilizing various asset allocation mixes to illustrate impacts on key metrics such as Days Cash on Hand and Assets Under Management, based on the South Broward Hospital District's long-term financial projections. Mr. Wyniemko then reviewed the details of two Asset Allocation mixes used in the ERM studies. Going forward, the ERM tool will be utilized to measure the investment risk associated with any proposed changes to asset allocation mixes.

No action is required by the Board of Commissioners.

SUBJECT: **Fixed Income Manager Guideline Adjustments**

Mr. Wyniemko proposed adjustments to the Operating portfolio's fixed income guidelines to remove constraints hindering investment managers under the current Investment Manager Agreements (IMA) and Investment Policy Statement (IPS). The following guideline changes were discussed for consistency across all IMAs:

1. Remove the restriction requiring the average duration of the total fixed income portfolio, not to exceed four years, to equal the Bloomberg Aggregate Index.
2. Increase the maximum allocation in BBB rated securities from 15% to 20%.
3. Increase the maximum combined Corporate/Securitized bond restriction from 50% to 65%.

4. Allow holdings in Yankee Bonds.
5. Eliminate the restriction to trade only with Primary Security Dealers.
6. Eliminate the guideline requiring corporate bonds to have a listed equity security on a national exchange.
7. Increase the maximum final maturity from 10 years to 10 years and one quarter.
8. Lower the minimum rating on securitized bonds from AAA to AA.
9. Increase the restriction on 144A securities from 10% to 20%.

It was agreed that the next step in this process would be to discuss these Fixed Income Guidelines with all the members of the Board of Commissioners present.

No action is required by the Board of Commissioners.

SUBJECT: **Financial Report**

Mr. Mirza presented an overview of the Financial Results for the month and year ending June 30, 2024. The committee engaged in discussion regarding these operating results. The June financial reports will be formally presented to the full Board during its regular July Board meeting (Annual Board Meeting) on July 24, 2024.

No action is required by the Board of Commissioners.

SUBJECT: **Millage Rate Options for TRIM Notice**

Mr. Smith provided an overview and analysis of the proposed tax millage rate for fiscal year 2025. This will be presented to the full Board at its Annual Board Meeting in July, to adopt a proposed millage rate and to set a date for a subsequent preliminary first public meeting. The committee discussed the options, noting that while the millage rate proposed at the July Annual Board Meeting can be reduced at the Preliminary Tax Hearing, it cannot be increased. The proposed tax millage options will be shared with the other Commissioners ahead of the July Annual Board Meeting.

No action is required by the Board of Commissioners.

SUBJECT: **New Business**

None.

SUBJECT: **Adjournment**

There being no further business, the Finance Committee adjourned at 2:30 p.m.

Respectfully submitted,

Elizabeth Justen

Elizabeth Justen
Chairwoman
Finance Committee

Memorial Healthcare System

JULY 2024 UPDATE

MEMORIAL HEALTHCARE SYSTEM

JULY 2024

Dave Moore, ARM, CEBS, CPCU, Partner
Gary Wyniemko, CFA, Partner
Deirdre Robert, CFA, CAIA, Partner

NEPC

TABLE OF CONTENTS

Q2 MARKET UPDATE

JUNE 30, 2024

CALENDAR YEAR INDEX PERFORMANCE

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Jun	QTD	YTD
S&P 500	13.7%	1.4%	12.0%	21.8%	-4.4%	31.5%	18.4%	28.7%	-18.1%	26.3%	3.6%	4.3%	15.3%
Russell 1000	13.2%	0.9%	12.1%	21.7%	-4.8%	31.4%	21.0%	26.5%	-19.1%	26.5%	3.3%	3.6%	14.2%
Russell 2000	4.9%	-4.4%	21.3%	14.6%	-11.0%	25.5%	20.0%	14.8%	-20.4%	16.9%	-0.9%	-3.3%	1.7%
Russell 2500	7.1%	-2.9%	17.6%	16.8%	-10.0%	27.8%	20.0%	18.2%	-18.4%	17.4%	-1.5%	-4.3%	2.3%
MSCI EAFE	-4.9%	-0.8%	1.0%	25.0%	-13.8%	22.0%	7.8%	11.3%	-14.5%	18.2%	-1.6%	-0.4%	5.3%
MSCI EM	-2.2%	-14.9%	11.2%	37.3%	-14.6%	18.4%	18.3%	-2.5%	-20.1%	9.8%	3.9%	5.0%	7.5%
MSCI ACWI	4.2%	-2.4%	7.9%	24.0%	-9.4%	26.6%	16.3%	18.5%	-18.4%	22.2%	2.2%	2.9%	11.3%
Private Equity	12.6%	9.9%	9.0%	21.0%	11.1%	17.6%	32.9%	39.4%	-9.1%	5.7%	-	-	-
BBG TIPS	3.6%	-1.4%	4.7%	3.0%	-1.3%	8.4%	11.0%	6.0%	-11.8%	3.9%	0.8%	0.8%	0.7%
BBG Municipal	9.1%	3.3%	0.2%	5.4%	1.3%	7.5%	5.2%	1.5%	-8.5%	6.4%	1.5%	0.0%	-0.4%
BBG Muni High Yield	13.8%	1.8%	3.0%	9.7%	4.8%	10.7%	4.9%	7.8%	-13.1%	9.2%	2.4%	2.6%	4.1%
BBG US Corporate HY	2.5%	-4.5%	17.1%	7.5%	-2.1%	14.3%	7.1%	5.3%	-11.2%	13.4%	0.9%	1.1%	2.6%
BBG US Agg Bond	6.0%	0.5%	2.6%	3.5%	0.0%	8.7%	7.5%	-1.5%	-13.0%	5.5%	0.9%	0.1%	-0.7%
BBG Global Agg	0.6%	-3.2%	2.1%	7.4%	-1.2%	6.8%	9.2%	-4.7%	-16.2%	5.7%	0.1%	-1.1%	-3.2%
BBG Long Treasuries	25.1%	-1.2%	1.3%	8.5%	-1.8%	14.8%	17.7%	-4.6%	-29.3%	3.1%	1.7%	-1.8%	-5.0%
BBG US Long Credit	16.4%	-4.6%	10.2%	12.2%	-6.8%	23.4%	13.3%	-1.2%	-25.3%	10.7%	0.6%	-1.7%	-3.3%
BBG US STRIPS 20+ Yr	46.4%	-3.7%	1.4%	13.7%	-4.1%	20.9%	24.0%	-5.2%	-39.6%	1.1%	2.3%	-3.9%	-9.6%
JPM GBI-EM Global Div	-5.7%	-14.9%	9.9%	15.2%	-6.2%	13.5%	2.7%	-8.7%	-11.7%	12.7%	-1.1%	-1.6%	-3.7%
JPM EMBI Glob Div	7.4%	1.2%	10.2%	10.3%	-4.3%	15.0%	5.3%	-1.8%	-17.8%	11.1%	0.6%	0.3%	2.3%
CS Hedge Fund	4.1%	-0.7%	1.2%	7.1%	-3.2%	9.3%	6.4%	8.2%	1.1%	5.8%	-	0.9%	6.2%
BBG Commodity	-17.0%	-24.7%	11.8%	1.7%	-11.2%	7.7%	-3.1%	27.1%	16.1%	-7.9%	-1.5%	2.9%	5.1%
Alerian Midstream	16.4%	-37.3%	33.8%	-2.4%	-13.3%	24.0%	-23.4%	38.4%	21.5%	14.0%	2.9%	5.4%	16.1%
FTSE NAREIT Equity REITs	30.1%	3.2%	8.5%	5.2%	-4.6%	26.0%	-8.0%	43.2%	-24.4%	13.7%	2.9%	0.1%	-0.1%

*Private Equity return represents calendar year pooled IRR and is subject to a one quarter lag
Source: FactSet, Barclays, Thomson One

TRAILING ANNUAL INDEX PERFORMANCE

Equity							
	Jun-24	QTD	YTD	1 YR	3 YR	5 YR	10 YR
MSCI ACWI	2.2%	2.9%	11.3%	20.9%	5.3%	10.8%	8.5%
S&P 500	3.6%	4.3%	15.3%	26.7%	10.1%	15.0%	12.9%
Russell 1000	3.3%	3.6%	14.2%	25.9%	8.8%	14.6%	12.5%
Russell 2000	-0.9%	-3.3%	1.7%	11.9%	-2.7%	6.9%	7.0%
Russell 2500	-1.5%	-4.3%	2.3%	12.4%	-0.4%	8.3%	8.0%
MSCI EAFE	-1.6%	-0.4%	5.3%	12.5%	2.5%	6.5%	4.4%
MSCI EM	3.9%	5.0%	7.5%	12.4%	-5.2%	3.1%	2.8%

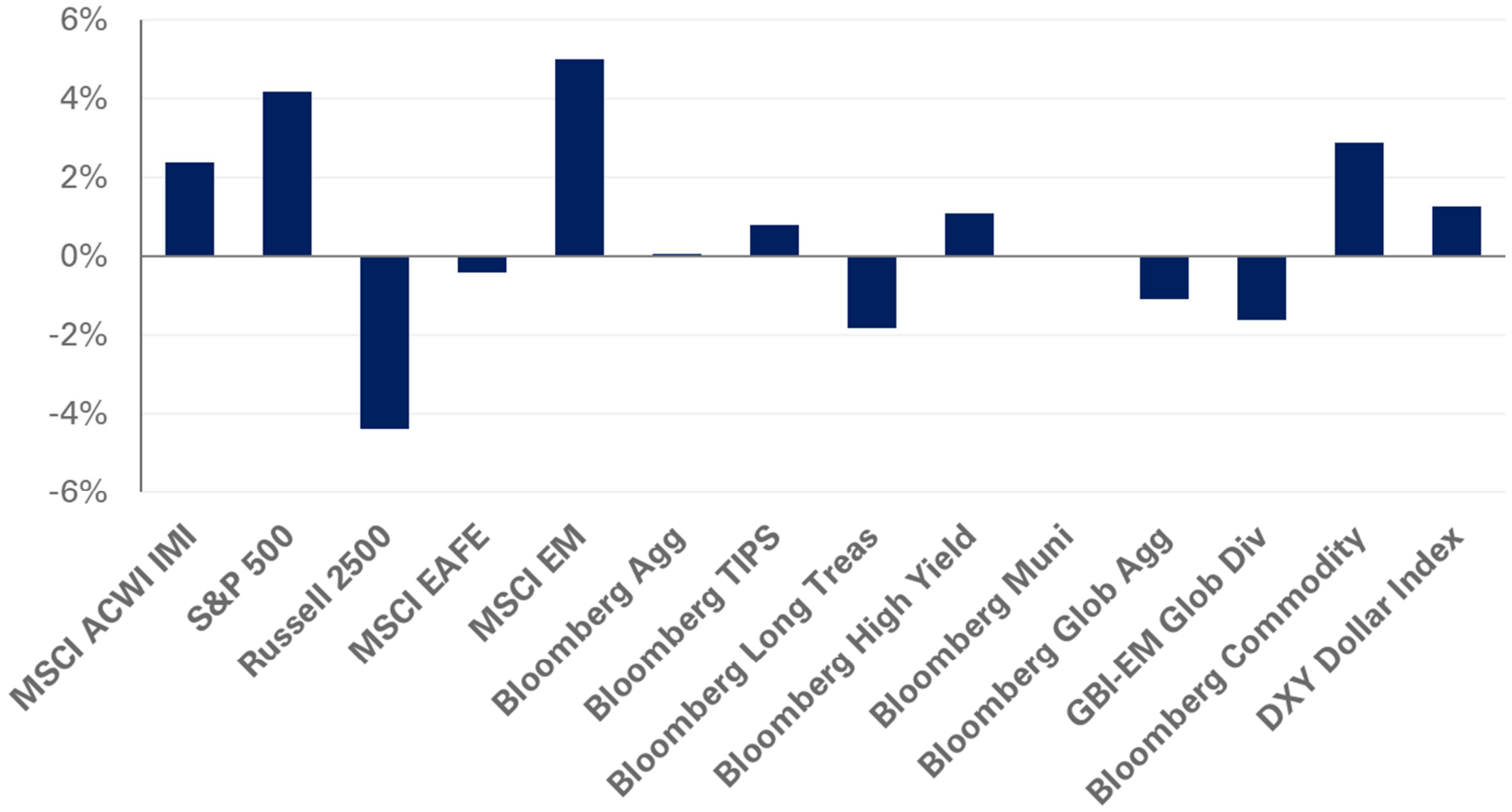
Credit							
	Jun-24	QTD	YTD	1 YR	3 YR	5 YR	10 YR
BBG Global Agg	0.1%	-1.1%	-3.2%	0.6%	-5.5%	-2.0%	-0.4%
BBG US Agg	0.9%	0.1%	-0.7%	2.1%	-3.0%	-0.2%	1.4%
BBG Credit	0.7%	0.0%	-0.5%	4.2%	-2.9%	0.5%	2.2%
BBG US HY	0.9%	1.1%	2.6%	10.7%	1.7%	3.9%	4.3%
BBG Muni	1.5%	0.0%	-0.4%	3.1%	-0.9%	1.2%	2.4%
BBG Muni HY	2.4%	2.6%	4.1%	8.7%	0.2%	3.0%	4.6%
BBG TIPS	0.8%	0.8%	0.7%	2.4%	-1.3%	2.1%	1.9%
BBG 20+ STRIPS	2.3%	-3.9%	-9.6%	-13.6%	-16.1%	-7.3%	0.1%
BBG Long Treasuries	1.7%	-1.8%	-5.0%	-6.3%	-10.3%	-4.3%	0.6%
BBG Long Credit	0.6%	-1.7%	-3.3%	1.9%	-6.6%	-0.9%	2.4%
BBG Govt/Credit 1-3 Yr	0.6%	1.0%	1.4%	4.7%	0.6%	1.2%	1.4%
JPM EMBI Glob Div	0.6%	0.3%	2.3%	9.2%	-2.6%	0.0%	2.6%
JPM GBI-EM Glob Div	-1.1%	-1.6%	-3.7%	0.9%	-3.4%	-1.3%	-0.9%

Real Assets							
	Jun-24	QTD	YTD	1 YR	3 YR	5 YR	10 YR
BBG Commodity	-1.5%	2.9%	5.1%	6.2%	6.2%	7.2%	-1.4%
Alerian Midstream Index	2.9%	5.4%	16.1%	28.5%	17.0%	11.3%	3.8%
NAREIT Composite Index	2.2%	-0.9%	-2.2%	7.5%	-2.1%	3.1%	5.9%

Source: S&P, MSCI, Russell, Bloomberg, JPM, Alerian, FTSE, FactSet

U.S. AND EMERGING EQUITIES OUTPERFORMED

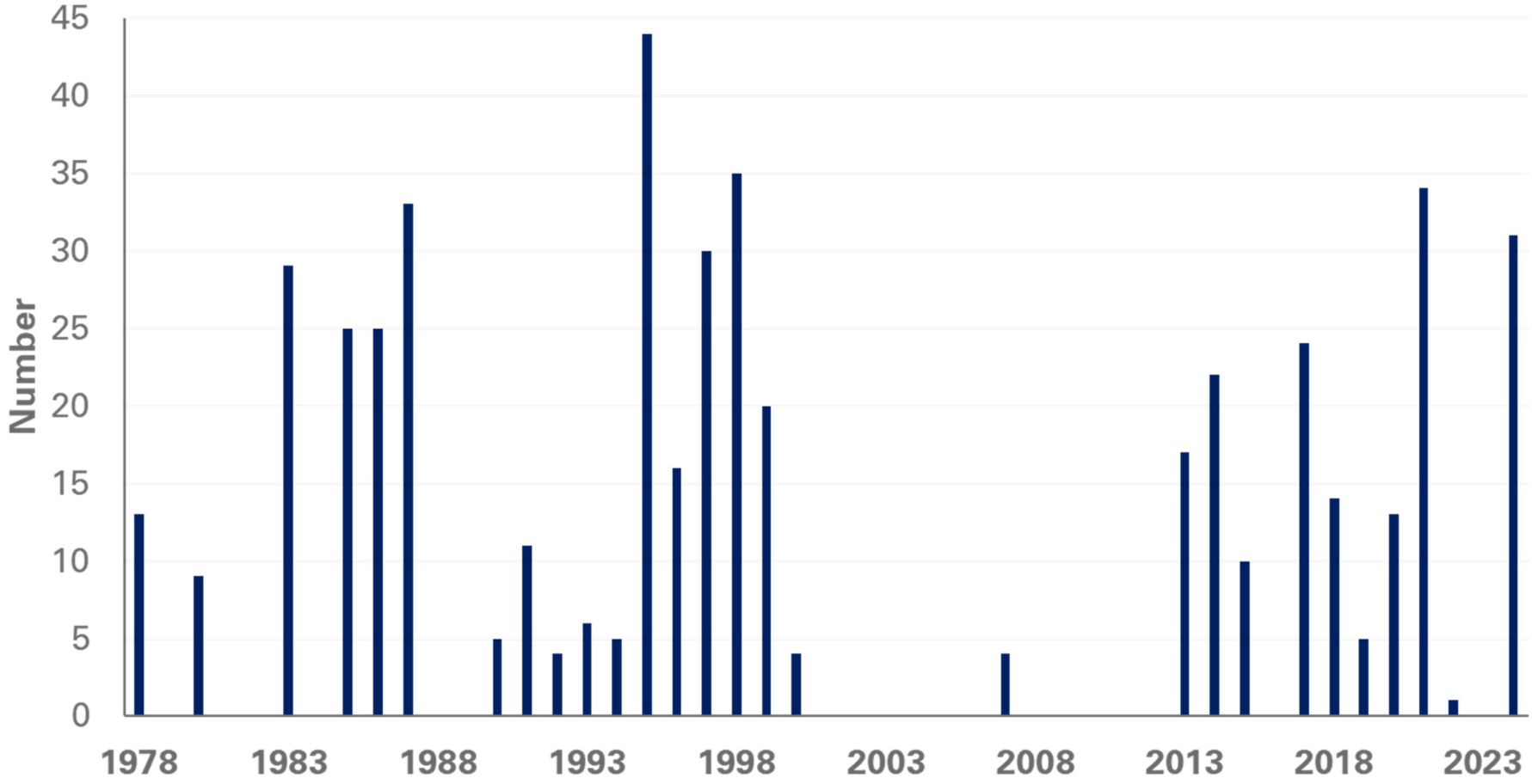
QUARTERLY TOTAL RETURNS



Sources: MSCI, S&P, Russell, Bloomberg, JP Morgan, FactSet

THE S&P 500 HIT NEW ALL-TIME HIGHS

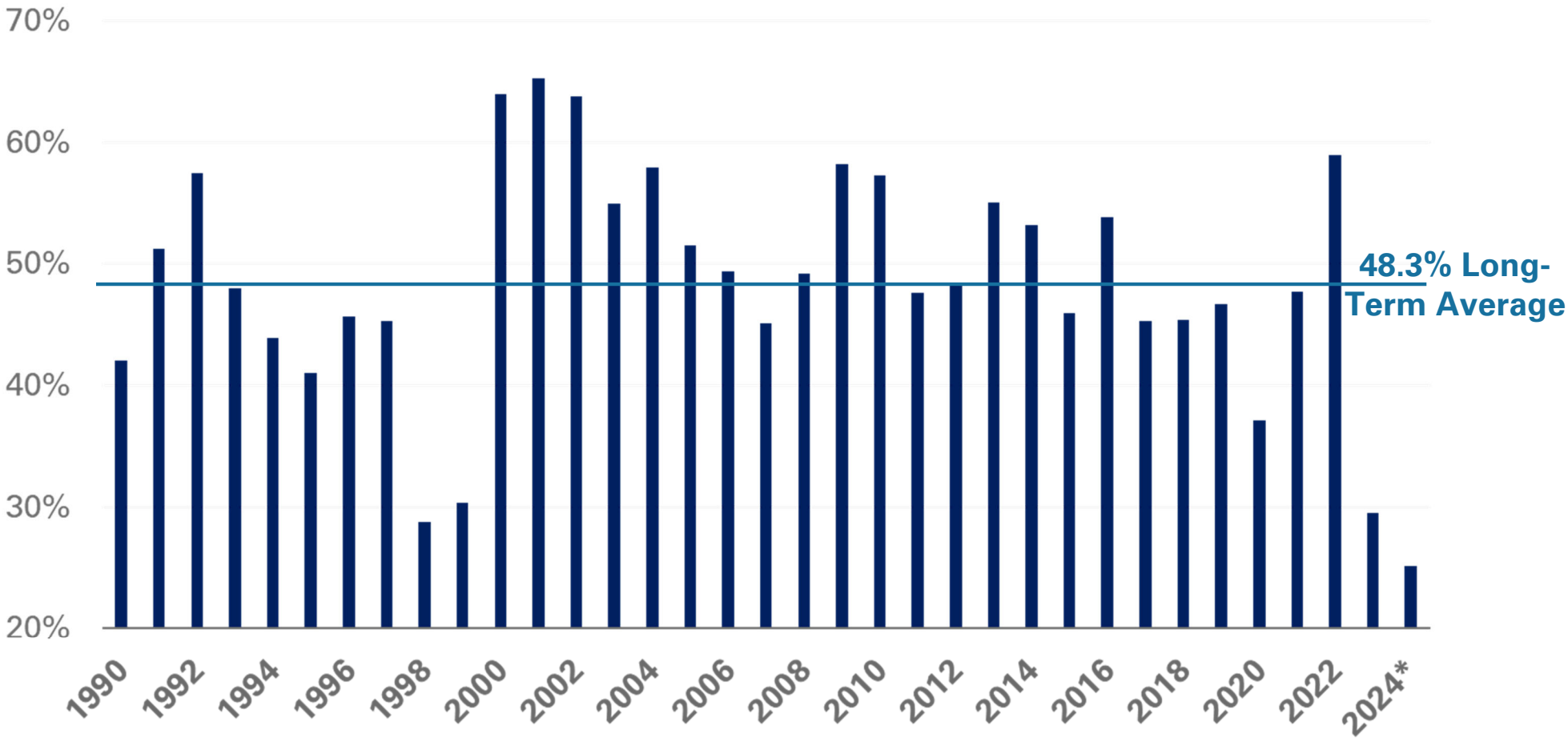
NUMBER OF RECORD HIGHS HIT IN FIRST 6 MONTHS OF YEAR



Sources: S&P, FactSet

EQUITY MARKET BREADTH REMAINS LIMITED

S&P 500 INDEX: % OF STOCKS OUTPERFORMING THE INDEX



Note: *2024 reflects year-to-date returns through 06/30/2024. Data reflects price returns
Sources: S&P, FactSet

THE MARKET IS HIGHLY SENSITIVE TO ONE NAME

Nvidia has gained 154% in 2024

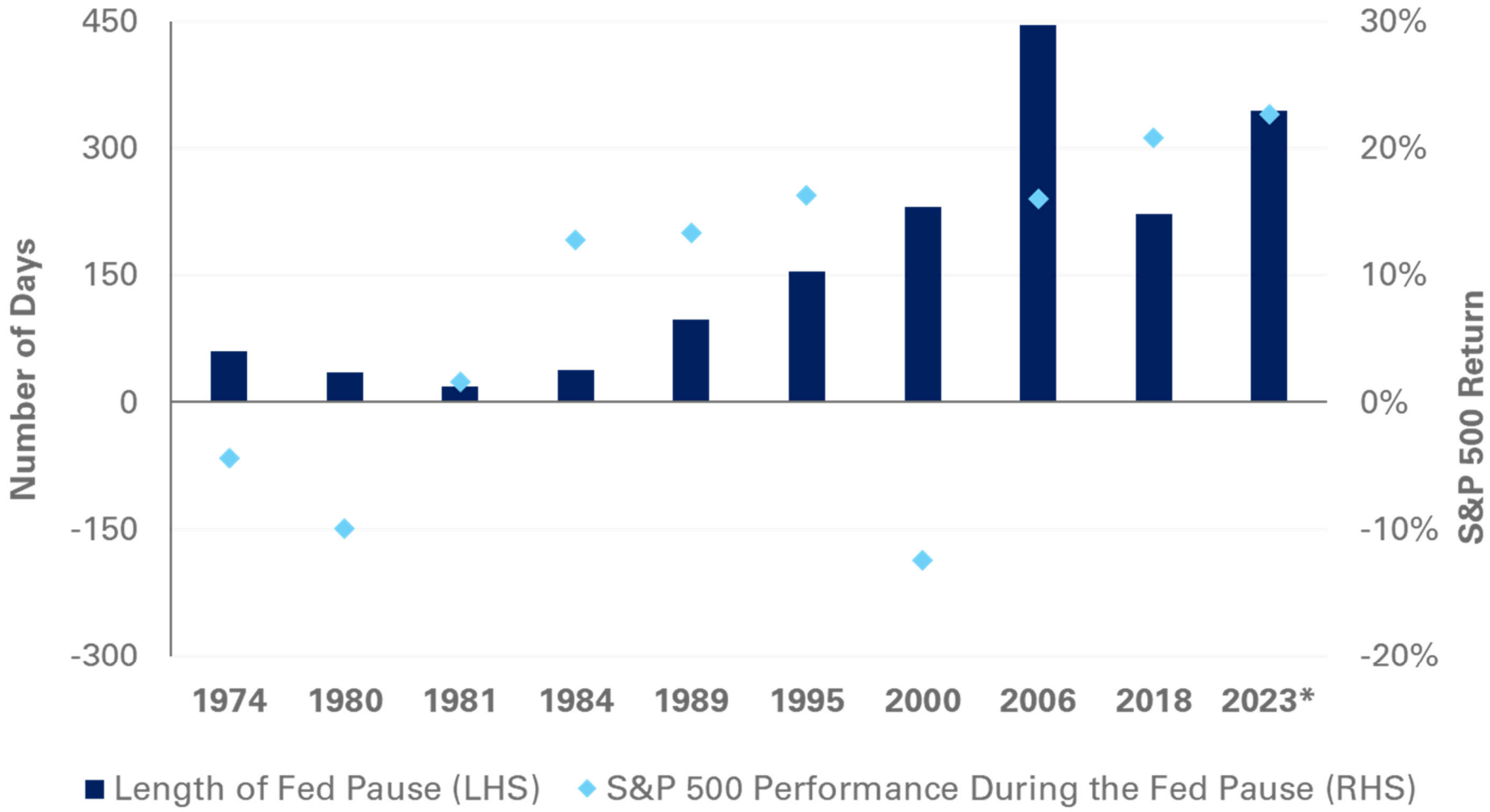
The company hit a $3T market capitalization in June

Nvidia is now larger than the GDP of every country in the world except for six*

Note: *The six countries are the U.S., China, Japan, Germany, India, and the U.K.
Sources: IMF, FactSet

FED PAUSES TEND TO BE FAVORABLE FOR STOCKS

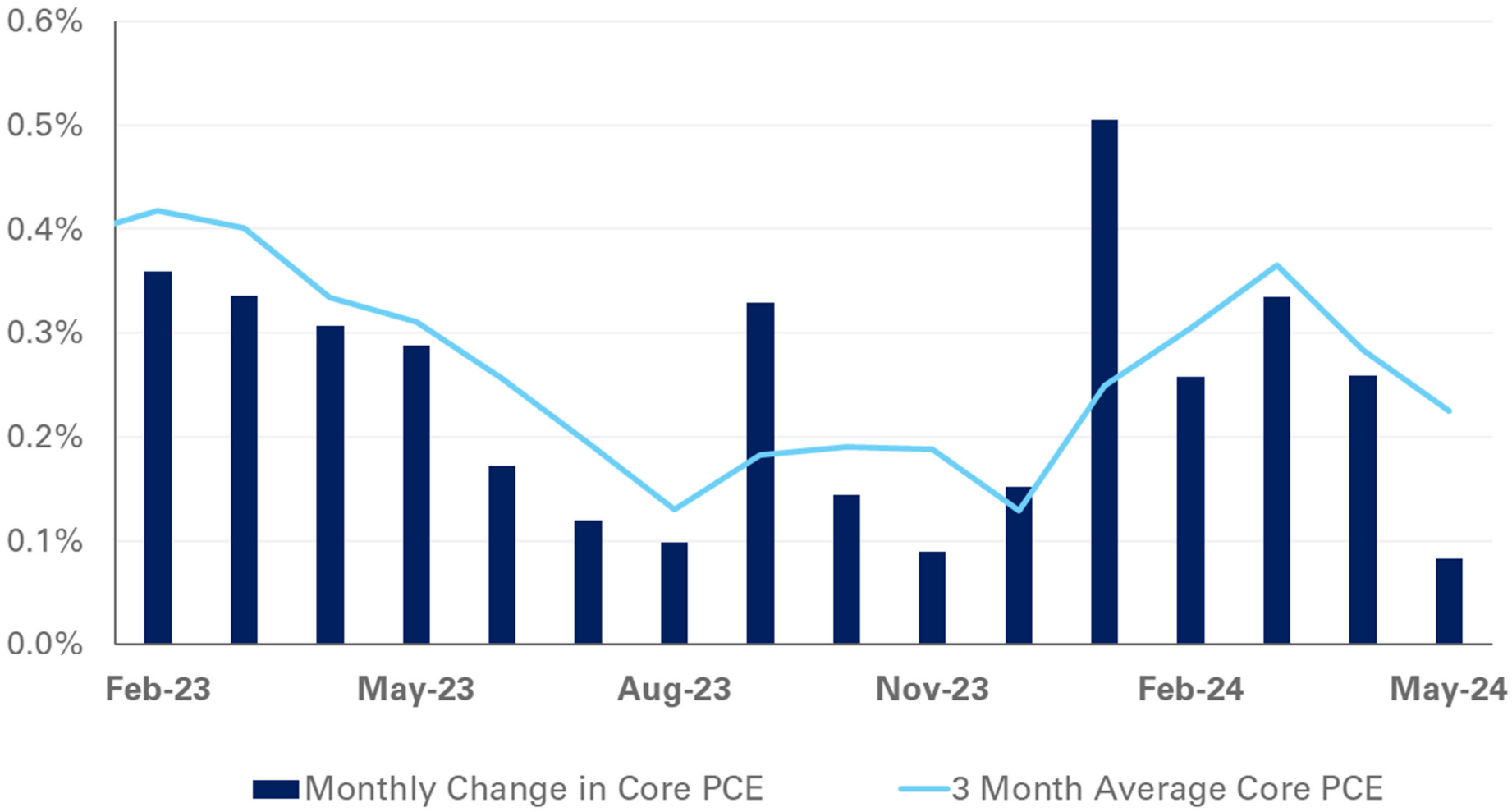
THE S&P 500 DURING FED PAUSES



Note: *2023 reflects data through 06/30/2024. Fed "pauses" reflect the length of time between the last Fed hike and the first Fed rate cut
Sources: Federal Reserve, S&P, FactSet

INFLATION PRESSURES BROADLY SOFTENED

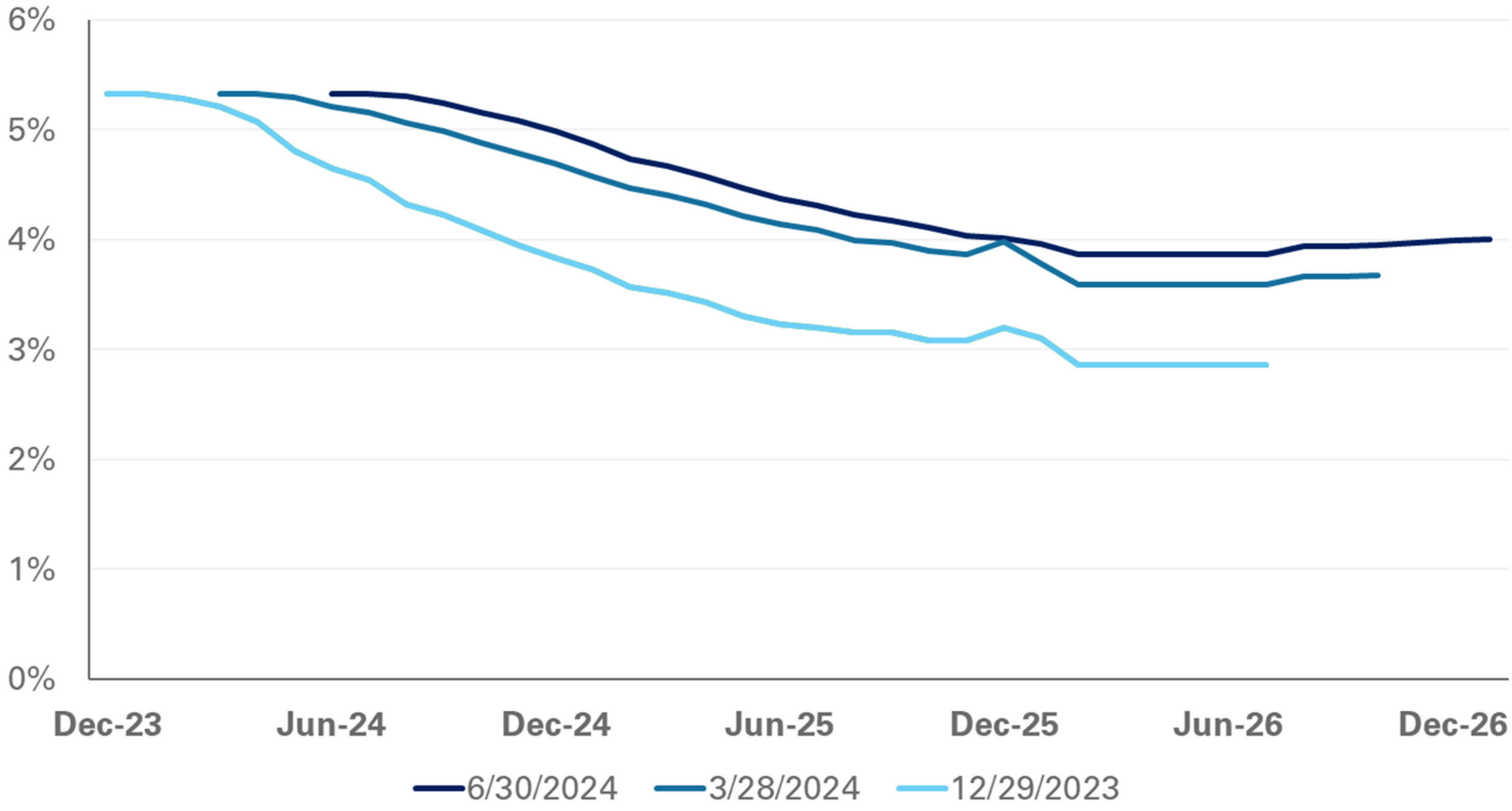
U.S. CORE PCE PRICE INDEX



Sources: Bureau of Economic Analysis, FactSet

RATE CUT EXPECTATIONS HAVE BEEN PUSHED OUT

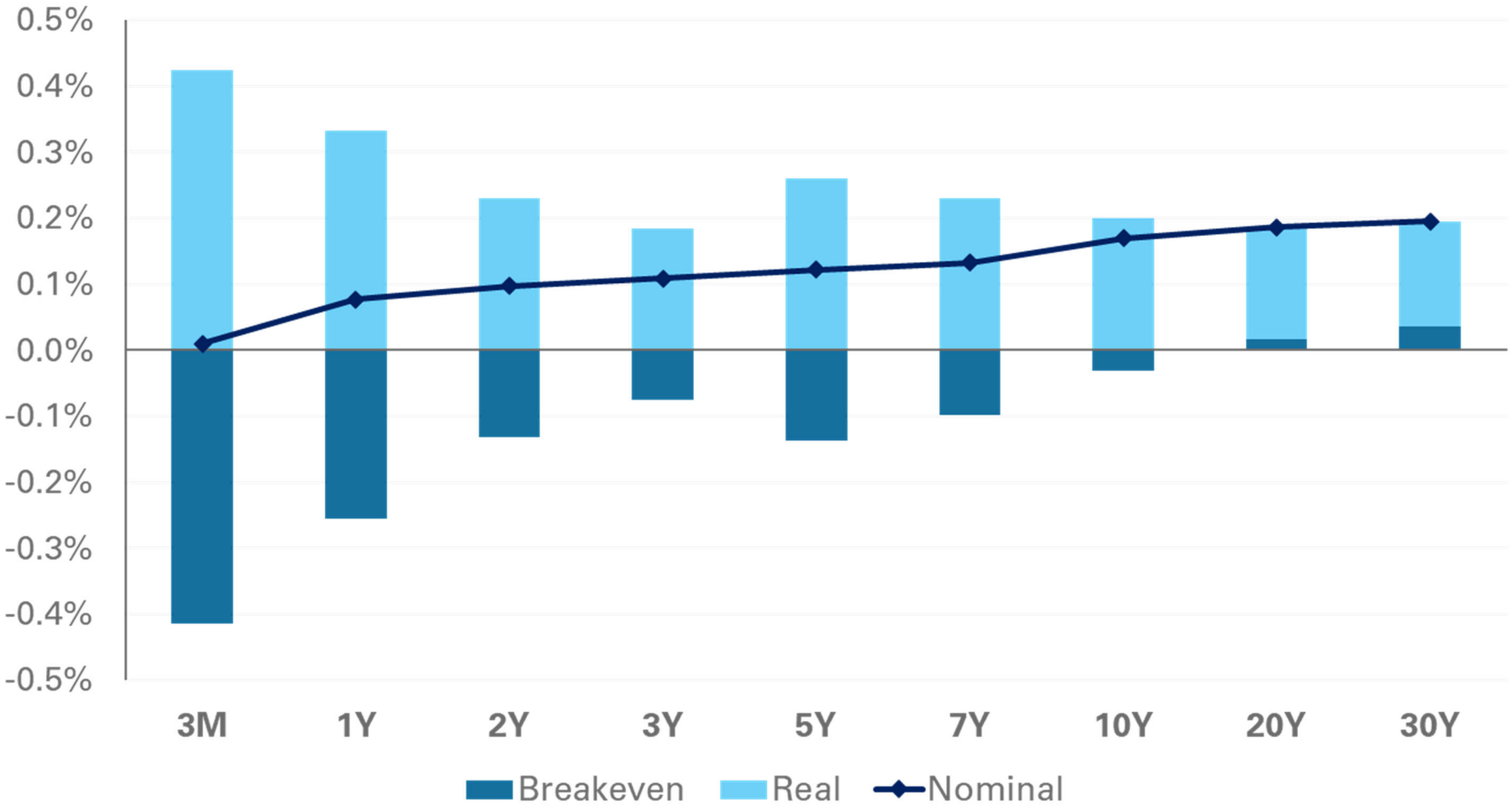
FED FUNDS FUTURES EXPECTATIONS



Source: FactSet

REAL YIELDS DROVE THE CURVE HIGHER

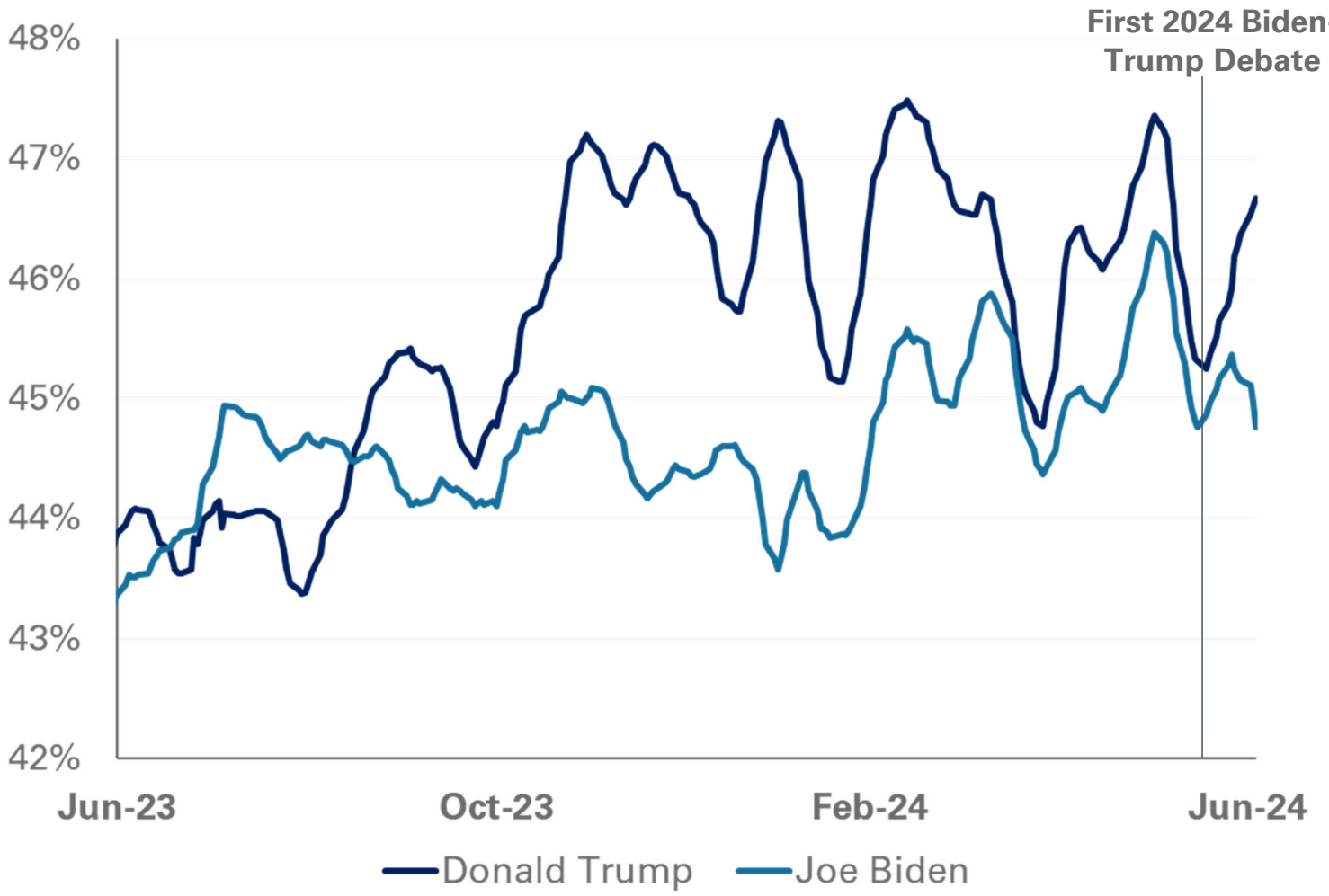
QUARTERLY CHANGE IN THE U.S. YIELD CURVE



Source: FactSet

U.S. ELECTION SEASON KICKED OFF EARLY

2024 U.S. PRESIDENTIAL ELECTION POLLS



U.S. Election Key Dates:

July 15-18
Republican National Convention

August 19-22
Democratic National Convention

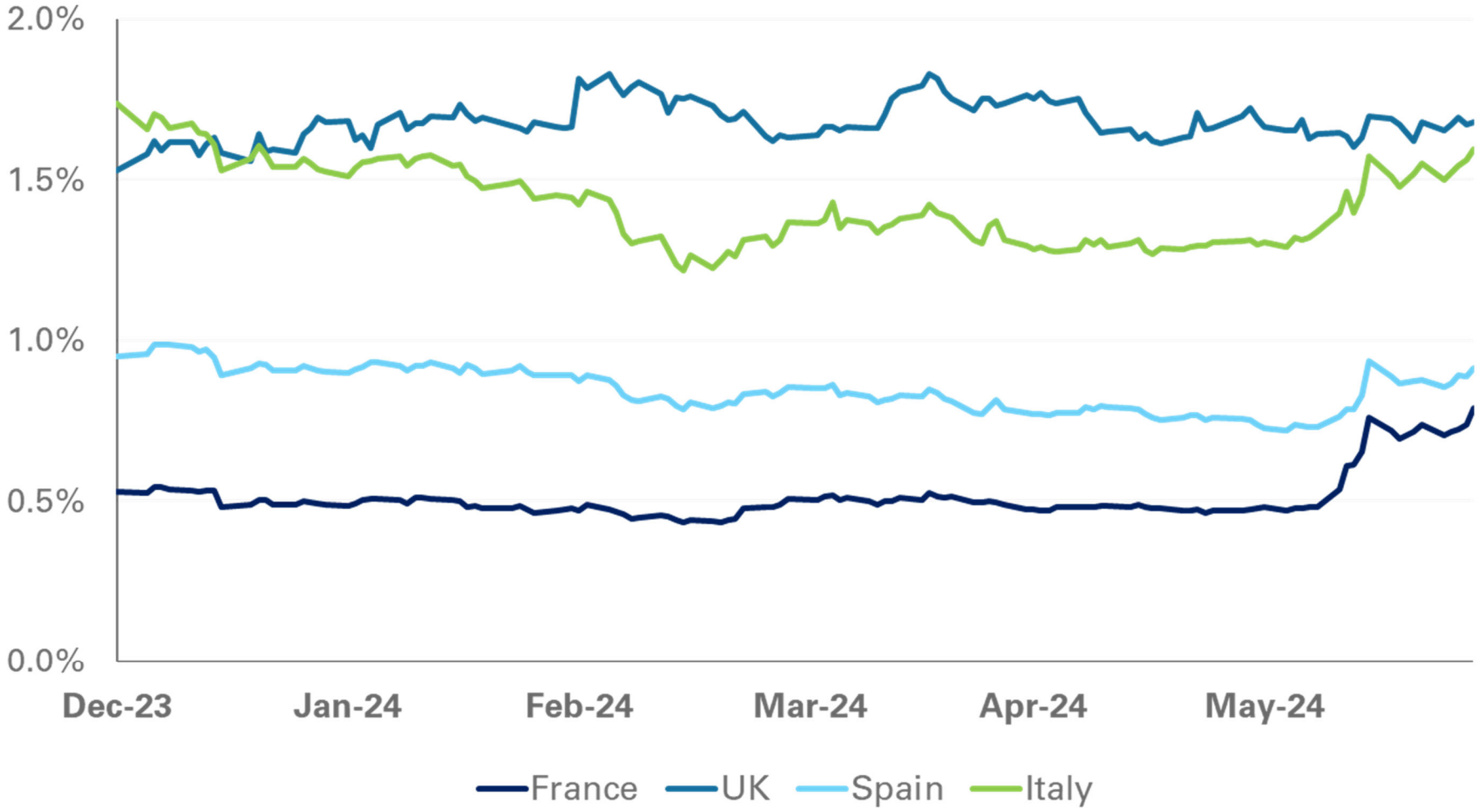
September 10
Second confirmed presidential debate

November 5
Election Day

Note: Reflects 7-day moving average
Sources: RealClearPolitics, FactSet

POLITICAL RISKS WEIGHED ON EUROPEAN ASSETS

SOVEREIGN YIELD SPREAD OVER 10-YEAR GERMAN BUND



Source: FactSet

PERFORMANCE UPDATE

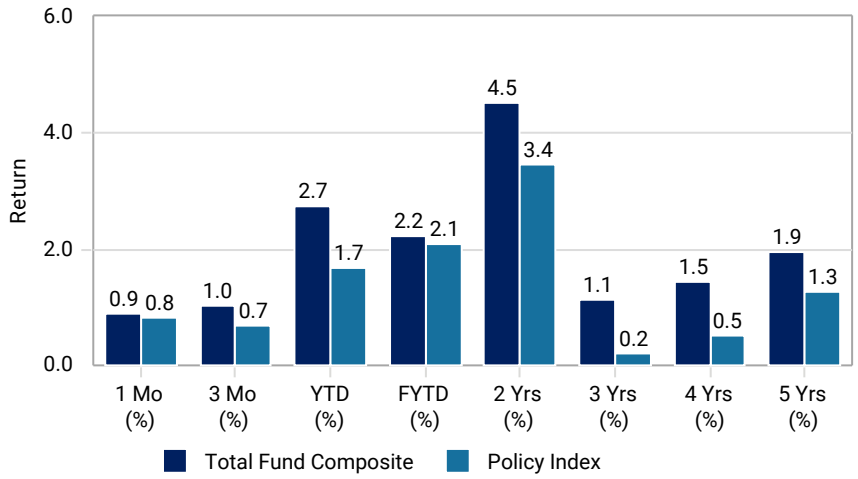
June 30, 2024

SOUTH BROWARD HOSPITAL DISTRICT – OPERATING FUNDS

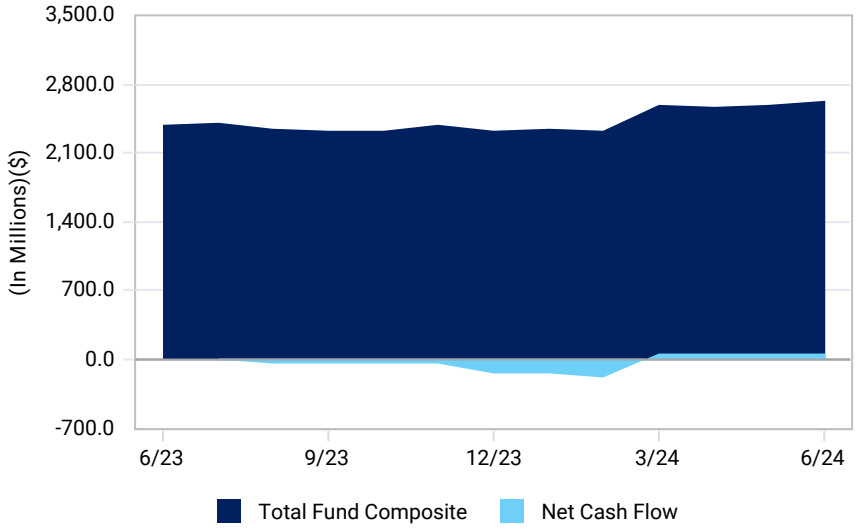
June 30, 2024

EXECUTIVE SUMMARY

Return Summary
Ending June 30, 2024

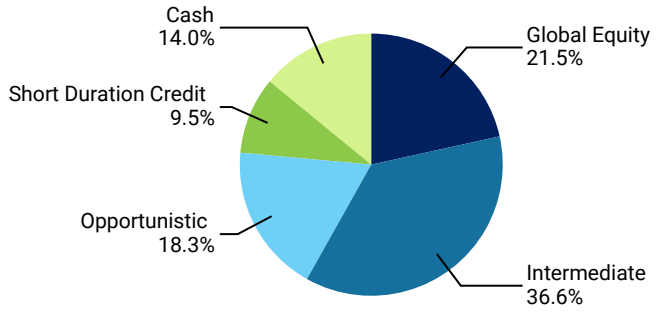


Market Value History
1 Year Ending June 30, 2024



	Current ($)	Current (%)	Policy (%)	Differences (%)
Global Equity	566,045,040	21.5	20.0	1.5
Intermediate	961,976,697	36.6	35.0	1.6
Opportunistic	481,524,653	18.3	20.0	-1.7
Short Duration Credit	249,629,522	9.5	10.0	-0.5
Cash	369,277,946	14.0	15.0	-1.0
Total	**2,628,453,858**	**100.0**	**100.0**	**0.0**

Current Allocation

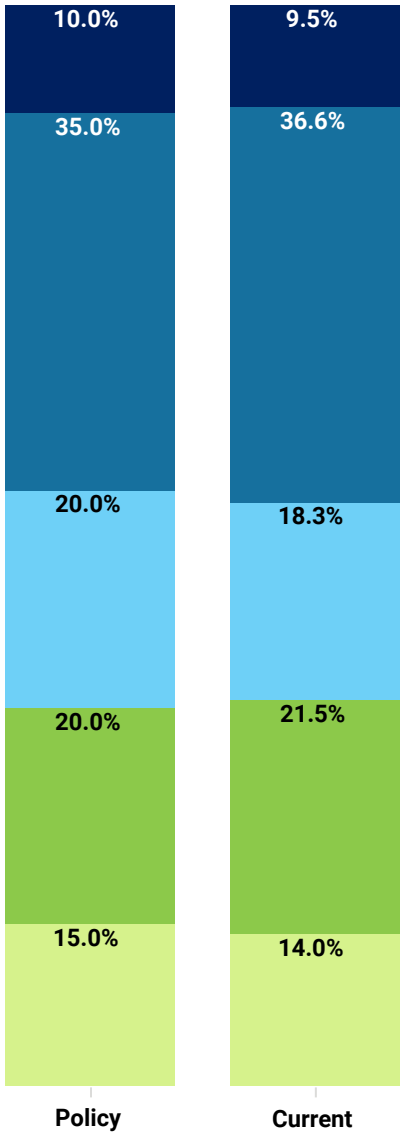


Summary of Cash Flows

	1 Month	FYTD	3 Years
Beginning Market Value	2,605,198,286	2,571,247,053	2,572,985,477
Net Cash Flow			-25,949,128
Net Investment Change	23,255,572	57,206,805	81,417,509
Ending Market Value	**2,628,453,858**	**2,628,453,858**	**2,628,453,858**

ASSET ALLOCATION VS. POLICY

Asset Allocation vs. Target

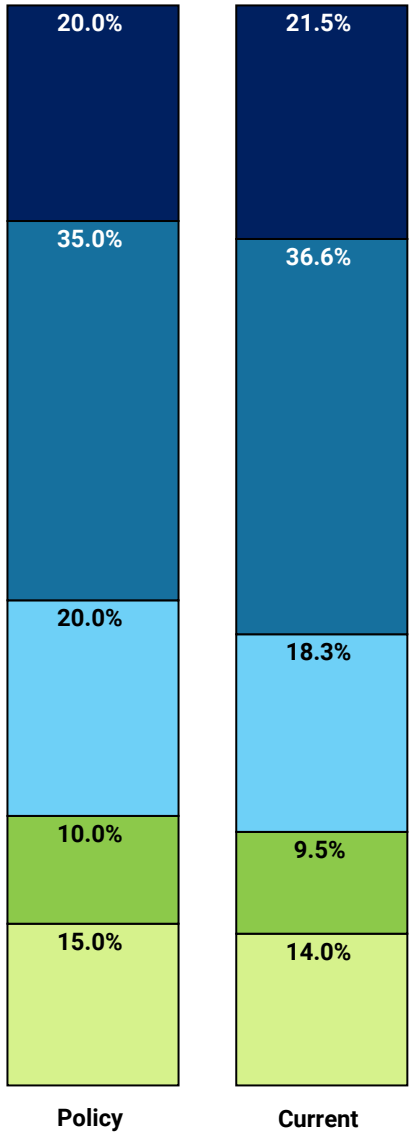


	Current ($)	Current (%)	Policy (%)	Differences* (%)	Policy Range (%)	Within Range
Short Term Composite	249,629,522	9.5	10.0	-0.5	5.0 - 15.0	Yes
Intermediate Term Composite	961,976,697	36.6	35.0	1.6	30.0 - 40.0	Yes
Opportunistic Composite	481,524,653	18.3	20.0	-1.7	15.0 - 25.0	Yes
Global Equity Composite	566,045,040	21.5	20.0	1.5	15.0 - 25.0	Yes
Cash Composite	369,277,946	14.0	15.0	-1.0	15.0 - 20.0	No
Total Fund Composite	**2,628,453,858**	**100.0**	**100.0**	**0.0**		

*Difference between Policy and Current Allocation

ASSET ALLOCATION VS. POLICY

Asset Allocation vs. Target



	Current Balance ($)	Policy (%)	Current Allocation (%)	Differences (%)	Policy Range (%)	Within Range
Global Equity	**566,045,040**	**20.0**	**21.5**	**1.5**	**15.0 - 25.0**	**Yes**
Vanguard Global Minimum Volatility Equity	264,079,167		10.0			
Parametric Global Defensive Equity	301,965,873		11.5			
Intermediate	**961,976,697**	**35.0**	**36.6**	**1.6**	**30.0 - 40.0**	**Yes**
Galliard Intermediate Government	233,110,424		8.9			
Merganser Intermediate Bond	226,801,351		8.6			
Fort Washington Intermediate Bond	194,402,564		7.4			
Lord Abbett Intermediate Bond	223,403,188		8.5			
PFM - Self Insurance Fund	46,685,734		1.8			
PFM - Disability Fund	20,668,727		0.8			
PFM - Workmen's Compensation Fund	11,338,330		0.4			
PFM - Health & Dental Fund	5,566,379		0.2			
Opportunistic	**481,524,653**	**20.0**	**18.3**	**-1.7**	**15.0 - 25.0**	**Yes**
Galliard Opportunistic	148,402,091		5.6			
Merganser Opportunistic	148,872,747		5.7			
Fort Washington Active Fixed Income	184,249,815		7.0			
Short Duration Credit	**249,629,522**	**10.0**	**9.5**	**-0.5**	**5.0 - 15.0**	**Yes**
Lord Abbett Short Duration	125,673,477		4.8			
Loop Capital Asset Management	123,956,045		4.7			
Cash	**369,277,946**	**15.0**	**14.0**	**-1.0**	**15.0 - 20.0**	**No**
PNC Treasury Management	369,273,810		14.0			
U.S. Bank Cash	4,136		0.0			
Total	**2,628,453,858**	**100.0**	**100.0**	**0.0**		

*Difference between Policy and Current Allocation

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)								
	Market Value ($)	% of Portfolio	1 Mo (%)	3 Mo (%)	YTD (%)	FYTD (%)	1 Yr (%)	2 Yrs (%)	3 Yrs (%)	4 Yrs (%)	5 Yrs (%)
Total Fund Composite	**2,628,453,858**	**100.0**	**0.9**	**1.0**	**2.7**	**2.2**	**6.6**	**4.5**	**1.1**	**1.5**	**1.9**
Policy Index			*0.8*	*0.7*	*1.7*	*2.1*	*5.3*	*3.4*	*0.2*	*0.5*	*1.3*
Fixed Income Composite	**1,693,130,872**	**64.4**	**0.8**	**0.8**	**1.0**	**2.1**	**4.7**	**2.4**	**-0.7**	**-0.5**	**0.7**
Short Term Composite	**249,629,522**	**9.5**	**0.7**	**1.0**	**1.4**	**1.7**	**5.1**	**2.7**	**0.0**	**0.1**	**0.9**
Blmbg. 1-5 Year Gov/Credit			*0.7*	*0.8*	*1.0*	*1.6*	*4.7*	*2.4*	*-0.2*	*0.0*	*1.0*
Lord Abbett Short Duration	125,673,477	4.8	0.7	1.0	1.3	1.7	5.0	2.8			
Blmbg. 1-5 Year Gov/Credit			*0.7*	*0.8*	*1.0*	*1.6*	*4.7*	*2.4*			
Loop Capital Asset Management	123,956,045	4.7	0.6	1.0	1.4	1.6	5.3	2.6	0.0	0.0	0.8
Blmbg. 1-5 Year Gov/Credit			*0.7*	*0.8*	*1.0*	*1.6*	*4.7*	*2.4*	*-0.2*	*0.0*	*1.0*
Intermediate Term Composite	**961,976,697**	**36.6**	**0.8**	**0.8**	**1.0**	**2.0**	**4.7**	**2.4**	**-0.8**	**-0.5**	**0.7**
Blmbg. Intermed. U.S. Government/Credit			*0.8*	*0.6*	*0.5*	*2.0*	*4.2*	*2.0*	*-1.2*	*-0.8*	*0.7*
Galliard Intermediate Government	233,110,424	8.9	0.9	0.8	1.1	2.2	5.1	2.6	-0.6	-0.4	0.8
Blmbg. Intermed. U.S. Government/Credit			*0.8*	*0.6*	*0.5*	*2.0*	*4.2*	*2.0*	*-1.2*	*-0.8*	*0.7*
Merganser Intermediate Bond	226,801,351	8.6	0.8	0.9	1.1	2.0	4.7	2.5	-0.7	-0.4	0.7
Blmbg. Intermed. U.S. Government/Credit			*0.8*	*0.6*	*0.5*	*2.0*	*4.2*	*2.0*	*-1.2*	*-0.8*	*0.7*
Fort Washington Intermediate Bond	194,402,564	7.4	0.8	0.9	0.9	2.1	4.5	2.5			
Blmbg. Intermed. U.S. Government/Credit			*0.8*	*0.6*	*0.5*	*2.0*	*4.2*	*2.0*			
Lord Abbett Intermediate Bond	223,403,188	8.5	0.8	0.8	0.8	2.1	4.5	2.2			
Blmbg. Intermed. U.S. Government/Credit			*0.8*	*0.6*	*0.5*	*2.0*	*4.2*	*2.0*			
PFM - Self Insurance Fund	46,685,734	1.8	0.7	0.9	1.1	1.6	4.8	2.5	0.0	0.1	1.1
ICE BofA 1-5 Yr Treasury & Agency			*0.7*	*0.8*	*0.8*	*1.6*	*4.2*	*1.9*	*-0.3*	*-0.3*	*0.8*
PFM - Disability Fund	20,668,727	0.8	0.7	0.9	1.1	1.6	4.8	2.5	0.0	0.1	1.1
ICE BofA 1-5 Yr Treasury & Agency			*0.7*	*0.8*	*0.8*	*1.6*	*4.2*	*1.9*	*-0.3*	*-0.3*	*0.8*
PFM - Workmen's Compensation Fund	11,338,330	0.4	0.5	1.0	1.6	1.2	5.0	3.0	1.0	0.8	1.4
ICE BofA U.S. Agencies, 1-3yr			*0.5*	*1.0*	*1.5*	*1.2*	*4.9*	*2.6*	*0.6*	*0.5*	*1.1*
PFM - Health & Dental Fund	5,566,379	0.2	0.5	1.0	1.6	1.2	5.1	3.0	1.0	0.8	1.4
ICE BofA U.S. Agencies, 1-3yr			*0.5*	*1.0*	*1.5*	*1.2*	*4.9*	*2.6*	*0.6*	*0.5*	*1.1*

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)								
	Market Value ($)	% of Portfolio	1 Mo (%)	3 Mo (%)	YTD (%)	FYTD (%)	1 Yr (%)	2 Yrs (%)	3 Yrs (%)	4 Yrs (%)	5 Yrs (%)
Opportunistic Composite	**481,524,653**	**18.3**	**0.9**	**0.8**	**0.7**	**2.3**	**4.4**	**2.2**	**-1.1**	**-0.8**	**0.7**
Blmbg. U.S. Intermediate Aggregate			*0.9*	*0.5*	*0.0*	*2.4*	*3.5*	*1.5*	*-1.8*	*-1.3*	*0.2*
Galliard Opportunistic	148,402,091	5.6	1.0	0.7	0.7	2.5	4.5	2.0	-1.3	-0.9	0.7
Blmbg. U.S. Intermediate Aggregate			*0.9*	*0.5*	*0.0*	*2.4*	*3.5*	*1.5*	*-1.8*	*-1.3*	*0.2*
Merganser Opportunistic	148,872,747	5.7	0.9	0.8	0.9	2.2	4.5	2.3	-0.9	-0.8	0.7
Blmbg. U.S. Intermediate Aggregate			*0.9*	*0.5*	*0.0*	*2.4*	*3.5*	*1.5*	*-1.8*	*-1.3*	*0.2*
Fort Washington Active Fixed Income	184,249,815	7.0	0.9	0.8	0.7	2.3	4.4	2.4			
Blmbg. U.S. Intermediate Aggregate			*0.9*	*0.5*	*0.0*	*2.4*	*3.5*	*1.5*			
Global Equity Composite	**566,045,040**	**21.5**	**1.4**	**1.5**	**8.6**	**3.6**	**13.2**	**11.3**	**5.8**	**9.3**	**6.6**
MSCI AC World Minimum Volatility Index (Net)			*1.2*	*0.3*	*5.1*	*3.0*	*9.1*	*7.4*	*2.6*	*6.6*	*4.7*
Vanguard Global Minimum Volatility Equity	264,079,167	10.0	1.4	0.2	8.9	3.0	13.4	10.4	5.4	8.2	5.3
MSCI AC World Minimum Volatility Index (Net)			*1.2*	*0.3*	*5.1*	*3.0*	*9.1*	*7.4*	*2.6*	*6.6*	*4.7*
Parametric Global Defensive Equity	301,965,873	11.5	1.5	2.6	8.3	4.1	13.1	12.3	6.2	10.1	7.0
50% MSCI ACWI / 50% 90 Day T-Bill			*1.3*	*2.1*	*6.9*	*3.6*	*12.4*	*11.4*	*4.6*	*7.9*	*6.8*
Cash Composite	**369,277,946**	**14.0**									
90 Day U.S. Treasury Bill			*0.4*	*1.3*	*2.6*	*0.9*	*5.4*	*4.5*	*3.0*	*2.3*	*2.2*
PNC Treasury Management	369,273,810	14.0	0.4	1.3	2.6	0.9	5.4	4.6	3.0	2.3	2.2
90 Day U.S. Treasury Bill			*0.4*	*1.3*	*2.6*	*0.9*	*5.4*	*4.5*	*3.0*	*2.3*	*2.2*
U.S. Bank Cash	4,136	0.0									
90 Day U.S. Treasury Bill			*0.4*	*1.3*	*2.6*	*0.9*	*5.4*	*4.5*	*3.0*	*2.3*	*2.2*

* All data prior to 5/2023 was received from Marquette Associates.
* Policy Index consist of 35% Bloomberg Intermediate U.S. Gov/Credit, 20% Bloomberg U.S. Intermediate Aggregate, 10% Bloomberg 1-5 Year Gov/Credit, 20% MSCI AC World Minimum Volatility Index (Net), and 15% 90 Day U.S. T-Bills.

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)								
	Market Value ($)	% of Portfolio	2023	2022	2021	2020	2019	2018	2017	2016	2015
Total Fund Composite	**2,628,453,858**	**100.0**	**6.7**	**-5.9**	**1.1**	**3.9**	**5.3**	**1.2**	**1.3**	**1.1**	**1.1**
Policy Index			*5.7*	*-7.1*	*1.0*	*3.9*	*5.7*	*1.2*	*0.8*	*0.9*	*0.8*
Short Term Composite	**249,629,522**	**9.5**	**5.1**	**-5.2**	**-1.0**	**3.2**	**3.5**	**1.6**	**0.7**	**0.8**	**0.6**
Blmbg. 1-5 Year Gov/Credit			*4.9*	*-5.5*	*-1.0*	*4.7*	*5.0*	*1.4*	*1.3*	*1.6*	*1.0*
Lord Abbett Short Duration	125,673,477	4.8	5.1	-4.9							
Blmbg. 1-5 Year Gov/Credit			*4.9*	*-5.5*							
Loop Capital Asset Management	123,956,045	4.7	5.1	-5.6	-0.9	3.2	3.5	1.6	0.7	1.0	0.4
Blmbg. 1-5 Year Gov/Credit			*4.9*	*-5.5*	*-1.0*	*4.7*	*5.0*	*1.4*	*1.3*	*1.6*	*1.0*
Intermediate Term Composite	**961,976,697**	**36.6**	**5.5**	**-7.5**	**-1.0**	**4.8**	**4.6**	**1.5**	**1.3**	**1.2**	**1.2**
Blmbg. Intermed. U.S. Government/Credit			*5.2*	*-8.2*	*-1.4*	*6.4*	*6.8*	*0.9*	*2.1*	*2.1*	*1.1*
Galliard Intermediate Government	233,110,424	8.9	5.8	-8.1	-0.6	5.1	4.6	1.5	1.4	1.3	1.1
Blmbg. Intermed. U.S. Government/Credit			*5.2*	*-8.2*	*-1.4*	*6.4*	*6.8*	*0.9*	*2.1*	*2.1*	*1.1*
Merganser Intermediate Bond	226,801,351	8.6	5.5	-7.6	-1.0	4.6	4.6	1.5	1.3	1.2	1.0
Blmbg. Intermed. U.S. Government/Credit			*5.2*	*-8.2*	*-1.4*	*6.4*	*6.8*	*0.9*	*2.1*	*2.1*	*1.1*
Fort Washington Intermediate Bond	194,402,564	7.4	5.6	-7.9							
Blmbg. Intermed. U.S. Government/Credit			*5.2*	*-8.2*							
Lord Abbett Intermediate Bond	223,403,188	8.5	5.5	-7.7							
Blmbg. Intermed. U.S. Government/Credit			*5.2*	*-8.2*							
PFM - Self Insurance Fund	46,685,734	1.8	5.0	-5.0	-0.9	4.6	4.6	1.4	1.1	1.3	1.0
ICE BofA 1-5 Yr Treasury & Agency			*4.3*	*-5.2*	*-1.1*	*4.2*	*4.2*	*1.5*	*0.7*	*1.1*	*1.0*
PFM - Disability Fund	20,668,727	0.8	5.0	-5.1	-0.9	4.6	4.6	1.3	1.1	1.3	1.0
ICE BofA 1-5 Yr Treasury & Agency			*4.3*	*-5.2*	*-1.1*	*4.2*	*4.2*	*1.5*	*0.7*	*1.1*	*1.0*
PFM - Workmen's Compensation Fund	11,338,330	0.4	5.1	-3.0	-0.5	2.8	3.5	1.6	0.7	1.0	0.7
ICE BofA U.S. Agencies, 1-3yr			*4.7*	*-3.7*	*-0.4*	*2.7*	*3.5*	*1.8*	*0.7*	*1.0*	*0.7*
PFM - Health & Dental Fund	5,566,379	0.2	5.0	-3.1	-0.5	2.8	3.5	1.7	0.7	1.0	0.7
ICE BofA U.S. Agencies, 1-3yr			*4.7*	*-3.7*	*-0.4*	*2.7*	*3.5*	*1.8*	*0.7*	*1.0*	*0.7*

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)								
	Market Value ($)	% of Portfolio	2023	2022	2021	2020	2019	2018	2017	2016	2015
Opportunistic Composite	**481,524,653**	**18.3**	5.7	-8.5	-1.4	6.3	5.9	1.3	2.0	1.6	1.5
Blmbg. U.S. Intermediate Aggregate			*5.2*	*-9.5*	*-1.3*	*5.6*	*6.7*	*0.9*	*2.3*	*2.0*	*1.2*
Galliard Opportunistic	148,402,091	5.6	5.7	-9.2	-1.1	6.6	5.9	1.3	2.2	1.6	1.4
Blmbg. U.S. Intermediate Aggregate			*5.2*	*-9.5*	*-1.3*	*5.6*	*6.7*	*0.9*	*2.3*	*2.0*	*1.2*
Merganser Opportunistic	148,872,747	5.7	5.6	-8.3	-1.4	5.9	5.8	1.4	1.7	1.6	1.2
Blmbg. U.S. Intermediate Aggregate			*5.2*	*-9.5*	*-1.3*	*5.6*	*6.7*	*0.9*	*2.3*	*2.0*	*1.2*
Fort Washington Active Fixed Income	184,249,815	7.0	5.8	-8.2							
Blmbg. U.S. Intermediate Aggregate			*5.2*	*-9.5*							
Global Equity Composite	**566,045,040**	**21.5**	11.2	-6.0	12.7	1.4	17.0				
MSCI AC World Minimum Volatility Index (Net)			*7.7*	*-10.3*	*13.9*	*2.7*	*21.1*				
Vanguard Global Minimum Volatility Equity	264,079,167	10.0	8.0	-4.5	12.0	-3.9	22.7				
MSCI AC World Minimum Volatility Index (Net)			*7.7*	*-10.3*	*13.9*	*2.7*	*21.1*				
Parametric Global Defensive Equity	301,965,873	11.5	14.6	-7.5	13.1	2.6	14.1				
50% MSCI ACWI / 50% 90 Day T-Bill			*13.6*	*-8.5*	*9.0*	*9.1*	*14.1*				
Cash Composite	**369,277,946**	**14.0**									
PNC Treasury Management	369,273,810	14.0	5.1	1.3	0.1	0.8	2.4	1.9	0.9	0.5	0.2
90 Day U.S. Treasury Bill			*5.0*	*1.5*	*0.0*	*0.7*	*2.3*	*1.9*	*0.9*	*0.3*	*0.0*
U.S. Bank Cash	4,136	0.0									
90 Day U.S. Treasury Bill			*5.0*	*1.5*	*0.0*	*0.7*	*2.3*				

* All data prior to 5/2023 was received from Marquette Associates.
* Policy Index consist of 35% Bloomberg Intermediate U.S. Gov/Credit, 20% Bloomberg U.S. Intermediate Aggregate, 10% Bloomberg 1-5 Year Gov/Credit, 20% MSCI AC World Minimum Volatility Index (Net), and 15% 90 Day U.S. T-Bills.

CASH FLOW SUMMARY BY MANAGER

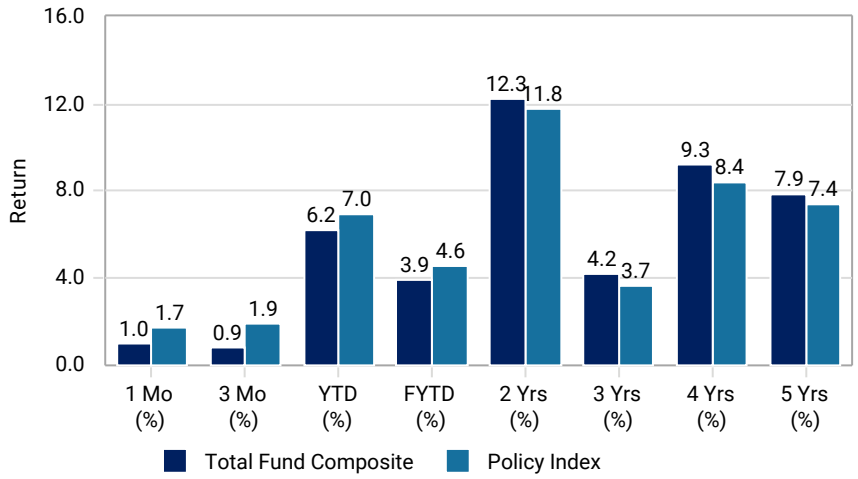
	1 Month Ending June 30, 2024					
	Beginning Market Value	Contributions	Withdrawals	Net Cash Flows	Gain/ Loss	Ending Market Value
Lord Abbett Short Duration	$124,804,655	-	-	-	$868,821	$125,673,477
Loop Capital Asset Management	$123,175,438	-	-	-	$780,607	$123,956,045
Galliard Intermediate Government	$231,110,901	-	-	-	$1,999,523	$233,110,424
Merganser Intermediate Bond	$224,993,018	-	-	-	$1,808,332	$226,801,351
Fort Washington Intermediate Bond	$192,824,649	-	-	-	$1,577,916	$194,402,564
Lord Abbett Intermediate Bond	$221,625,632	-	-	-	$1,777,556	$223,403,188
PFM - Self Insurance Fund	$46,378,292	-	-	-	$307,442	$46,685,734
PFM - Disability Fund	$20,533,966	-	-	-	$134,761	$20,668,727
PFM - Workmen's Compensation Fund	$11,280,047	-	-	-	$58,283	$11,338,330
PFM - Health & Dental Fund	$5,537,374	-	-	-	$29,005	$5,566,379
Galliard Opportunistic	$146,938,181	-	-	-	$1,463,910	$148,402,091
Merganser Opportunistic	$147,573,417	-	-	-	$1,299,330	$148,872,747
Fort Washington Active Fixed Income	$182,627,667	-	-	-	$1,622,148	$184,249,815
Vanguard Global Minimum Volatility Equity	$260,462,824	-	-	-	$3,616,343	$264,079,167
Parametric Global Defensive Equity	$297,573,283	-	-	-	$4,392,590	$301,965,873
PNC Treasury Management	$367,754,823	-	-	-	$1,518,988	$369,273,810
U.S. Bank Cash	$4,118	-	-	-	$18	$4,136
Total	**$2,605,198,286**	**-**	**-**	**-**	**$23,255,572**	**$2,628,453,858**

SOUTH BROWARD HOSPITAL DISTRICT – RETIREMENT PLAN

June 30, 2024

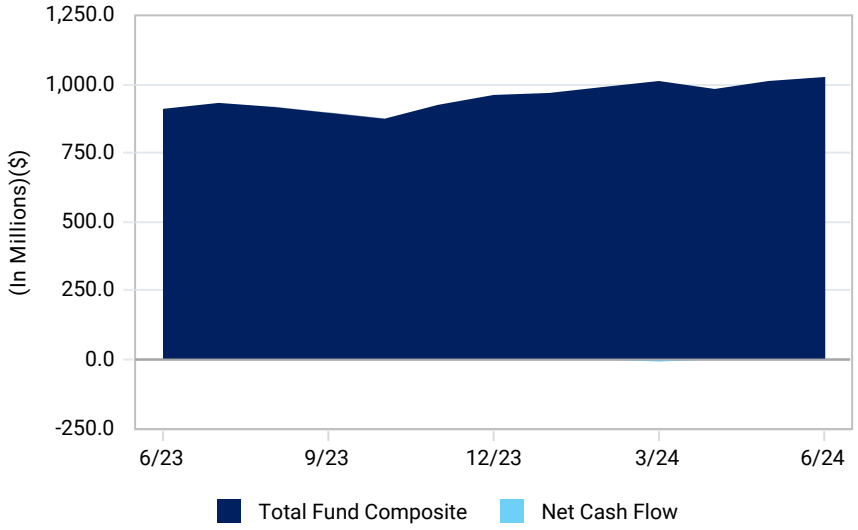
EXECUTIVE SUMMARY

Return Summary
Ending June 30, 2024

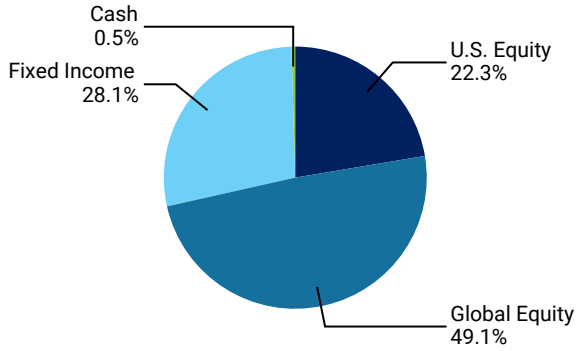


	Current ($)	Current (%)	Policy (%)	Differences (%)
U.S. Equity	229,223,618	22.3	20.0	2.3
Global Equity	504,084,031	49.1	45.0	4.1
Fixed Income	287,855,789	28.1	35.0	-6.9
Cash	4,672,303	0.5	0.0	0.5
Total	**1,025,835,742**	**100.0**	**100.0**	**0.0**

Market Value History
1 Year Ending June 30, 2024



Current Allocation

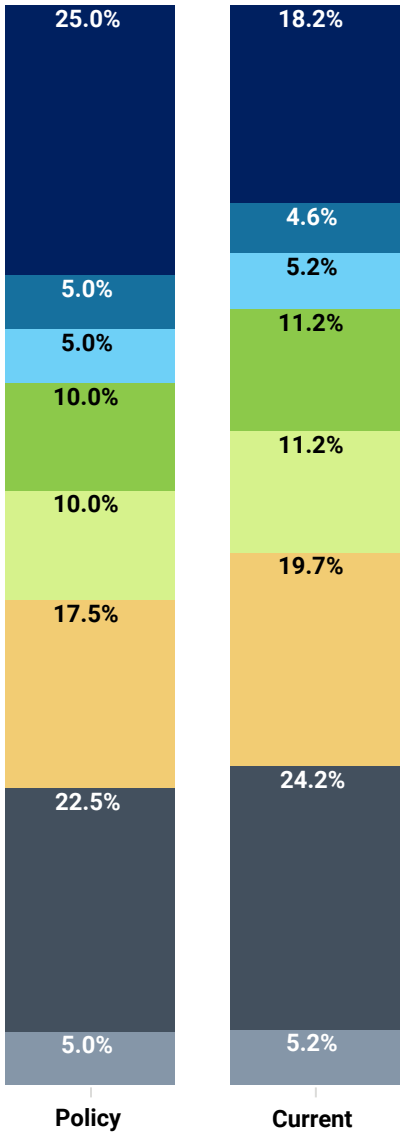


Summary of Cash Flows

	1 Month	FYTD	3 Years
Beginning Market Value	1,016,257,909	987,737,648	907,221,574
Net Cash Flow	-540,802	-401,457	-5,749,892
Net Investment Change	10,118,634	38,499,550	124,364,059
Ending Market Value	**1,025,835,742**	**1,025,835,742**	**1,025,835,742**

ASSET ALLOCATION VS. POLICY

Asset Allocation vs. Target

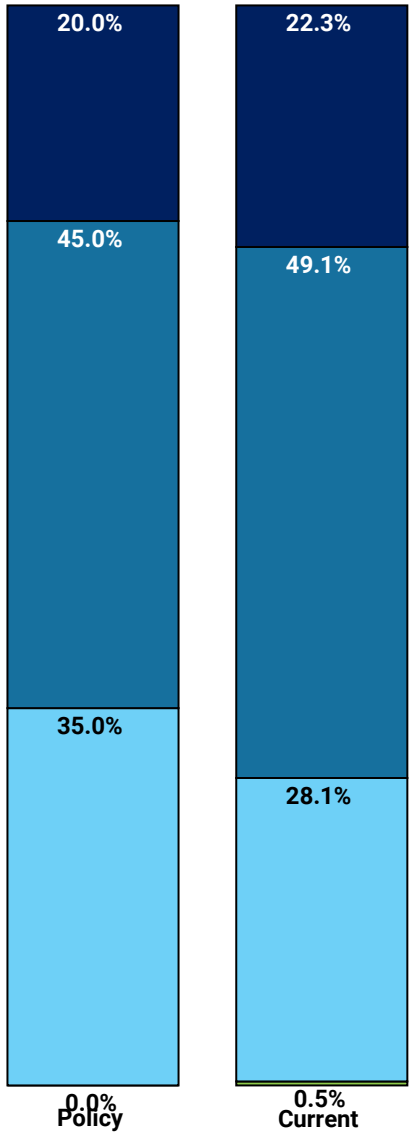


	Current ($)	Current (%)	Policy (%)	Differences* (%)	Policy Range (%)	Within Range
C.S. McKee Aggregate Fixed Income	187,057,087	18.2	25.0	-6.8	20.0 - 30.0	No
Chartwell High Yield	47,119,594	4.6	5.0	-0.4	2.5 - 7.5	Yes
Aristotle Floating Rate Income	53,664,885	5.2	5.0	0.2	2.5 - 7.5	Yes
Vanguard Total Stock Market Fund	114,451,746	11.2	10.0	1.2	5.0 - 15.0	Yes
Parametric Defensive Equity	114,771,872	11.2	10.0	1.2	5.0 - 15.0	Yes
Dodge & Cox	202,048,863	19.7	17.5	2.2	12.5 - 22.5	Yes
Walter Scott & Partners	248,687,399	24.2	22.5	1.7	17.5 - 27.5	Yes
Vanguard Global Minimum Volatility	53,347,769	5.2	5.0	0.2	2.5 - 7.5	Yes
Total Fund Composite	**1,025,835,742**	**100.0**	**100.0**	**0.0**		

*Difference between Policy and Current Allocation

ASSET ALLOCATION VS. POLICY

Asset Allocation vs. Target



	Current Balance ($)	Policy (%)	Current Allocation (%)	Differences (%)	Policy Range (%)	Within Range
U.S. Equity	**229,223,618**	**20.0**	**22.3**	**2.3**	**15.0 - 25.0**	**Yes**
Vanguard Total Stock Market Fund	114,451,746		11.2			
Parametric Defensive Equity	114,771,872		11.2			
Global Equity	**504,084,031**	**45.0**	**49.1**	**4.1**	**40.0 - 50.0**	**Yes**
Dodge & Cox	202,048,863		19.7			
Walter Scott & Partners	248,687,399		24.2			
Vanguard Global Minimum Volatility	53,347,769		5.2			
Fixed Income	**287,855,789**	**35.0**	**28.1**	**-6.9**	**30.0 - 40.0**	**No**
C.S. McKee Aggregate Fixed Income	187,057,087		18.2			
Chartwell High Yield	47,119,594		4.6			
Aristotle Floating Rate Income	53,664,885		5.2			
Wellington LCP Legacy Portfolio	14,225		0.0			
Cash	**4,672,303**	**0.0**	**0.5**	**0.5**	**0.0 - 0.0**	**No**
Money Market	694,626		0.1			
Vanguard Treasury Money Market	3,977,678		0.4			
Total	**1,025,835,742**	**100.0**	**100.0**	**0.0**		

*Difference between Policy and Current Allocation

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)								
	Market Value ($)	% of Portfolio	1 Mo (%)	3 Mo (%)	YTD (%)	FYTD (%)	1 Yr (%)	2 Yrs (%)	3 Yrs (%)	4 Yrs (%)	5 Yrs (%)
Total Fund Composite	**1,025,835,742**	**100.0**	**1.0**	**0.9**	**6.2**	**3.9**	**12.2**	**12.3**	**4.2**	**9.3**	**7.9**
Policy Index			*1.7*	*1.9*	*7.0*	*4.6*	*12.9*	*11.8*	*3.7*	*8.4*	*7.4*
Fixed Income Composite	**287,855,789**	**28.1**	**0.9**	**0.7**	**1.1**	**2.4**	**5.2**	**3.9**	**-0.5**	**0.2**	**1.4**
Custom Index			*0.8*	*0.5*	*0.5*	*2.3*	*4.6*	*3.2*	*-0.9*	*0.0*	*1.2*
C.S. McKee Aggregate Fixed Income	187,057,087	18.2	1.1	0.2	-0.1	3.0	3.1	1.3	-2.8	-2.1	0.0
Blmbg. U.S. Aggregate Index			*0.9*	*0.1*	*-0.7*	*2.7*	*2.6*	*0.8*	*-3.0*	*-2.4*	*-0.2*
Chartwell High Yield	47,119,594	4.6	0.8	1.4	2.8	1.6	8.0	7.3	2.7	3.8	3.2
ICE BofA U.S. High Yield Cash Pay BB 1-3 Year			*0.7*	*1.4*	*2.8*	*1.5*	*8.1*	*7.6*	*3.1*	*4.5*	*4.0*
Aristotle Floating Rate Income	53,664,885	5.2	0.4	1.6	4.1	1.1	10.5	10.9	6.0	6.8	5.0
Credit Suisse Leveraged Loan Index			*0.3*	*1.9*	*4.4*	*1.2*	*11.0*	*10.6*	*6.0*	*7.4*	*5.4*
Wellington LCP Legacy Portfolio	14,225	0.0									
U.S. Equity Composite	**229,223,618**	**22.3**	**2.6**	**3.2**	**11.4**	**6.5**	**18.6**	**17.8**	**7.9**	**14.1**	**11.8**
CRSP U.S. Total Market TR Index			*3.1*	*3.2*	*13.6*	*8.0*	*23.2*	*21.0*	*7.9*	*16.1*	*14.1*
Vanguard Total Stock Market Fund	114,451,746	11.2	3.1	3.3	13.6	8.0	23.3	21.0	7.9	16.1	14.1
CRSP U.S. Total Market TR Index			*3.1*	*3.2*	*13.6*	*8.0*	*23.2*	*21.0*	*7.9*	*16.1*	*14.1*
Parametric Defensive Equity	114,771,872	11.2	2.2	3.2	9.8	5.1	15.0	15.3	8.1	11.9	9.2
50% S&P 500/50% 90 Day T-Bill			*2.0*	*2.9*	*8.9*	*4.8*	*14.9*	*13.4*	*6.9*	*9.8*	*8.9*
Global Equity Composite	**504,084,031**	**49.1**	**0.3**	**-0.1**	**7.1**	**3.6**	**13.8**	**15.5**	**5.6**	**13.3**	**10.4**
MSCI AC World Index (Net)			*2.2*	*2.9*	*11.3*	*6.4*	*19.4*	*17.9*	*5.4*	*13.0*	*10.8*
Dodge & Cox	202,048,863	19.7	-2.0	-0.4	5.3	2.0	14.1	13.7	6.0	16.5	11.0
MSCI AC World Index Value (Net)			*-0.5*	*-0.6*	*6.2*	*2.5*	*13.9*	*11.9*	*4.8*	*12.3*	*7.0*
Walter Scott & Partners	248,687,399	24.2	2.1	0.1	8.2	5.1	13.6	18.3	5.3	11.9	10.3
MSCI World Growth (Net)			*4.8*	*6.3*	*17.2*	*10.8*	*26.4*	*26.4*	*7.4*	*14.7*	*15.3*
Vanguard Global Minimum Volatility	53,347,769	5.2	1.4	0.2	8.9	3.0	13.4	10.3	5.4	8.2	5.2
MSCI AC World Minimum Volatility Index (Net)			*1.2*	*0.3*	*5.1*	*3.0*	*9.1*	*7.4*	*2.6*	*6.6*	*4.7*
Cash Composite	**4,672,303**	**0.5**	**0.3**	**1.1**	**2.3**	**0.8**	**5.1**	**3.5**	**2.4**	**1.8**	**1.7**
90 Day U.S. Treasury Bill			*0.4*	*1.3*	*2.6*	*0.9*	*5.4*	*4.5*	*3.0*	*2.3*	*2.2*

* All data is preliminary. Memorial Health Systems' Fiscal Year ends in April.
* All data prior to 5/2023 was received from Marquette Associates.
* Policy Index consist of 40% MSCI ACWI, 5% MSCI ACWI Minimum Volatility, 25% Bloomberg U.S. Aggregate, 10% CRSP US Total Market Index, 10% CBOE Put Write Index, 5% BofAML 1-3 Year High Yield BB, and 5% Credit Suisse Leveraged Loan Index.
* Custom Index consist of 71.4% Bloomberg U.S. Aggregate,14.3% BofA Merrill Lynch 1-3 Yrs High Yield BB, and 14.3% Credit Suisse Leveraged Loan Index.

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)				
	Market Value ($)	% of Portfolio	2023	2022	2021	2020	2019
Total Fund Composite	**1,025,835,742**	**100.0**	**16.3**	**-11.9**	**13.4**	**11.0**	**19.5**
Policy Index			*15.7*	*-13.9*	*12.6*	*11.7*	*19.6*
Fixed Income Composite	**287,855,789**	**28.1**	**7.5**	**-9.5**	**-0.2**	**6.3**	**8.6**
Custom Index			*7.1*	*-10.0*	*0.1*	*6.7*	*8.7*
C.S. McKee Aggregate Fixed Income	187,057,087	18.2	5.9	-12.9	-1.8	7.6	8.9
Blmbg. U.S. Aggregate Index			*5.5*	*-13.0*	*-1.5*	*7.5*	*8.7*
Chartwell High Yield	47,119,594	4.6	8.1	-3.0	2.3	4.2	7.0
ICE BofA U.S. High Yield Cash Pay BB 1-3 Year			*8.9*	*-3.1*	*3.2*	*5.4*	*8.7*
Aristotle Floating Rate Income	53,664,885	5.2	13.4	-0.8	4.6	1.6	8.3
Credit Suisse Leveraged Loan Index			*13.0*	*-1.1*	*5.4*	*2.8*	*8.2*
Wellington LCP Legacy Portfolio	14,225	0.0					
U.S. Equity Composite	**229,223,618**	**22.3**	**21.0**	**-13.8**	**21.8**	**13.6**	**23.5**
CRSP U.S. Total Market TR Index			*26.0*	*-19.5*	*25.7*	*21.0*	*30.8*
Vanguard Total Stock Market Fund	114,451,746	11.2	26.0	-19.5	25.7	21.0	30.7
CRSP U.S. Total Market TR Index			*26.0*	*-19.5*	*25.7*	*21.0*	*30.8*
Parametric Defensive Equity	114,771,872	11.2	16.9	-7.7	17.2	5.0	16.0
50% S&P 500/50% 90 Day T-Bill			*15.5*	*-8.2*	*13.7*	*10.1*	*16.3*
Global Equity Composite	**504,084,031**	**49.1**	**20.2**	**-12.8**	**19.0**	**12.4**	**27.1**
MSCI AC World Index (Net)			*22.2*	*-18.4*	*18.5*	*16.3*	*26.6*
Dodge & Cox	202,048,863	19.7	20.3	-5.8	20.8	6.0	23.8
MSCI AC World Index Value (Net)			*11.8*	*-7.5*	*19.6*	*-0.3*	*20.6*
Walter Scott & Partners	248,687,399	24.2	23.1	-19.6	18.7	18.9	30.5
MSCI World Growth (Net)			*37.0*	*-29.2*	*21.2*	*33.8*	*33.7*
Vanguard Global Minimum Volatility	53,347,769	5.2	8.0	-4.5	12.0	-3.9	22.7
MSCI AC World Minimum Volatility Index (Net)			*7.7*	*-10.3*	*13.9*	*2.7*	*21.1*
Cash Composite	**4,672,303**	**0.5**	**4.2**	**0.7**	**0.0**	**0.4**	**2.0**
90 Day U.S. Treasury Bill			*5.0*	*1.5*	*0.0*	*0.7*	*2.3*

* All data is preliminary. Memorial Health Systems' Fiscal Year ends in April.
* All data prior to 5/2023 was received from Marquette Associates.
* Policy Index consist of 40% MSCI ACWI, 5% MSCI ACWI Minimum Volatility, 25% Bloomberg U.S. Aggregate, 10% CRSP US Total Market Index, 10% CBOE Put Write Index, 5% BofAML 1-3 Year High Yield BB, and 5% Credit Suisse Leveraged Loan Index.
* Custom Index consist of 71.4% Bloomberg U.S. Aggregate,14.3% BofA Merrill Lynch 1-3 Yrs High Yield BB, and 14.3% Credit Suisse Leveraged Loan Index.

CASH FLOW SUMMARY BY MANAGER

	1 Month Ending June 30, 2024					
	Beginning Market Value	Contributions	Withdrawals	Net Cash Flows	Gain/ Loss	Ending Market Value
C.S. McKee Aggregate Fixed Income	$185,112,021	-	-	-	$1,945,066	$187,057,087
Chartwell High Yield	$47,321,674	-	-$564,784	-$564,784	$362,703	$47,119,594
Aristotle Floating Rate Income	$53,440,408	-	-	-	$224,477	$53,664,885
Wellington LCP Legacy Portfolio	$14,226	-	-	-	-$1	$14,225
Vanguard Total Stock Market Fund	$111,426,910	-	-$407,262	-$407,262	$3,432,098	$114,451,746
Parametric Defensive Equity	$112,355,269	-	-	-	$2,416,604	$114,771,872
Dodge & Cox	$206,164,435	-	-	-	-$4,115,572	$202,048,863
Walter Scott & Partners	$243,568,257	-	-	-	$5,119,142	$248,687,399
Vanguard Global Minimum Volatility	$52,617,216	-	-	-	$730,553	$53,347,769
Money Market	$295,365	$407,262	-$9,333	$397,929	$1,331	$694,626
Vanguard Treasury Money Market	$3,942,130	$3,907,178	-$3,873,864	$33,314	$2,234	$3,977,678
Total	**$1,016,257,909**	**$4,314,440**	**-$4,855,242**	**-$540,802**	**$10,118,634**	**$1,025,835,742**

MEMORIAL HEALTHCARE SYSTEM DEFINED CONTRIBUTION PLANS

June 30, 2024

ASSET ALLOCATION VS. POLICY

Current Allocation

	Current ($)	Current (%)
JPMorgan Target Date Funds	1,007,191,322	62.3
Transamerica Stable Value	825,095	0.1
Transamerica Guaranteed Investment Option	141,216,904	8.7
Dodge & Cox Income X (DOXIX)	27,441,987	1.7
Fidelity US Bond Index (FXNAX)	9,690,517	0.6
Fidelity Inflation Protected Bond Index (FIPDX)	16,882,856	1.0
American Beacon Large Cap Value Fund (AALRX)	25,369,482	1.6
Fidelity Spartan 500 Index (FXAIX)	124,829,721	7.7
Fidelity Large Cap Growth Index (FSPGX)	90,523,848	5.6
Fidelity Extended Market Index (FSMAX)	42,299,059	2.6
Dimensional US Targeted Value Strategy (DFFVX)	20,387,629	1.3
T. Rowe Price New Horizons (PRJIX)	36,290,286	2.2
Vanguard International-Growth (VWILX)	38,950,840	2.4
Fidelity Global ex US Index (FSGGX)	13,769,092	0.9
Charles Schwab Personal Choice	21,331,885	1.3
Total Fund Composite	**1,617,000,523**	**100.0**

MULTI PERIOD ASSET ALLOCATION

	Total Fund	
	$	%
Total Fund Composite	**1,345,582,191**	**100.0**
JP Morgan Target Date Funds	**826,523,480**	**61.4**
JPMorgan SmartRetirement Blend Income (JIYBX)	40,820,896	3.0
JPMorgan SmartRetirement Blend 2020 (JSYRX)	66,853,544	5.0
JPMorgan SmartRetirement Blend 2025 (JBYSX)	130,620,502	9.7
JPMorgan SmartRetirement Blend 2030 (JRBYX)	141,602,259	10.5
JPMorgan SmartRetirement Blend 2035 (JPYRX)	124,192,314	9.2
JPMorgan SmartRetirement Blend 2040 (JOBYX)	95,839,177	7.1
JPMorgan SmartRetirement Blend 2045 (JMYAX)	85,316,445	6.3
JPMorgan SmartRetirement Blend 2050 (JNYAX)	77,048,432	5.7
JPMorgan SmartRetirement Blend 2055 (JTYBX)	40,396,553	3.0
JPMorgan SmartRetirement Blend 2060 (JAAYX)	21,048,852	1.6
JPMorgan SmartRetirement Blend 2065 (JSBYX)	2,784,505	0.2
Core Funds	**500,954,473**	**37.2**
Transamerica Stable Value	680,336	0.1
Transamerica Guaranteed Investment Option	129,932,478	9.7
Dodge & Cox Income X (DOXIX)	22,533,416	1.7
Fidelity US Bond Index (FXNAX)	8,417,351	0.6
Fidelity Inflation Protected Bond Index (FIPDX)	14,035,079	1.0
American Beacon Large Cap Value Fund (AALRX)	22,228,938	1.7
Fidelity Spartan 500 Index (FXAIX)	102,089,308	7.6
Fidelity Large Cap Growth Index (FSPGX)	72,740,359	5.4
Fidelity Extended Market Index (FSMAX)	35,597,278	2.6
Dimensional US Targeted Value Strategy (DFFVX)	17,295,674	1.3
T. Rowe Price New Horizons (PRJIX)	30,540,432	2.3
Vanguard International-Growth (VWILX)	32,545,840	2.4
Fidelity Global ex US Index (FSGGX)	12,317,985	0.9
Brokerage	**18,104,239**	**1.3**
Charles Schwab Personal Choice	18,104,239	1.3

MULTI PERIOD ASSET ALLOCATION

	Total Fund	
	$	%
Total Fund Composite	**105,234,278**	**100.0**
JPMorgan Target Date Funds	**88,815,365**	**84.4**
JPMorgan SmartRetirement Blend Income (JIYBX)	1,133,346	1.1
JPMorgan SmartRetirement Blend 2020 (JSYRX)	2,461,818	2.3
JPMorgan SmartRetirement Blend 2025 (JBYSX)	6,266,257	6.0
JPMorgan SmartRetirement Blend 2030 (JRBYX)	8,466,869	8.0
JPMorgan SmartRetirement Blend 2035 (JPYRX)	11,315,307	10.8
JPMorgan SmartRetirement Blend 2040 (JOBYX)	11,718,649	11.1
JPMorgan SmartRetirement Blend 2045 (JMYAX)	14,473,339	13.8
JPMorgan SmartRetirement Blend 2050 (JNYAX)	15,557,649	14.8
JPMorgan SmartRetirement Blend 2055 (JTYBX)	11,392,767	10.8
JPMorgan SmartRetirement Blend 2060 (JAAYX)	5,331,282	5.1
JPMorgan SmartRetirement Blend 2065 (JSBYX)	698,081	0.7
Core Funds	**16,418,913**	**15.6**
Transamerica Stable Value	54,569	0.1
Transamerica Guaranteed Investment Option	1,267,480	1.2
Dodge & Cox Income X (DOXIX)	265,989	0.3
Fidelity US Bond Index (FXNAX)	642,262	0.6
Fidelity Inflation Protected Bond Index (FIPDX)	574,006	0.5
American Beacon Large Cap Value Fund (AALRX)	908,106	0.9
Fidelity Spartan 500 Index (FXAIX)	4,225,464	4.0
Fidelity Large Cap Growth Index (FSPGX)	3,203,475	3.0
Fidelity Extended Market Index (FSMAX)	1,099,266	1.0
Dimensional US Targeted Value Strategy (DFFVX)	855,121	0.8
T. Rowe Price New Horizons (PRJIX)	817,791	0.8
Vanguard International-Growth (VWILX)	1,115,970	1.1
Fidelity Global ex US Index (FSGGX)	1,389,415	1.3
Brokerage		**0.0**
Charles Schwab Personal Choice		0.0

MULTI PERIOD ASSET ALLOCATION

	Total Fund	
	$	%
Total Fund Composite	**140,062,464**	**100.0**
JPMorgan Target Date Funds	**68,906,539**	**49.2**
JPMorgan SmartRetirement Blend Income (JIYBX)	3,918,298	2.8
JPMorgan SmartRetirement Blend 2020 (JSYRX)	5,427,735	3.9
JPMorgan SmartRetirement Blend 2025 (JBYSX)	11,906,888	8.5
JPMorgan SmartRetirement Blend 2030 (JRBYX)	12,009,340	8.6
JPMorgan SmartRetirement Blend 2035 (JPYRX)	10,623,861	7.6
JPMorgan SmartRetirement Blend 2040 (JOBYX)	8,096,656	5.8
JPMorgan SmartRetirement Blend 2045 (JMYAX)	8,215,520	5.9
JPMorgan SmartRetirement Blend 2050 (JNYAX)	6,056,962	4.3
JPMorgan SmartRetirement Blend 2055 (JTYBX)	1,920,894	1.4
JPMorgan SmartRetirement Blend 2060 (JAAYX)	720,419	0.5
JPMorgan SmartRetirement Blend 2065 (JSBYX)	9,967	0.0
Core Funds	**67,928,278**	**48.5**
Transamerica Stable Value	2,271	0.0
Transamerica Guaranteed Investment Option	9,732,418	6.9
Dodge & Cox Income X (DOXIX) - 457(b) Retirement Plan	4,536,292	3.2
Fidelity US Bond Index (FXNAX) - 457(b) Plan	630,904	0.5
Fidelity Inflation Protected Bond Index (FIPDX)	1,917,924	1.4
American Beacon Large Cap Value Fund (AALRX)	2,164,588	1.5
Fidelity Spartan 500 Index (FXAIX)	17,185,062	12.3
Fidelity Large Cap Growth Index (FSPGX)	14,024,688	10.0
Fidelity Extended Market Index (FSMAX)	5,492,257	3.9
Dimensional US Targeted Value Strategy (DFFVX)	2,236,834	1.6
T. Rowe Price New Horizons (PRJIX)	4,720,013	3.4
Vanguard International-Growth (VWILX)	5,223,335	3.7
Fidelity Global ex US Index (FSGGX)	61,693	0.0
Brokerage	**3,227,646**	**2.3**
Charles Schwab Personal Choice	3,227,646	2.3

MULTI PERIOD ASSET ALLOCATION

	Total Fund	
	$	%
Total Fund Composite	**26,121,590**	**100.0**
JPMorgan Target Date Funds	**22,945,938**	**87.8**
JPMorgan SmartRetirement Blend Income (JIYBX)	244,089	0.9
JPMorgan SmartRetirement Blend 2020 (JSYRX)	267,352	1.0
JPMorgan SmartRetirement Blend 2025 (JBYSX)	7,031,230	26.9
JPMorgan SmartRetirement Blend 2030 (JRBYX)	7,620,044	29.2
JPMorgan SmartRetirement Blend 2035 (JPYRX)	4,265,231	16.3
JPMorgan SmartRetirement Blend 2040 (JOBYX)	2,231,167	8.5
JPMorgan SmartRetirement Blend 2045 (JMYAX)	1,244,894	4.8
JPMorgan SmartRetirement Blend 2050 (JNYAX)	41,931	0.2
JPMorgan SmartRetirement Blend 2055 (JTYBX)		0.0
JPMorgan SmartRetirement Blend 2060 (JAAYX)		0.0
JPMorgan SmartRetirement Blend 2065 (JSBYX)		0.0
Core Funds	**3,175,652**	**12.2**
Transamerica Stable Value	87,920	0.3
Transamerica Guaranteed Investment Option	284,529	1.1
Dodge & Cox Income X (DOXIX)	106,290	0.4
Fidelity US Bond Index (FXNAX)		0.0
Fidelity Inflation Protected Bond Index (FIPDX)	355,847	1.4
American Beacon Large Cap Value Fund (AALRX)	67,850	0.3
Fidelity Spartan 500 Index (FXAIX)	1,329,887	5.1
Fidelity Large Cap Growth Index (FSPGX)	555,326	2.1
Fidelity Extended Market Index (FSMAX)	110,258	0.4
Dimensional US Targeted Value Strategy (DFFVX)		0.0
T. Rowe Price New Horizons (PRJIX)	212,051	0.8
Vanguard International-Growth (VWILX)	65,695	0.3
Fidelity Global ex US Index (FSGGX)		0.0
Brokerage		**0.0**
Charles Schwab Personal Choice		0.0

PERFORMANCE DETAIL

	Allocation		Performance (%)							
	Market Value ($)	% of Portfolio	1 Mo (%)	3 Mo (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	7 Yrs (%)	10 Yrs (%)
Total Fund Composite	**1,617,000,523**	**100.0**								
JPMorgan Target Date Funds	**1,007,191,322**	**62.3**								
JPMorgan SmartRetirement Blend Income (JIYBX)	46,116,628	2.9	1.2	1.2	4.4	9.6	0.9	4.2	4.4	4.2
S&P Target Date Retirement Income Index			*1.1*	*1.1*	*3.5*	*8.2*	*1.1*	*3.9*	*4.2*	*3.9*
JPMorgan SmartRetirement Blend 2020 (JSYRX)	75,010,449	4.6	1.2	1.2	4.5	9.7	1.0	4.4	4.8	4.7
S&P Target Date 2020 Index			*1.2*	*1.3*	*4.5*	*9.8*	*1.8*	*5.3*	*5.5*	*5.2*
JPMorgan SmartRetirement Blend 2025 (JBYSX)	155,824,877	9.6	1.2	1.3	4.9	10.4	1.2	5.3	5.6	5.4
S&P Target Date 2025 Index			*1.2*	*1.3*	*4.8*	*10.3*	*2.1*	*6.1*	*6.2*	*5.8*
JPMorgan SmartRetirement Blend 2030 (JRBYX)	169,698,512	10.5	1.3	1.5	6.0	12.1	2.0	6.5	6.6	6.2
S&P Target Date 2030 Index			*1.2*	*1.4*	*5.7*	*11.8*	*2.8*	*7.0*	*7.0*	*6.5*
JPMorgan SmartRetirement Blend 2035 (JPYRX)	150,396,713	9.3	1.5	1.7	7.2	13.8	2.9	7.6	7.5	7.0
S&P Target Date 2035 Index			*1.3*	*1.6*	*6.9*	*13.6*	*3.5*	*8.1*	*7.9*	*7.2*
JPMorgan SmartRetirement Blend 2040 (JOBYX)	117,885,649	7.3	1.5	1.9	8.2	15.1	3.6	8.5	8.2	7.5
S&P Target Date 2040 Index			*1.4*	*1.8*	*7.9*	*15.1*	*4.2*	*8.9*	*8.6*	*7.7*
JPMorgan SmartRetirement Blend 2045 (JMYAX)	109,250,199	6.8	1.6	2.0	8.9	16.1	4.1	9.1	8.7	7.9
S&P Target Date 2045 Index			*1.3*	*1.8*	*8.5*	*15.9*	*4.6*	*9.4*	*9.0*	*8.0*
JPMorgan SmartRetirement Blend 2050 (JNYAX)	98,704,974	6.1	1.6	2.1	9.3	16.5	4.2	9.3	8.8	8.0
S&P Target Date 2050 Index			*1.4*	*2.0*	*8.9*	*16.5*	*4.9*	*9.7*	*9.2*	*8.2*
JPMorgan SmartRetirement Blend 2055 (JTYBX)	53,710,215	3.3	1.6	2.1	9.3	16.6	4.3	9.3	8.8	8.0
S&P Target Date 2055 Index			*1.4*	*1.9*	*8.9*	*16.5*	*4.9*	*9.8*	*9.3*	*8.3*
JPMorgan SmartRetirement Blend 2060 (JAAYX)	27,100,553	1.7	1.6	2.1	9.3	16.6	4.3			
S&P Target Date 2060 Index			*1.4*	*1.9*	*8.9*	*16.5*	*4.9*			
JPMorgan SmartRetirement Blend 2065 (JSBYX)	3,492,553	0.2	1.6	2.0	9.4	16.5				
S&P Target Date 2065+ Index			*1.5*	*2.1*	*9.2*	*16.9*				

PERFORMANCE DETAIL

	Allocation		Performance (%)							
	Market Value ($)	% of Portfolio	1 Mo (%)	3 Mo (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	7 Yrs (%)	10 Yrs (%)
Core Funds	**574,708,223**	**35.5**								
Transamerica Stable Value	825,095	0.1	0.2	0.6	1.3	2.6	2.0	1.7	1.6	1.4
90 Day U.S. Treasury Bill			*0.4*	*1.3*	*2.6*	*5.4*	*3.0*	*2.2*	*2.1*	*1.5*
Transamerica Guaranteed Investment Option	141,216,904	8.7	0.2	0.6	1.3	2.6	2.4	2.2	1.9	1.6
90 Day U.S. Treasury Bill			*0.4*	*1.3*	*2.6*	*5.4*	*3.0*	*2.2*	*2.1*	*1.5*
Dodge & Cox Income X (DOXIX)	27,441,987	1.7	1.1	0.5	0.2	4.7	-1.3	1.5	2.2	2.4
Blmbg. U.S. Aggregate Index			*0.9*	*0.1*	*-0.7*	*2.6*	*-3.0*	*-0.2*	*0.9*	*1.3*
Fidelity US Bond Index (FXNAX)	9,690,517	0.6	1.1	0.2	-0.6	2.7	-3.0	-0.2	0.9	1.3
Blmbg. U.S. Aggregate Index			*0.9*	*0.1*	*-0.7*	*2.6*	*-3.0*	*-0.2*	*0.9*	*1.3*
Fidelity Inflation Protected Bond Index (FIPDX)	16,882,856	1.0	0.8	1.0	0.9	2.7	-1.4	2.0	2.4	1.9
Blmbg. U.S. TIPS			*0.8*	*0.8*	*0.7*	*2.7*	*-1.3*	*2.1*	*2.5*	*1.9*
American Beacon Large Cap Value Fund (AALRX)	25,369,482	1.6	-0.8	-1.5	8.2	17.4	7.4	11.0	9.8	8.7
Russell 1000 Value Index			*-0.9*	*-2.2*	*6.6*	*13.1*	*5.5*	*9.0*	*8.6*	*8.2*
Fidelity Spartan 500 Index (FXAIX)	124,829,721	7.7	3.6	4.3	15.3	24.6	10.0	15.0	14.3	12.8
S&P 500 Index			*3.6*	*4.3*	*15.3*	*24.6*	*10.0*	*15.0*	*14.3*	*12.9*
Fidelity Large Cap Growth Index (FSPGX)	90,523,848	5.6	6.7	8.3	20.7	33.5	11.3	19.3	18.6	
Russell 1000 Growth Index			*6.7*	*8.3*	*20.7*	*33.5*	*11.3*	*19.3*	*18.6*	
Fidelity Extended Market Index (FSMAX)	42,299,059	2.6	-0.1	-3.4	3.3	15.0	-2.5	8.7	8.8	8.3
Dow Jones U.S. Completion Total Stock Market Indx			*-0.1*	*-3.4*	*3.3*	*14.7*	*-2.6*	*8.6*	*8.7*	*8.1*
Dimensional US Targeted Value Strategy (DFFVX)	20,387,629	1.3	-2.9	-4.0	0.5	13.6	6.8	12.1	9.2	8.0
Russell 2000 Value Index			*-1.7*	*-3.6*	*-0.8*	*10.9*	*-0.5*	*7.1*	*5.9*	*6.2*
T. Rowe Price New Horizons (PRJIX)	36,290,286	2.2	0.5	-8.5	-2.9	1.7	-9.4	6.4	10.9	11.0
Russell 2000 Growth Index			*-0.2*	*-2.9*	*4.4*	*9.1*	*-4.9*	*6.2*	*7.3*	*7.4*
Vanguard International-Growth (VWILX)	38,950,840	2.4	-1.0	2.4	7.8	9.0	-7.2	8.5	8.7	7.6
MSCI AC World ex USA (Net)			*-0.1*	*1.0*	*5.7*	*11.6*	*0.5*	*5.5*	*5.2*	*3.8*
Fidelity Global ex US Index (FSGGX)	13,769,092	0.9	-0.6	1.0	5.8	11.3	0.5	5.6	5.2	3.9
MSCI AC World ex USA (Net)			*-0.1*	*1.0*	*5.7*	*11.6*	*0.5*	*5.5*	*5.2*	*3.8*
Brokerage	**21,331,885**	**1.3**								
Charles Schwab Personal Choice	21,331,885	1.3								

- All data prior to 5/2023 was received from Marquette Associates
- Transamerica Stable Value Fund is not an open option for plan participants
- Assets include: Memorial Healthcare System RSP Gold 403(b) Plan, Memorial Healthcare System 401(a) Plan, Memorial Healthcare System 457(b) Plan, Memorial Healthcare System SERP 457(f Plan
- Performance is net of fees and is annualized for periods longer than one year. Performance is ranked within PARis's style-specific universes, where "1" refers to the top percentile and "100" th bottom percentile.

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)								
	Market Value ($)	% of Portfolio	2023	2022	2021	2020	2019	2018	2017	2016	2015
Total Fund Composite	**1,617,000,523**										
JPMorgan SmartRetirement Blend Income (JIYBX)	**46,116,628**		**11.8**	**-13.7**	**6.3**	**9.6**	**14.1**	**-3.8**	**10.7**	**5.8**	**-0.7**
S&P Target Date Retirement Income Index			*10.3*	*-11.2*	*5.1*	*8.8*	*13.3*	*-2.5*	*8.5*	*5.0*	*-0.2*
JPMorgan SmartRetirement Blend 2020 (JSYRX)	**75,010,449**		**12.0**	**-13.7**	**6.4**	**10.1**	**15.5**	**-4.5**	**13.4**	**6.8**	**-0.7**
S&P Target Date 2020 Index			*12.3*	*-12.8*	*8.8*	*10.2*	*16.5*	*-4.2*	*12.8*	*7.2*	*-0.2*
JPMorgan SmartRetirement Blend 2025 (JBYSX)	**155,824,877**		**13.4**	**-15.2**	**9.1**	**11.3**	**18.3**	**-5.7**	**15.6**	**7.2**	**-0.7**
S&P Target Date 2025 Index			*13.0*	*-13.1*	*10.7*	*11.2*	*18.4*	*-5.0*	*14.6*	*7.8*	*-0.3*
JPMorgan SmartRetirement Blend 2030 (JRBYX)	**169,698,512**		**15.3**	**-16.1**	**11.3**	**12.2**	**20.4**	**-6.6**	**17.4**	**7.9**	**-0.8**
S&P Target Date 2030 Index			*14.8*	*-14.0*	*12.6*	*11.9*	*20.4*	*-6.0*	*16.2*	*8.3*	*-0.3*
JPMorgan SmartRetirement Blend 2035 (JPYRX)	**150,396,713**		**17.1**	**-16.7**	**14.1**	**12.6**	**22.3**	**-7.4**	**18.9**	**8.3**	**-1.0**
S&P Target Date 2035 Index			*16.6*	*-15.0*	*14.9*	*12.8*	*22.2*	*-6.9*	*17.8*	*8.9*	*-0.3*
JPMorgan SmartRetirement Blend 2040 (JOBYX)	**117,885,649**		**18.4**	**-17.2**	**15.9**	**13.0**	**23.8**	**-8.0**	**20.3**	**8.8**	**-1.1**
S&P Target Date 2040 Index			*18.2*	*-15.6*	*16.5*	*13.4*	*23.4*	*-7.4*	*18.9*	*9.2*	*-0.4*
JPMorgan SmartRetirement Blend 2045 (JMYAX)	**109,250,199**		**19.5**	**-17.6**	**17.7**	**13.1**	**24.6**	**-8.3**	**20.5**	**8.8**	**-1.0**
S&P Target Date 2045 Index			*19.1*	*-15.8*	*17.5*	*13.7*	*24.0*	*-7.7*	*19.6*	*9.5*	*-0.5*
JPMorgan SmartRetirement Blend 2050 (JNYAX)	**98,704,974**		**19.8**	**-17.6**	**17.8**	**13.4**	**24.6**	**-8.3**	**20.5**	**8.8**	**-1.1**
S&P Target Date 2050 Index			*19.6*	*-16.0*	*18.0*	*13.9*	*24.4*	*-7.9*	*20.2*	*9.7*	*-0.5*
JPMorgan SmartRetirement Blend 2055 (JTYBX)	**53,710,215**		**19.7**	**-17.6**	**17.8**	**13.2**	**24.7**	**-8.4**	**20.4**	**8.8**	**-1.0**
S&P Target Date 2055 Index			*19.6*	*-16.0*	*18.2*	*13.9*	*24.5*	*-8.0*	*20.5*	*9.9*	*-0.5*
JPMorgan SmartRetirement Blend 2060 (JAAYX)	**27,100,553**		**19.7**	**-17.4**	**17.8**						
S&P Target Date 2060 Index			*19.7*	*-16.0*	*18.0*						
JPMorgan SmartRetirement Blend 2065 (JSBYX)	**3,492,553**		**19.1**								
S&P Target Date 2065+ Index			*19.8*								
Transamerica Stable Value	**825,095**		**2.5**	**1.6**	**1.0**	**1.2**	**1.8**	**1.3**	**1.0**	**1.0**	**1.0**
90 Day U.S. Treasury Bill			*5.0*	*1.5*	*0.0*	*0.7*	*2.3*	*1.9*	*0.9*	*0.3*	*0.0*
Transamerica Guaranteed Investment Option	**141,216,904**		**2.5**	**2.2**	**2.3**	**1.6**	**1.8**	**1.3**	**1.0**	**1.0**	**1.0**
90 Day U.S. Treasury Bill			*5.0*	*1.5*	*0.0*	*0.7*	*2.3*	*1.9*	*0.9*	*0.3*	*0.0*

TOTAL FUND PERFORMANCE DETAIL

	Allocation		Performance (%)								
	Market Value ($)	% of Portfolio	2023	2022	2021	2020	2019	2018	2017	2016	2015
Dodge & Cox Income X (DOXIX)	**27,441,987**		7.8	-10.8	-0.9	9.5	9.7	-0.3	4.4	5.6	-0.6
Blmbg. U.S. Aggregate Index			*5.5*	*-13.0*	*-1.5*	*7.5*	*8.7*	*0.0*	*3.5*	*2.6*	*0.5*
Fidelity US Bond Index (FXNAX)	**9,690,517**		**5.5**	**-13.0**	**-1.8**	**7.8**	**8.5**	**0.0**	**3.5**	**2.5**	**0.6**
Blmbg. U.S. Aggregate Index			*5.5*	*-13.0*	*-1.5*	*7.5*	*8.7*	*0.0*	*3.5*	*2.6*	*0.5*
Fidelity Inflation Protected Bond Index (FIPDX)	**16,882,856**		**3.8**	**-12.0**	**5.9**	**10.9**	**8.3**	**-1.4**	**3.0**	**4.9**	**-1.7**
Blmbg. U.S. TIPS			*3.9*	*-11.8*	*6.0*	*11.0*	*8.4*	*-1.3*	*3.0*	*4.7*	*-1.4*
American Beacon Large Cap Value Fund (AALRX)	**25,369,482**		13.5	-5.2	28.0	3.4	29.7	-12.0	17.1	16.0	-6.1
Russell 1000 Value Index			*11.5*	*-7.5*	*25.2*	*2.8*	*26.5*	*-8.3*	*13.7*	*17.3*	*-3.8*
Fidelity Spartan 500 Index (FXAIX)	**124,829,721**		**26.3**	**-18.1**	**28.7**	**18.4**	**31.5**	**-4.4**	**21.8**	**12.0**	**1.4**
S&P 500 Index			*26.3*	*-18.1*	*28.7*	*18.4*	*31.5*	*-4.4*	*21.8*	*12.0*	*1.4*
Fidelity Large Cap Growth Index (FSPGX)	**90,523,848**		42.8	-29.2	27.6	38.4	36.4	-1.6	30.1		
Russell 1000 Growth Index			*42.7*	*-29.1*	*27.6*	*38.5*	*36.4*	*-1.5*	*30.2*		
Fidelity Extended Market Index (FSMAX)	**42,299,059**		25.4	-26.4	12.4	32.2	28.0	-9.4	18.2	16.1	-3.3
Dow Jones U.S. Completion Total Stock Market Indx			*25.0*	*-26.5*	*12.4*	*32.2*	*27.9*	*-9.6*	*18.1*	*15.7*	*-3.4*
Dimensional US Targeted Value Strategy (DFFVX)	**20,387,629**		19.3	-4.6	38.8	3.8	21.5	-15.8	9.6	26.9	-5.7
Russell 2000 Value Index			*14.6*	*-14.5*	*28.3*	*4.6*	*22.4*	*-12.9*	*7.8*	*31.7*	*-7.5*
T. Rowe Price New Horizons (PRJIX)	**36,290,286**		21.5	-36.9	9.8	57.9	37.8	4.2	31.7	7.9	4.5
Russell 2000 Growth Index			*18.7*	*-26.4*	*2.8*	*34.6*	*28.5*	*-9.3*	*22.2*	*11.3*	*-1.4*
Vanguard International-Growth (VWILX)	**38,950,840**		14.8	-30.8	-0.7	59.7	31.5	-12.6	43.2	1.8	-0.5
MSCI AC World ex USA (Net)			*15.6*	*-16.0*	*7.8*	*10.7*	*21.5*	*-14.2*	*27.2*	*4.5*	*-5.7*
Fidelity Global ex US Index (FSGGX)	**13,769,092**		**15.6**	**-15.7**	**7.8**	**10.7**	**21.3**	**-13.9**	**27.4**	**4.6**	**-5.6**
MSCI AC World ex USA (Net)			*15.6*	*-16.0*	*7.8*	*10.7*	*21.5*	*-14.2*	*27.2*	*4.5*	*-5.7*
Charles Schwab Personal Choice	**21,331,885**										

- All data prior to 5/2023 was received from Marquette Associates
- Transamerica Stable Value Fund is not an open option for plan participants
- Assets include: Memorial Healthcare System RSP Gold 403(b) Plan, Memorial Healthcare System 401(a) Plan, Memorial Healthcare System 457(b) Plan, Memorial Healthcare System SERP 457(f Plan
- Performance is net of fees and is annualized for periods longer than one year. Performance is ranked within PARis's style-specific universes, where "1" refers to the top percentile and "100" th bottom percentile.

INVESTMENT WORKPLAN DETAIL

SAMPLE INVESTMENT WORK PLAN

- **NEPC has developed an investment workplan detail that provides a tentative path to a modified portfolio**
- **Laid out in "phases" to provide a sequence that aims to (1) provide a clear road map to potential allocation changes, (2) allow a pace to ensure Committee education and support of each move, and (3) be flexible to make changes as we progress**

Phase 1, 2nd Half of 24

- Enterprise Risk analysis, assess System's ability to take additional investment risk
- Suggested potential asset allocation shifts (potential destination)
- Review Fixed Income Manager Guidlines

Phase 2, 2nd Half of 24

- Revisit Fixed Income opportunities – High Quality HY and Global Multi Sector, ACWI investment and commingled funds
- Develop plan going forward for Core Fixed Income – separating Treasury and Credit exposures
- Potential increase to and modify equity allocation
    - Discuss implementation
- Update IPS to include all approvals

Phase 3, 1st Half of 25

- Additional education on private market investing
- Separate education session which would include NEPC experts in Private Markets space
- Evaluate the 'why' in utilizing private markets, and how they are different from a legal, regulatory, reporting, and terms perspective relative to public investments

Phase 4, 2025

- Potential to approve/finalize asset allocation that allows for a strong risk/reward tradeoff
- IPS updated and codified to reflect new asset allocation
- Depending on structure approved, new work plan to be updated and approved – could include private market pacing and any subsequent implementation steps

REMAINING 2024 WORK PLAN

MEMORIAL HEALTH SYSTEM OPERATING AND PENSION PLANS

	July	August	Sept	October	November	December
Standard Monthly	Capital Markets Update and Performance Review	Capital Markets Update and Performance Review	Capital Markets Update and Performance Review	Capital Markets Update and Performance Review	Capital Markets Update and Performance Review	Capital Markets Update and Performance Review
Quarterly		Quarterly Performance and Due Diligence			Quarterly Performance and Due Diligence	
Additional Topics	ERM Analysis	IPS Review	Fee Review			
	Asset Allocation Review	Potential Manager Review(s)				
	Review Fixed Income Guidelines					
Votes / Approvals		Asset Allocation				
		IPS Changes				
		Potential Manager Approvals(s)				

The Work Plan can be thought of as a living calendar and will get updated and tailored to MHS annually based on the goals and objectives of the system.

ENTERPRISE RISK ANALYSIS

ENTERPRISE RISK MANAGEMENT TOOLS

NEPC'S SKYAN – OVERVIEW

Online NEPC ERM application allowing you to integrate organizational risks (operations, debt, pension contributions) when considering how much risk to take in your investment program

Operating Pools
Revenue | Expense | Depreciation | Interest Capital Expenditures | Change in Working Capital | CapEx

Debt Management
Debt Financing | Debt Service

Pension Contributions

Budgeted Investment Gain/Loss
Comparison with Market Projections/Scenarios

Scenarios, Metrics (Assets/DCOH), Budgets

Benefits

- ✓ Framework for more dynamic decision making
- ✓ Determine organizational & investment risk budgeting
- ✓ More robust scenario forecasting
- ✓ Better strategic & financial outcomes

Note: SKYAN is a propriety online tool enabling healthcare clients to integrate the organizational risks (operations, debt, pension contributions) when considering how much risk to take in their investment program

ERM ANALYSIS OVERVIEW

- **Memorial Healthcare's Operating portfolio currently has an allocation which is forecasted to be more conservative risk profile than the average Healthcare Operating fund**
  - Memorial Operating Standard Deviation: 4.6%
  - InvMetrics Healthcare Operating Funds >$500mm (Net) Standard Deviation: 11.1%
- **Given the results of the ERM analysis, there is sufficient evidence that the portfolio could take on additional, measured risk**
  - As the analysis will show, implementing the changes to achieve Phase II has the ability to increase the overall risk/return of the portfolio, while still maintaining a conservative approach
  - We also modelled a mix with private markets, and it does show that we can potentially add to the overall risk/return profile of the portfolio
  - Under either allocation (Phase II and Phase IV), Memorial's overall risk profile is forecasted to be well below peers as demonstrated on the following page

ASSET ALLOCATION ROADMAP

	Current Policy	Phase II	Phase IV	Average HC Operating Universe > $500M
Cash	15%	15%	15%	5%
Total Cash	**15%**	**15%**	**15%**	**5%**
Global Equity	0%	25%	25%	48%
Defensive Equity	10%	0%	0%	0%
Global Low Volatility	10%	0%	0%	0%
Total Public Equity	**20%**	**25%**	**25%**	**48%**
US Corporate Bond	0%	5%	5%	0%
US Opportunistic	20%	15%	10%	35%
High Quality High Yield Corporate	0%	5%	5%	0%
Global Multi-Sector Fixed Income	0%	5%	5%	0%
Short Term Pool	10%	10%	10%	0%
Intermediate Pool	35%	20%	15%	0%
Total Fixed Income	**65%**	**60%**	**50%**	**35%**
Private Equity	0%	0%	5%	-
Private Debt	0%	0%	5%	-
Total Alternatives	**0%**	**0%**	**10%**	**12%**
Asset Duration	**3.2**	**2.9**	**2.3**	**2.1**

Expected Return 10 yrs	**5.1%**	**5.3%**	**5.7%**	**5.6%**
Expected Return 30 yrs	**5.3%**	**5.9%**	**6.4%**	**6.7%**
Standard Dev	**4.6%**	**6.4%**	**7.7%**	**11.1%**
Sharpe Ratio (10 years)	**0.21**	**0.19**	**0.21**	**0.14**
Sharpe Ratio (30 years)	**0.40**	**0.37**	**0.38**	**0.29**

- **Phase II Completion Mix**
  - Phase II increases risk by expanding the equity profile from 20% to 25% and introduces US Corporate bonds and High Quality High Yield Fixed Income
  - US Aggregate bonds, Intermediate Treasuries and Intermediate Corporate allocations are reduced to allow for a more diversified fixed income approach
- **Phase IV**
  - Potential goal destination allocation to get to over time
  - This mix increases portfolio expected return by adding Private Equity and Private Debt
- **Average HC Operating Universe**
  - The final column shows the breakdown of the average asset allocation for the InvMetrics Healthcare Operating Funds >$500mm Net universe, and the resulting metrics using NEPC's asset class assumptions

The Average HC Operating Universe > $500M Total Alternatives is comprised of 50% Private Equity and 50% Hedge Funds

REVIEW OF HISTORICAL ASSET ALLOCATION

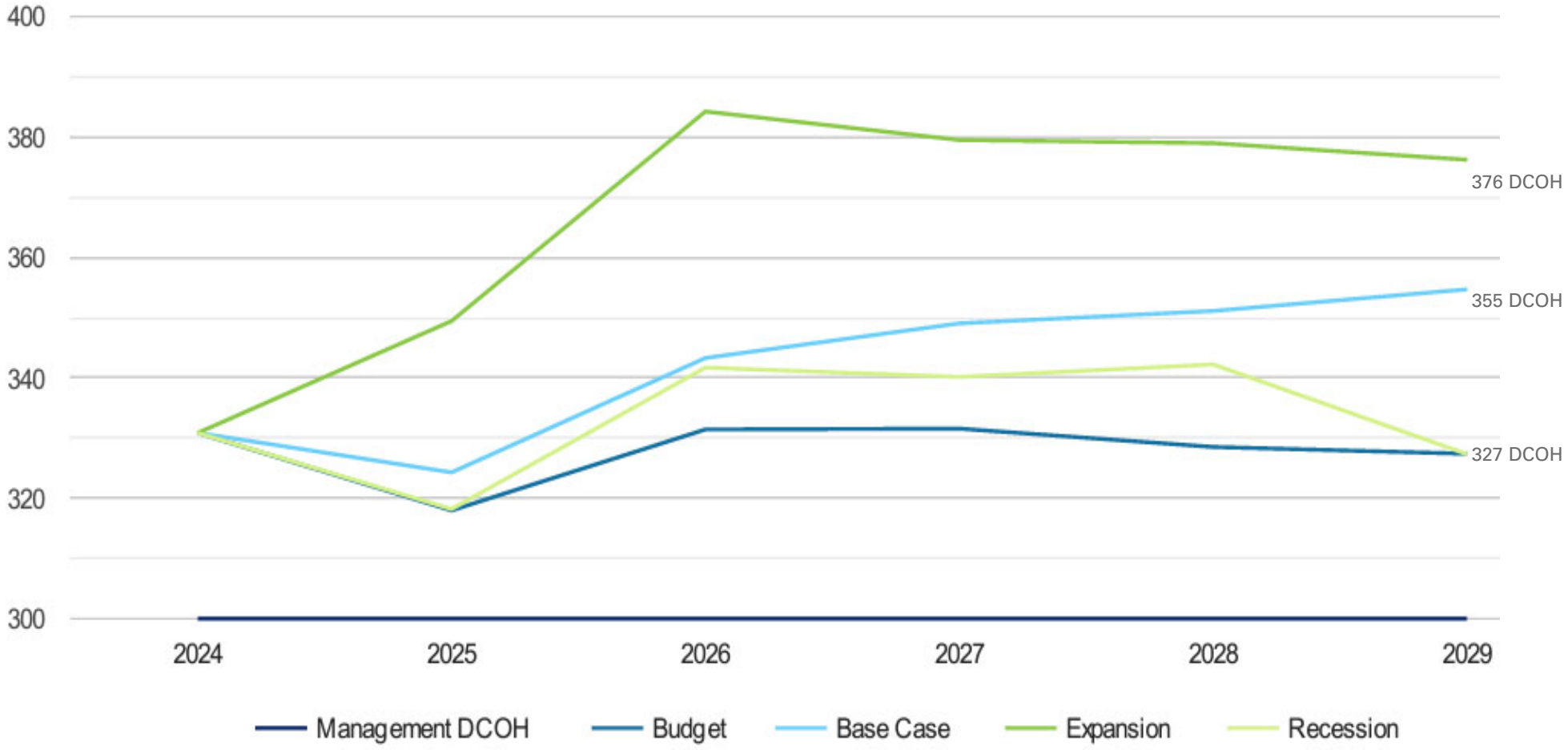
Asset Allocation	3-year Annualized Return
Current Policy	0.20%
Phase II	1.08%
Phase IV	1.46%
Average HC Operating Universe > $500M	2.09%

Asset Allocation	Estimated Market Value	Estimated Cumulative Difference
Current Policy	$ 2,588,454,286.20	n/a
Phase II	$ 2,657,533,770.33	$ 69,079,484.12
Phase IV	$ 2,687,640,361.49	$ 99,186,075.29
Average HC Operating Universe > $500M	$ 2,737,721,354.31	$ 149,267,068.11

- **This analysis represents Memorial Healthcare's current and proposed asset allocations if each had been invested passively (e.g. benchmark performance)**
  - If MHS had been invested passively in the Phase II allocation, the portfolio could have returned an estimated ~1.1%
  - Had MHS been fully invested in Phase IV, including the private markets programs built to targets, the portfolio could have returned an estimated 1.46%
- **Based on a comparable universe, MHS has historically been more conservative in its asset allocation**
  - Based upon MHS strong operating performance and financial strength, it does appear there is more ability to take incremental risk in the investment portfolio to generate potentially higher returns

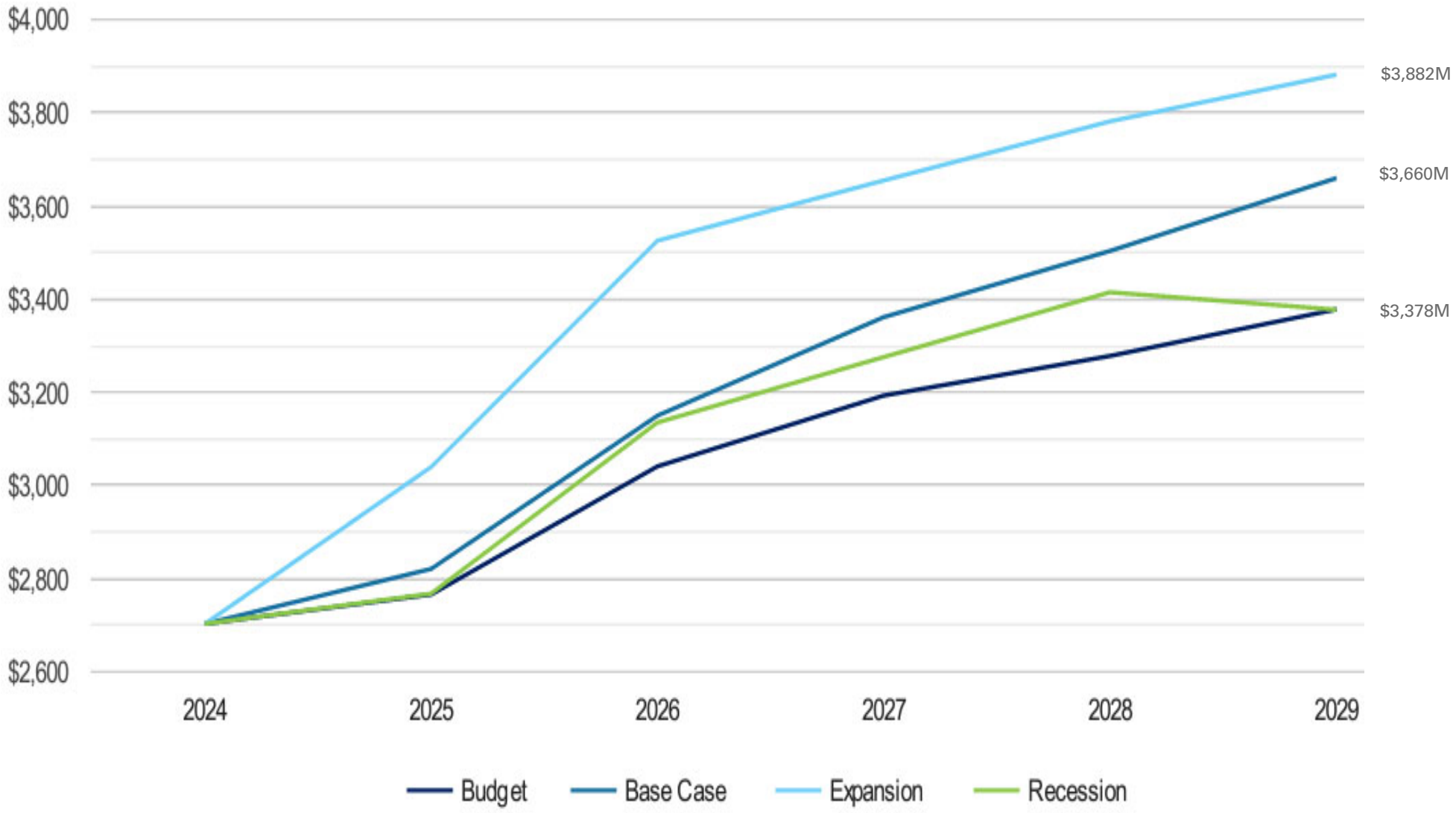
Starting point for market value calculations is June 2021 Operating market value of $2,572,985,476.93
Annualized returns are calculated from multiplying asset allocation by respective asset class benchmark
Estimated market values were calculated by taking the June 2021 market value and annualizing the return for 3 years
Estimated cumulative difference is the difference between the respective asset allocation market value and the current policy market value if invested passively

MEMORIAL ERM – CURRENT POLICY

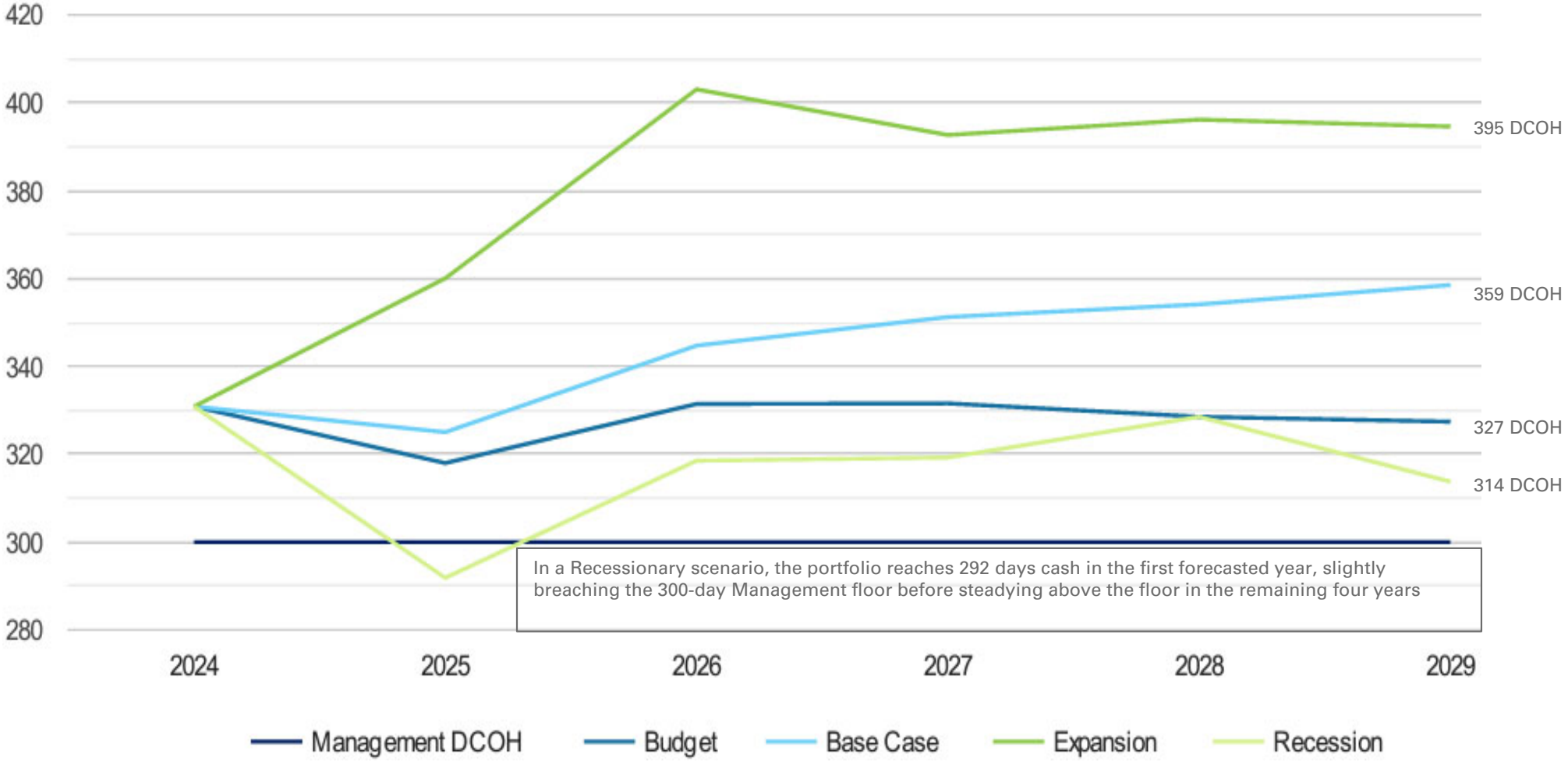


- Memorial Healthcare's Operating portfolio, using the current policy set forth in the IPS, has a base case scenario which gradually increases Days Cash On Hand over the course of the next five years
- In an Expansionary period, the portfolio's DCOH will rise to 384 days cash before a marginal decline in the remaining three years
- In a Recessionary scenario, the portfolio could dip down to a DCOH level of 318 days but staying well above the 300-day Management floor

SCENARIO ANALYSIS – CURRENT POLICY

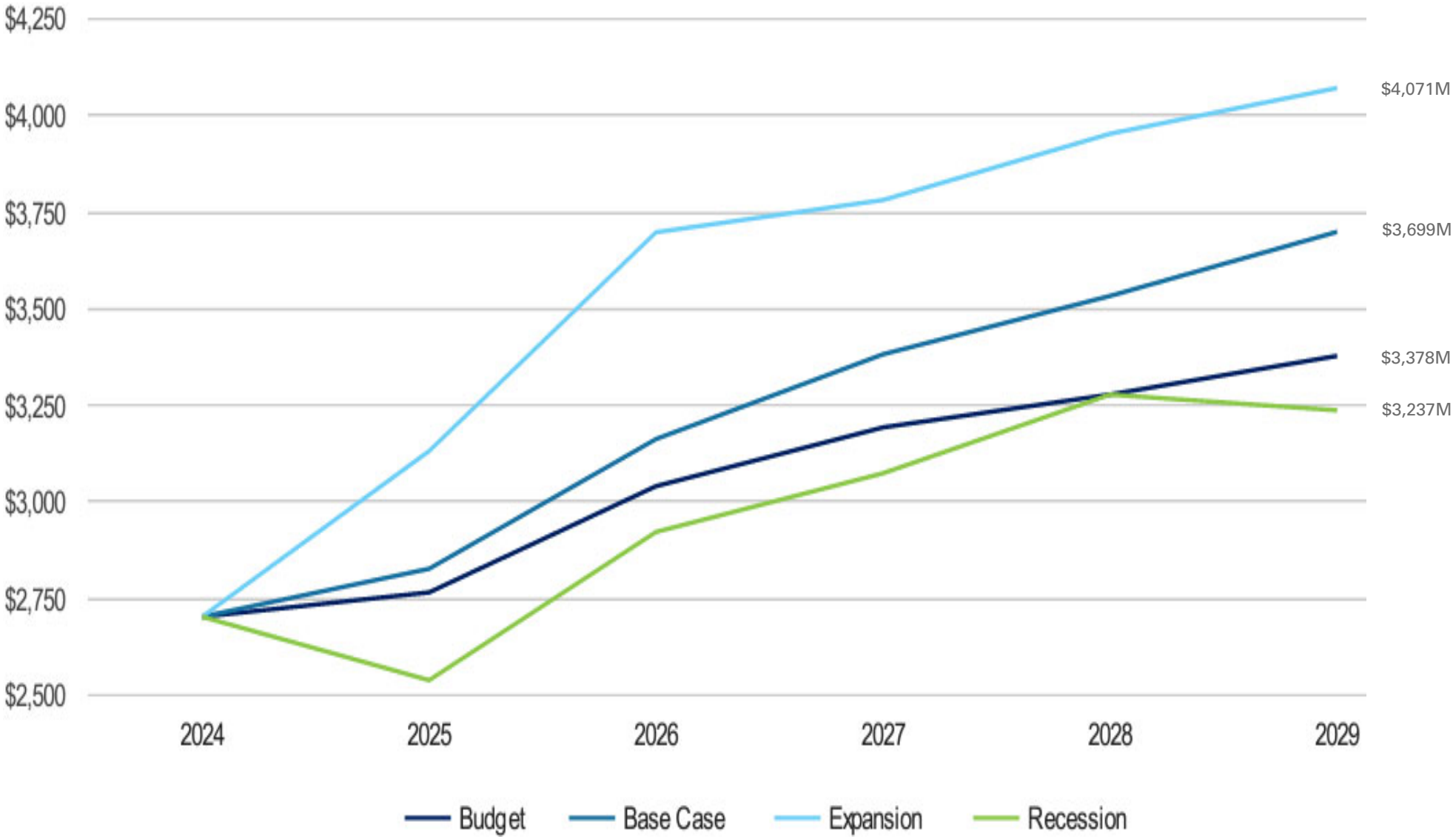


MEMORIAL ERM – PHASE II COMPLETION

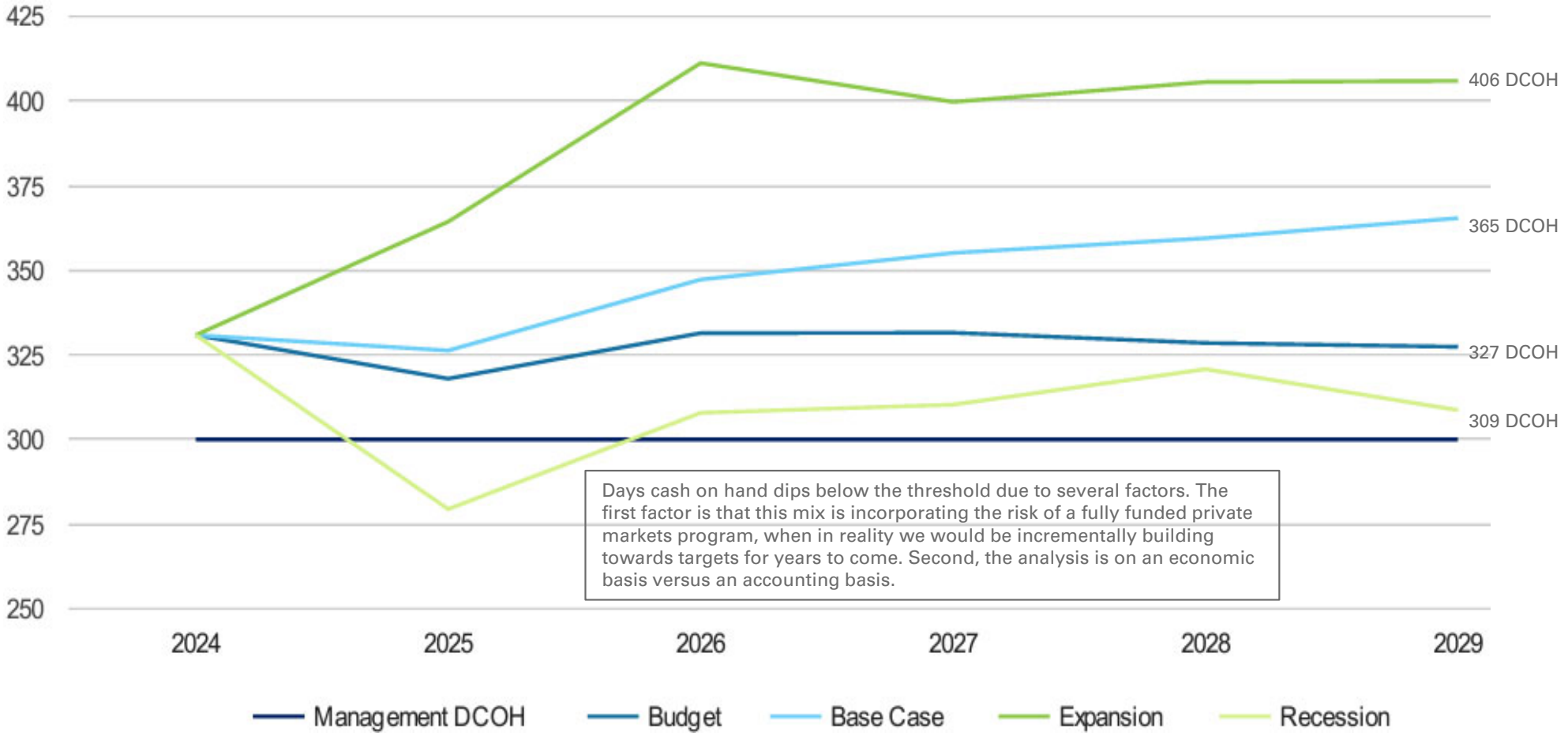


- Memorial Healthcare's Operating portfolio, using the Phase 1 Completion mix has a base case scenario which gradually increases Days Cash On Hand over the course of the next five years
- In an Expansionary period, the portfolio's DCOH will rise to 403 days cash before flattening in the remaining three years

SCENARIO ANALYSIS – PHASE II COMPLETION

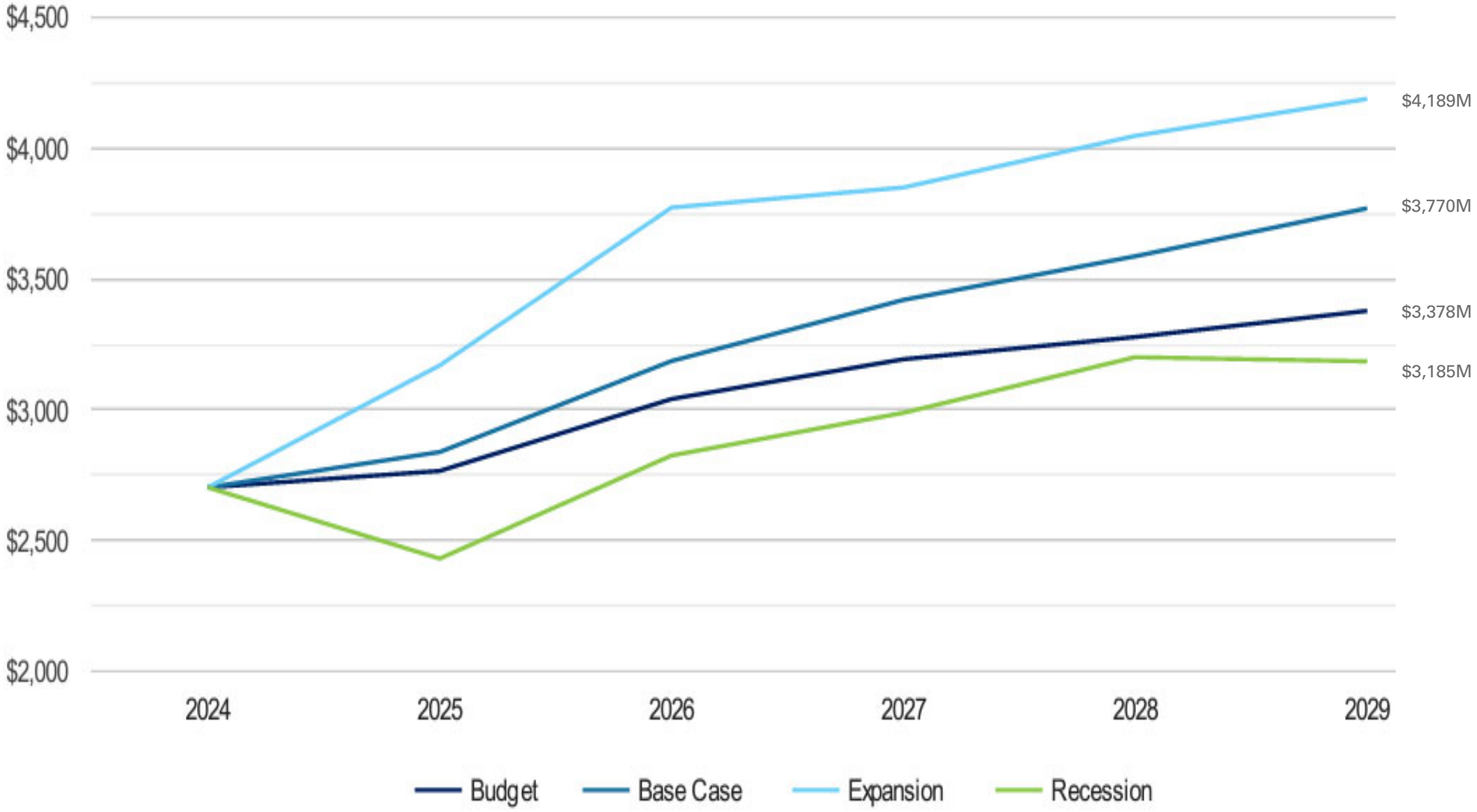


MEMORIAL ERM – PHASE IV

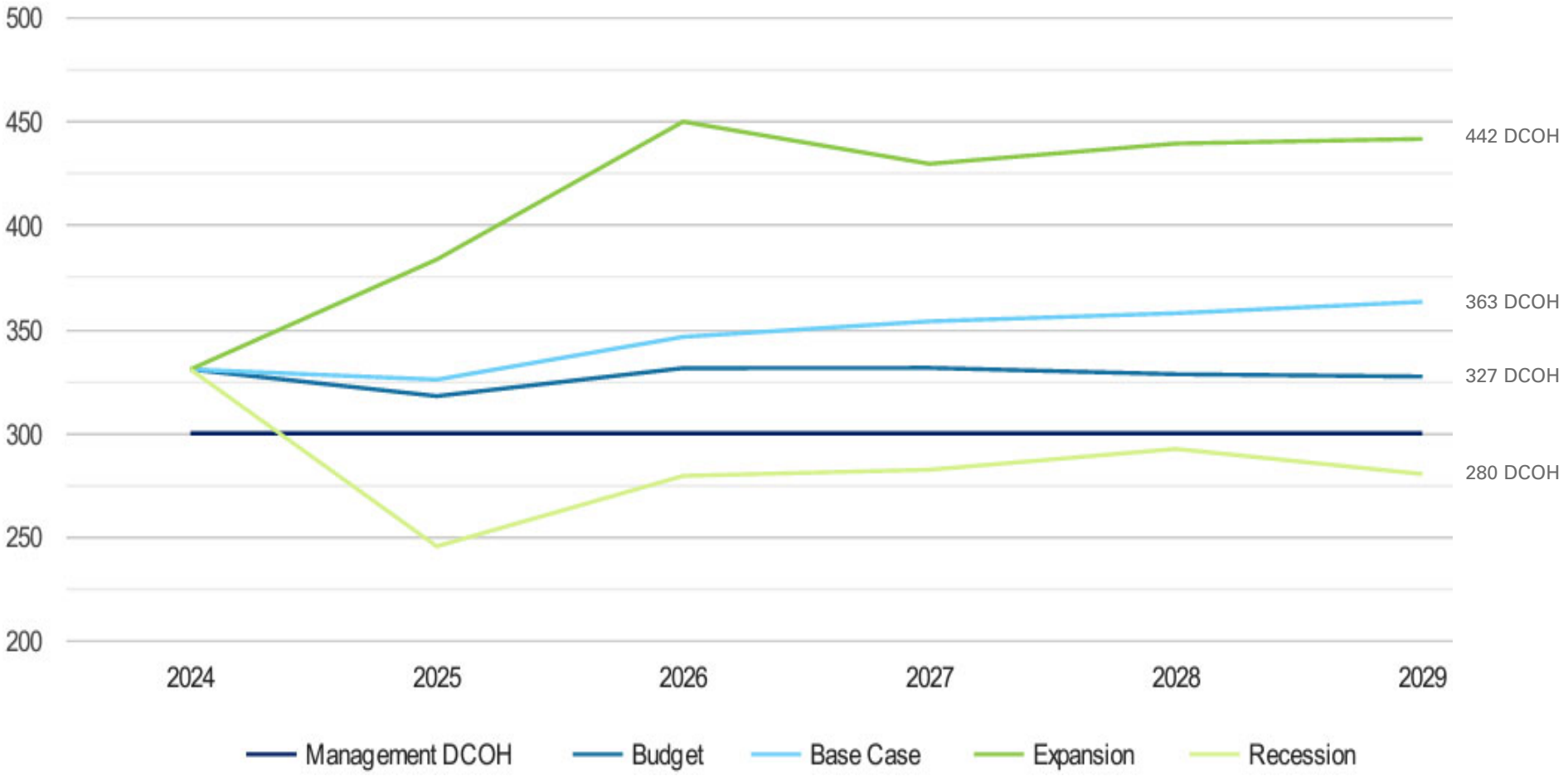


- Memorial Healthcare's Operating portfolio, using NEPC's preferred asset allocation, has a base case scenario which results in DCOH increasing steadily over the next five years
- In an Expansionary period, the portfolio's DCOH will rise to 411 days before flattening out and stabilizing for the remaining three years
- Alternatively, in a Recessionary scenario, the portfolio drops to 279 days cash, breaching the 300-day Management threshold, before exceeding the floor after year 2
  - DCOH remains stable over the final three years after the initial recessionary shock

SCENARIO ANALYSIS – PHASE IV

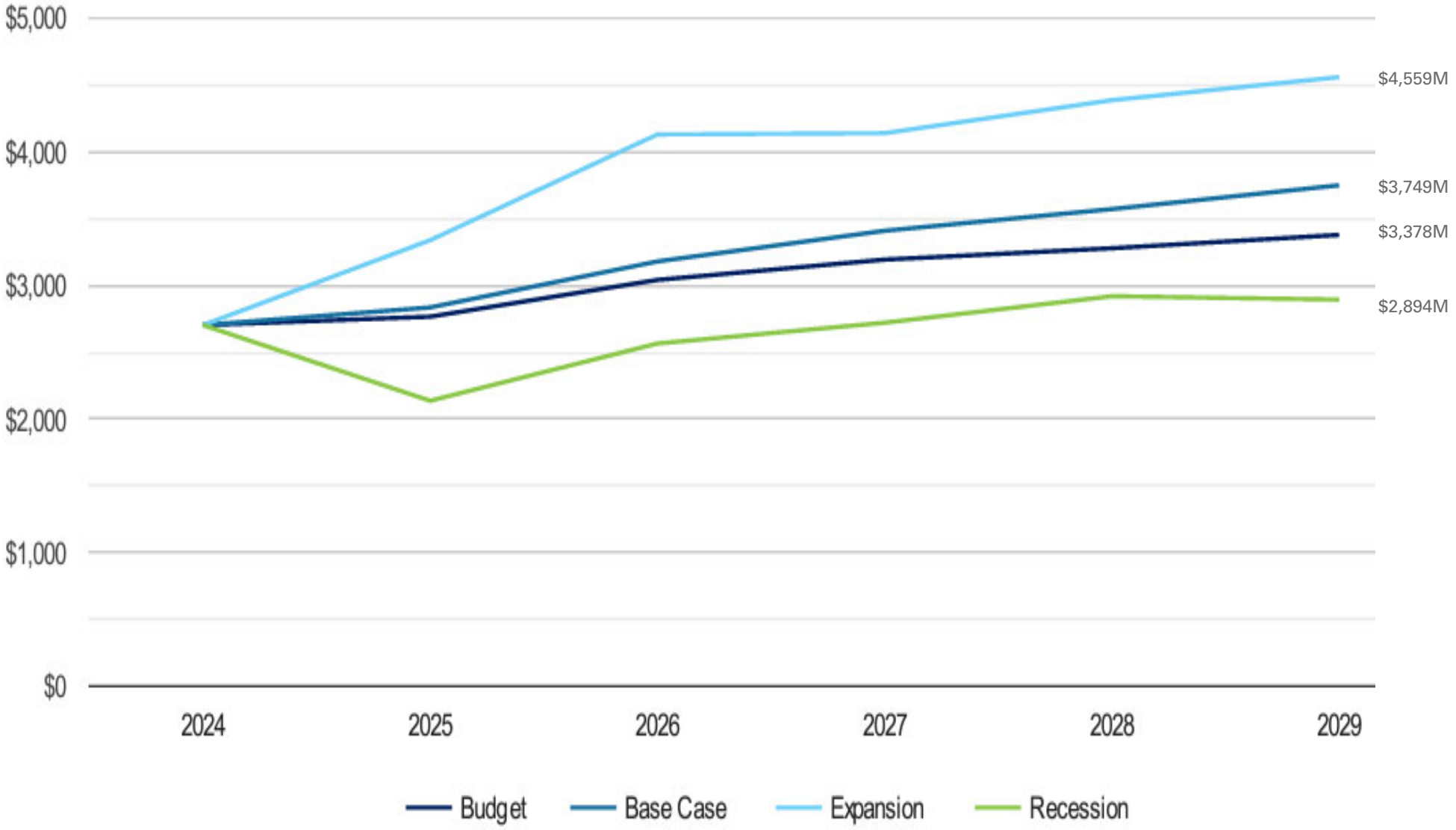


MEMORIAL ERM – AVERAGE HC UNIVERSE



- Memorial Healthcare's Operating portfolio, using the Average Healthcare Universe mix has a base case scenario which gradually increases Days Cash On Hand over the course of the next five years
- The Average HC Universe mix incorporates riskier assets classes such as Private Equity and Hedge Funds which, in turn, benefits the portfolio significantly on the upside but struggles mightily on the downside
- In a Recessionary scenario, the portfolio hits 246 days cash in the first forecasted year, and then steadies below the threshold for the remaining years

SCENARIO ANALYSIS – AVERAGE HC UNIVERSE



FIXED INCOME MANAGER GUIDELINE ADJUSTMENTS

OVERVIEW OF FIXED INCOME GUIDELINE REVIEW

- **NEPC reviewed (and discussed with the managers) the guidelines for each fixed income manager in the MHS Operating portfolio to assess three key areas**
  - Are the fixed income IPS restrictions limiting and/or present an obstacle to maximizing yield given the managers mandate?
  - Are there differences in the guidelines amongst managers – both what is included and their interpretation?
  - Are there restrictions that are included in the investment management agreement (IMA) that are not in the IPS?
- **It was concluded that all three situations are taking place – which could be limiting the potential of the fixed income portfolio**
  - It does appear that many restrictions were discussed/implemented with managers at different points several years ago during different market conditions
- **NEPC and Staff would recommend the Committee approve the changes to the IPS outlined on the following slides. Goals of the changes are as follows:**
  - Improve fixed income yield/return at a normal level of market risk
  - Bring a degree of uniformity to the fixed income guidelines and remove unintended outcomes
  - MHS and NEPC will further work with managers to remove non-IPS restrictions that currently exist

IPS GUIDELINE CHANGES – FIXED INCOME

- **Change restriction requiring the average duration of the total fixed income portfolio not exceed four years**
  - Propose a duration limit equal to that of the Bloomberg Aggregate Index
- **Increase maximum amount in BBB rated securities from 15% to 20%**
  - Currently creates a structural underweight vs. the benchmark
  - Minimum average credit quality of A is preserved in guidelines limiting risk associated with change
- **Increase the maximum combined Corporate and Securitized bond restriction from 50% to 65%**
- **Allow holdings in "Yankee bonds"**
  - US Dollar denominated securities of a foreign bank or corporation

IPS GUIDELINE CHANGES – FIXED INCOME (CONT.)

- **Eliminate restriction to only trade with Primary Security Dealers**
  - Current restriction can result in higher trading costs
- **Eliminate Guideline requiring corporate bonds have a listed equity security on a national exchange**
- **Increase final maturity maximum from 10 years to 10 years and one quarter**
    - Current restriction eliminates a fair number of bonds on the edges
    - 10 years + 1 quarter would fix approximately 95% of this
- **Reduce minimum rating on securitized from AAA to AA**
  - Still high quality and allows managers to "ride the credit quality up"
- **Increase the 144A restriction from 10% to 20%**
  - 144A securities issuance has increased and these securities do not face the same liquidity issues as previously

APPENDIX

GLOSSARY OF TERMS

Alpha - Measures the relationship between the fund performance and the performance of another fund or benchmark index and equals the excess return while the other fund or benchmark index is zero.

Alpha Jensen - The average return on a portfolio over and above that predicted by the capital asset pricing model (CAPM), given the portfolio's beta and the average market return. Also known as the abnormal return or the risk adjusted excess return.

Annualized Excess Return over Benchmark - Annualized fund return minus the annualized benchmark return for the calculated return.

Annualized Return - A statistical technique whereby returns covering periods greater than one year are converted to cover a 12 month time span.

Beta - Measures the volatility or systematic risk and is equal to the change in the fund's performance in relation to the change in the assigned index's performance.

Information Ratio - A measure of the risk adjusted return of a financial security, asset, or portfolio.

Formula:
(Annualized Return of Portfolio - Annualized Return of Benchmark)/Annualized Standard Deviation(Period Portfolio Return – Period Benchmark Return). To annualize standard deviation, multiply the deviation by the square root of the number of periods per year where monthly returns per year equals 12 and quarterly returns is four periods per year.

R-Squared – Represents the percentage of a fund's movements that can be explained by movements in an index. R-Squared values range from 0 to 100. An R-Squared of 100 denotes that all movements of a fund are completely explained by movements in the index.

Sharpe Ratio - A measure of the excess return or risk premium per unit of risk in an investment asset or trading strategy.

Sortino Ratio - A method to differentiate between good and bad volatility in the Sharpe Ratio. The differentiation of up and down volatility allows the calculation to provide a risk adjusted measure of a security or fund's performance without upward price change penalties.

Formula:
*Calculation Average (X-Y)/Downside Deviation (X-Y) * 2*
Where X=Return Series X Y = Return Series Y which is the risk free return (91 day T-bills)

Standard Deviation - The standard deviation is a statistical term that describes the distribution of results. It is a commonly used measure of volatility of returns of a portfolio, asset class, or security. The higher the standard deviation the more volatile the returns are.

Formula:
(Annualized Return of Portfolio – Annualized Return of Risk Free) / Annualized Standard Deviation (Portfolio Returns)

Tracking Error - Tracking error, also known as residual risk, is a measure of the degree to which a portfolio tracks its benchmark. It is also a measure of consistency of excess returns. Tracking error is computed as the annualized standard deviation of the difference between a portfolio's return and that of its benchmark.

Formula:
*Tracking Error = Standard Deviation (X-Y) * √(# of periods per year)*
Where X = periods portfolio return and Y = the period's benchmark return
For monthly returns, the periods per year = 12
For quarterly returns, the periods per year = 4

Treynor Ratio - A risk-adjusted measure of return based on systematic risk. Similar to the Sharpe ratio with the difference being the Treynor ratio uses beta as the measurement of volatility.

Formula:
(Portfolio Average Return - Average Return of Risk-Free Rate)/Portfolio Beta

Up/Down Capture Ratio - A measure of what percentage of a market's returns is "captured" by a portfolio. For example, if the market declines 10% over some period, and the manager declines only 9%, then his or her capture ratio is 90%. In down markets, it is advantageous for a manager to have as low a capture ratio as possible. For up markets, the higher the capture ratio the better. Looking at capture ratios can provide insight into how a manager achieves excess returns. A value manager might typically have a lower capture ratio in both up and down markets, achieving excess returns by protecting on the downside, whereas a growth manager might fall more than the overall market in down markets, but achieve above-market returns in a rising market.

UpsideCapture = TotalReturn(FundReturns)/TotalReturns(BMReturn) when Period Benchmark Return is > = 0

DownsideCapture = TotalReturn(FundReturns)/TotalReturns(BMReturn) when Benchmark <0

INFORMATION DISCLAIMER

Past performance is no guarantee of future results.

The goal of this report is to provide a basis for monitoring financial markets. The opinions presented herein represent the good faith views of NEPC as of the date of this report and are subject to change at any time.

Information on market indices was provided by sources external to NEPC. While NEPC has exercised reasonable professional care in preparing this report, we cannot guarantee the accuracy of all source information contained within.

All investments carry some level of risk. Diversification and other asset allocation techniques do not ensure profit or protect against losses.

Group:	S.B.H.D. Contracts Committee	**Date:**	July 15, 2024
Chairman:	Mr. Steven Harvey	**Time:**	3:00 p.m.
Vice Chairman:	Dr. Luis E. Orta		
Location:	Executive Conference Room, 3111 Stirling Road, Hollywood, Florida, 33312		

In Attendance: Mr. Steven Harvey, Ms. Elizabeth Justen, Mr. Brad Friedman, Mr. Scott Wester, Mr. Vedner Guerrier, Mr. David Smith, Aharon Sareli, M.D. (via Webex), Ms. Leah Carpenter, Mr. Frank Rainer, Ms. Esther Surujon, and Ms. Kim Kulhanjian

---

The Contracts Committee meeting convened at 3:00 p.m. on July 15, 2024.

1) CALL TO ORDER / PUBLIC MEETING NOTICE CERTIFICATION

The meeting was called to order and legal certification of compliance with Florida's Public Meetings Law was given by Mr. Frank Rainer, General Counsel. The meeting materials were not posted based on assertion of confidentiality.

2) BOARD APPROVAL CONTRACTS

The following agenda items were discussed:

a) Renewal Physician Employment Agreement between Amy Aronovitz, M.D., for Chief, Endocrinology Services, and South Broward Hospital District

The Committee reviewed the Renewal Physician Employment Agreement between the South Broward Hospital District and Amy Aronovitz, M.D., for Chief, Endocrinology Services.

Dr. Aronovitz received a B.A. Degree in 1998 from the University of Pennsylvania, Philadelphia, PA, and her M.D. Degree in 2002 from MCP Hahnemann University, Philadelphia, PA. She completed an Internal Medicine Residency (2002–2005) at Mount Sinai Hospital, New York, NY, and an Endocrinology Fellowship (2005–2008) at McGaw Medical Center of Northwestern University, Chicago, IL. She also completed a Master of Science and Clinical Investigation Degrees (2006–2008) at Northwestern University Feinberg School of Medicine, Chicago, IL. Since 2008, Dr. Aronovitz has held clinical and academic positions at NorthShore University Health System, Evanston, IL, and University of Chicago Pritzker School of Medicine, Chicago, IL. She is board-certified in Internal Medicine and the sub-specialty of Endocrinology, Diabetes and Metabolism. She has been employed by MHS since 2016.

Dr. Aronovitz will be responsible for providing Adult Endocrinology Services consistent with the clinical scope of her privileges. She will provide medical care and treatment to all patients who require the services of an Endocrinologist. She shall provide such services assuring that patient care is delivered in a manner which results in safe, high-quality care, as measured by clinical outcomes and patient satisfaction. Dr. Aronovitz may also be required to perform other medical administrative services. Under this employment agreement, she will be required to perform such services at any Hospital District location.

The details of Dr. Aronovitz's compensation package were discussed. The Committee noted that Dr. Aronovitz's salary was evaluated based upon the 2023–2024 Physician Salary Matrix for Chief, Adult Endocrinology.

The Employment Agreement shall be effective August 1, 2024, and shall remain in effect for five (5) years. The Employment Agreement may be terminated for cause as stipulated in the agreement or by either party, without cause, by giving the other party at least 90 days prior written notice.

During the Term of the Agreement and for a period of one (1) year following the Term, physician shall not, without the prior written consent of the Hospital District, provide services within the geographic boundaries of the Restricted Area of Broward County plus five (5) miles.

Following further discussion:

> **The Contracts Committee recommends to the Board of Commissioners approval of the Renewal Physician Employment Agreement with Amy Aronovitz, M.D., for Chief, Endocrinology Services**

b) Renewal Physician Employment Agreement between Miguel Castro, M.D., for Cardiology – Advanced Heart Failure Services, and South Broward Hospital District

The Committee reviewed the Renewal Physician Employment Agreement between the South Broward Hospital District and Miguel Castro, M.D., for Cardiology - Advanced Heart Failure Services.

Dr. Castro received his Medical Doctor degree from Pontificia Universidad Católica Madre y Maestra (PUCMM) Santiago, Dominican Republic in 2012. He completed an internship and residency in Internal Medicine at Cleveland Clinic Florida, Weston, FL (2017), a Clinical Fellowship in Cardiovascular Disease (2020) and Advanced Heart Failure/Transplant Cardiology (2021). He has been employed by MHS since 2021.

Dr. Castro will be responsible for providing Advanced Heart Failure Services consistent with the clinical scope of his privileges. He will provide medical care and treatment to all patients who require the services of an advanced heart failure Cardiologist. He shall provide such services assuring that patient care is delivered in a manner which results in safe, high-quality care, as measured by clinical outcomes and patient satisfaction. Dr. Castro may also be required to perform other medical administrative services. Under this employment agreement, he will be required to perform such services at any Hospital District location.

The details of Dr. Castro's compensation package were discussed. The Committee noted that that Dr. Castro's salary was evaluated based upon the 2023–2024 Physician Salary Matrix for Advanced Heart Failure Services.

The Employment Agreement shall be effective September 1, 2024, and shall remain in effect for five (5) years. The Employment Agreement may be terminated for cause as stipulated in the agreement or by either party, without cause, by giving the other party at least 180 days prior written notice.

During the Term of the Agreement and for a period of two (2) years following the Term, physician shall not, without the prior written consent of the Hospital District, provide Advanced Heart Failure services within the Restricted Area of Palm Beach, Broward and Miami Dade Counties. In addition, during the Term of the Agreement and for a period of one (1) year following the Term, physician shall not, without the prior written consent of the Hospital District, provide Cardiology services within the Restricted Area of Broward County plus five (5) miles.

Following further discussion:

The Contracts Committee recommends to the Board of Commissioners approval of the Renewal Physician Employment Agreement with Miguel Castro, M.D., for Cardiology - Advanced Heart Failure Services

3) FYI CONTRACTS

a) New Physician Employment Agreement between Adarsh Vijay, M.D., for Surgical Director, Adult Abdominal Transplant Program Services, and South Broward Hospital District. The Employment Agreement shall become effective January 2, 2025, and shall remain in effect for three (3) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Medical Director - General Transplant Surgery, is within the President and CEO's Board-approved authority.

b) New Physician Employment Agreement between Alipasha Rassouli, M.D., for Otolaryngology Services, and South Broward Hospital District. The Employment Agreement shall become effective November 1, 2024, and shall remain in effect for three (3) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Otolaryngology, is within the President and CEO's Board-approved authority.

c) New Physician Employment Agreement between Neenu Cherian, M.D., for Physical Medicine and Rehabilitation Services, and South Broward Hospital District. The Employment Agreement shall become effective September 23, 2024, and shall remain in effect for three (3) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Physical Medicine and Rehabilitation, is within the President and CEO's Board-approved authority.

d) New Physician Employment Agreement between Brian Raitzin, M.D., for Family Medicine - MPG Services, and South Broward Hospital District. The Employment Agreement shall become effective October 1, 2024, and shall remain in effect for three (3) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Family Medicine, is within the President and CEO's Board-approved authority.

e) New Physician Employment Agreement between Wen Wu, D.O., for Family Medicine - Memorial Primary Care Services, and South Broward Hospital District. The Employment Agreement shall become effective November 4, 2024, and shall remain in effect for three (3) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Family Medicine, is within the President and CEO's Board-approved authority.

f) New Physician Employment Agreement between Nathan Boire, M.D., for Internal Medicine - Memorial Primary Care Services, and South Broward Hospital District. The Employment Agreement shall become effective September 2, 2024, and shall remain in effect for three (3) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Internal Medicine, is within the President and CEO's Board-approved authority.

g) New Physician Employment Agreement between Ingrid Haza, M.D., for Child and Adolescent Psychiatry Services, and South Broward Hospital District. The Employment Agreement shall become effective October 1, 2024, and shall remain in effect for three (3) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Child and Adolescent Psychiatry, is within the President and CEO's Board-approved authority.

h) Renewal Physician Employment Agreement between Edison Cano Cevallos, M.D., for Infectious Disease Services, and South Broward Hospital District. The Employment Agreement shall become effective August 16, 2024, and shall remain in effect for five (5) years. The proposed salary, as reflected in the 2023–2024 Physician Salary Matrix for Infectious Disease, is within the President and CEO's Board-approved authority.

4) NEW BUSINESS

There was no new business.

5) ADJOURNMENT

There being no further business, the meeting was adjourned at 3:12 p.m.

Respectfully Submitted,

Steven Harvey
Chairman
Contracts Committee

Group: S.B.H.D. Audit and Compliance Committee **Date:** July 15, 2024
Chairman: Mr. Steven Harvey **Time:** 3:30 p.m.
Vice Chairman: Mr. Douglas Harrison
Location: Executive Conference Room, 3111 Stirling Road, Hollywood, Florida, 33312

In Attendance: Steven Harvey, Brad Friedman, Elizabeth Justen, Scott Wester, Frank Rainer, Dave Smith, Irfan Mirza, Christina Mullins, Lindsay Welding, Kimisha Smith, Jeff Sturman, Rich Leon, Denny DiCesare, Robin Conner, Valerie Morris, Carlos Hernandez of RSM US LLP, Kirk Cornack of RSM US LLP, Katie Carabeo of RSM US LLP, Betty Martin of ZOMMA, LLP, and Jenny Ballesteros of ZOMMA Group, LLP

---

1. PUBLIC MEETING NOTICE REQUIREMENT

Mr. Frank Rainer, Senior Vice President and General Counsel, confirmed that all public notice requirements had been complied with.

2. NEW BUSINESS

PRESENTATION OF THE AUDITED FINANCIAL STATEMENTS FOR FISCAL YEAR 2024:

Mr. Hernandez of RSM US LLP stated that this is the last time that he would be the Audit Engagement Partner for MHS. He presented the audit results of the Fiscal Year 2024 Financial Statements and noted a clean audit. There were no significant changes to the planned audit strategy. There were no changes to the significant risks except for the addition of the GASB 96 Subscription-Based Information Technology Arrangements implementation, for which a new accounting policy was adopted. Kirk Cornack of RSM communicated the Significant Accounting Estimates, and Katie Carabeo of RSM communicated that there were no Audit Adjustments and only one recurring immaterial uncorrected misstatement related to a balance sheet reclass that management is aware of but chooses to not reclass as it is not relevant to the users of the financial statements. Mr. Hernandez provided the Committee with the RSM fraud evaluation of the lobbyist investigation and noted that the transaction risks were isolated to credit card transactions and only the credit card used by the lobbyist.

Request Board Approval of the Audited Financial Statements, Audit Results Report and Management Letter for the Fiscal Period Ended April 30, 2024.

Betty Martin of ZOMMA Group, LLP provided an update regarding the April 30, 2024, MHS Single Audit noting a clean audit with no material weaknesses for Memorial Healthcare System.

Request Board Approval of the Single Audit Report and Schedule of Expenditures of Federal Awards, State Financial Assistance, and Local and Other Entities Awards, and Supplementary Information and Schedule of Findings and Questioned Costs for the Year Ended April 30, 2024.

3. REVIEW OF THE AUDIT AND COMPLIANCE FOURTH QUARTER REPORT:

I. WRITTEN STANDARDS AND PROCEDURES

The Federal and State Government Agency Audits, Interviews and Searches, Records Management, Hazardous and Medical Waste Disposal, and Managed Care were reviewed, and none were revised during the quarter.

II. COMPLIANCE OFFICER

The Compliance Officer attended two sessions of the Florida Compliance and Privacy Consortium and one session of Becker's Hospital Review 14th Annual Meeting during the quarter as part of her ongoing efforts to stay abreast of emerging industry compliance matters.

III. TRAINING AND EDUCATION

The Compliance Department provided compliance training at thirteen sessions of New Employee Orientation, two sessions of Leadership Essentials, one session of the Compliance Working Committee, and one session of an ADA Walkthrough and Training.

IV. OPEN LINES OF COMMUNICATION

A. Hotline Calls

During the quarter, 46 calls, with no callbacks, were placed to the System's Compliance Hotline covering 36 new topics and two old topics.

Three topics were compliance allegations (five calls). Two topics were HIPAA privacy allegation (two calls).

All of the calls were investigated and one of the compliance allegations was substantiated.

Finally, four topics were uncompleted calls (four calls), and 27 new topics and two old topics (35 calls) were employee-management relations issues. The employee-management relations issues have been forwarded to the Employee Relations and Human Resources Departments.

V. ENFORCEMENT & DISCIPLINE

Sanction checks were conducted of employees, physicians, vendors, volunteers, and students. One non-staff referring physician was sanctioned. Accounts Receivable Management was notified so that appropriate action can be taken.

The Calendar Year (CY) 2024 Conflicts of Interest Questionnaire cumulative employee completion rate is 12,622, of which 151 reported a possible or potential conflict of interest.

The Conflicts of Interest Subcommittee has been established to evaluate and manage disclosed potential conflicts. Policies and procedures, a risk evaluation tool, and training have been developed to assist the Subcommittee determine appropriate management of conflicts.

IV. RISK ASSESSMENT, MONITORING & AUDITING

V. RESPONSE & PREVENTION

A. Recurring internal audits were conducted of:

- Construction Projects;
- Requests For Proposal And Competitive Quotes; and
- Board Expenses.

No irregularities were found in the audits.

B. Internal Audits were conducted of:

- Internal Audit of Dual Access to Epic Assigned to Users at MHS; and
- Internal Audit of Purchases During Workday Cutover at Memorial Healthcare System.

Opportunities for improvement in record documentation were noted in the Internal Audit of Dual Access to Epic Assigned to Users at MHS. Management has developed a detailed corrective action plan for this audit.

C. Compliance audits were conducted of:

- 340B Program at Memorial Healthcare System Contract Pharmacies - FY 2024 Fourth Quarter;
- Documentation and Billing of Malnutrition at MRH;
- Emergency Medical Treatment and Labor Act at MRH;
- Memorial Outpatient Physical Therapy at Home Program; and
- Professional Coding and Billing of Breast Oncology Procedures for MPG.

Opportunities for improvement in record documentation were noted in the EMTALA at MRH, Memorial Outpatient Physical Therapy at Home Program; and Professional Coding and Billing of Breast Oncology Procedures for MPG. Management has developed detailed corrective action plans for each of these audits.

A. The following other reports were provided to the Committee:

Privacy: The Committee was updated on the number of investigations for the first quarter of calendar year 2024 and the HIPAA/FIPA breaches that resulted from those investigations. The Committee was also updated on the status of an OCR case notification with the resolution and two incidents that occurred with Epic and other organizations participating in the health data exchange framework.

Cybersecurity: Rich Leon, Chief Information Security Officer, provided the Committee members with the External Penetration Review and the Internal Vulnerability test conducted by Protiviti during the quarter and the remediation to the subsequent observations. The Committee was also updated on the Workday Implementation Review that was also conducted by Protiviti.

Investor Log: Committee members were provided with a copy of the Investor Contact Log for the quarter.

Non-Audit: Committee members were provided with a copy of the list of RSM and Zomma Group Non-Audit Engagements for the quarter.

Compliance Environment: Committee members were provided with an update on the nationwide audit and investigation activities of various federal and state agencies.

There being no further business, the meeting was adjourned at 5:04 p.m.

Respectfully Submitted,

Steven Harvey
Chairman
Audit and Compliance Committee

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL ● MEMORIAL REGIONAL HOSPITAL SOUTH ● JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST ● MEMORIAL HOSPITAL MIRAMAR ● MEMORIAL HOSPITAL PEMBROKE

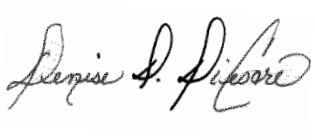
DATE: April 30, 2024

TO: K. Scott Wester, President and Chief Executive Officer, MHS

SUBJECT: **AUDIT AND COMPLIANCE – FOURTH QUARTERLY REPORT FISCAL YEAR 2024**

Attached is a copy of the fourth quarterly report of fiscal year 2024 summarizing the activities of the Internal Audit and Compliance Department from February 1, 2024, through April 30, 2024, for your records.

Please let me know if you have any questions regarding this report.



Denise (Denny) DiCesare
Chief Compliance and Internal Audit Officer

cc: Leah Carpenter, Executive Vice President and Chief Operations Officer, MHS
Dave Smith, Executive Vice President and Chief Financial Officer, MHS
Frank Rainer, Senior Vice President and General Counsel, SBHD

I. WRITTEN STANDARDS AND PROCEDURES

The following policies and procedures were reviewed and/or revised during the quarter:

Reviewed:

- Federal and State Government Agency Audits, Interviews and Searches
- Records Management,
- Hazardous and Medical Waste Disposal, and
- Managed Care

Revised:

- None.

II. COMPLIANCE LEADERSHIP AND OVERSIGHT

The Compliance Officer attended the following meetings during the quarter:

- Florida Compliance and Privacy Consortium – 2 Sessions; and
- Becker's Hospital Review 14th Annual Meeting.

III. TRAINING AND EDUCATION

The following compliance training was provided during the quarter:

- New Employee Orientation: Thirteen Sessions,
- Leadership Essentials: Two Sessions,
- Compliance Working Committee: One Session, and
- ADA Walkthrough and Training: One Session.

IV. OPEN LINES OF COMMUNICATION

A. Hotline Calls

During the quarter, 46 calls, with no callbacks, were placed to the System's Compliance Hotline covering 36 new topics and two old topics. Three topics were compliance allegations (five calls). Two topics were HIPAA privacy allegation (two calls). All of the calls were investigated and one of the compliance allegations was substantiated.

Finally, four topics were uncompleted calls (four calls), and 27 new topics and two old topics (35 calls) were employee-management relations issues. The employee-management relations issues have been forwarded to the Employee Relations and Human Resources Departments.

V. ENFORCEMENT & DISCIPLINE

A. Sanctions Checks

Sanction checks were conducted of employees, physicians, vendors, volunteers, and students. There was one referring physician who was sanctioned during the quarter.

B. Conflicts of Interest

The Calendar Year (CY) 2024 Conflicts of Interest Questionnaire cumulative employee completion rate is 12,622, of which 151 reported a possible or potential conflict of interest.

The Conflicts of Interest Subcommittee has been established to evaluate and manage disclosed potential conflicts. Policies and procedures, a risk evaluation tool, and training have been developed to assist the Subcommittee determine appropriate management of conflicts. Five of

eight employees have accepted a position on the Subcommittee.

VI. RISK ASSESSMENT, MONITORING & AUDITING

VII. RESPONSE & PREVENTION

A. Internal Audit

Recurring Quarterly Reports

South Broward Hospital District Construction Projects

Thirty payment vouchers for 13 construction projects were audited during the quarter, as shown on Exhibit A. No irregularities were found during these audits.

South Broward Hospital District Requests for Proposal and Competitive Quotes

Eleven Requests for Proposal and 30 Competitive Quotes were audited during the quarter, as shown on Exhibit B. No irregularities were found during these audits.

Board Expenses

Board Expenses were audited during the quarter. The list of expenses audited for the quarter will be presented and discussed during the meeting.

Internal Audit of the Dual Access to Epic Assigned to Users at Memorial Healthcare System

Background

During the pandemic, personnel shortages were critical in the healthcare industry where it was essential to maintain staff levels to adequately treat and care for patients in a safe environment. Some Memorial Healthcare System (MHS) employees took second jobs to help in physician practices. In the past, this arrangement was prohibited because there was not an established way to monitor for employee activity that presented a potential conflict of interest, such as rounding on patients on behalf of the physician while working on MHS time. This scenario poses billing, liability, and timekeeping concerns as well. To make accommodations, controls were established to manage conflicts of interest by requiring disclosure of potential conflicts on the annual MHS Conflicts of Interest (COI) Questionnaires, user training, signing a memorandum of understanding (MOU) attestation, and Privacy and IT Security monitoring the users' activity. The Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules state that covered entities must take reasonable steps to limit the use or disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose and ensure the confidentiality, integrity, and availability of all electronic personal health information (ePHI). The Florida Statute on Security of Confidential Personal Information states that each covered entity shall take reasonable measures to protect and secure data in electronic form from unauthorized access. The MHS Business Ethics and Conflicts of Interest Standard Practice states that a conflict can be considered to exist when an employee holds a position with a vendor, contracted entity, or competitor of MHS. MHS Human Resources (HR) Policy E-38, titled "Outside Employment", requires employees to notify the Compliance Office of outside employment for potential conflicts to be evaluated. MHS employees with Epic access as part of their MHS job can obtain additional or secondary access to Epic for an outside employment. Dual access includes two network and two Epic accounts, community access is a separate account to MHS EPIC through Community Connect platforms such as Epic Community Connect, PlanLink or EpicCare Link. Multiple security templates are used for a second job with a vendor that is assigned to work at MHS, such

as TeamHealth and Envision. All accesses create separate event logs so that access can be monitored.

Observations

The System Access Team (SAT) identified eight MHS users with Epic dual access, two of which did not update their COI Questionnaire or sign the MOU. Three of the eight dual access users used their secondary access, and the SAT confirmed the dual access was no longer needed for the remaining five before removing it. One user accessed their non-MHS account while working on MHS time and the Privacy Department provided the user with training. We noted that five of the eight dual access users are not required to clock in and out and schedules are not always kept in the timekeeping software, therefore monitoring could not be completed. The SAT identified 198 MHS accounts that access Epic from the community platform that belong to users who might already have MHS Epic access. There is not a positive identifier to determine if two account holders have the same name or one user has two accounts. SAT also identified 1,547 Epic users with multiple security templates assigned to them. We evaluated 30 accounts and there were 23 with an appropriate ticket requesting access but the ticket did not include a MHS business reason to clarify whether the multiple security templates were different roles at MHS or for an outside employment.

Recommendations

We recommended developing a procedure where employees are required to update their COI Questionnaire disclosing a second job and signing the MOU prior to finalizing dual access. We recommended the dual access users be required to inform the SAT when dual access is no longer required, and that SAT periodically verify that the dual access is still being used. We recommended monitoring to verify that MHS employees are using dual access appropriately, including salaried employees. We recommended a process be developed to verify that users requesting access to MHS Epic do not already have an account and if they do, we recommended verifying there is valid reason for expanded access, users are appropriately provided supplemental access, and determining whether the access is for the job duties within MHS, for an outside activity, and length of time additional access is required.

Jeffrey Sturman, Senior Vice President and Chief Digital Officer and Frank Rainer, Senior Vice President and General Counsel, SBHD agreed with our findings and recommendations of this audit and have provided a detailed action plan.

Internal Audit of Purchases During Workday Cutover at Memorial Healthcare System

Background

Memorial Healthcare System (MHS) transitioned its Enterprise Resource Planning (ERP) system from Lawson (Infor) to Workday. The Go-Live for Supply Chain Management (SCM) was scheduled for January 1, 2024. Multiple milestones were set as part of the transition phase, one of which was the Ramped up Buying phase during Workday cutover period. Purchase Orders (POs) were issued from November 27, 2023, to December 18, 2023, to cover the blackout period of December 19, 2023, to December 31, 2023, when no POs would be issued using the Lawson requisition process. Leaders were advised to review requisitions during the Ramped up Buying phase dates for the forthcoming blackout dates to mitigate cutover impact. The purpose of this audit was to determine if adequate controls were in place during the Ramped up Buying phase of the Workday transition.

We obtained a download of 42,302 POs from the system SuperGL issued between the period of November 27, 2023, and December 18, 2023. Using RAT-STATS Random Number Generator, we selected 30 POs to check if appropriate controls were in place. MHS utilized the Requisition module of Lawson to manage the purchase requisitions and approvals.

Observations

We noted routine requisitions for the Operating Room (OR) par-orders, which is the level at which stock items are reordered and substituted items. POs are issued based on the requesting location and represent pre-approved contractual items. These POs are issued without going through an approval workflow. This workflow change was approved by the MHS facility Chief Operating Officers (CFOs) on May 20, 2022, to sustain efficiency in procuring items for OR. We were able to review the meeting agenda for this change. This change also aligns with the Central Supply workflow, which is on a perpetual inventory since the Lawson Go-Live in 1998. The perpetual inventory supply requisition items too do not go through an approval workflow before a PO is issued. Some items for Radiology are part of the perpetual inventory that do not go through an approval workflow. The remaining requisition from Laboratory, Home Infusion, other Radiology items, and Facilities, we noted controls were consistently applied for approvals.

There were no new non-approval changes applied to POs being issued during the Ramped up Buying phase.

Recommendations

None.

Saul Kredi, Vice President, SCM agreed with the result of this audit and since there were no recommendations, an action plan was not required.

B. Compliance

Compliance Audit of the 340B Program at Memorial Healthcare System Contract Pharmacies - FY 2024 Fourth Quarter

Background

The 340B Program is administered and overseen by the Health Resources and Services Administration (HRSA) which is within the Department of Health and Human Services (HHS). The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices. To participate in the 340B Program, eligible organizations must register and be enrolled with the 340B Program and comply with all the requirements, that include maintaining an up to date 340B database; recertifying eligibility every year; and preventing duplicate discounts by having mechanisms in place to prevent receiving a 340B price and a Medicaid drug rebate for the same drug. To prevent duplicate discounts, Memorial Healthcare System (MHS) bills Medicaid for 340B purchased medications, meaning it carves-in Medicaid which is approved by HRSA/ Office of Pharmacy Affairs (OPA). Covered entities are subject to audit by the manufacturers and/or the federal government. Any covered entity that fails to comply with 340B Program requirements may be liable to the manufacturers for refunds of the discounts obtained. To be eligible to receive 340B-purchased drugs, patients must have an established relationship with the covered entity such that the entity maintains records of the individual's care; and must receive health care services from a health care professional employed by the covered entity or under contract or other arrangement with the covered entity such that responsibility for the care remains with the covered entity. Under the guidelines, an individual is not considered a patient of the covered entity if the only health care service received by the individual from the entity is the dispensing of a drug for subsequent self-administration or administration in the home setting. An individual may receive a 340B drug in

connection with treatment rendered outside the covered entity if the treatment is proximate in type and time to prior services provided by the covered entity. A non-hospital prescription is proximate in type and time to hospital-based services if the prescription or refill is presented within an appropriate time frame of the MHS encounter and the prescriber's services are part of the same continuum of care as the prior hospital encounter. A continuum of care exists if MHS makes a referral to the outside provider for follow-up care and there is an established patient care relationship with MHS. The only exception is patients of state-operated or -funded acquired immunodeficiency syndrome (AIDS) drug purchasing assistance programs. The Ryan White Clinic provides Human Immunodeficiency Virus (HIV)/AIDS treatment and related services to low-income people living with HIV/AIDS. All prescriptions written in this location and prescriptions of continuum care for Ryan White patients are 340B eligible. MHS participates in the 340B Program for Memorial Regional Hospital (MRH) which includes Memorial Regional Hospital South (MRHS) and Joe DiMaggio Children's Hospital (JDCH); Memorial Hospital Pembroke (MHP); Memorial Hospital West (MHW); and Memorial Hospital Miramar (MHM).

HRSA has developed guidelines to allow covered entities to contract with one or more outside pharmacies to act as dispensing agents. The covered entity and contract pharmacy must establish and maintain a tracking system to prevent diversion of drugs to individuals who are not patients of the covered entity. MHS uses Verity Solutions Group, Inc.'s (Verity) application to help manage its contract pharmacy arrangements. There are seven contract pharmacies and a Ryan White Clinic. The purpose of this audit was to determine if MHS contract pharmacies are in compliance with the HRSA 340B Program requirements.

Observations

We examined 240 340B eligible contract pharmacy claims, 30 for each of the seven outpatient pharmacies and Ryan White clinic, of which 20 were specific targeted areas. All 240 340B contract pharmacy claims met the 340B eligibility requirements.

Recommendations

None.

Dorinda Segovia, Vice President & Chief Pharmacy Officer, MHS and Scott Davis, Vice President, Reimbursement and Revenue Integrity, Corporate Finance, MHS agreed with this audit and since there were no recommendations, an action plan was not required.

Compliance Audit of Documentation and Billing of Malnutrition at Memorial Regional Hospital

Background

Malnutrition refers to deficiencies, excesses or imbalances in intake of energy and/or nutrients. Malnutrition may be undernutrition and overnutrition that is associated with disease that consists of a combination of reduced food intake and varying degrees of acute or chronic inflammation, leading to altered body composition and diminished biological function. Secondary diagnoses are those impacting clinical evaluation, therapeutic treatment, diagnostic procedures, extend the length of stay or nursing care required. The Academy of Nutrition and Dietetics (The Academy) and American Society for Parenteral and Enteral Nutrition (ASPEN) have developed criteria which assists the process of standardizing definitions of malnutrition. Memorial Regional Hospital (MRH) Registered Dieticians (RD) use these criteria when assessing patients at risk of malnutrition. When malnutrition is determined, diagnosis and nutrition intervention is

recommended by the RD. The attending provider can agree or disagree with the suggested diagnosis and intervention. Also, providers are able to diagnose malnutrition and order intervention without the consultation of an RD.

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), based on appropriate weighting factors assigned to each Medicare Severity Diagnosis Related Group (MS-DRG). When a patient is admitted as an inpatient for a primary reason other than malnutrition but meets criteria for malnutrition, it is classified as a major complication or comorbidity (MCC). Adding MCC to a Medicare claim can result in a higher Medicare payment. The purpose of this audit was to determine if documentation supports the criteria for malnutrition and determine the accuracy of coding, charging and billing for inpatient accounts at MRH.

Observations

Of 30 patient accounts reviewed, 27 had consultation for nutrition assessment. These patients had initial nutrition assessment and follow up reassessments according to MRH policy. Attending providers reviewed and agreed with the suggested diagnosis and interventions. Three patient accounts did not have nutritional assessment documented by RD. Two of the three patient accounts indicated malnutrition assessment and diagnosis were documented by the attending provider as both patients had malnutrition caused by unchanged chronic diseases in the recent admissions. Documentation for one of the three patient accounts indicated the admitting provider agreed with the malnutrition diagnosis from a recent admission but nutritional assessment or intervention was not documented. Discharge notes documented by a different provider indicated malnutrition was ruled out.

Twenty-nine of 30 accounts were coded with the MCC diagnosis of malnutrition and severity accurately. One account coded with malnutrition did not concur with documentation. The account was reviewed by a clinical documentation integrity specialist (CDIS), Health Information Management (HIM), Memorial Healthcare System (MHS) while the patient was in the hospital for accuracy of diagnosis. A query for clarification was sent to the specific provider as documentation did not support the malnutrition diagnosis and severity. The provider updated the discharge summary documentation to include malnutrition is ruled out however, coding was completed prior to the query being placed and documentation updated. According to HIM management, this account is an outlier where communication was not followed according to process for CDIS to notify the coder by email when there is response to a query from the provider after coding initially completed with an update to the documentation. Subsequently, HIM corrected the account, reeducated specific CDIS to always follow the current process and Accounts Receivable Management (ARM) rebilled. There was no change to MS-DRG. All 30 accounts were paid according to the assigned MS-DRG.

Recommendations

None.

Peter Powers, Chief Executive Officer, MRH and Walter Bussell, Chief Financial Officer, MRH agreed with the result of this audit and since there were no recommendations, an action plan was not required.

Compliance Audit of the Emergency Medical Treatment and Labor Act at Memorial Regional Hospital

Background

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted by Congress to ensure public access to emergency services regardless of the patient's ability to pay. The law details three main obligations necessary to comply with the EMTALA law. These include providing a medical screening examination (MSE) when a request is made for examination or for the treatment of an emergency medical condition (EMC), providing stabilizing treatment and lastly, if the hospital is not equipped to stabilize a patient within its capacity, or if the patient requests, implementing an appropriate transfer when medically necessary and when certain conditions are met to the next closest health care facility with the capacity to provide stabilizing treatment. The Centers for Medicare and Medicaid Services (CMS) outlined the responsibilities to comply with the EMTALA statute. Violations of EMTALA results in large fines, and possible termination of the Medicare provider agreement for the facility involved.

Memorial Regional Hospital (MRH) has a dedicated Emergency Department (ED) catering to adult individuals seeking emergency services. The purpose of this audit is to determine if MRH main ED is in compliance with EMTALA regulations regarding policies and procedures, signage, triage, registration, MSE, stabilizing treatment, transfers in and out, and documentation.

Observations

We observed that the requirements for EMTALA were met on adopting policies/procedures adhering to EMTALA, and using appropriate signage, transfer logs and physicians' on-call lists. All 35 accounts reviewed have complete documentation of triage including timely MSE and stabilizing treatment provided. Out of 35 accounts, six were transferred out of MRH ED in stable condition. Of the six, one was a transfer back to MRH Behavioral Health unit as the patient was cleared for admission and did not need a transfer form. One was a transfer to a non-Memorial Healthcare System (MHS) facility as per patient's physician request and the remaining four were transferred for admission to another MHS facility as inpatient admission at MRH was at capacity. We noted an opportunity for improvement on the completion of the transfer form. For the non-MHS facility transfer, the form was missing the date and time for the part where the physician certifies that the patient is stable for transfer or any other acceptable condition, and the name of the accepting staff from the receiving facility. On three accounts that were transferred out to another MHS facility, the forms were noted that patient provided verbal consents. These were not EMTALA violations as documentation was noted in the medical records that were transferred with the patient and written consent is only necessary for transfer requests by patient or family. For the transfers in from another MHS facility, we noted one out of nine transfers was missing the scanned form in Epic. As this is a MHS transfer, all necessary medical information were noted in Epic and hence, not an EMTALA violation. We noted on all but one account that the time stamps for registration were completed after the physician had seen the patient and stabilizing treatment were provided. According to Patient Financial Service (PFS) management, documentation showed attempt to register the patient after being seen by the physician and provision of stabilizing treatment. We noted registration was completed and verified after the patient was transferred to another MHS facility.

Recommendations

We recommended ED leadership to reeducate the staff on the completeness of the transfer form which includes scanning the form in Epic for the transfers in and conduct regular reviews to monitor for completeness. We recommended Transfer Center management reeducate the

nurses on the procedure for filling the transfer form particularly when patient is unable to sign the form and perform regular audits to monitor for completeness.

Peter Powers, Chief Executive Officer, MRH and Walter Bussell, Chief Financial Officer, MRH agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of Memorial Outpatient Physical Therapy at Home Program

Background

The Centers for Medicare and Medicaid Services (CMS) covers outpatient (OP) physical therapy (PT) services when services are medically necessary, the Plan of Care (POC) is established and reviewed periodically, and the individual is under the care of a physician. The POC must be certified by a physician/non-physician practitioner (NPP) for coverage and payment. Timely certification of the initial plan is met when done in the 30 days following the first day of treatment. Recertifications should be signed whenever there is a significant modification of the plan or at least every 90 days after initiation of treatment. To bill Medicare, total timed codes in minutes and total treatment time must be documented in the medical record for each service date. The total timed codes in minutes refer to the total minutes for the timed Current Procedural Terminology (CPT) codes which represents each 15 minutes increment the therapists performs one-on-one treatment such as therapeutic exercise and therapeutic activity. The total treatment time refers to the total timed codes plus the untimed codes, which are one-time therapy services such as the evaluation time. Memorial Rehabilitation Institute at Memorial Regional Hospital South (MRHS) partnered with Luna to expand access for patients to have OP PT services in-home. As per the agreement, Luna will deliver PT by a duly licensed, qualified therapist. Luna will be responsible for the scheduling, coding, charging, and billing under Memorial Healthcare System (MHS) name, federal Employer identification (ID) number, National Provider Identifier (NPI) and applicable provider number, and for the collection of all services provided. In return, MHS will compensate Luna for the services per visit. MHS Compliance and Internal Audit Department's audit of this program was at the request from management to evaluate the design, controls and performance of the Memorial OP PT at Home Program.

Observations

Luna medical documentation and claims are maintained in Luna's electronic health records (EHR). Audit access was requested to Luna's EHR but denied. We requested and reviewed copies of clinical documentation and claims for 37 accounts. All met medical necessity, had a referral for the PT services and were under the care of a physician. We noted that all accounts have initial evaluations, completed POCs, progress notes every 10th treatment day, and the therapists' dated and timed signature on all notes. For the 16 Medicare accounts, 12 had the initial certification complete with the physician's dated and timed signature, one had the physician's signature but did not approve the POC, and three accounts were missing the initial certification. Four out of eight accounts with recertifications, were appropriate since modifications were made to the patient's POC. For all 16 Medicare accounts, we noted in the documentation the minutes spent for each timed therapy procedures but were unable to locate documentation of the total timed codes in minutes and the total treatment time. Medicare Advantage (MA) accounts should follow CMS coverage guidelines as per CMS Final rule effective January 1, 2024. For the 12 MA accounts, nine had the initial certifications and three accounts did not. Three out of five accounts with recertifications were appropriate since modifications were made to the patient's POC. For all 12 MA accounts, we were unable to locate documentation for the total timed codes in minutes and the total treatment time.

The remaining nine accounts were classified as Medicaid Managed, Commercial payors and self-pay patients and may follow different documentation guidelines. Subsequently, Luna started a remediation plan which addresses the findings discussed for the documentation errors.

The insufficient documentation for the total timed codes in minutes and the total treatment time made the claims unbillable for the 16 Medicare and the 12 MA accounts. We identified other opportunities in claims processing. There were 183 dates of service (DOS) for the 16 Medicare accounts. We noted four DOS claims had codes for therapy procedures not supported by documentation, 17 DOS claims had charging errors caused when the total timed codes were incorrectly converted to units, and 28 DOS claims billed the incorrect units charged or reported incorrect charge master amounts. There were 195 DOS for the 12 MA accounts. We noted three DOS claims had codes for therapy procedures not supported by documentation, 40 DOS claims had the incorrect units charged, and 58 DOS claims billed the incorrect units charged or reported incorrect charge master amounts. We noted that for one Medicare account, the incorrect claim form was used for the month of service. We noted that for one MA account, the incorrect claim form was used for three months of service. The billing errors from the insufficient documentation resulted in a Medicare overpayment of $54,186.43 and loss from expected revenue of $210,338.43 for the unbillable claims as based on the average reimbursements from the 2023 Medicare and MA claims and refund for overpayment. For the two Medicaid accounts, we noted documentation supported codes used on all 28 DOS claims. We noted 21 DOS claims had the incorrect units charged, 22 DOS claims had billed the incorrect units charged or reported incorrect charge master amounts. On the Commercial payors, we noted two DOS claims with codes for therapy procedures not supported by documentation, 23 DOS claims had the incorrect units charged and 23 DOS claims had billing errors. Invoices were noted for the remaining three self-pay patients as appropriate. We noted Modifier 59 was used on some DOS claims in 2024 for all payors. As per CMS, Modifier 59 identifies distinct, non-evaluation/management procedures or services that are not normally reported together but were performed on the same day. We verified that Modifier 59 was not appropriate as the services are not distinct or meet pairing restrictions as per National Correct Coding Initiative (NCCI) edits. We also observed that for DOS in 2024, Medicare and MA claims were not submitted and did not follow MHS monthly cadence for billing. Subsequently, as part of Luna's remediation plan, processes were developed to address the coding and billing errors identified in the audit.

The 37 patient accounts had 496 DOS claims reviewed, of which 369 DOS claims were submitted to payors and 252 DOS claims were paid. Of the 252 DOS claims paid, 121 were Medicare accounts, 67 were MA accounts, 18 were commercial payors, and 46 were self-pay accounts. Medicare denied 26 DOS claims with one of the reasons cited as secondary to maximum benefit has been reached for the time period or occurrence. All financial reports are recorded under Luna's EHR, and we requested them for review. We noted that some accounts were categorized under the inappropriate payor classification, which can affect the accuracy of the financial reports. Luna had billed Memorial in error $8,055 less for the invoice on the completed visits for the month of June 2023. We verified 54 duly licensed and credentialed physical therapists who were not sanctioned from participation from any federal health care program. Two of the therapists were current MHS employees and had disclosed employment with Luna on their conflicts of interest (COI) questionnaire as per MHS policy.

Recommendations

We recommended monitoring the process developed to ensure certification and recertifications have the necessary physician signature approving the POC. We recommended monitoring PT treatment notes to ensure completion of the template on the total timed codes in minutes and total treatment time for future encounters. We recommended Luna report the total pending certifications with the monthly financial reports. We recommended reeducating the therapists on the Medicare documentation requirements for obtaining recertifications when changes are made on the POC. We recommended refunding the claims on all Medicare accounts noted with insufficient documentation from April 2023 and on all MA accounts from January 2024, when necessary. We recommended to hold the claims with insufficient documentation errors for all Medicare, and MA accounts. We recommended monitoring the developed process when the charge master rates are updated and verify the charge rates on the claims before submission to the payors. We recommended to review the existing process for charging units of service and fix logic to limit errors with claims not matching treatment documentation. We recommended to correct the coding and billing errors noted, and utilization of the UB-04 for Commercial and Medicaid managed claims. We recommended developing a process to review the claims for Medicare and MA accounts before submission to the payors. We recommended MHS and Luna perform routine audits to ensure claims follow CMS guidelines. We recommended developing a process to report payments and denials routinely and allow for MHS and Luna to monitor and reconcile payments for the services provided. We recommended developing a process to allow for denials to be reviewed in a timely manner so claims can be appealed and resubmitted to payors. We recommended developing a process to provide documentation of Luna's therapy services including claims in MHS Epic system. We recommended reviewing the monthly financial reports to validate data and reclassifying payor classification. We recommended MHS to work out a plan with Luna regarding the loss of expected revenue and invoices paid to Luna which includes the miscalculation for the month of June.

Phil A. Wright, II, Chief Executive Officer (CEO), MRHS and David Webb, Chief Financial Officer (CFO), MRHS agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of Breast Oncology Procedures for Memorial Physician Group Professional Coding and Billing

Background

Memorial Cancer Institute (MCI) offers nationally recognized breast cancer care with a team of highly skilled medical and surgical oncologists who deliver leading treatments. Centers for Medicare and Medicaid Services (CMS) requires reasonable documentation of medical and surgical services provided by the healthcare providers in all settings. The documentation validates medical necessity, place of service, and correct reporting of the services billed to the insurances for reimbursement. The physicians and the Advanced Practice Registered Nurses (APRNs) report health care services using code sets to identify medical procedures and professional services on the health care billing claims. The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10–CM) diagnosis codes are used to indicate the reason for care. The Current Procedural Terminology (CPT) codes are used to report services and procedures. Modifiers are appended to the CPT codes to report services that are altered under certain circumstances. CMS has established a global surgical package to ensure that Medicare Administrative Contractors (MACs) make payments for the same services consistently across all jurisdictions nationwide. CMS's Center for Program Integrity manages the Open Payments

Program, a federally mandated program to increase the transparency of financial relationships between the drug and medical device companies and the healthcare providers.

Observations

We reviewed 95 accounts for eight physicians and eight APRNs. Some findings may overlap. We noted that 77 of the 95 accounts reviewed used CPT procedure codes for billing that were supported by the medical record documentation. There were thirteen accounts in which documentation supported billing for different or additional CPT codes than billed. There were five accounts that documentation did not support billing for the services. Three were for laboratory (lab) tests that were billed without appropriate orders and only two tests were completed. Charges are automatically dropped when labs results are available. Subsequent to this finding, we were told that the lab orders were verbal and phone orders not documented in Epic. EPIC Information Technology (IT) team corrected the technical documentation gap ensuring prospectively that verbal and phone orders are routed to the provider for signature in EPIC. One was for durable medical equipment (DME) that was ordered without the required quantity and billed before the surgical procedure and without documented proof of equipment delivery. Finally, one account for biopsy lacked appropriate documentation. There were 21 of 30 accounts that needed a billing modifier that were appropriately applied. Reimbursement was not affected because the modifiers were informational in nature. We noted that 59 accounts used the ICD-10-CM codes in accordance with the coding guidelines and opportunities for improvement were identified in assigning accurate ICD-10-CM diagnosis codes to the highest specificity in the remaining accounts. There were 42 accounts in which payment was denied for authorization related issues, additional documentation requests, inclusive services that are not separately billable, or claims that needed to be filed under the correct payor. All accounts identified for denials are expected to be paid except for two accounts that were denied for authorization related issues. The CMS Open Payments were reviewed for all providers and payment category errors were identified for two physicians.

Recommendations

We recommended that Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate. We recommended that the MPG Business Office reeducate providers on medical record documentation, coding, and billing of breast oncology procedures, and ensuring there are signed orders for lab services. We recommended Lab Services and Oncology Services continue to research the cause and monitor the process for lab tests being drawn, resulted and billed based on verbal orders without documentation. We recommended Lab Services reeducate the lab technicians to appropriately route verbal and phone lab orders in Epic to ordering providers for signature prior to drawing and resulting labs. We recommended MPG Business Office retrospectively review Breast Oncology Lab Services for orders signed by a laboratory technician and refund as appropriate. We recommended MPG Business Office develop, implement, and monitor the process to ensure there is a physician order for DME that contains the quantity to be dispensed if applicable and is delivered to the patient prior to billing. We recommended MPG Business Office initiate a retrospective review of DME services to identify charge capture errors and correct and rebill if appropriate. We recommended that MPG physicians ensure that incorrect Open Payments data is disputed and corrected.

Mario Salceda-Cruz, Chief Operating Officer, MPG and Esther Surujon, Chief Financial Officer, MPG, agreed with the findings and recommendations and have provided an action plan.

D. Services Provided by Protiviti

A list of Services Provided by Protiviti for the quarter will be discussed during the meeting.

E. Other Reports

Investor Log

The Investor Contact Log for the quarter is attached for your review. See Exhibit C.

Non-Audit Engagements

A list of RSM and Zomma Group Non-Audit Engagements for the quarter is attached for your review. See Exhibit D.

Compliance Environment

A discussion of Nationwide Audit and Investigation Activities for the quarter will be held during the meeting.

SBHD Construction Projects
Period Ending 4/30/2024

Exhibit A

	Interventional Radiology Turner Construction Co. #401622 MHS	Urgent Care Center Miami Gardens Gerrits Construction Inc. #650322 MHS	Central Sterile Processing Thornton Construction Co. Inc. #430122 MHW	Wind Retrofit Turner Construction Co. #409020 MRH	Family Birthplace Turner Constuction Co., Inc. #400622 MRH
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 1,826,577	$ 1,929,942	$ 1,620,971	$ 4,924,483	$ 43,850,159
Prior Change Orders					
Budget Transfer					
Current Change Orders	(394,612)		(261,732)		
Prior Owner Purchase Orders		(180,621)		(270,947)	(9,703,000)
Current Owner Purchase Orders		890		(104,688)	
Current Contract Sum to Date	$ 1,431,965	$ 1,750,211	$ 1,359,239	$ 4,548,849	$ 34,147,159
Previous Payments		1,725,175		4,548,849	13,382,548
1	32,243	13 24,145	1 103,753	23 0	12 1,340,331
2	114,029		2 185,026		13 1,549,153
3	16,617		3 580,220		14 1,805,685
4	46,681				
Total Payments	209,570	1,749,320	868,999	4,548,849	18,077,715
Balance	$ 1,222,395	$ 891	$ 490,240	$ 0	$ 16,069,444
Owner Purchased Materials					
Retainage	3,574		35,538		964,435
Payments	209,570	1,749,320	868,999	4,548,849	18,077,715
Work completed	$ 213,144	$ 1,749,320	$ 904,537	$ 4,548,849	$ 19,042,150
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 4/30/2024

Exhibit A

	Main Electrical Panel Upgrade Thornton Construction Co. Inc. #410222 MRHS	MOB II Second Floor Pediatric Fit Out Thornton Construction Co. Inc. #800122 MHM	MOB Women Center ANF Group, Inc. #450218 MHM	Memorial Cancer Center Expansion DPR Construction #431019 MHW	Hurricane Hardening Thornton Construction Co. #410121 MRHS
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 1,120,307	$ 10,650,417	$ 35,067,236	$ 86,165,924	$ 13,613,113
Prior Change Orders			(5,101,409)	(15,571,906)	
Budget Transfer					
Current Change Orders					
Prior Owner Purchase Orders	(75,607)	(2,591,108)	(750,000)	162,630	(2,804,433)
Current Owner Purchase Orders		108,194			99,239
Current Contract Sum to Date	$ 1,044,700	$ 8,167,503	$ 29,215,826	$ 70,756,649	$ 10,907,919
Previous Payments	288,708	6,947,788	27,791,202	61,673,884	9,458,904
	3 234,803	10 531,480		28 688,129	18 315,195
	4 428,423			29 269,475	
	5 23,369			30 175,524	
Total Payments	975,303	7,479,269	27,791,202	62,807,012	9,774,099
Balance	$ 69,397	$ 688,234	$ 1,424,624	$ 7,949,637	$ 1,133,820
Owner Purchased Materials					
Retainage	21,758			1,713,539	514,426
Payments	975,303	7,479,269	27,791,202	62,807,012	9,774,099
Work completed	$ 997,061	$ 7,479,269	$ 27,791,202	$ 64,520,551	$ 10,288,525
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 4/30/2024

Exhibit A

	MOB II 3rd Floor Time Share Fit Out Thornton Construction Co. #830922 MHM	JDCH ER Room Finishes Engel Construction, Inc. #460120 JDCH	Memorial Cancer Institute ANF Group, Inc. #401820 MHS	Emergency Department Trauma Center Turner Construction Company #400222 MRH	JDCH Vertical Expansion Robins & Morton Group #460117 JDCH
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 2,148,948	$ 1,920,630	$ 3,318,035	$ 16,401,716	$ 108,993,259
Prior Change Orders			(578,606)		
Budget Transfer					
Current Change Orders					
Prior Owner Purchase Orders	(450,000)	(218,164)	182,424	(3,300,002)	(15,093,946)
Current Owner Purchase Orders		39,487			(19,979)
Current Contract Sum to Date	$ 1,698,948	$ 1,741,953	$ 2,921,853	$ 13,101,714	$ 93,879,334
Previous Payments		316,444	2,808,328	4,929,828	87,400,462
1	326,923	7 68,623		12 447,311	28 372,456
2	327,814	8 100,126		13 389,814	
3	158,577	9 257,701		14 487,443	
Total Payments	813,314	742,894	2,808,328	6,254,396	87,772,918
Balance	$ 885,634	$ 999,059	$ 113,525	$ 6,847,318	$ 6,106,416
Owner Purchased Materials					
Retainage	35,243	39,100		216,138	
Payments	813,314	742,894	2,808,328	6,254,396	87,772,918
Work completed	$ 848,558	$ 781,993	$ 2,808,328	$ 6,470,533	$ 87,772,918
Status	Active	Active	Active	Active	Active

Memorial Healthcare System
RFP and Competitive Quote Audits

	RFPs	Current Phase - 4th Quarter FY 2024	Audited Through	Exceptions
1	Joint Replacement RFP	Advertising/Mailing	Design	None
2	Janitorial Services RFP	Ranking & Selection	Design	None
3	Rewards and Recognition RFP	Ranking & Selection	Design	None
4	Contact Center Augmentation RFP	Ranking & Selection	Advertising & Mailing	None
5	Parking Management Service	Ranking & Selection	Design	None
6	Employee Survey Tool	Ranking & Selection	Analysis	None
7	Talent Acquisition Center Exterior Painting RFQ	Analysis	Analysis	None
8	Clinical Engineering Computerized Maintenance Management System	Selection	Oral Presentation	None
9	Audit Management Software RFQ	Selection	Selection	None
10	Compliance Program Evaluation RFP	Oral Presentation	Oral Presentation	None
11	Merchant Services Processor RFP	Selection	Analysis	None

Memorial Healthcare System
RFP and Competitive Quote Audits

	Completed Competitive Quotes	Amount $	Exceptions
1	Laboratory Equipment for MRHS	428,759	None
2	Construction of Kosher Lounge at JDCH	405,863	None
3	Patient Data Privacy Data Source & Management Services for MHS	374,120	None
4	Network Upgrade at MRHS	364,485	None
5	Three Year Service Maintenance of Cardiac Equipment for Operating Room at MRH	357,194	None
6	Landscaping Agreement for MHM	326,294	None
7	Healthcare Advisory Services for MHS	305,000	None
8	Sterilization Equipment for Operating Room at MHM	294,741	None
9	Influenza Vaccines for MRH	246,663	None
10	Equipment Rental for the Operating Room at MRH	241,780	None
11	Landscaping Agreement for MRH	221,522	None
12	Rental Equipment for Laboratory at JDCH	210,151	None
13	Patient Beds for MRHS	196,986	None
14	Caterpillar Generator Warranty for MRH	183,900	None
15	Radiology Equipment for MPG	179,343	None
16	Service Maintenance for Surgical Robotic Equipment for MHP	172,000	None
17	Laboratory Equipment for MRH	148,186	None
18	Consumer Engagement Solution for MHS	144,000	None
19	Service Agreement Renewal for Fire Alarm and Electrical Maintenance at MHM	134,012	None
20	Replacement of Cameras for Medical Office Building at MHW	129,692	None
21	Cardiovascular Equipment for MRH	123,547	None
22	Fiber Optic Upgrade at MRH	117,619	None
23	Labor and Deliivery Patient Bed Replacement at MHM	502,299	None
24	Tetanus Medication for Speciality Pharmacy at MHW	462,000	None
25	Two Year Microsoft Volume Licenses for MHS	4,688,100	None
26	Five Year Insulin Management Software and Service for MHS	2,265,000	None
27	Pharmacy Technology Solution for MHS	2,037,500	None
28	Workday Managed Services for MHS	1,255,982	None
29	Zebra Mobile Computers for MHS	108,362	None
30	Operating Room Equipment for MHM	101,138	None

Exhibit C

Memorial Healthcare System
Investor Contact Log
Fiscal Year 2024

Quarter: Ended	Contact:	Representing:	Discussion:
July 31,2023	Beth Wexler	Moody's Investor Service	Post-ratings discussion
October 31, 2023	None.		
January 31, 2024	None.		
April 30, 2024	None.		

Memorial Healthcare System
Non Audit Engagement Report
Q4 FY 2024

Quarter Ended	RSM US LLP Engagement:		
Q4 FY2024	For professional services rendered and expenses incurred in connection with implementing GASB 96 Technical subscription based information technology arrangements accounting.	$	64,513
	Total	$	64,513
Q3 FY2023	Total spend, provided for comparative purpose	$	9,765

Quarter Ended	Zomma Group LLP Engagement:		
Q4 FY2024	For professional services rendered and expenses incurred in connection with Non Audit Engagements.	$	-
Q3 FY2023	Total spend, provided for comparative purpose	$	-

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • MEMORIAL REGIONAL HOSPITAL SOUTH • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: December 21, 2023

From: Jeffrey Sturman, Senior Vice President and Chief Digital Officer, MH
Frank Rainer, Senior Vice President & General Counsel, SBHD

DocuSigned by: F31E2B8A4E484E6...
DocuSigned by: CDF8649D4A25436...

Subject: **Action Plan: INTERNAL AUDIT OF THE DUAL ACCESS TO EPIC ASSIGNED TO EMPLOYED USERS AT MEMORIAL HEALTHCARE SYSTEM**

Attached is our Action Plan for, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend developing a procedure where employees are required to complete their Conflicts of Interest (COI) Questionnaire to disclose a second job or other potential conflict prior to finalizing dual access.	For new employees: System Access Team ("SAT") is working with Talent Acquisition Center ("TAC") to add a new question to their questionnaire to see if the employee will continue to work with another organization and MHS. Then follow up with Compliance for feedback/approval. For existing users: SAT to escalate to compliance to verify if approved and/or complete COI and Memorandum of Understanding ("MOU").	4/30/24
We recommend developing a policy on the management and maintenance of signed Memorandum of Understanding (MOU).	HR needs to decide how this is going to be communicated to employees. Should be part of "Employee Conduct"? Needs to be owned by HR.	Human Resource to design a process.

We recommend the dual access user be required to inform System Access Team (SAT) when dual access is no longer required.	The quarterly Periodic Access Review (“PAR”) shows the manager/sponsor the access the user has and should let SAT know if the access needs to end. OR Site verification completed by the site manager/sponsor, is done on a monthly basis. If they have multiple templates, that is identified on the quarterly PAR.	Currently Available
We recommend SAT periodically verify that the dual access is still being used.	For users with dual access identified, there will be regularly scheduled audits to confirm if dual access is still required.	4/30/24
We recommend monitoring be developed to identify when Memorial Healthcare System (MHS) employees with dual access are using the appropriate user access.	SAT is identifying the users with dual access with new Active Directory (“AD”) groups. With these new AD groups, options will be evaluated within Fairwarning (“FW”) to ascertain if monitoring can be done. FW findings will be shared once evaluation is completed. 90 days is required for the evaluation by Fairwarning. If Fairwarning is unable to monitor dual access/account, MHS leadership to determine if manual audit should be done. OR MHS to stop allowing users to do dual jobs.	4/30/24 7/30/2024 (FW)

We recommend developing a procedure to ensure that salaried employees with dual access can be monitored for appropriate user access for their MHS role or their non-MHS role.	SAT is identifying the users with dual access with new AD groups. With these new AD groups, options will be evaluated within Fairwarning ("FW") to ascertain if monitoring can be done. FW findings will be shared once evaluation is completed. 90 days is required for the evaluation by Fairwarning. If Fairwarning is unable to monitor, MHS leadership to determine if manual audit should be done. OR Stop allowing users to do dual jobs.	Identifying AD groups- 4/30/24 7/30/2024 (FW)
We recommend a process is developed to verify that users requesting access to any platform of MHS Epic does not already have an account.	Epic does not allow for duplicate users. If an Epic account is requested for a user with existing access, SAT will follow the process mentioned above for existing users.	4/30/24
We recommend that the new requests follow a process to ensure there is valid reason for dual access, a MOU is signed with HR, and the user updates the COI Questionnaire disclosing the potential conflict.	For new employees: SAT is working with TAC to add a new question to their questionnaire to see if the employee will continue to work with another organization and MHS. Then follow up with Compliance for feedback/approval. For existing users: SAT to escalate to compliance to verify if approved and/or complete COI and MOU.	4/30/24
We recommend monitoring that the users are appropriately provided supplemental access.	We currently require approval for supplemental access and guidance from the Epic team(s) on what level of access the user needs based on the request.	Currently happening

We recommend developing process to manage requests for expanded security access to MHS Epic to determine whether the access is for the job duties within MHS, for an outside activity, and length of time additional access is required.	We will be implementing to consistently entering an end date on the Epic template for additional access.	4/30/24
We recommend that if the additional security access is for outside activities, the request be approved by HR, a MOU is obtained, the COI Questionnaire is updated, and the Compliance and Internal Audit Department has evaluated the potential conflict of interest,	For new employees: SAT is working with TAC to add a new question to their questionnaire to see if the employee will continue to work with another organization and MHS. Then follow up with Compliance for feedback/approval . For existing users: SAT to escalate to compliance to verify if approved and/or complete COI and MOU.	4/30/24

cc: K. Scott Wester, President and Chief Executive Officer, MHS

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • MEMORIAL REGIONAL HOSPITAL SOUTH • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: June 19, 2024

From: Peter Powers, Chief Executive Officer, MRH
Walter Bussell, Chief Financial Officer, MRH

Subject: **Action Plan: COMPLIANCE AUDIT OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT AT MEMORIAL REGIONAL HOSPITAL**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend Emergency Department (ED) leadership reeducate the staff on the completeness of the transfer form which includes scanning the form in Epic for the transfers-in to Memorial Regional Hospital (MRH) ED and conduct regular reviews to monitor for completeness.	The ED clinical managers will receive re-education on the importance of completing the transfer form accurately. The completed form will be scanned into EPIC for all transfers leaving the ED. In addition, ED Leadership will conduct quarterly audits of the transfer documentation.	July 1, 2024
We recommend Transfer Center management reeducate the nurses on the procedure for filling the transfer form particularly when patient is unable to sign the form and perform regular audits to monitor for completeness.	The Transfer Center nurses were reeducated during the course of the audit, on 5/10/24, regarding obtaining signatures from two RN's when the patient is unable to sign. The chart auditing is on going.	June 6, 2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • MEMORIAL REGIONAL HOSPITAL SOUTH • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: June 21, 2024

From: Philoron A. Wright, II, Chief Executive Officer, MRHS
David Webb, Chief Financial Officer, MRHS

Subject: **Action Plan: COMPLIANCE AUDIT OF THE MEMORIAL OUTPATIENT PHYSICAL THERAPY AT HOME PROGRAM**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend monitoring the process developed to ensure certification and recertifications have the necessary physician signature approving the plan of care (POC).	Luna will provide detailed reporting on POCs monthly going forward.	7/1/24
We recommend monitoring physical therapy (PT) treatment notes to ensure the completion of the template on the total timed codes in minutes and total treatment time for future encounters.	MHS has validated that the templated notes have been corrected and meets requirements. Operational leadership will conduct random audits to ensure this is consistently correct.	6/12/24
We recommend Luna report the total pending certifications with the monthly reports.	Luna will include in monthly reports, example shared on 6/21 pending approval by MHS	7/30/24
We recommend reeducating the therapists on the Medicare documentation requirements for obtaining recertifications when changes are made on the POC.	Operational leadership to ensure Luna updates their processes with staff to send recertifications if plan has changed.	7/30/24

We recommend refunding the claims on all Medicare accounts noted with insufficient documentation from April 2023 and on all Medicare Advantage (MA) accounts from January 2024, when necessary.	2023 Medicare claims and 2024 MA claims refund submitted 6/13 to payers. Patient refunds submitted 6/21. Secondary payer claims cancellation pending.	7/15/24
We recommend holding the claims with insufficient documentation errors for all Medicare, and MA accounts in 2024.	All claims were put on hold 5/9 and none have been released for any payer. 100% audit of all claims for 90 days will be conducted by MHS personnel before submission	5/9/24
We recommend monitoring the developed process when the charge master rates are updated and verify the charge rates on the claims before submission to the payors.	Luna will request charge master updates in April each year as MHS updates the charge master for the start of each fiscal year on 5/1	4/15/25
We recommend reviewing the existing process for charging units of service and fix logic to limit errors with claims not matching treatment documentation.	This has been corrected and will be monitored during auditing of claims.	6/15/24
We recommend correcting the coding and billing errors noted particularly on reporting the hospital taxonomy code, and utilization of the Uniform Billing-04 (UB-04) for Commercial and Medicaid managed claims.	This has been corrected, Revenue Cycle leadership has reviewed and approved the release of 20 claims that will go to commercial payers to ensure expected payment. Auditing will continue for remaining claims.	6/25/24
We recommend developing a process to review the claims for Medicare and MA accounts before submission to the payors.	MHS Revenue Cycle will be conducting a 100% audit of all claims prior to submission for 90 days. They will then step down to 75%, 50% and 25% for each subsequent 90 days period, subject to results of the audit. There will be 1 full year of audits prior to submission before switching	6/30/25

	to 5% audit post submission.	
We recommend Memorial Healthcare System (MHS) and Luna perform routine audits to ensure claims follow Centers for Medicare and Medicaid Services (CMS) guidelines.	Luna will be conducting their own internal 100% audit in addition MHS Revenue Cycle will be conducting a 100% audit of all claims prior to submission for 90 days. They will then step down to 75%, 50% and 25% for each subsequent 90 days period, subject to results of the audit. There will be 1 full year of audits prior to submission before switching to 5% audit post submission.	6/30/25
We recommend developing a process to report payments and denials routinely and allow for MHS and Luna to monitor and reconcile payments to the services provided.	MHS will establish a denial review process on a monthly cadence along with financial reporting review.	11/30/24
We recommend developing a process to allow for denials to be reviewed in a timely manner so claims can be reappealed and resubmitted to payors.	MHS will establish a denial review process on a monthly cadence along with financial reporting review.	11/30/24
We recommend developing a process to transfer documentation of Luna's therapy services including claims into the MHS Epic system.	Luna will provide MHS with a list of all patients and their therapy dates for inclusion in their Epic record. In the event of a medical records request, this will trigger MHS to reach out to Luna for the medical records to include. This process will be manual initially but Luna will work with MHS IT to develop some automation. MHS Revenue Cycle does not need claims data loaded into Epic.	11/30/24
We recommend reviewing the monthly financial reports	Luna Revenue Cycle system was updated to	6/15/24

to validate data submitted and reclassifying payor classification as required.	classify insurance plans correctly and payer classification will be validated during auditing.	
We recommend MHS work out a plan with Luna regarding the loss of expected revenue ($210,338.43) and invoices paid to Luna ($203,965 for Medicare and MA plans) which includes the miscalculation for the month of June.	MHS is working with Luna to reconcile this.	11/30/24

cc: K. Scott Wester, President and Chief Executive Officer, MHS

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • MEMORIAL REGIONAL HOSPITAL SOUTH • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: **May 20, 2024**

From: Mario Salceda-Cruz, Chief Operating Officer, MPG MS
Esther Surujon, Chief Financial Officer, MPG ES
Patrick Brillantes, Senior Vice President Service Lines, MHS PB

Subject: **Action Plan: COMPLIANCE AUDIT OF BREAST ONCOLOGY PROCEDURES FOR MEMORIAL PHYSICIAN GROUP PROFESSIONAL CODING AND BILLING**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate.	Identified transactions are in review and will be processed for refund if applicable.	8/1/2024
We recommend that the MPG Business Office reeducate providers on medical record documentation, coding, and billing of breast oncology procedures, and ensuring there are signed orders for lab services.	Reeducation for documentation coding and procedures will be provided. The business office cannot review lab orders prior to billing as the reimbursement is minimal and it would be cost prohibitive. The laboratory personnel should ensure they have an order prior to resulting a lab test and charges should be dropping once lab is resulted.	8/31/2024 for training. Can not accommodate 4th item related to lab orders.
We recommend Lab Services and Oncology Services continue to research the cause and	A review was performed. EPIC IT team immediately corrected the technical documentation gap	6/11/2024

monitor the process for lab tests being drawn, resulted and billed based on verbal orders without documentation.	ensuring prospectively that verbal/ phone orders are routed to the provider for signature in EPIC.	
We recommend Lab Services reeducate the lab technicians to appropriately route verbal and phone lab orders in Epic to ordering providers for signature prior to drawing and resulting labs.	Ed Peterson will be working with the Lab Directors at West and Regional on the requested action plan.	July 2024
We recommend MPG Business Office retrospectively review Breast Oncology Lab Services for orders signed by a laboratory technician and refund as appropriate.	The business office needs to review the number of transactions and associated dollar impact since the reimbursement is minimal and it is could cost more to review every lab charge. It may cost less money to refund all labs. We need to analyze the data. Refund will be processed in either scenario (meaning refund either true refunds or all labs).	10/31/2024
We recommend MPG Business Office develop, implement, and monitor the process to ensure there is a physician order for DME that contains the quantity to be dispensed if applicable and is delivered to the patient prior to billing.	An IT request for creation of edit will be created to capture DME orders for review.	9/15/2024
We recommend MPG Business Office initiate a retrospective review of DME services to identify charge capture errors and correct and rebill if appropriate.	The affected services are in the process of being identified and corrections or refunds will be performed if appropriate.	9/30/2024
We recommend that MPG physicians ensure that incorrect Open Payments data is disputed and corrected.	The Business Office will coordinate with MCI providers and leadership to correct disputed data.	9/30/2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS

South Broward Hospital District
d/b/a Memorial Healthcare System

Single Audit Report and Schedule of
Expenditures of Federal Awards, State Financial Assistance,
Local and Other Entities Awards, and
Supplementary Information and
Schedule of Findings and Questioned Costs
For the Year Ended
April 30, 2024

South Broward Hospital District d/b/a Memorial Healthcare System
Table of Contents

ZOMMA GROUP
CPAs AND CONSULTANTS

Independent Auditor's Report

To the Board of Commissioners of
South Broward Hospital District d/b/a Memorial Healthcare System

Report on Schedule of Expenditures of Federal Awards, State Financial Assistance, Local and Other Entities Awards

Opinion

We have audited the accompanying Schedule of Expenditures of Federal Awards, State Financial Assistance, Local and Other Entities Awards of South Broward Hospital District d/b/a Memorial Healthcare System (the System) for the year ended April 30, 2024, and the related notes (the Schedule).

In our opinion, the Schedule referred to above presents fairly, in all material respects, the expenditures of Federal Awards, State Financial Assistance, Local and Other Entities Awards of the System for the year ended April 30, 2024, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the audit requirements of Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* and Title 45 CFR Part 74, Appendix E, *Principles for Determining Cost Applicable to Research and Development Under Grants and Contracts with Hospitals* (Uniform Guidance) and Chapter 10.550, Rules of the Auditor General. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Schedule section of our report.

We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Schedule

Management is responsible for the preparation and fair presentation of the Schedule in accordance with accounting principles generally accepted in the United States of America and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the Schedule that is free from material misstatement, whether due to fraud or error.

ZOMMA Group, LLP
355 Alhambra Circle, Suite 1100, Coral Gables, Florida 33134
P: 305.444.8288 F: 305.444-8280
www.zommagroup.com

Auditor's Responsibilities for the Audit of the Schedule

Our objectives are to obtain reasonable assurance about whether the Schedule as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. 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 generally accepted auditing standards, *Government Auditing Standards*, and the Uniform Guidance and Chapter 10.550, Rules of the Auditor General, will always detect a material misstatement when it exists. 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, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the Schedule.

In performing an audit in accordance with generally accepted auditing standards, *Government Auditing Standards*, the Uniform Guidance, and Chapter 10.550, Rules of the Auditor General, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the Schedule, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the Schedule.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the Schedule.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the Schedule. The accompanying Actual Expenses and Revenue Schedule, Schedule of Bed-Day Availability Payments, Schedule of State Earnings, and Schedule of Related Party Transaction Adjustments are presented for purposes of additional analysis as required by the State of Florida Department of Children and Families Community Substance Abuse and Mental Health Services Grants and are not a required part of the Schedule. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the Schedule. The information has been subjected to the auditing procedures applied in the audit of the Schedule and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the Schedule or to the Schedule itself, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the Schedule as a whole.

ZOMMA Group, LLP

Coral Gables, FL
July 15, 2024

ZOMMA GROUP
CPAs AND CONSULTANTS

Independent Auditor's Report on Compliance for Each Major Federal Program and State Project on Internal Control Over Compliance Required by the Uniform Guidance and Chapter 10.550, Rules of the Auditor General

To the Board of Commissioners of
South Broward Hospital District d/b/a Memorial Healthcare System

Report on Compliance for Each Major Federal Program and State Project

Opinion on Each Major Federal Program and State Project

We have audited South Broward Hospital District d/b/a Memorial Healthcare System's (the System) compliance with the types of compliance requirements described in the *OMB Compliance Supplement,* and the requirements described in the Department of Financial Services' *State Projects Compliance Supplement*, that could have a direct and material effect on each of the System's major Federal programs and State projects for the year ended April 30, 2024. The System's major Federal programs and State projects are identified in the summary of auditor's results section of the accompanying Schedule of Findings and Questioned Costs.

In our opinion, the System complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major Federal programs and State projects for the year ended April 30, 2024.

Basis for Opinion on Each Major Federal Program and State Project

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the audit requirements of Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* and Title 45 CFR Part 74, Appendix E, *Principles for Determining Cost Applicable to Research and Development Under Grants and Contracts with Hospitals* (Uniform Guidance); and Chapter 10.550, Rules of the Auditor General. Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for each major Federal program and State project. Our audit does not provide a legal determination of the System's compliance with the compliance requirements referred to above.

ZOMMA Group, LLP
355 Alhambra Circle, Suite 1100, Coral Gables, Florida 33134
P: 305.444.8288 F: 305.444-8280
www.zommagroup.com

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to the System's Federal programs and State projects.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the System's compliance based on our audit. 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 generally accepted auditing standards, *Government Auditing Standards*, the Uniform Guidance, and Chapter 10.550, Rules of the Auditor General will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the System's compliance with the requirements of each major Federal program and State project as a whole.

In performing an audit in accordance with generally accepted auditing standards, *Government Auditing Standards*, the Uniform Guidance, and Chapter 10.550, Rules of the Auditor General, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the System's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.

- Obtain an understanding of the System's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a Federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a Federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with the type of compliance requirement of a Federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Our audit was not designated for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and results of that testing based on the requirements of the Uniform Guidance and Chapter 10.550, Rules of the Auditor General. Accordingly, this report is not suitable for any other purpose.

ZOMMA Group, LLP

Coral Gables, FL
July 15, 2024

South Broward Hospital District d/b/a Memorial Healthcare System
Schedule of Expenditures of Federal Awards, State Financial Assistance, Local and Other Entities Awards
For the Year Ended April 30, 2024

Federal Agency / Passed Through Agency	Program Title	Assistance Listing Number**	Contract Number	Expenditures		
				Direct Award	Indirect Award	Total
FEDERAL AWARDS						
U.S. Department of Health & Human Services						
Passed through North Broward Hospital District	Consolidated Health Centers	93.224	Unknown	$	$ 124,656	$ 124,656
					124,656	**124,656**
Passed through OIC of Broward County Inc.	Teenage Pregnancy Prevention Program (PAUSE)	93.297	1 TP1AH000254-01-01		165,005	165,005
					165,005	**165,005**
Passed through NIH, Alliance for Clinical Trials in Oncology Foundation & Partners	Cancer Treatment Research	93.395	1UG1CA189823-01		65,050	65,050
					65,050	**65,050**
Passed through NIH, Florida Association of Pediatric Tumor Programs, Inc.	Cancer Control	93.399	Unknown		86,695	86,695
					86,695	**86,695**
Passed through State of Florida Department of Health	Injury Prevention and Control Research and State and Community Based Programs	93.136	BW756		76,154	76,154
					76,154	**76,154**
Passed through Broward Regional Health Planning Council	Maternal, Infant, & Early Childhood Home Visiting Program	93.505	NFP-MHS 22-23		175,846	175,846
					175,846	**175,846**
Substance Abuse and Mental Health Services Administration	Solutions and Opportunities for Uplifting Life	93.696	1H79SM086844-01	1,197,587		1,197,587
				1,197,587		**1,197,587**
Passed through Broward Healthy Start Coalition, Inc.	Medical Assistance Program	93.778	MHS22HS		75,194	75,194
Passed through Broward Healthy Start Coalition, Inc.	Medical Assistance Program	93.778	MHS23HS		1,026,219	1,026,219
					1,101,413	**1,101,413**
Passed through DCF, Broward Behavioral Health Coalition, Inc.	State Opioid Response Grants	93.788	34368-22		1,881,211	1,881,211
					1,881,211	**1,881,211**
Passed through Broward County Board of Commissioners	HIV Emergency Relief Project Grant	93.914	21-CP-HCS-8312-RW-01		803,561	803,561
					803,561	**803,561**
Passed through Broward County Board of Commissioners	Health Literacy Program	93.137	22-CP-HCS-8312-HL-01		20,582	20,582
					20,582	**20,582**
Passed through State of Florida Department of Health	HIV Prevention Activities - Health Dept. Based	93.940	CODPK		146,130	146,130
					146,130	**146,130**
Passed through DCF, Broward Behavioral Health Coalition, Inc.	Block Grants for Community Mental Health Services	93.958	34368-22		2,296,030	2,296,030
					2,296,030	**2,296,030**
Passed through DCF, United Way of Broward County Inc.,	Block Grant for Prevention and Treatment of Substance Abuse	93.959	65301		610,353	610,353
Passed through DCF, Broward Behavioral Health Coalition, Inc.	Block Grant for Prevention and Treatment of Substance Abuse	93.959	34368-22		2,161,416	2,161,416
					2,771,769	**2,771,769**
Passed through Broward Healthy Start Coalition, Inc.	Maternal and Child Health Services Block Grant	93.994	MHS22HS		175,453	175,453
Passed through Broward Healthy Start Coalition, Inc.	Maternal and Child Health Services Block Grant	93.994	MHS23HS		160,144	160,144
Passed through State of Florida Department of Health	Maternal and Child Health Services Block Grant	93.994	COQVO		255,675	255,675
					591,272	**591,272**
	Total U.S. Department of Health & Human Services			**1,197,587**	**10,305,374**	**11,502,961**
Federal Emergency Management Agency						
Passed through State of Florida Division of Emergency Management	COVID-19 Public Assistance Program	97.036	Z2024		22,429,225	**22,429,225**
					22,429,225	**22,429,225**
	Total Federal Emergency Management Agency				**22,429,225**	**22,429,225**
	Total Federal Awards			**$ 1,197,587**	**$ 32,734,599**	**$ 33,932,186**

*** All programs are grouped and totaled by CFDA / CSFA.*

Continued on next page

The accompanying notes are an integral part of this Schedule.

South Broward Hospital District d/b/a Memorial Healthcare System
Schedule of Expenditures of Federal Awards, State Financial Assistance,
Local and Other Entities Awards
For the Year Ended April 30, 2024

Federal Agency / Passed Through Agency	Program Title	CSFA Number**	Contract Number	Expenditures		
				Direct Award	Indirect Award	Total
STATE PROJECTS						
Passed through Broward Healthy Start Coalition, Inc.	HSTART & Fatherhood	64.131	MHS23HS	$	$ 111,286	$ 111,286
					111,286	**111,286**
	Total Broward Healthy Start Coalition, Inc.				**111,286**	**111,286**
Department of Children and Families	Healthy Families Broward	N/A	BHSC HFB 23-24 MHS	225,375		225,375
				225,375		**225,375**
	Total Florida Department of Children and Families			**225,375**		**225,375**
State of Florida Department of Health	Trauma Center Financial Support	64.075	MOU TRA11	233,910		233,910
				233,910		**233,910.0**
	Children's Specialty Health Care - Contracted	64.076	COQAF	106,449		106,449
				106,449		**106,449**
	Telehealth Minority Maternity Care Pilot Program	64.052	CM072	326,560		326,560
				326,560		**326,560**
	Total State of Florida Department of Health			**666,919**		**666,919**
	Total State Projects			**892,294**	**111,286**	**1,003,580**
LOCAL GOVERNMENT AWARDS						
Broward County Commissioners	Consumer Support Project	N/A	22-CP-HCS-0126-01	432,330		432,330
	Psychiatric Inpatient Services	N/A	22-CP-HCS-0126-01	1,236,459		1,236,459
	Adult Mental Health Program	N/A	22-CP-HCS-0126-01	315,960		315,960
				1,984,749		**1,984,749**
	Primary Care Services	N/A	19-CP-HCS-8312-01	4,987,957		4,987,957
				4,987,957		**4,987,957**
	Behavioral Health -Substance Abuse	N/A	19-CP-CSA-8312-01	262,737		262,737
				262,737		**262,737**
	Total Broward County Commissioners			**7,235,443**		**7,235,443**
Children Services Council of Broward County						
	CSC Youth Force Program	N/A	20-2170	513,415		513,415
				513,415		**513,415**
	CSC Youth Force PYD	N/A	20-2172	253,861		253,861
				253,861		**253,861**
	New DAY Program	N/A	22-2176	644,784		644,784
				644,784		**644,784**
	Family TIES Program	N/A	19-2178	950,817		950,817
				950,817		**950,817**
	Teen REACH Program	N/A	19-2179	428,083		428,083
				428,083		**428,083**
	Supporting MOMS Program	N/A	19-2177	738,101		738,101
				738,101		**738,101**
	CSC HEAL	N/A	21-2174	559,357		559,357
				559,357		**559,357**
	Behavioral Respite & Engagement for At-Risk-Kids (BREAK)	N/A	21-2173	114,063		114,063
				114,063		**114,063**
	Healthy Youth Transition	N/A	20-2171	744,557		744,557
				744,557		**744,557**
	Maximazing Out-of-School Time	N/A	22-2175	131,856		131,856
				131,856		**131,856**
	Total Children Services Council of Broward County			**5,078,894**		**5,078,894**
	Total Local Government Awards			**$ 12,314,337**	**$**	**$ 12,314,337**

*** All programs are grouped and totaled by CFDA / CSFA.*

Continued on next page

The accompanying notes are an integral part of this Schedule.

South Broward Hospital District d/b/a Memorial Healthcare System
Schedule of Expenditures of Federal Awards, State Financial Assistance,
Local and Other Entities Awards
For the Year Ended April 30, 2024

Agency / Passed Through Agency	Program Title	Assistance Listing/CSFA Number**	Contract Number	Expenditures		
				Direct Award	Indirect Award	Total
OTHER ENTITIES AWARDS						
KID INC Kinship Initiatives Support Services (KISS)	Kids in Distress	N/A	KID-MHS-20-1	$ 284,086	$	$ 284,086
				284,086		**284,086**
Broward Healthy Start Coalition	Project HOPE	N/A	HOPE2022MHS	54,772		54,772
				54,772		**54,772**
City of West Park						
	Families Matter	N/A	Unknown	65,307		65,307
	Youth Force	N/A	Unknown	133,999		133,999
				199,306		**199,306**
Girls and Boys Club	Case Management Services	N/A	Unknown	16,454		16,454
				16,454		**16,454**
Essential Hospital Association	Improving Obsteric Outcomes	N/A	27-1021-011	15,000		15,000
				15,000		**15,000**
Broward County Public School	Childrens Mental Health	N/A	34368-BSC	78,701		78,701
				78,701		**78,701**
Passed through DCF, Broward Behavioral Health Coalition, Inc.	Block Grants for Community Mental Health Services	N/A	34368-22		416,667	416,667
					416,667	**416,667**
State of Florida Department of Health	Primary Care Services	N/A	BW744	151,917		151,917
				151,917		**151,917**
Lilly USA, LLC	Patients with Solid Tumors	N/A	A-33710	22,239		22,239
				22,239		**22,239**
FADAA	MAT Program	N/A	Unknown	5,272		5,272
				5,272		**5,272**
United Way	Publix Last Resort Emergency Fund			7,664		7,664
	Teens & Fentanyl Dangers	N/A	Unknown	25,000		25,000
				32,664		**32,664**
	Total Other Entities Awards			**860,411**	**416,667**	**1,277,078**
	Total Award Expenditures Per Schedule FY 2024			**$ 15,264,629**	**$ 33,262,552**	**$ 48,527,181**

*** All programs are grouped and totaled by CFDA / CSFA.*

The accompanying notes are an integral part of this Schedule.

Note 1 Purpose of the Schedule

The accompanying Schedule of Expenditures of Federal Awards, State Financial Assistance Local, and Other Entities Awards, hereafter referred to as "the Schedule," of South Broward Hospital District d/b/a Memorial Healthcare System (the System) is supplementary information and is an important part of the reporting package required by:

- Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* and Title 45 CFR Part 74, Appendix E, *Principles for Determining Cost Applicable to Research and Development Under Grants and Contracts with Hospitals* (Uniform Guidance).
- Chapter 10.550, Rules of the Auditor General for Local Government Entity Audits, State of Florida and Chapter 215.97, Florida Statutes and Department of Financial Services Rules, Chapter 69I-5, Florida Administrative Code.

As a result, some amounts presented in the Schedule may differ from amounts presented in, or used in the presentation of the Schedule of the System.

The Schedule includes the grant activities for the System for the year ended April 30, 2024. The auditor is required to determine and provide an opinion on whether the Schedule is presented fairly, in all material respects, in relation to the Schedule as a whole. Further, the information in the Schedule serves as the primary basis for the auditor's major programs, which is a key component of performing a single audit. The Schedule also provides assurance to those agencies that award financial assistance, that their programs or grants are included in the audit.

Note 2 Summary of Significant Accounting Policies

Basis of Presentation

The information in the Schedule is presented in accordance with the Uniform Guidance and Chapter 10.550, Rules of the Auditor General. The Schedule, at a minimum, entails the following:

1. Listing of individual Federal, State, Local, and Other Entities programs by awarding agency for which the System expended funds for the year ended April 30, 2024
2. Total Federal, State, Local, and Other Entities awards expended for the year ended April 30, 2024
3. Assistance Listing number and Catalog of State Financial Assistance (CSFA) number for each program that had expenditures for the year ended April 30, 2024
4. The name of the pass-through entity and the identifying number assigned by the pass-through entity for awards received as a subrecipient
5. The total amount provided to subrecipients from each Federal, State, and Local program, if any
6. Notes that describe the significant accounting policies used in preparing the Schedule and notes indicating the indirect cost rate applied

Note 2 Summary of Significant Accounting Policies (continued)

Basis of Presentation (continued)

Reporting Entity
The System's reporting entity is described in Note 1 of the Schedule. The Schedule includes all Federal and State assistance programs administered by the System during the year ended April 30, 2024, that are subject to a Uniform Guidance and State Single audit.

Basis of Accounting
The expenditures presented on the Schedule are reported on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America and following the Uniform Guidance and Chapter 10.550, Rules of the Auditor General, wherein certain types of expenditures are unallowable or have conditions or limits as far as the reimbursement.

- Indirect Costs – The Schedule includes a portion of allocated costs from a federally approved indirect cost rate plan. The System did not elect to use the 10% de minimis cost rate.

- Matching Costs – All expenditures are recorded based on funded amounts, while additional costs, such as matching costs, are not included in the Schedule.

- Capital Costs – The System records grant funds restricted for the acquisition of capital assets as non-operating revenue in the accounting period in which they are earned and become measurable.

Because the Schedule presents only a selected portion of the operations of the System, it is not intended to and does not present the financial position, changes in net assets or cash flows of the System.

Note 3 Pass-Through Federal and State Assistance

- The majority of the System's Federal assistance is received from pass-through entities and are identified as such on the Schedule. State Funds are typically directly awarded from the State but can also be awarded through a pass-through entity.

- The System records expenditures of Federal programs and State awards when paid in cash to a pass-through entity (Subrecipients of the District). For the year ended April 30, 2024, the System did not pass-through any funds to sub-recipients as reflected on the Schedule.

Note 4 Federal Programs and State Awards Not Subject to a Uniform Guidance Audit

Matching Resources and Maintenance of Effort amounts for Federal programs and State project as well as vendor-relationship specified contracts, are listed on the Schedule, but are not included when computing the threshold for single audit requirements totals.

State Contracts on the Schedule, not Subject to a Uniform Guidance Audit or Section 215.97, F.S:

- BW744 – State of Florida Department of Health – Vendor relationship
- 34368-22 - Broward Behavioral Health Coalition, Inc. – Not subject to Uniform Guidance Audit or Section 215.97, F.S.

Note 5 Program Clusters

The U.S. Office of Management and Budget Compliance Supplement defines a cluster of programs as a grouping of closely related programs that share common compliance requirements. There were programs that met this criterion for the current year.

Note 6 Contingencies

Grant monies received and disbursed by the System are for specific purposes subject to review by grantor agencies. Such reviews may result in requests for reimbursement due to unallowable expenditures. Based on prior experience, the System does not believe that such unallowances, if any, would have a material effect on the financial position of the System. As of April 30, 2024, management is not aware of any material questioned or unallowable costs as a result of grant audits in process or completed.

Note 7 State of Florida Department of Children and Families

The State of Florida Department of Children and Families requires the accompanying Actual Expenses and Revenue Schedule, Schedule of Bed-Day Availability Payments, Schedule of State Earnings, and Schedule of Related Party Transaction Adjustments be presented for their contract year ending June 30, 2023.

Note 8 Subsequent Event

Subsequent events have been evaluated through July 15, 2024, which is the date the Schedule was available to be issued. Subsequent to April 30, 2024, the System recognized approximately $76,152,000 of additional COVID-19 related relief funds that were obligated by FEMA after the year ended.

South Broward Hospital District d/b/a Memorial Healthcare System
Schedule of Findings and Questioned Costs
For the Year Ended April 30, 2024

Part I – Summary of Auditor's Results

Financial Statements Section

The auditor's report and opinion on the Schedule and report on compliance and internal control based on the audit of the Schedule were prepared by other auditors.

Type of auditor's report issued (unmodified, qualified, adverse, or disclaimer).	**Unmodified**		
Internal control over financial reporting:			
Material weakness(es) identified?	____ Yes	**X** No	
Significant deficiency(ies) identified that are not considered to be material weaknesses?	____ Yes	**X** None reported	
Noncompliance material to the schedule noted?	____ Yes	**X** No	

Federal Awards and State Financial Assistance Section

Type of auditor's report issued on compliance for major programs unmodified, qualified, adverse, or disclaimer).	**Unmodified**		
Internal control over major programs:			
Material weakness(es) identified?	____ Yes	**X** No	
Significant deficiency(ies) identified that are not considered to be material weaknesses?	____ Yes	**X** None reported	
Any audit findings disclosed that are required to be reported in accordance with 2 CFR section 200.516(a) of the Uniform Guidance?	____ Yes	**X** No	

Part I – Summary of Auditor's Results (continued)

Federal Awards and State Financial Assistance Section (continued)

Identification of major Federal programs / State projects:

Assistance Listing Number(s)	Name of Federal Program or Cluster
93.696	Solutions and Opportunities for Uplifting Life
93.778	Medical Assistance Program
93.914	HIV Emergency Relief Project Grant
97.036	COVID-19 Public Assistance Program

CSFA Number(s)	Name of State Project
n/a	Healthy Families Broward
64.052	Telehealth Minority Maternity Care Pilot Program

Dollar threshold used to distinguish between Type A and Type B programs:

- Federal Programs $ 1,017,966
- State Financial Assistance $ 300,000

Auditee qualified as low-risk auditee for Federal purposes? **X** Yes _____ No

Part II – Financial Statement Findings Section

This section identifies the significant deficiencies, material weaknesses, fraud, illegal acts, violation of provisions of contracts and grant agreements, and abuse related to the Schedule for Government Auditing Standards that require reporting in a Uniform Guidance, Chapter 10.550, Rules of the Auditor General and *Government Auditing Standards* audit.

- **No matters were reported.**

Part III – Federal Awards Findings and Questioned Cost Section

This section identifies the audit findings required to be reported by the Uniform Guidance and Florida Statute Section 215.98(8)(i) and 215.97 (e) and Chapter 10.554 (1)(1) 4, Rules of the Auditor General (for example, material weaknesses, significant deficiencies, and material instances of noncompliance, including questioned costs), as well as any abuse findings involving federal awards or state financial assistance that are material to a major Federal program or State project.

- **No matters were reported.**

Part IV – Other Matters

Corrective Action Plan – Current Year Findings

This section is intended to address each audit finding included in the current year auditor's reports.

- No corrective plan per 2 CFR sections 200.511(a) and 200.511(c) of the Uniform Guidance Section .315, AG Rule 10.557 (3)(e)6 and Section 215.97(8)(i), Florida Statutes, is required because there were no audit findings related to Federal programs or State projects.

Summary Schedule of Prior Audit Findings – Federal programs and State projects

This section reports the status of any audit findings included in the prior audit's Schedule of findings and questioned costs related to Federal awards. The summary Schedule also includes audit findings reported in the prior audit's summary Schedule of prior audit findings except audit findings listed as corrected or no longer valid or not warranting further action.

- No Summary of Prior Audit Findings per Uniform Guidance Subpart F 200.516 and AG Rules 10.557 (3)(e) 5 is required because there were no prior audit findings related to Federal programs or State projects.

Supplementary Information

South Broward Hospital District d/b/a Memorial Healthcare System
Actual Expenses and Revenue Schedule
For the Contract Year Ended June 30, 2023

STATE-FUNDED

FUNDING SOURCES & REVENUES	Provider Subcontract#	Funding Source: F-Federal S-State F/S-Federal and State	Case Management 02	Crisis Support/ Emergency 04	Drop-In/Self Help Ctr. 07	Inpatient 09	Outpatient (Indiv.) 14	Outreach 15	Incidental Expenses 28	Outpatient Group 35	Recovery Support (Indiv.) 46	Cost Reimbursement B3	CAT Team B4	Mental Health Total B	Crisis Support/ Emergency 04	Intervention (Indiv.) 11	Medical Services 12	Medication-Assisted Tx 13	Outpatient (Indiv.) 14	Outreach 15	Inpatient Detoxification 24	Incidental Expenses 28	Outpatient Detoxification 32	Outpatient Group 35	Intervention (Group) 42	Aftercare (Group) 43	Recovery Support (Indiv.) 46	Recovery Support (Group) 47	Substance Abuse Total C	Total for State SAMH-Funded Covered Services or Projects (B+C) D	Total for Non-State-Funded Covered Services or Projects E	Total for All Covered Services or Projects (D+E) F	Non-SAMH Covered Services or Projects G	Total Funding (F+G) H
A																																			
IA. STATE SAMH FUNDING																																			
Current Year Funding																																			
MH009	34368-17	F/S		$ 48,150.83	$ 92,767.28		$ 1,569.40	$ 49,434.14		$ 916.87	$ 7,617.50	$ 12,500.00		$ 212,956.02															$ -	$ 212,956.02		$ 212,956.02		$ 212,956.02
MH018	34368-17	F/S		$ 154,685.85		$ 3,854.15								$ 158,540.00															$ -	$ 158,540.00		$ 158,540.00		$ 158,540.00
MHCAT	34368-17	S							$ 1,883.00				$ 1,341,946.68	$ 1,343,829.68															$ -	$ 1,343,829.68		$ 1,343,829.68		$ 1,343,829.68
MS011	34368-17	F/S												$ -		$ 157,806.63	$ 56,373.65	$ 221.48	$ 59,139.94				$ 1,491.00		$ 35,307.49	$ 7,256.34	$ 2,059.02	$ 1,336.50	$ 107.25	$ 321,099.30	$ 321,099.30		$ 321,099.30		$ 321,099.30
MS021	34368-17	F/S												$ -	$ 59,989.17						$ 326,346.68		$ 414,995.99						$ 801,331.84	$ 801,331.84		$ 801,331.84		$ 801,331.84
MS912	34368-17	S												$ -						$ 1,000,000.00									$ 1,000,000.00	$ 1,000,000.00		$ 1,000,000.00		$ 1,000,000.00
MSSM4	34368-17	F												$ -	$ 532,638.02	$ 154,967.68	$ 248,487.18	$ 121,260.31	$ 17,785.43	$ 118,720.25		$ 30,188.99		$ 46,363.65		$ 686.33	$ 5,796.99	$ 177.39	$ 1,277,072.22	$ 1,277,072.22		$ 1,277,072.22		$ 1,277,072.22
MSTV2	34368-17	F												$ -								$ 41,092.00							$ 41,092.00	$ 41,092.00		$ 41,092.00		$ 41,092.00
MSTVS	34368-17	F												$ -								$ 34,640.00							$ 34,640.00	$ 34,640.00		$ 34,640.00		$ 34,640.00
MH0CN	34368-17	F/S		$ 218,810.69				$ 183,739.98						$ 402,550.67															$ -	$ 402,550.67		$ 402,550.67		$ 402,550.67
MHCOM	34368-18	F		$ 32,332.00										$ 32,332.00															$ -	$ 32,332.00		$ 32,332.00		$ 32,332.00
Total Current Year Funding			$ -	$ 453,979.37	$ 92,767.28	$ 3,854.15	$ 1,569.40	$ 233,174.12	$ 1,883.00	$ 916.87	$ 7,617.50	$ 12,500.00	$ 1,341,946.68	$ 2,150,208.37	$ 592,627.19	$ 312,774.31	$ 304,860.83	$ 121,481.79	$ 76,925.37	$ 1,118,720.25	$ 326,346.68	$ 107,411.99	$ 414,995.99	$ 81,671.14	$ 7,256.34	$ 2,745.35	$ 7,133.49	$ 284.64	$ 3,475,235.36	$ 5,625,443.73		$ 5,625,443.73		$ 5,625,443.73
Carry Forward Funding																																			
MH065	34368-17	S	$ 6,768.09											$ 6,768.09															$ -	$ 6,768.09		$ 6,768.09		$ 6,768.09
MHCAT	34368-17	S											$ 132,920.65	$ 132,920.65															$ -	$ 132,920.65		$ 132,920.65		$ 132,920.65
Total Carry Forward Funding			$ 6,768.09	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 132,920.65	$ 139,688.74	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 139,688.74		$ 139,688.74		$ 139,688.74
TOTAL STATE SAMH FUNDING =			$ 6,768.09	$ 453,979.37	$ 92,767.28	$ 3,854.15	$ 1,569.40	$ 233,174.12	$ 1,883.00	$ 916.87	$ 7,617.50	$ 12,500.00	$ 1,474,867.33	$ 2,289,897.11	$ 592,627.19	$ 312,774.31	$ 304,860.83	$ 121,481.79	$ 76,925.37	$ 1,118,720.25	$ 326,346.68	$ 107,411.99	$ 414,995.99	$ 81,671.14	$ 7,256.34	$ 2,745.35	$ 7,133.49	$ 284.64	$ 3,475,235.36	$ 5,765,132.47		$ 5,765,132.47		$ 5,765,132.47
IB. OTHER GOVERNMENTT FUNDING																																			
(1) Other State Agency Funding														$ -															$ -	$ -		$ -		$ -
(2) Medicaid														$ -															$ -	$ -		$ -		$ -
(3) Local Government														$ -															$ -	$ -	$ 1,648,677.49	$ 1,648,677.49		$ 1,648,677.49
(4) Federal Grants and Contracts														$ -															$ -	$ -		$ -		$ -
(5) In-kind from local govt. only														$ -															$ -	$ -		$ -		$ -
TOTAL OTHER GOVERNMENT FUNDING =			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,648,677.49	$ -	$ 1,648,677.49
IC. ALL OTHER REVENUES																																			
(1) 1st & 2nd Party Payments														$ -															$ -	$ -		$ -		$ -
(2) 3rd Party Payments (except Medicare)														$ -															$ -	$ -		$ -		$ -
(3) Medicare														$ -															$ -	$ -		$ -		$ -
(4) Contributions and Donations														$ -															$ -	$ -		$ -		$ -
(5) Other														$ -															$ -	$ -		$ -		$ -
(6) In-kind														$ -															$ -	$ -		$ -		$ -
TOTAL ALL OTHER REVENUES =			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL FUNDING =			$ 6,768.09	$ 453,979.37	$ 92,767.28	$ 3,854.15	$ 1,569.40	$ 233,174.12	$ 1,883.00	$ 916.87	$ 7,617.50	$ 12,500.00	$ 1,474,867.33	$ 2,289,897.11	$ 592,627.19	$ 312,774.31	$ 304,860.83	$ 121,481.79	$ 76,925.37	$ 1,118,720.25	$ 326,346.68	$ 107,411.99	$ 414,995.99	$ 81,671.14	$ 7,256.34	$ 2,745.35	$ 7,133.49	$ 284.64	$ 3,475,235.36	$ 5,765,132.47	$ 1,648,677.49	$ 7,413,809.96	$ -	$ 7,413,809.96

SAMH COVERED SERVICES

*except IIC & IID

EXPENSE CATEGORIES	Case Management 02	Crisis Support/ Emergency 04	Drop-In/Self Help Ctr. 07	Inpatient 09	Outpatient (Indiv.) 14	Outreach 15	Incidental Expenses 28	Outpatient Group 35	Recovery Support (Indiv.) 46	Cost Reimbursement B3	CAT Team B4	Mental Health Total B	Crisis Support/ Emergency 04	Intervention (Indiv.) 11	Medical Services 12	Medication-Assisted Tx 13	Outpatient (Indiv.) 14	Outreach 15	Inpatient Detoxification 24	Incidental Expenses 28	Outpatient Detoxification 32	Outpatient Group 35	Intervention (Group) 42	Aftercare (Group) 43	Recovery Support (Indiv.) 46	Recovery Support (Group) 47	Substance Abuse Total C	Total for State SAMH-Funded Covered Services (B+C) D	Total for Non-State-Funded Covered Services E	Total for All Covered Services (D+E) F	Non-SAMH Covered Services G	Other Support Costs (optional) H	Total Expenses (F+G+H*+I*) J
A																																	
IIA. PERSONNEL EXPENSES																																	
(1) Salaries	$ 7,129.87	$ 482,000.08	$ 80,292.21	$ 6,717.45	$ 1,358.35	$ 244,932.19		$ 793.56	$ 6,593.12		$ 929,089.83	$ 1,758,906.66	$ 574,050.59	$ 471,014.53	$ 331,821.16	$ 130,939.78	$ 1,109,330.74	$ 282,112.24	$ 226,023.27	$ 471,241.46	$ 90,262.53	$ 9,113.07	$ 3,077.78	$ 7,765.36	$ 312.96	$ 3,798,727.05	$ 5,557,633.71	$ 1,564,785.00	$ 7,122,418.71			$ 7,122,418.71
(2) Fringe Benefits	$ 170.74	$ 79,465.96	$ 15,885.19	$ 1,313.84	$ 268.74	$ 33,725.86		$ 157.00	$ 1,304.40		$ 86,354.42	$ 218,646.15	$ 108,853.53	$ 29,905.52	$ 50,807.52	$ 24,781.68	$ 7,282.20	$ 211,359.49	$ 53,191.58	$ 17,254.13	$ 183.93	$ 9,627.40	$ 595.62	$ 141.18	$ 1,185.30	$ 36.30	$ 515,205.38	$ 733,851.53	$ 204,223.43	$ 938,074.96			$ 938,074.96
TOTAL PERSONNEL EXPENSES =	$ 7,300.61	$ 561,466.04	$ 96,177.40	$ 8,031.29	$ 1,627.09	$ 278,658.05	$ -	$ 950.56	$ 7,897.52	$ -	$ 1,015,444.25	$ 1,977,552.81	$ 682,904.12	$ 500,920.05	$ 382,628.68	$ 155,721.46	$ 98,943.78	$ 1,320,690.23	$ 335,303.82	$ 243,277.40	$ 471,425.39	$ 99,889.93	$ 9,708.69	$ 3,218.96	$ 8,950.66	$ 349.26	$ 4,313,932.43	$ 6,291,485.24	$ 1,769,008.43	$ 8,060,493.67	$ -	$ -	$ 8,060,493.67
IIB. OTHER EXPENSES																																	
(1) Building Occupancy	$ 2,253.19	$ 4,587.36	$ 9,481.80	$ 1.77	$ 167.53	$ 9,941.73		$ 97.87	$ 963.16		$ 35,404.39	$ 62,898.80	$ 31,494.09	$ 19,316.48	$ 24,103.40	$ 7,206.91	$ 13,178.04	$ 17,269.91	$ 84.72	$ 15,473.57	$ 69,277.28	$ 8,454.88	$ 427.94	$ 384.30	$ 565.88	$ 28.39	$ 207,265.79	$ 270,164.59	$ 113,573.61	$ 383,738.20			$ 383,738.20
(2) Professional Services	$ 11.77	$ 258,866.42	$ 376.51	$ 72.93	$ 6.37	$ 214.25	$ 2,000.00	$ 3.72	$ 30.92		$ 198,286.19	$ 459,869.08	$ 845.67	$ 134.90	$ 1,452.92	$ 196.68	$ 325.84	$ 188.49	$ 25,835.43	$ 179.24	$ 7,791.45	$ 705.86	$ 3.28	$ 39.75	$ 34.29	$ 2.29	$ 37,736.09	$ 497,605.17	$ 112,612.22	$ 610,217.39			$ 610,217.39
(3) Travel												$ -			$ 34.92	$ 0.14	$ 9.16			$ 0.92	$ 257.07	$ 20.84		$ 1.28	$ 0.83	$ 0.07	$ 325.23	$ 325.23	$ 76.40	$ 401.63			$ 401.63
(4) Equipment	$ 299.33	$ 1,329.99	$ 58.55	$ 1.59	$ 0.99	$ 1,324.60		$ 0.58	$ 4.81			$ 3,020.44	$ 131.38	$ 6,904.33	$ 466.08	$ 31.50	$ 495.92	$ 29.28	$ 216.02	$ 2,995.32	$ 2,979.84	$ 256.04	$ 63.05	$ 14.95	$ 11.03	$ 0.81	$ 14,595.55	$ 17,615.99	$ 1,994.47	$ 19,610.46			$ 19,610.46
(5) Food Services		$ 1.77		$ 0.04							$ 10,692.00	$ 10,693.81															$ -	$ 10,693.81	$ 162.14	$ 10,855.95			$ 10,855.95
(6) Medical and Pharmacy	$ 2.59	$ 83.05		$ 0.53		$ 6.16					$ 53.45	$ 145.78	$ 1,628.27	$ 29.74	$ 11,878.56	$ 414.37	$ 2,974.37	$ 7,957.72	$ 165.66	$ 408.66	$ 81,852.33	$ 6,775.91	$ 0.67	$ 408.21	$ 281.33	$ 21.69	$ 114,797.49	$ 114,943.27	$ 5,493.20	$ 120,436.47			$ 120,436.47
(7) Subcontracted Services												$ -															$ -	$ -		$ -			$ -
(8) Insurance												$ -															$ -	$ -		$ -			$ -
(9) Interest Paid												$ -															$ -	$ -		$ -			$ -
(10) Operating Supplies & Expenses										$ 16,151.70		$ 16,151.70	$ 3,062.94	$ 4,941.80	$ 7,791.19	$ 722.31	$ 2,672.62	$ 682.70	$ 1,758.55	$ 5,163.77	$ 46,835.94	$ 3,830.00	$ 147.54	$ 236.33	$ 184.18	$ 13.12	$ 78,042.99	$ 94,194.69	$ 15,560.52	$ 109,755.21			$ 109,755.21
(11) Other-Bad Debt		$ 44.32	$ 1,606.55	$ 0.26	$ 27.18	$ 752.38		$ 15.88	$ 131.92		$ 2,824.84	$ 5,403.33	$ 3,585.40	$ 76,854.58	$ 3,185.49	$ 822.19	$ 516.45	$ 799.15	$ 98.65	$ 243.22	$ 11,136.65	$ 1,481.31		$ 59.87	$ 74.89	$ 4.07	$ 98,861.92	$ 104,265.25	$ 18,617.52	$ 122,882.77			$ 122,882.77
(12) Donated Items												$ -															$ -	$ -		$ -			$ -
TOTAL OTHER EXPENSES =	$ 2,566.88	$ 264,912.91	$ 11,523.41	$ 77.12	$ 202.07	$ 12,239.12	$ 2,000.00	$ 118.05	$ 1,130.81	$ 16,151.70	$ 247,260.87	$ 558,182.94	$ 40,747.75	$ 108,181.83	$ 48,912.56	$ 9,394.10	$ 20,172.40	$ 26,927.25	$ 28,159.03	$ 24,464.70	$ 220,130.56	$ 21,524.84	$ 642.48	$ 1,144.69	$ 1,152.43	$ 70.44	$ 551,625.06	$ 1,109,808.00	$ 268,090.08	$ 1,377,898.08	$ -	$ -	$ 1,377,898.08
TOT. PERSONNEL & OTH. EXP. =	$ 9,867.49	$ 826,378.95	$ 107,700.81	$ 8,108.41	$ 1,829.16	$ 290,897.17	$ 2,000.00	$ 1,068.61	$ 9,028.33	$ 16,151.70	$ 1,262,705.12	$ 2,535,735.75	$ 723,651.87	$ 609,101.88	$ 431,541.24	$ 165,115.56	$ 119,116.18	$ 1,347,617.48	$ 363,462.85	$ 267,742.10	$ 691,555.95	$ 121,414.77	$ 10,351.17	$ 4,363.65	$ 10,103.09	$ 419.70	$ 4,865,557.49	$ 7,401,293.24	$ 2,037,098.51	$ 9,438,391.75	$ -	$ -	$ 9,438,391.75
IIC. DISTRIBUTED INDIRECT COSTS																																	
(a) Other Support Costs (Optional)												$ -															$ -	$ -		$ -		$ -	$ -
(b) Administration	$ 1,600.60	$ 129,114.20	$ 22,120.80	$ 1,847.20	$ 374.23	$ 62,063.89		$ 218.63	$ 1,816.43		$ 233,462.18	$ 452,618.16	$ 157,067.95	$ 115,211.61	$ 88,004.59	$ 35,815.94	$ 22,757.07	$ 303,758.75	$ 77,119.88	$ 55,953.82	$ 108,427.84	$ 22,974.68	$ 2,233.00	$ 740.36	$ 2,058.65	$ 80.33	$ 992,204.47	$ 1,444,822.63	$ 412,142.29	$ 1,856,964.92		XXXXXXXXXX	$ 1,856,964.92
TOT. DISTR'D INDIRECT COSTS =	$ 1,600.60	$ 129,114.20	$ 22,120.80	$ 1,847.20	$ 374.23	$ 62,063.89	$ -	$ 218.63	$ 1,816.43	$ -	$ 233,462.18	$ 452,618.16	$ 157,067.95	$ 115,211.61	$ 88,004.59	$ 35,815.94	$ 22,757.07	$ 303,758.75	$ 77,119.88	$ 55,953.82	$ 108,427.84	$ 22,974.68	$ 2,233.00	$ 740.36	$ 2,058.65	$ 80.33	$ 992,204.47	$ 1,444,822.63	$ 412,142.29	$ 1,856,964.92	$ -	XXXXXXXXXX	
TOTAL ACTUAL OPER. EXPENSES =	$ 11,468.09	$ 955,493.15	$ 129,821.61	$ 9,955.61	$ 2,203.39	$ 352,961.06	$ 2,000.00	$ 1,287.24	$ 10,844.76	$ 16,151.70	$ 1,496,167.30	$ 2,988,353.91	$ 880,719.82	$ 724,313.49	$ 519,545.83	$ 200,931.50	$ 141,873.25	$ 1,651,376.23	$ 440,582.73	$ 323,695.92	$ 799,983.79	$ 144,389.45	$ 12,584.17	$ 5,104.01	$ 12,161.74	$ 500.03	$ 5,857,761.96	$ 8,846,115.87	$ 2,449,240.80	$ 11,295,356.67	$ -	$ 0.00	$ 11,295,356.67
IID. UNALLOWABLE COSTS												$ -															$ -	$ -		$ -		XXXXXXXXXX	$ -
TOT. ALLOWABLE OPER. EXP. =	$ 11,468.09	$ 955,493.15	$ 129,821.61	$ 9,955.61	$ 2,203.39	$ 352,961.06	$ 2,000.00	$ 1,287.24	$ 10,844.76	$ 16,151.70	$ 1,496,167.30	$ 2,988,353.91	$ 880,719.82	$ 724,313.49	$ 519,545.83	$ 200,931.50	$ 141,873.25	$ 1,651,376.23	$ 440,582.73	$ 323,695.92	$ 799,983.79	$ 144,389.45	$ 12,584.17	$ 5,104.01	$ 12,161.74	$ 500.03	$ 5,857,761.96	$ 8,846,115.87	$ 2,449,240.80	$ 11,295,356.67	$ -	XXXXXXXXXX	$ 11,295,356.67
IIE. CAPITAL EXPENDITURES												$ -															$ -	$ -		$ -			$ -
III. UNEARNED FUNDS, FUNDING ALLOCATIONS, AND EXCESS FUNDS																																	
IIIA. Unearned Funds	$ (4,700.00)	$ (501,513.78)	$ (37,054.33)	$ (6,101.46)	$ (633.99)	$ (119,786.94)	$ (117.00)	$ (370.37)	$ (3,227.26)	$ (3,651.70)	$ (21,299.97)	$ (698,456.80)	$ (288,092.63)	$ (411,539.18)	$ (214,685.00)	$ (79,449.71)	$ (64,947.88)	$ (532,655.98)	$ (114,236.05)	$ (216,283.93)	$ (384,987.80)	$ (62,718.31)	$ (5,327.83)	$ (2,358.66)	$ (5,028.25)	$ (215.39)	$ (2,382,526.60)	$ (3,080,983.40)					

South Broward Hospital District d/b/a Memorial Healthcare System
Schedule of Bed-Day Availability Payments
For the Contract Year Ended June 30, 2023

Program	Cost Center	State Contracted Rate	Total Units of Service Provided	Total Units of Service Paid for by 3rd Party Contracts, Local Govt. or Other State Agencies	Maximum # of Units Eligible for Payment by Department	Amount Paid for Services by the Department	Maximum $ Value of Units in Column F	Amount Owed to Department (G-H or $0, whichever is greater)
A	B	C	D	E	(D-E) F	G	(F x C) H	I
Children's Mental Health	Crisis Stabilization Unit	-	-	-	-	-	-	-
Adult Mental Health	Crisis Stabilization Unit	-	-	-	-	-	-	-
Children's Substance Abuse	Substance Abuse Detox	$ 369.29	2,190	515	1,675	$ 190,055	$ 618,690	-
Adult Substance Abuse	Substance Abuse Detox	-	-	-	-	-	-	-
Adult Mental Health	Short-term Residential Treatment	-	-	-	-	-	-	-

Total Amount Owed to Department = $ -

South Broward Hospital District d/b/a Memorial Healthcare System
Schedule of State Earnings
For the Contract Year Ended June 30, 2023

Total Expenditures (Line 1)	$ 7,413,810
Less Other State and Federal Funds (Line 2)	-
Less Non-Match SAMH Funds (Line 3)	(5,062,849)
Less Unallowable Costs per 65E-14, F.A.C. (Line 4)	-
Total Allowable Expenditures (Line 5: Sum of lines 1, 2, 3, and 4)	2,350,961
Maximum Available Earnings (Line 6: Line 5 times 75%)	1,763,221
Amount of State Funds Requiring Match (Line 7)	562,595
Amount Due to Department (Line 6 - Line 7 or $0, whichever is less)	$ -

This computation determines whether local match requirements (as stated in the Department of Children and Families Substance Abuse and Mental Health Contract) have been satisfied. The computation of allowable matching is governed by Chapter 65E-14 Community Substance Abuse & Mental Health Services - Financial Rules.

South Broward Hospital District d/b/a Memorial Healthcare System
Schedule of Related Party Transaction Adjustments
For the Contract Year Ended June 30, 2023

Revenues From Grantee	Related Party	Allocation of Related Party Transactions Adjustment				
		State-Designated Cost Centers				
		1	2	3	.....	Total
Rent	XXX					
Services	XXX					
Interest	XXX					
Other	XXX					
Total Revenue From Grantee	XXX	NOT APPLICABLE				
Expenses Associated with Grantee Transactions						
Personnel Services	YYY					
Depreciation	YYY					
Interest	YYY					
Other	YYY					
Total Associated Expenses	YYY					
Related Party Transaction Adjustment	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ

Group:	S.B.H.D. Building Committee	**Date:**	July 16, 2024
Chairman:	Mr. Jose Basulto	**Time:**	4:00 p.m.
Vice-Chairman:	Mr. Brad Friedman		
Location:	Executive Conference Room, 3111 Stirling Road, Hollywood, Florida, 33312		

In Attendance: Mr. Jose Basulto (via WebEx), Ms. Elizabeth Justen, Mr. Scott Wester, Ms. Leah Carpenter, Mr. David Smith, Mr. Frank Rainer, Mr. Mark Greenspan, Ms. Denise DiCesare, Ms. Carmen Gonzalez, Ms. Valerie Morris (via WebEx), Mr. Steven Demers, and Ms. Dionne Blackwood

---

There being a quorum present, the .meeting was called to order by Mr. Basulto.

1. **SUBJECT:** Public Meeting Notice Certification

Mr. Rainer provided the Legal Certification of compliance with Florida's Public Meeting Laws.

2. **SUBJECT:** Construction Progress Report

Mr. Greenspan provided an overview on the status of each of the projects. All projects remain on schedule as indicated on the report. He noted that the Interventional Radiology project at Memorial Regional Hospital was successfully completed and approved by the Florida Agency for Health Care Administration.

Mr. Greenspan updated the Building Committee regarding the status of the Memorial Regional Hospital Emergency Department and Trauma project. He advised the completion date had been revised to accommodate ongoing challenges with ED capacity and due to unforeseen conditions.

Additionally, Mr. Greenspan provided an update regarding the Memorial Regional Hospital Family Birthplace project. He indicated the project remains on schedule for completion. He complimented the contractor and the Memorial Healthcare System Construction Services team for successfully resolving numerous unforeseen conditions.

3. **SUBJECT:** Projects in Planning Report

The Committee reviewed the report. Added to the report since the Committee last met were Memorial Hospital Miramar MOB II 3rd Floor Urology, Memorial Hospital West MCI Shell Space Renovation, and the Memorial Hospital West MRI Upgrade.

Mr. Greenspan provided an informational update on the status of the Memorial Regional Hospital Surgical and Critical Care Tower (Master Plan), which remains under design. He advised that site plan is in progress with the City of Hollywood. Work is presently underway with the Memorial Regional Hospital team to coordinate / finalize logistics plans. Permitting is proceeding via the use of a private provider. Also, he indicated that Robins & Morton, the Board approved construction manager, is currently performing preconstruction planning and will provide a Guaranteed Maximum Price amendment, along with value engineering options, for Board consideration later this year. Funding for current work in progress remains within the authorized $16.994 million.

Mr. Greenspan indicated that staff is working to validate Guaranteed Maximum Price proposals for the Douglas Road Free Standing Emergency Department and Red Road Free Standing Emergency Department.

Other items reported to the Committee included the following:

- Urgent Care Center / Primary Care Center at 10175 Pines Boulevard (Chase Building) – permitting and land use approval are now underway.

- Manor FEMA Hardening – anticipate finalizing design in August. Mr. Greenspan informed the Committee that MHS Construction Services will begin the process of identifying a Construction Manager for the Manor FEMA Hardening Project. He responded to Committee questions and advised there are no costs associated with the selection process. Following discussion, members of the Committee supported moving ahead with the selection process.

4. **SUBJECT:** Bid Openings

Bids from four, Board approved, pre-qualified general contractors were received and validated by Memorial Healthcare System Construction Services for the following projects:

a) Memorial Hospital Miramar – MRI / CT / Infusion Project

After review and discussion,

The Building Committee recommends to the Board of Commissioners acceptance of the lowest responsive and responsible bidder, Lee Construction Group, Inc., in the amount of $3,140,550, for the Memorial Hospital Miramar – MRI / CT / Infusion Project, and allocate a $471,000 contingency amount, to be controlled by Memorial Healthcare System

Motion: Ms. Justen
Second: Mr. Basulto
Motion Approved: Unanimous

b) Urgent Care / Primary Care Center located at 10175 Pines Boulevard (Chase Building) Project

After Review and discussion,

The Building Committee recommends to the Board of Commissioners acceptance of the lowest responsive and responsible bidder, Lee Construction Group, Inc., in the amount of $2,188,200, for the Urgent Care / Primary Care Center located at 10175 Pines Boulevard (Chase Building) Project, and allocate a $328,230 contingency amount, to be controlled by Memorial Healthcare System

Motion: Ms. Justen
Second: Mr. Basulto
Motion Approved: Unanimous

5. **SUBJECT:** New Business

Ms. Justen requested that additional information be added to the construction progress report. Additionally, she requested the development of a presentation regarding the project development process, with specific focus on funding / governance approval.

Mr. Greenspan informed the Committee that efforts were underway to update Memorial Healthcare System Standard Practices, based on recent legislative changes, which will be presented to the Committee at a future meeting.

6. **SUBJECT:** Adjournment

There being no further business, the meeting adjourned at 4:30 p.m.

Respectfully submitted,

Jose Basulto
Chairman
Building Committee

South Broward Hospital District

Board Building Committee

Construction Progress Report

June 2024

Active Projects	*Contractor*	*Architect*	*Scheduled Completion Date*	*Current Status*	*Comments*
Memorial Healthcare System					
Command Center	Lee Construction	Saltz Michelson	April 2024	08/01/2024	AHJ Comments
Primary Care Plantation	Thornton Construction	Saltz Michelson	December 2024	On Schedule	None
Buildout Dania Beach Center (**)	Lee Construction	Saltz Michelson	**		None
Dr. Davis Blue Water	Thornton Construction	HKS Architects	December 2024	On Schedule	None
Memorial Hospital Miramar					
Interventional Radiology Room	Engel Construction	HKS Architects	September 2024	On Schedule	None
Campus Signage (**)	Lee Construction	Harvard Jolly	**		None
Memorial Hospital Pembroke					
OR Cysto Room	Lee Construction	Saltz Michelson	March 2025	On Schedule	Supply Chain
Memorial Hospital West					
Outpatient Nursing	Gerrits Construction	HKS Architects	July 2024	Complete	None
2nd FL Labor & Delivery (**)	Lee Construction	HKS Architects	March 2025	On Schedule	None
Memorial Regional Hospital					
Emerg Dept and Trauma Bay Renovation	Turner Construction	Harvard Jolly	May 2025	On Schedule	None
Family Birthplace 4th Floor	Turner Construction	HKS Architects	December 2024	March 2025	Unforeseen Conditions
Linear Accelerator Replacement	Gerrits Construction	HKS Architects	August 2024	On Schedule	None
Memorial Regional Hospital South					
Chiller 3 Replacement	Lee Construction	Saltz Michelson	June 2025	On Schedule	None

* Denotes Item Added to Report

** Pending Permit

South Broward Hospital District
Board Building Committee
Projects in Planning
June 2024

Memorial Regional Hospital	**Contractor** /	**Architect**
Surgical and Critical Care Tower Expansion	Robins & Morton	HKS Architect
Memorial Healthcare System		
Free Standing Emergency Dept (Douglas Rd)	DPR	HKS Architects
Free Standing Emergency Dept (Red Road)	DPR	HKS Architects
Manor FEMA Hardening	TBD	Saltz Michelson
UCC 10175 Pines Blvd (Chase Bldg)	Lee Construction	Saltz Michelson
Memorial Hospital Miramar		
Imaging MOB II MRI/CT	Lee Construction	Harvard Jolly
Miramar MOB II 3rd Floor Urology*		Harvard Jolly
Memorial Hospital West		
MHW MCI Shell Space Renovation*		HKS Architects
MHW MRI Upgrade*		Harvard Jolly

*Denotes Item Added to Report

TO: Scott Wester, President and Chief Executive Officer

FROM: Mark Greenspan, Vice President
Construction and Property Management

SUBJECT: Bid Openings: (1) Memorial Hospital Miramar MRI / CT Infusion in MOB 2
(2) Urgent Care Center, 10175 Pines Blvd - Primary / Urgent Care

DATE: July 9, 2024

Bids for were opened at 4:00 P.M. on Tuesday, July 9, 2024, in the Executive Conference Room and via Teleconference for the above-named projects.

In attendance were Jose Basulto (via telephone), Elizabeth Justen, Laura Raybin Miller, Scott Wester, Leah Carpenter, David Smith, Carmen Gonzalez, Scott Strauss, and Mark Greenspan. In attendance (via telephone) were representatives from Engel Construction, Inc., Lee Construction, Inc., Lego Construction Co., and Thornton Construction Company, Inc.

The following bids were received for Memorial Hospital Miramar MRI / CT Infusion in MOB 2:

- Engel Construction, Inc. $ 3,763,858.35
- Lee Construction Group, Inc. $ 3,140,550.00 (x)
- Lego Construction Co. $ 4,490,183.25
- Thornton Construction Company, Inc. $ 3,705,832.69

The following bids were received for the Urgent Care Center at 10175 Pines Blvd - Primary / Urgent Care:

- Engel Construction, Inc. $ 3,006,468.15
- Lee Construction Group, Inc. $ 2,188,200.00 (x)
- Lego Construction Co. $ 2,797,777.50
- Thornton Construction Company, Inc. $ 2,398,945.00

Mr. Greenspan informed the group, as has been the standard practice, that the bids would be reviewed and verified for accuracy.

Recommendation for award will be presented at the next regularly scheduled Board Building Committee Meeting.