COASTAL HEALTH & WELLNESS

GOVERNING BOARD

9850-A.106 Boardroom Emmett F. Lowry Expressway, Texas City

AGENDA
Thursday, October 28, 2021 – 12:30 PM

CONSENT AGENDA: ALL ITEMS MARKED WITH A SINGLE ASTERICK (*) ARE PART OF THE CONSENT AGENDA AND REQUIRE NO DELIBERATION BY THE GOVERNING BOARD. ANY BOARD MEMBER MAY REMOVE AN ITEM FROM THIS AGENDA TO BE CONSIDERED SEPARATELY.

PROCEED TO BOTTOM OF THIS DOCUMENT FOR APPEARANCE & EXECUTIVE SESSION GUIDELINES

In accordance with the provisions of the Americans with Disabilities Act (ADA), persons in need of a special accommodation in order to participate in this proceeding should, within two (2) days prior to the proceeding, request necessary accommodations by contacting CHW's Executive Assistants at 409-949-3406, or via email at trollins@gchd.org or ahernandez@gchd.org

ANY MEMBERS NEEDING TO BE REACHED DURING THE MEETING MAY BE CONTACTED AT 409-938-2288

REGULARLY SCHEDULED MEETING

Meeting Called to Order
Pledge of Allegiance

Item #1 ..... Comments from the Public

***Item #2 ACTION**..... Agenda

***Item #3 ACTION**..... Excused Absence(s)

***Item #4 ACTION**..... Consider for Approval Minutes from September 30, 2021 Governing Board Meeting

*Item #5 **ACTION**..... Consider for Approval Minutes from October 14, 2021 Governing Board QA Meeting

*Item #6 **ACTION**..... Consider for Approval Quarterly Investment Report

*Item #7 **ACTION**..... Consider for Approval the Coastal Health & Wellness 2021-2022 Environment of Care Plans

a) Equipment Management Plan 2021-2022
b) Fire Safety Management Plan 2021-2022
c) Hazardous Materials and Waste Management Plan 2021-2022
d) Safety Management Plan 2021-2022
e) Security Management Plan 2021-2022
f) Utilities Management Plan 2021-2022

*Item #8 **ACTION**..... Consider for Approval the Coastal Health & Wellness Risk Management Report for the Quarter Ending September 30, 2021

Item #9 ..... Executive Director will report on Coastal Health & Wellness/COVID-19 Updates Submitted by Dr. Keiser

a) Executive Director
b) Dental Director

Item #10 **ACTION**..... Consider for Approval September 2021 Financial Report Submitted by Marlene Garcia

Item #11	**ACTION**	Consider for Approval Quarterly Visit and Analysis Report Including Breakdown of New Patients by Payor Source for Recent New Patients Submitted by Marlene Garcia
Item #12	**ACTION**	Consider for Approval the Quarterly Compliance Report for the Period Ending September 30, 2021 Submitted by Richard Mosquera
Item #13	**ACTION**	Consider for Approval the Coastal Health & Wellness Risk Management Training Plan 2021-2022 Submitted by Richard Mosquera
Item #14	**ACTION**	Consider for Approval Coastal Health & Wellness Performance Improvement Plan Submitted by Ann O'Connell
Item #15	**ACTION**	Consider for Approval Re-Privileging Rights for Emily Bailey, MSW, LCSW, Submitted by Ann O'Connell
Item #16	**ACTION**	Consider for Approval Privileging Rights for UTMB Resident Neda Shaghaghi, DO, Submitted by Ann O'Connell
Item #17	**ACTION**	Consider for Approval Privileging Rights for UTMB Resident Sara Hassan-Youssef, MD, Submitted by Ann O'Connell
Item #18		Review of Coastal Health & Wellness & United Board of Health Organizational Chart
Item #19	**EXECUTIVE SESSION**	The Governing Board will enter into a closed meeting as permitted under the Section 551.074(b) of the Texas Government Code, Personnel Matters; specifically, to discuss the Executive Director
Item #20		Reconvene into Regularly Schedule Meeting
Item #21	**ACTION**	Possible Action from Executive Session
Item #22		Comments from Board Members

Adjournment

Next Regular Scheduled Meeting: November 18, 2021

Appearances before the Coastal Health & Wellness Governing Board

The Coastal Health & Wellness Governing Board meetings are conducted under the provisions of the Texas Open Meetings Act, and members of the public that wish to address the Board about an item presented on the agenda shall be offered three minutes to do so. The Board cordially requests that individuals desiring to make a such a statement notify the Board of their intention by writing their name on the sign-in sheet located at the Boardroom's main entrance.

A citizen desiring to make comment to the Board regarding an item not listed on the agenda shall submit a written request to the Executive Director by noon on the Thursday immediately preceding the Thursday of the Board meeting. A statement of the nature of the matter to be considered shall accompany the request. The Executive Director shall include the requested appearance on the agenda, and the person shall be heard if he or she appears.

Executive Sessions

When listed, an Executive Session may be held by the Governing Board in accordance with the Texas Open Meetings Act. An Executive Session is authorized under the Open Meetings Act pursuant to one or more the following exceptions: Tex. Gov't Code §§ 551.071 (consultation with attorney), 551.072 (deliberation regarding real property), 551.073 (deliberation regarding a prospective gift or donation), 551.074 (personnel matters), 551.0745 (personnel matters affecting Coastal Health & Wellness advisory body), 551.076 (deliberation regarding security devices or security audits), and/or 551.087 (deliberations regarding

economic development negotiations). The Presiding Officer of the Governing Board shall announce the basis for the Executive Session prior to recessing into Executive Session. The Governing Board may only enter into Executive Session if such action is specifically noted on the posted agenda.

Governing Board
October 2021
Item#3
Excused Absence(s)

Governing Board
October 2021
Item#4
Consider for Approval Minutes from September 30, 2021 Governing Board Meeting

Coastal Health & Wellness
Governing Board
September 30, 2021

Board Members
Zoom Call:

Dr. Southerland
Virginia Valentino
Miroslava Bustamante
Flecia Charles
Kevin Avery
Elizabeth Williams
Victoria Dougharty

Staff:

Philip Keiser, Interim Executive Director
Ann O'Connell, Chief Operations Officer
Richard Mosquera, Chief Compliance Officer
Dr. Lindskog, Dental Director
Ami Cotharn, Chief Nursing Officer
Chantelle Smith
Marlene Garcia
Kristina Garcia
Pisa Ring
Martha Vallin
Virginia Lyles
Jonathan Jordan
Kenna Pruitt
Ashley Tompkins
Tikeshia Thompson-Rollins
Anthony Hernandez

Excused Abcence: Samantha Robinson, and Dr. Thompson
Unexcused Absence: Dorothy Goodman, and Brent Hartzell

Items #1 Comments from the Public
There were no comments from the public.

Items #2-6 Consent Agenda
A motion was made by Virginia Valentino to approve the consent agenda items two through six. Elizabeth Williams seconded the motion, and the Board unanimously approved the consent agenda.

Item #7 Executive Director will Report on Coastal Health & Wellness/COVID-19 Updates Submitted by Dr. Keiser
Dr. Keiser, Executive Director, presented an update on COVID-19

Ann O'Connell, Chief Operations Officer, would like to recognize Dr. Lindskog our Dental Director, on being installed as a director on the Texas Academy of General Dentistry and Ami Cotharn, Chief Nursing Director, on being named a Women in Leadership Award finalist. Job well done Dr. Lindskog and Ami Cotharn.

Dr. Lindskog, Dental Director, updated the Board on dental services in the Coastal Health & Wellness Clinic:

- We continue to follow CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel which has a section dedicated to Dental Facilities.
- Our infection control nurse recently completed annual fit testing on all dental staff. All dental staff wears N95 respirators and face shields for all aerosol generating procedures.
- We are currently providing all dental services in Texas City. We have started purchasing equipment to expand our root canal and crown services to Galveston.
- Staffing: We recently extended an offer to a dental assistant who is scheduled to complete paperwork today. As soon as we have a start date for the assistant, we will move forward with posting the dentist position.

- Dr. Lindskog is continuing to attend College of The Mainland (COM) Dental Hygiene School Advisory Committee meetings and is working to establish a partnership with the school for hygiene student rotations. COM recently lost their Dental Hygiene Program Coordinator, but they are working to fill the position, and we will continue to work towards a partnership with them. The school has not opened, and we likely will not have students rotate until at least 2023, but I wanted to update the board on our progress.
- October is Dental Hygiene Awareness month. We have exciting things planned, including "story time" from our hygienists at the Texas City library as well as internally recognizing our hygienists.

Item #8 Consider for Approval August 2021 Financial Report Submitted by Marlene Garcia

Marlene Garcia, Business Director, presented the August 2021 financial report to the Board. A motion to accept the financial report as presented was made by Virginia Valentino. Victoria Dougharty seconded the motion and the Board unanimously approved.

Item #9 Consider for Approval Coastal Health & Wellness Care Transitions, Tracking and Follow up Policy Submitted by Martha Vallin

Martha Vallin, Referral Manager/Health Educator Specialist, presented the care transitions, tracking and follow up policy to the Board. A motion to accept the policy as presented was made by Virginia Valentino. Victoria Dougharty seconded the motion and the Board unanimously approved.

Item #10 Consider for Approval Coastal Health & Wellness Title V Child Health & Dental Eligibility Policy Submitted by Kristina Garcia

Kristina Garcia, Patient Services Manager, asked the Board to consider for approval CHW Title V Child Health & Dental Eligibility Policy. A motion to accept the policy as presented was made by Miroslava Bustamante. Virginia Valentino seconded the motion and the Board unanimously approved.

Item #11 Consider for Approval Coastal Health & Wellness Medical Referral Tracking and Care Management Policy Submitted by Martha Vallin

Martha Vallin, Referral Manager/Health Educator Specialist, asked the Board to consider for approval the CHW medical referrals tracking and care management policy. Richard Mosquera suggested bringing more information regarding Greater Houston HealthConnect to the next Board meeting. A motion to accept the policy as presented was made by Virginia Valentino. Victoria Dougharty seconded the motion and the Board unanimously approved.

Item #12 Consider for Approval the 2020-2021 Annual Risk Management Report Submitted by Richard Mosquera

Richard Mosquera, Chief Compliance Officer, asked the Board to consider for approval the 2020-2021 Annual Risk Management Report. A motion to accept the report as presented was made by Virginia Valentino. Victoria Dougharty seconded the motion and the Board unanimously approved.

Item #13 Consider for Approval Re-Privileging Rights for Oyetokunbo Ibidapo- Obe, MD, UTMB Contractor Submitted by Ann O'Connell

Ann O'Connell, Chief Operations Officer, asked the Board to consider for approval re-privileging rights for Oyetokunbo Ibidapo-Obe, MD, UTMB Contractor. A motion to accept re-privileging rights for Oyetokunbo Ibidapo-Obe, MD, was made by Victoria Dougharty and seconded by Virginia Valentino. The Board unanimously approved the motion.

Item #14 Consider for Approval Privileging Rights for UTMB Resident Jayshere Thomas, DO, Submitted by Ann O'Connell

Ann O'Connell, Chief Operations Officer, asked the Board to consider for approval privileging rights for UTMB Resident Jayshere Thomas, DO. A motion to accept privileging rights for Jayshere Thomas, DO, was made by Miroslava Bustamante and seconded by Victoria Dougharty. The Board unanimously approved the motion.

Item #15 Consider for Approval Privileging Rights for Deatra Josiah, APRN- CNP, Submitted by Ann O'Connell

Ann O'Connell, Chief Operations Officer, asked the Board to consider for approval privileging rights for Deatra Josiah, APRN- CNP. A motion to accept privileging rights for Deatra Josiah, APRN- CNP, was made by Virginia Valentino and seconded by Victoria Dougharty. The Board unanimously approved the motion.

Item #16 Update on Governing Board Member Vacancies Submitted by Submitted by Ann O'Connell

Ann O'Connell, Chief Operations Officer, updated the Board on member vacancies. Ann informed the Board our goal is to have 15 Governing Board members and currently we have four community and six consumer members positions filled. This does meet our HRSA requirements however we are currently looking to fill two more consumers and three more community member positions. Ann is actively working with providers and staff on who would be a great consumer member for our Board and asked that the community members currently on the Board help with looking for community members.

Item #17 Update on Meeting Between Coastal Health & Wellness and United Board of Health Submitted by Ann O'Connell

Ann O'Connell, Chief Operations Officer, informed the Board that there will be a meeting setup between the United Board of Health and Governing Board to understand each of the Boards and their duties.

Item #18 Shared Services Agreement Discussion Submitted by Richard Mosquera

Richard Mosquera, Chief Compliance Officer, presented the shared services agreement.

Item #19 The Joint Commission Survey Results Submitted by Ann O'Connell

Ann O'Connell, Chief Operations Officer, updated the Board on the Joint Commission unannounced site visit. Ann informed the Board TJC has 10 days to conduct a final written assessment. On Friday September 17, 2021 we were provided "preliminary results." There were only 4 small findings:

- Credentialing/privileging files for our three contracted radiologists were incomplete. Considered to be "low" on the SAFER matrix. There was documentation that the files were not as incomplete as found on September 16th and 17th.
- One patient record lacked evidence that the team had identified and documented the patient's health literacy needs (an element of PCMH). Low on the SAFER matrix.
- CHW not collecting data on patient's perception of the comprehensiveness and coordination of care (an element of PCMH). Low on the SAFER matrix.
- 3 out of 3 patient records reviewed lacked work history, including occupational risk factors or exposures (an element of PCMH). Low on the SAFER matrix.

Richard Mosquera informed the Board that CHW has 60 days to respond to Joint Commission and Joint Commission has 60 days to notify CHW with response.

Item #20 Comments from Board Members
No comments

The meeting was adjourned at 1:55p.m.

_____	_____
Chair	Secretary/Treasurer
_____	_____
Date	Date

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Governing Board
October 2021
Item#5
Consider for Approval Minutes from October 14, 2021 Governing Board QA Meeting

Coastal Health & Wellness Governing Board

Quality Assurance Committee
Meeting
October 15, 2021

BOARD QA COMMITTEE MEMBERS PRESENT:
Samantha Robinson, BSN – Chair
Virginia Valentino-Treasurer
Kevin Avery- Consumer Member

EMPLOYEES PRESENT:
Philip Keiser, MD (Interim Executive Director), Ann O'Connell (Chief Operations Officer), Ami Cotharn (Chief Nursing Director), Richard Mosquera (Chief Compliance Officer), Shonta' Hill (Dental Assistant Supervisor), Pisa Ring (Patient Information Manager), Tiffany Carlson (Nursing Director), Marlene Garcia (Business Director), & Tyler Tipton (Public Health Emergency Preparedness Manager), Tikeshia Thompson Rollins (Executive Assistant III)

(Minutes recorded by Tikeshia Thompson Rollins)

ITEM	
Patient Access/Satisfaction Report • Quarterly Access to Care Report submitted by Pisa Ring • Quarterly Patient Satisfaction Reports Submitted by Pisa Ring • CHW Call Center Queue Abandonment Rates	**Quarterly Access to Care Report** • Pisa reviewed the quarterly access to care report and will look into sending patients appointment reminders two weeks prior to appointments and again two days prior to appointment. **Quarterly Patient Satisfaction Report** • Report reviewed and discussed; team will work on survey questions and bring back to committee. **Call Center Queue Abandonment Rates** • Team will bring back a plan on how to decrease abandonment rates.
Clinic Measures • Quarterly Report on UDS Medical Measures in Comparison to Goals Submitted by Jason Borillo	• UDS measures were reviewed and will be brought back to the Committee in January 2022.
Quarterly Assurance/Risk Management/Emergency Management Reports • Quarterly Risk Management Reports Submitted by Richard Mosquera • Risk Management Training Plan Submitted by Richard Mosquera • Dental Quarterly Summary Submitted by Dr. Lindskog	**Quarterly Risk Management Report** • Rocky reviewed the Quarterly Risk Management report in comparison to current goals. Report will be presented at the GB October meeting. **Risk Management Training Plans** • Plan reviewed; will be presented at the GB October meeting. **Dental Quarterly Summary** • Shonta' reviewed the dental quarterly summary. The committee was informed that the sealants program for children were at 100%.

• Quarterly Emergency Management Report Submitted by Tyler Tipton	• Report reviewed; no action needed.
Plans and Policies • 2021-2022 Environment of Care Plans Submitted by Richard Mosquera ➢ Equipment Management Plan: 2021-2022 ➢ Fire Safety Management Plan: 2021-2022 ➢ Hazardous Materials and Waste Management Plan: 2021-2022 ➢ Safety Management Plan: 2021-2022 ➢ Security Management Plan: 2021-2022 ➢ Utilities Management Plan: 2021-2022	• Plans reviewed and discussed; will be presented at the GB October meeting.

Next Meeting: January 13, 2022

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Governing Board
October 2021
Item#6
Consider for Approval Quarterly Investment Report

Coastal Health & Wellness
Investment Report
For the period ending September 30, 2021

Coastal Health & Wellness	Money Market Account			Tex Pool Investments		
	Jul	Aug	Sep	Jul	Aug	Sep
Beginning Balance	$5,816,776	$6,157,552	$6,901,733	$26,452.50	$26,452.81	$26,453.32
Deposits	931,900	917,000	444,600	$0.00	$0.00	$0.00
Withdrawals	(593,147)	(175,000)	(448,865)	$0.00	$0.00	$0.00
Interest Earned	2,023	2,181	2,157	$0.31	$0.51	$0.68
Ending Balance	$6,157,552	$6,901,733	$6,899,625	$26,452.81	$26,453.32	$26,454.00
Current Annual Yield	0.40%	0.40%	0.40%	0.01%	0.01%	0.01%
Previous Quarter Yield (10/2020 - 12/2020)	1.40%	1.40%	0.40%	0.08%	0.04%	0.02%

Summary	Interest Earned	Avg Balance	Yield
October 1, 2020 to December 31, 2020	$20,235	$5,775,637	0.19%
January 1, 2021 to March 31, 2021	$15,573	$5,977,232	0.14%
April 1, 2021 to June 30, 2021	$5,968	$6,008,553	0.05%
July 1, 2021 to September 30, 2021	$6,363	$6,338,957	0.05%
YTD Totals	$48,139	$6,025,095	0.43%

Coastal Health & Wellness	Q1	Q2	Q3	Q4	YTD Comparison
Interest Yield Year to Year Comparison	Oct 1-Dec 31	Jan 1-Mar 31	Apr 1-June 30	Jul 1-Sept 30	Total as of 9/30
FY2018	0.14%	0.20%	0.30%	0.38%	**1.02%**
FY2019	0.43%	0.47%	0.47%	0.46%	**1.83%**
FY2020	0.40%	0.36%	0.21%	0.20%	**1.17%**
FY2021 (Current year)	0.19%	0.14%	0.05%	0.05%	**0.43%**

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Governing Board
October 2021
Item#7
Consider for Approval the Coastal Health & Wellness 2021-2022 Environment of Care Plans

a) Equipment Management Plan 2021-2022
b) Fire Safety Management Plan 2021-2022
c) Hazardous Materials and Waste Management Plan 2021-2022
d) Safety Management Plan 2021-2022
e) Security Management Plan 2021-2022
f) Utilities Management Plan 2021-2022

Coastal Health & Wellness
Serving, Healing, Caring

Effective: 10/2021
Last Approved: 08/2020
Expires: 09/2022

ENVIRONMENT OF CARE
Equipment Management Plan: 2021 - 2022

I. PURPOSE

The Equipment Management Plan (the "Plan") is established to provide a safe and secure environment for all patients, staff, and other individuals who enter Coastal Health & Wellness ("CHW") facilities. The Equipment Management Plan describes the framework to manage all medical, dental and laboratory equipment used by CHW staff. This Plan is written in accordance with Joint Commission standards EC.02.04.01 and EC.02.04.03

II. OBJECTIVES

a. To promote safe and effective use of medical equipment used for the diagnosis, treatment, and monitoring of patient care; and
b. To proactively mitigate risk through timely preventive equipment maintenance, servicing and calibration.

III. RESPONSIBILITIES

a. The ~~Infection Control and Environment of Care~~Joint Commission Committee (the "Committee") shall:

1. Review sentinel events related to any aspect outlined in the Equipment Management Plan and, as necessary, propose and implement follow-up regulations which shall be no less stringent than those designated by the manufacturer for each type of equipment utilized by Coastal providers;
2. When applicable, develop new procedures and guidelines for medical equipment deemed necessary to ensure optimal levels of patient safety and care, and remain consistent with changes in The Joint Commission Environment of Care standards along with relevant regulatory updates established by other applicable authoritative agencies and/or the equipment's manufacturer;
3. Select and implement procedures and controls to achieve objectives of the Equipment Management Plan; and
4. Review the Equipment Management Plan as deemed necessary, and no less than once annually (see Section V. Annual Evaluation).

b. The Procurement Agent shall:

1. Assist in maintaining a current Equipment Inventory Log, to be retained in a protected shared drive accessible solely by pertinent staff, of selected items which shall include, amongst other elements, each piece of equipment's Equipment Management Assessment Score ("EMAS"), if applicable;
2. Coordinate the acquisition of equipment in conjunction with the Medical Director, Dental Director, Laboratory Director, Director of Dental Assistants, or the Nursing Director ("Department Directors") and/or designees;
3. When requested, assist the Department Directors or designees prior to the purchase of equipment to determine if said equipment meets all requisite safety requirements and includes appropriate warranties, satisfies manufacturers' suggestions for inspection, etc.;
4. Ensure that all received equipment classified as high-risk, or of which requires any form of maintenance or inspection, or that has an electrical cord, is inspected and approved upon delivery;
5. Update the Equipment Inventory Log to include new equipment;
6. When applicable, remove discarded or decommissioned equipment from the Equipment Inventory Log; and
7. In accordance with manufacturers' suggested maintenance schedules for all equipment on the inventory log, work in conjunction with Department Directors and the Risk and Safety Coordinator to monitor, track and arrange for appropriate servicing.

c. The Medical Director, Dental Director, Laboratory Director, Director of Dental Assistants or the Nursing Director (the "Department Directors") shall:

1. Assist the Procurement Agent during the selection and acquisition of equipment, and advise the Procurement Agent regarding pertinent specifications for acquisitions;
2. Complete an EMAS form for all equipment which poses *ANY* form of risk, and furnish a completed copy of the form to the Risk and Safety Coordinator;
3. Monitor equipment within their respective department and notify the Procurement Agent of all third-party maintenance, inspection and servicing required to be performed on applicable equipment; and
4. Notify and work in conjunction with the Risk and Safety Officer to produce equipment malfunction reports and, if necessary, appropriate follow-up procedures.

d. The Risk and Safety Coordinator shall:

1. Document and track any and all incidents, such as equipment failures or user errors;

2. In conjunction with the Procurement Agent, coordinate hazard notices and recalls;
3. Work with the Procurement Agent to maintain an updated Equipment Inventory Log;
4. Assist the Procurement Agent in ensuring that all received equipment classified as high-risk, or of which requires any form of maintenance or inspection, or that has an electrical cord, is inspected and approved upon delivery and annually thereafter;
5. During monthly Environmental Safety Assessments, verify that equipment requiring certain inspection or maintenance is not overdue;
6. Oversee compliance with the Equipment Assessment Plan and ensure a valid EMAS is retained for each piece of applicable equipment;
7. With the Chief Compliance Officer, report all significant findings, discrepancies, observations, and noted opportunities for improvement and recommendations to the Committee for review and consideration.

e. <u>All staff, personnel, and volunteers shall</u>:

1. Follow the policies, procedures, and guidelines approved by the Committee and the Coastal Health & Wellness Governing Board;
2. Immediately submit an incident report to his/her supervisor and the Risk and Safety Coordinator for any event related to equipment malfunction;
3. Ensure that equipment which malfunctioned is tagged and removed from the floor until repaired; and
4. Immediately submit an Equipment Malfunction Report to his/her supervisor and the Procurement Agent.

f. <u>Incoming Equipment Inspection Procedure</u>:

The Procurement Agent shall:

1. Work with the Department Directors to ensure facilitation of equipment inspections before equipment is commissioned for use; and
2. Notify the manufacturer and/or distributor of any encountered issue, and supply the manufacturer with documentation explaining the problem.

g. <u>Equipment Inventory Log</u>

1. The Equipment Inventory Log shall identify equipment by type, serial number, location, department of oversight, frequency of recommended maintenance checks, and, if applicable, comments related to equipment failure history.
2. Items may be added to or removed from the Equipment Inventory Log by the Procurement Agent, Risk and Safety Coordinator, or designee.

h. Regular Inspection, Testing, & Maintenance:

1. Inspections, testing and maintenance shall be completed in accordance with the manufacturer's suggestion for all equipment, unless specifically designated in a more stringent capacity by the applicable Department Director; and
2. When required to be performed by a third-party, maintenance checks shall be arranged by the Procurement Agent and/or the Risk and Safety Coordinator.

i. Documentation of Maintenance & Testing:

1. All maintenance, servicing and testing of equipment will be documented in the Equipment Inventory Log, which shall denote the activity performed and the required date of follow-up.
2. Equipment denoted in the Equipment Inventory Log classified as high-risk, or of which requires any form of maintenance or inspection, or that has an electrical cord shall be denoted accordingly to ensure appropriate periodic maintenance and corrective work orders can be tracked.
3. The Procurement Agent, Risk and Safety Coordinator and Department Directors will be jointly responsible for ensuring such documentation is retained.

j. Hazard Notices & Recalls:

1. Equipment recalls and hazard notices received must immediately be forwarded to the Risk and Safety Coordinator for proper handling and action.
2. Recalled equipment shall be tagged and immediately removed from service until certified safe via repair or replaced entirely.

k. Safe Medical Device Act of 1990 (amended in 1996):

1. The Safe Medical Device Act of 1990 requires that device users report incidents to the device manufacturer when the facility determines a device's malfunction, at least in part, has or may have caused or contributed to the death or serious injury or illness of an individual. The facility must also send a copy of the report to the FDA in the case of death. Such reports will be drafted by the primary user and/or supervisor of the applicable machine and shall provide detailed information on medical device failures that may have caused or are suspected of causing serious illness, injury or death.
2. Such reporting measures will be conducted by the Chief Compliance Officer.

l. Equipment Failures & User Errors:

The following steps will be followed in the event of an equipment failure:

1. Staff will follow written procedures when medical equipment fails, including using emergency clinical interventions and back-up equipment.
2. Any defective equipment will be tagged and removed from service immediately and will remain out of service until the equipment is commissioned by a certified party as having been returned to its proper operating condition or until the piece of equipment has been replaced.
3. All equipment failures will be reported as an incident report and sent to the Risk and Safety Coordinator. An Equipment Malfunction Report is to be completed and in the report will include the error/failure date, location of the equipment, cause or affected area, resolution and follow-up. The report will be retained by the Risk and Safety Coordinator and Procurement Agent.
4. The Procurement Agent and Risk and Safety Coordinator will work collaboratively to have all documented problems corrected.
5. Once the problem is corrected, the equipment will be returned to service. Equipment that cannot be repaired will be disposed of in accordance with applicable procedures.
6. In the event a problem was caused by user error, the user(s) will be retrained on the operation and use of the equipment by the Department Director or otherwise qualified trainer.

m. Orientation & Education:

1. As a part of initial employee orientation and periodic continuing education, as required, staff will be provided by their supervisors with training that addresses:
    i. Capabilities, limitations and special applications of equipment;
    ii. Basic operating and safety procedures for equipment use;
    iii. Emergency procedures in the event of equipment failure;
    iv. Information/skills necessary to perform assigned maintenance responsibilities; and
    v. Processes for reporting equipment problems, failures and user errors.
2. Staff will periodically undergo competency assessments to determine if proficiency levels for operating equipment have been maintained. For equipment that requires documented training, staff may not utilize the equipment until documentation of successful training has been produced and a competency, if applicable, has been completed.
3. Trainings and competency assessments are to be tracked and enforced by Department Directors, or their designee.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce safety risks identified by individuals or the organization. Such processes shall include, but not be limited to:

1. Reviewing Incident Reports and trends related to equipment issues;
2. ~~Tracking any reportable~~Reporting equipment failures in accordance with the Safe Medical Devices Tracking Act; and
3. Documenting observed competence by medical equipment users.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.

b. The Committee keeps the Equipment Management Plan current by reviewing the plan at least annually (e.g. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based on the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee shall utilize a variety of sources to improve inspection and audit results, accident/incident reports, and other forms of tracking reports. The Committee may also review and seek input from alternative sources of relevance including leadership, management, staff, personnel, volunteers and third parties.

d. The annual review will include assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE OBJECTIVES: 2021 - 2022

Performance Objective/Goal	Performance Measure/Indicator
Ensure documentation of observed competence by medical equipment users.	100% of staff received documented training on equipment critical to job performance as designated by supervisor.
Managing risk through prompt preventive maintenance checks and calibration.	95% preventive maintenance and calibration completed by due dates (100% for high-risk equipment).
Product safety alerts and recall notices are documented and reported the Procurement Agent, Executive Management and Department Directors Managers	100% of received recall and safety alert notices are documented and the information dispersed within two days of receipt.
Ensure EMAS forms remain current.	10095% of applicable new equipment ~~equipment in the Equipment Inventory Log~~ must have an EMAS on-file and be added to the Equipment Management Log ~~no more than a year old (100% for critical equipment).~~before the equipment is used.

Coastal Health & Wellness
Serving, Healing, Caring

Effective: 10/2021
Last Approved: 08/2020
Expires: 09/2022

ENVIRONMENT OF CARE
Fire Safety Management Plan: 2021 - 2022

I. PURPOSE

The Fire Safety Management Plan (the "Plan") has been implemented to mitigate fire hazards, maintain an environment conducive to accessible egress, prevent potential injuries and safeguard property from any and all fire related threats. This Plan describes the framework used to manage fire risks and improve safety performance, and applies to all Coastal Health & Wellness facilities, employees, patients, contractors, volunteers, students, and visitors, and conforms to all mandates set forth by The Joint Commission standard EC.02.03.01.

II. OBJECTIVES

a. To minimize the chances of a fire;
b. To minimize the risk of injury in the occurrence of a fire; and
c. To ensure staff receives appropriate fire education and training.

III. RESPONSIBILITIES

The ~~Infection Control and Environment of Care~~Joint Commission Committee (the "Committee") and the Risk and Safety Coordinator are responsible for developing, implementing, and monitoring this Plan.

a. The Committee shall:

1. Review sentinel events and make recommendations regarding fire hazards and threats;
2. Develop procedures and guidelines consistent with the Coastal Health & Wellness Governing Board approved Emergency Operations Plan as they pertain to fire safety;
3. Implement and monitor approved policies, procedures, guidelines and recommendations in accordance with the Plan;
4. Respond appropriately when conditions involving potential fire hazards arise which may pose a foreseeable threat to life, human health and/or Coastal Health & Wellness property; and
5. Review the Fire Safety Management Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. The Risk and Safety Coordinator shall:

1. Conduct monthly proactive risk assessments to monitor compliance with the Fire Safety Management Plan;
2. Work with building landlords and maintenance associates to conduct fire drills annually;
3. Educate staff on fire-related policies, procedures and rules pertinent to their respective worksites and job duties;
4. Ensure exits remain unobstructed and appropriately identified;
5. Search for deficiencies, hazards, unsafe practices and other conditions that could either cause a fire or impede egress;
6. Investigate, track, and trend relevant incident reports; and
7. Present monthly reports about significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations to the Committee for review and consideration.

c. All staff, personnel, and volunteers shall:

1. Follow applicable policies, procedures, and guidelines pertaining to fire safety as determined by the Committee;
2. Prohibit smoking of any form within fifty (50) feet of CHW facilities, in accordance with the Drug-Free Workplace policy;
3. In case of an emergency, follow steps set forth by the Fire Response Plan, and the Emergency Operations Plan;
4. Assist patients and visitors to safe areas of refuge during building evacuations; and
5. Submit an incident report to his/her supervisor within one (1) business day from the occurrence of any fire related event, which includes any incident that may have but did not result in the manifestation of an actual fire.

d. Landlord/Maintenance Associates/Contractor

1. Coastal Health & Wellness does not own either of the facilities at which it has a practice; rather, these buildings are both leased. The Texas City site is located in the Mid-County Annex, which is owned and maintained by the County of Galveston. The Galveston clinic is located at the Island Community Center, which is owned and maintained by the Galveston Housing Authority.

2. Landlords for these respective properties are responsible for inspecting, testing and documenting fire safety equipment, and maintaining facilities in accordance with applicable fire safety codes. Additionally, landlords shall furnish the Risk & Safety Coordinator with documentation of any inspections, maintenance activities, tests or certificates relevant to fire safety mechanisms.

e. Unobstructed Egress:

All means of egress shall remain free from obstructions or impediments to allow for unhindered use in the case of a fire or other emergency in which evacuation is required. The Risk and Safety Coordinator routinely monitors all means of egress and, if necessary, resolves non-compliant issues immediately.

f. Fire Drills:

1. The Risk and Safety Coordinator, with the assistance of facility landlords and maintenance associates, conducts and documents fire drills on an annual basis;
2. Fire drills are conducted annually (one year from the date of the last drill, plus or minus 30 days) at each of the two facilities;
3. All CHW staff is required to partake in fire drills; and
4. Results of fire drills are analyzed by the Risk and Safety Coordinator, who notifies the Committee of any deficiencies or opportunities for improvement.

g. Fire Extinguishers:

1. On a monthly basis, the Risk and Safety Coordinator inspects all fire extinguishers located on CHW premises and documents his/her findings.
2. A third-party inspects and conducts preventative maintenance on all fire extinguishers located on CHW premises annually.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report and reduce safety risks identified by individuals or the organization. This includes, but is not limited to:

a. Documenting and evaluating fire drills and training;
b. Ensuring that building and maintenance checks are being facilitated by landlords and maintenance associates;
c. Ensuring that fire safety training is provided to all staff annually, and educating staff whenever possible to remain current with the Fire Response Plan; and
d. Periodically inspecting the clinic faculties and grounds to determine if any safety risks are present.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and

enhance employee orientation and training.

b. The Committee keeps the Plan current by reviewing it at least annually (i.e. one year from the date of the last review, plus or minus thirty-days) and making necessary modifications based upon the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Risk and Safety Coordinator works with the Committee to review inspection and audit results, incident reports that could have potential fire safety implications, and other applicable tracking and evaluation reports. The Committee may also use other forms of review and input from relevant sources such as leadership, management, staff, personnel, and volunteers.

d. The annual review includes the assessment of the plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE OBJECTIVES: 2021 - 2022

Performance Objective/Goal	Performance Measurement/Indicator
Exit doors unobstructed.	100~~95~~% of egress paths and doors shall remain entirely clear.
Storage (boxes, etc.) not less than 18" below sprinkler heads.	100~~95~~% of sprinkler heads will remain at least 18" above any potential obstructions.
Unobstructed fire extinguishers/cabinets.	100~~95~~% of paths leading to fire extinguishers shall remain entirely unobstructed.

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ENVIRONMENT OF CARE

Hazardous Materials and Waste Management Plan: 2021 - 2022

I. PURPOSE

The Hazardous Material and Waste Management Plan (the "Plan") describes the framework used to reduce dangers associated with hazardous materials and waste, and to manage activities to mitigate the risk of potential injuries and/or loss to property. This plan applies to all Coastal Health & Wellness ("CHW") facilities, employees, patients, contractors, volunteers, students, and visitors, and conforms to all required measures as set forth by Joint Commission standard EC.02.02.01.

II. DEFINITIONS:

a. **Biohazardous Waste:** Waste that has the risk of carrying infectious diseases.
b. **Other Potentially Infectious Material (OPIM), which include:**
    1. The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any bodily fluid that is visibly contaminated with blood, and all bodily fluids in situations where it is difficult or impossible to differentiate between them;
    2. Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
    3. HIV containing cell or tissue cultures, organ cultures, and HIV or HBV containing culture medium or other solutions.

III. OBJECTIVES

a. To manage critical information related to the safe use, storage, and disposal of hazardous chemicals retained in inventory; and
b. To ensure staff is adequately knowledgeable regarding procedures which define the proper handling of hazardous materials and waste.

IV. RESPONSIBILITIES

The ~~Infection Control and Environment of Care Committee~~Joint Commission Committee ("the Committee") shall:

1. Review sentinel events and make pertinent recommendations related to any events involving or potentially involving hazardous materials and/or waste;
2. Develop procedures and guidelines pertinent to specific events consistent with

those set forth by The Joint Commission, the Coastal Health & Wellness Emergency Operations Plan, and other authoritative guidelines;
3. Implement, train, and monitor approved policies, procedures, guidelines, and recommendations in accordance with the Hazardous Material and Waste Management Plan;
4. Respond appropriately when conditions involving hazardous material or waste arise which may pose an immediate threat to life, human health and/or Coastal Health & Wellness property; and
5. Review the Hazardous Material and Waste Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. <u>The Risk and Safety Coordinator shall</u>:

1. Conduct monthly proactive risk assessments via the Environmental Risk, Safety and Compliance Analysis ("ERSCA") to monitor compliance with the Hazardous Material and Waste Management Plan;
2. Identify deficiencies, hazards, unsafe practices, and potentially adverse impacts of any hazardous waste existing on or around Coastal Health & Wellness premises;
3. Educate staff on policies, procedures and rules pertinent to hazardous materials and waste that may affect their respective worksites and job duties;
4. Annually audit and, when necessary, update Safety Data Sheet ("SDS") binders for all CHW departments;
5. Respond punctually and appropriately when observations pertaining to hazardous materials arise which may pose an immediate threat to life, health and/or property; and
6. When applicable, report significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations to the Committee for review and consideration.

c. <u>Coastal Health & Wellness employs a certified Radiation Officer whose duties include</u>:

1. Annually reviewing and monitoring radiation safety procedures for compliance in accordance with the rules and regulations set forth by the Texas Department of State Health Services and other regulatory bodies;
2. Reviewing and monitoring radiation safety procedures for compliance in accordance with the rules and regulations set forth by the Texas Department of State Health Services and other regulatory bodies, immediately upon Coastal's acquisition of any equipment with the ability to produce radiation and in accordance with manufacturer's guidelines thereafter; and
3. Ensuring that radiation safety badges are consistently maintained by requisite personnel.

d. <u>The Infection Control Nurse shall:</u>

1. Annually facilitate the following trainings:
    a. Personal Protective Equipment (clinical staff);
    b. Blood Borne Pathogens (clinical staff);
    c. Hazardous Waste Disposal (clinical staff);
    d. Mask Wearing (all staff); and
    e. Hand Hygiene (all staff).

2. Present infection control reports, which incorporate hazardous waste prevention metrics, monthly to the Committee and quarterly to the Governing Board Quality Assurance Committee.

e. <u>All staff, personnel, and volunteers shall</u>:

1. Follow the policies, procedures and guidelines pertaining to any hazardous materials and/or waste as approved by the Committee;
2. Remain familiar with and, when applicable, adhere to all procedures delineated in the Coastal Health & Wellness Governing Board approved Emergency Operations Plan as they pertain to hazardous materials and waste; and
3. Annually complete a Hazardous Communication training.

f. <u>Safety Data Sheets (SDS)</u>:

1. SDS manuals shall be stored in yellow and red binders conspicuously affixed to the wall in all clinical areas and will contain an accurate inventory of all chemicals used in the respective areas.
2. The chemicals listed in the SDS binders are reviewed by supervisors and department heads annually, or whenever items are added to or removed from the chemical inventory. A follow-up audit to verify SDS inventory is performed twice annually by the Risk and Safety Coordinator.
3. Employees shall receive orientation on the use of SDS binders and chemical safety training from their direct supervisor as part of mandatory employee training, which shall be completed within thirty (30) days of the employee beginning work. Employees shall be precluded from using hazardous materials until the mandatory training has been completed and documented.
4. Each department will develop and train employees regarding procedures for handling hazardous materials. These procedures shall include, but not be limited to, the proper use of personal protective equipment such as gloves and masks, and the proper means by which hazardous waste should be disposed of.

g. <u>Oxygen and Gas Cylinders</u>:

1. All oxygen and gas cylinders will be secured in a container in order to prevent the cylinder from falling over; and
2. Oxygen and gas cylinders shall NEVER be stored near heat or open flames.

h. Eyewash Stations:

1. Eyewash stations shall be maintained in readily accessible areas for all Coastal Health and Wellness personnel at both the Texas City and Galveston clinics.
2. Supervisors or designees will test the eyewash stations weekly by conducting a "bump test," to ensure proper operation of each station's functionality and will log the results of such tests accordingly. Test results will be logged in a binder located within the applicable department.
3. Supervisors or designees will flush each eyewash station on a weekly basis.

i. Medical and Infectious Waste:

1. Liquid or semi-liquid blood or OPIM; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials must be discarded in an appropriate red biohazard bag or container.
    a. This includes, but is not limited to, used sharps, slides and slide covers contaminated with bodily fluids, vaccine ampoules and vials that have been used, and blood-soaked dressing or other blood-soaked materials.
    b. Urine is not considered OPIM unless it is contaminated with blood.
    c. Needles, syringes, contaminated slides, blood-filled test tubes, and glass ampoules and vials are to be disposed in red plastic sharps containers.
2. Sharps containers and used red bags must be placed in a red bag-lined transport box stored in a designated locked closet identified with the biohazard symbol (the Hazardous Waste Storage Room).
3. **Dental amalgam is not considered infectious and is disposed of by being suctioned into traps, which are periodically replaced.** Each dental operatory contains amalgam separators.
4. Coastal Health & Wellness currently contracts with Stericyle to remove and dispose of medical waste from its facilities.

j. Spill Procedures:

1. Standard precautions should be followed when a spill occurs, and the area should be blocked off from public access until it is entirely cleaned, and the affected area is deemed safe to return by the Risk and Safety Coordinator, Infection Control Nurse or department supervisor.
2. Staff should clean spills or leaks of most products in accordance with directions of the manufacturer of the spilled substance. In the absence of

such directions, staff should immediately barricade the area and notify the department supervisor.

3. Blood should be cleaned using appropriate PPE and approved virucidal disinfecting agents.
4. Hazardous material incidents involving radiological, chemical or biological contaminants may require evacuation of the facility. Employees will follow procedures as outline in the Coastal Health & Wellness *Emergency Operations Plan* during such circumstances.

V. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce hazardous risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying, and reporting incidents related to hazardous materials;
b. Reviewing incident reports and implementing new policies and procedures to prevent future adverse incidents; and
c. Periodically inspecting the clinic faculties and grounds to determine if any hazards are present.

VI. ANNUAL EVALUATION

a. The annual review, which includes the assessment of the Plan's scope, objectives, performance, and effectiveness is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.
b. The Committee maintains the Hazardous Material and Waste Management Plan by reviewing the plan at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based on the results of the evaluation and changes to regulatory laws, policies and standards.
c. While performing the annual review, the Committee should use a variety of sources such as inspection and audit results, incident reports and other statistical information and tracking reports. The Committee may also use other forms of review and input from relevant sources such as management, staff, personnel, and volunteers.

VII. PERFORMANCE MEASURES: 2021 – 2022

Performance Objective/Goal	Performance Measure/Indicator
Manage critical information related to the safe use, storage, and disposal of hazardous chemicals available to staff.	95% SDS binders correctly maintained at work areas.
Ensure staff is knowledge on segregation of hazardous waste at the point of generation is effective to control the potential for exposure or spills during collection, transport, storage, and disposal.	100% of staff handling biohazardous waste receive training for handling, packaging, and preparation of biohazardous material for transport within thirty (30) days of hire.
Ensure spill kits are maintained in each department where hazardous chemicals/waste spills can occur.	100% of clinical staff receive training on the appropriate use of spill kits relating to chemical/biohazardous spills within thirty (30) days of hire.

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ENVIRONMENT OF CARE
Safety Management Plan: 2021 - 2022

I. PURPOSE

The Coastal Health & Wellness ("CHW") Safety Management Plan ("the Plan") has been established to provide a safe, functional, and effective environment for all patients, staff, and other individuals in order to optimize the outcome of patient services. The Plan describes the framework used to reduce physical hazards, and to reduce the risk of injuries to individuals and loss to property. This plan applies to all CHW facilities, employees, patients, contractors, volunteers, students, and visitors, and conforms to all requirements set forth under The Joint Commission Standard EC.04.01.01.

II. OBJECTIVES

a. Ensuring staff awareness and performance of pertinent safety topics through education and training; and
b. Mitigating safety risks by promptly identifying and resolving perils.

III. RESPONSIBILITIES

a. The ~~Infection Control and Environment of Care~~Joint Commission Committee (the "Committee") shall:

1. Review sentinel events pertaining to potential safety issues occurring at CHW facilities or elsewhere, and make recommendations for prevention or improvement;
2. Develop procedures and guidelines related to safety management issues that are consistent with or integrate the Coastal Health & Wellness Governing Board approved Emergency Operations Plan;
3. Implement and monitor approved policies, procedures, guidelines and recommendations in accordance with the Safety Management Plan;
4. Investigate and track incident reports and workers' compensation claims to identify potentially trending safety issues;
5. Respond appropriately when conditions involving potential safety risks arise which may pose a foreseeable threat to life, human health and/or Coastal Health & Wellness property; and
6. Review the Safety Management Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. The Risk and Safety Coordinator shall:

1. Conduct a monthly risk assessment, the Environmental Risk Safety and Compliance Assessment ("ERSCA"), to monitor adherence to pertinent components of the Safety Management Plan;
2. Identify deficiencies, perils, unsafe practices, and practices potentially adverse to the promotion of safety in and around CHW facilities;
3. Educate staff on safety related policies, procedures and rules pertinent to their respective worksites and job duties;
4. Intervene when conditions immediately threaten life or human health, or threaten damage to CHW property;
5. Report monthly on significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations to the Committee for review and consideration; and
6. Manage product and equipment safety recalls.

c. All staff, personnel, and volunteers shall:

1. Immediately notify appropriate personnel when environmental conditions pose a potential threat to human life, health or damage to CHW property;
2. Follow the policies, procedures, and guidelines approved by the Committee; and
3. Submit an Incident Report Form to the Risk and Safety Coordinator, Fleet and Facilities Coordinator, and Chief Compliance Officer within twenty-four (24) hours of any event related to potential illness, injury or "near misses" to any person(s) occurring on CHW premises, or any property loss or damage.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce safety risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying and reporting incidents and trends related to occupational illnesses or injury and/or property loss or damage.

b. Reviewing and monitoring incident reports and workers' compensation claims to create activities that limit perils, with a goal to reduce risk of occupational illness or injury and/or property loss or damage.

c. Periodically inspecting clinic facilities and grounds to determine if any safety risks exist; and

d. Constantly monitoring and reporting cleanliness of the facility.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.

b. The Committee keeps the Plan current by reviewing it at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based on the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee shall use a variety of sources such as inspection and audit results, accident/incident reports, and other statistical information and tracking reports. The Committee may also use other forms of review and input from relevant sources such as leadership, management, staff, personnel, and volunteers.

d. The annual review includes the assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE MEASURES: 2020 - 2021

Performance Objective/Goal	Performance Measure/Indicator
Ensure staff performance through safety education and training.	95% of staff has documentation asserting their annual completion of safety and incident reporting training.
Manage safety risks by promptly reporting and resolving incidents.	100% of incident reports are submitted within two business days of the incident's occurrence.
Ensure cleanliness is practiced and maintained by housekeeping services for prevention of adverse employee and patient safety.	95% of reported cleanliness issues in all areas of the clinic or office setting are corrected or addressed within a ~~24~~ twenty four (24) hour period.

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ENVIRONMENT OF CARE
Security Management Plan: 2021 - 2022

I. PURPOSE

The Security Management Plan (the "Plan") has been established to ensure that Coastal Health & Wellness ("CHW") is providing the safest possible environments for all patients, staff, and other individuals that at any point enter a CHW facility. The Plan describes the framework for security management, which aims to: i) mitigate the occurrences of incidents that may pose dangers or threats by others; and ii) mitigate physical, structural, and infrastructural damages in the event of a security breach. The Plan applies to all facilities, employees, patients, contractors, volunteers, students, and visitors and conforms with the standards set forth by The Joint Commission in EC.02.01.01.

II. OBJECTIVES

a. Ensuring staff is knowledgeable of security risks and procedures through effective education and training;
b. Ensuring staff always has their CHW identification badge affixed to their person in a manner noticeable to patients and visitors; and
c. When necessary, updating the Plan in accordance with changes or relevant implementations set forth in the Coastal Health & Wellness approved Emergency Operations Plan, or by applicable regulatory authorities.

III. RESPONSIBILITIES

The Infection Control and Environment of Care Committee (the "Committee") is responsible for developing and implementing this Plan. The Risk and Safety Coordinator is responsible for monitoring and enforcing this Plan.

a. The ~~Infection Control and Environment of Care~~Joint Commission Committee shall:

1. Review sentinel events and make recommendations regarding security related incidents;
2. Develop procedures and guidelines consistent with the Coastal Health & Wellness Governing Board's approved Emergency Operations Plan;
3. Implement and monitor approved policies, procedures, guidelines, and recommendations in accordance with the Security Management Plan;

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4. Select and implement procedures and controls to achieve plan objectives;
5. Respond appropriately when potential security issues may pose a foreseeable threat to life, human health and/or Coastal Health & Wellness property; and
6. Review the Security Management Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. The Risk and Safety Coordinator shall:

1. Conduct proactive risk assessments on a monthly basis via the Environmental Risk, Safety and Compliance Assessment ("ERSCA") to monitor compliance with the Security Management Plan;
2. Identify unsafe practices or potential threats within CHW facilities which may pose adverse security circumstances, and present these findings to the Committee;
3. Educate staff on best practices for responding to security threats;
4. Immediately intervene and notify proper authorities when conditions that immediately threaten life or health, or damage to property are realized;
5. With the Chief Compliance Officer, serve as a primary liaison between staff and law enforcement when security issues are reported to law enforcement agencies; and
6. On a quarterly basis, work with the Chief Compliance Officer to prepare reports which document significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations for review and consideration by the Governing Board's Quality Assurance Committee.

c. The Information Technology ("IT") Manager shall:

1. Remain knowledgeable about current IT trends and industry practices;
2. When applicable and at least annually, update and implement procedures and protocols delineated in the GCHD Security Manual; and
3. In the occurrence of a breach, take any and all actions to mitigate its effects and immediately report losses to the Chief Compliance Officer and ~~Executive Director~~Chief Operations Officer.

d. Ancillary Security Measures

1. The Texas City clinic has a contracted a full-time security guard to remain on location during all times at which the clinic is open.
2. The Island Community Center, which houses the Galveston clinic, has one full-time police officer present at its main entrance from 7:00 am – 4:00 pm daily.
3. During late clinic at the Galveston location (Thursday from 5:00 pm – 8:00 pm) a contracted~~n off-duty~~ police officer is employed by and remains at the clinic to provide security services.
4. Each clinic has a security camera at its main entrance, which remains active

at all times, and an alarm system on all exterior doors which, when activated, immediately sends notification to the police department with jurisdictional authority over the respective clinic's location via the security system.

5. Numerous ingress doors at both locations remain locked at all times, and can be opened solely through badge access, which is restricted to CHW personnel deemed to have a professional need to~~of~~ enter~~ing~~ these restricted~~-locked~~ areas. Additionally, several ingress doors which serve as barriers to vital items (i.e. specific medications) can only be accessed through use of a physical key, assigned only to personnel with reason to enter the rooms.

e. Security Sensitive Areas

1. Areas that contain sharps, medications~~,~~ or dangerous chemicals, vulnerable IT equipment, and highly sensitive information will be locked when not attended by a staff member.
2. Keys and badges at no time will be shared among staff. Additionally, these items must be returned to Human Resources when the employee's relationship with Coastal Health & Wellness is severed.
3. Lost badges are immediately deactivated upon notification from the employee when the badge is reported lost, and badges surrendered upon separation of employment are promptly shredded.
4. Locks opened with security codes supplant several badge restricted ingress doors. Employees with a need to access these areas are issued individual codes which they are prohibited from sharing, and codes are immediately deactivated when an employee with knowledge of such codes separates from CHW.
5. All spaces, rooms or areas that may be considered hazardous must be clearly marked with the appropriate signage.
6. Warning signs denoting types of hazards must be placed in clear view of those attempting to enter a hazardous area.

f. Identification

1. All Coastal Health & Wellness staff are required to wear a CHW issued badge while present at work.
2. Badges contain the employee's picture and name and must be located on their person in a means easily visible to others.

g. Security Incidents

In the event of a security or potential security incident, staff members present at the site of the incident are required to:

1. Identify the nearest area deemed safe;
2. With patients and visitors, move to the safe area;
3. If possible, notify others in imminent danger of the threat; and
4. Call 9-1-1.

h. Patient Expulsion

Patients who threaten staff, other patients, visitors or property, or who commit illegal activity on or around CHW property will be reported to the Coastal Health & Wellness Medical Director or Dental Director, who with guidance from the ~~Executive Director~~Chief Operations Officer will determine whether the patient is prohibited from receiving medical or dental services at CHW facilities in the future.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce security risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying, and reporting incidents and trends related to security to management, security personnel, and/or the Coastal Health & Wellness Governing Board.

b. Reviewing and monitoring incident reports to create performance improvement activities; and

c. Performing monthly inspections of the clinic faculties and grounds to determine if any security risks are present.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.

b. The Committee keeps the Security Management Plan current by reviewing the plan at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based upon the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee uses a variety of sources such as inspections and audit results, incident reports, employee survey responses, and other statistical information and tracking reports. The Committee may also use other forms for review and input from relevant sources such as leadership, management, staff, personnel, volunteers and patients.

d. The annual review includes assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE IMPROVEMENTS: 2021 – 2022

Performance Objective/Goal	**Performance Measure/Indicator**
Ensuring staff is knowledgeable of security procedures for displaying identification badges.	<35% staff observed not properly displaying their identification badges during badge audits.
Ensuring staff is aware of how to react during potentially adverse circumstances.	Facilitate at least ~~three~~ six non-required emergency drills addressed in the Emergency Operations Policy (e.g. ~~active shooter~~shelter-in-place training).
Ensure staff is knowledgeable about when and how to respond to suspected human trafficking situations.	100% of Coastal employees who interact with patients as part of their professional responsibilities receive training pertaining to the detection and suggested follow-up actions for dealing with suspected human trafficking victims.
Ensure providers know the appropriate processes and when it's required that they report suspected cases of abuse or neglect.	100% of Coastal providers be trained on how to detect and report abuse and neglect.

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ENVIRONMENT OF CARE
Utilities Management Plan: 2021 - 2022

I. PURPOSE

The Utilities Management Plan (the "Plan") sets forth a means of warranting that Coastal Health & Wellness ("CHW") offers a safe, functional, and effective healthcare environment to all patients, staff, and visitors for the assurance of optimal patient care outcomes. This plan applies to all CHW facilities, employees, patients, contractors, volunteers, students and visitors, and conforms to all requirements set forth by The Joint Commission standard EC.02.05.01.

II. OBJECTIVES

a. To ensure optimal patient care and overall safety through stringent utility inspection; and
b. To foster the most efficient measures of communication between applicable CHW staff and ~~Coastal Health & Wellness~~ facility landlords and/or maintenance associates.

III. RESPONSIBILITIES

a. The ~~Infection Control and Environment of Care~~Joint Commission Committee (the "Committee") shall:

1. Review sentinel events related to any aspect outlined in the Utilities Management Plan and, as necessary, propose and implement new practices for utility improvements;
2. When applicable, develop new procedures and guidelines for utility systems necessary to remain consistent with the Coastal Health & Wellness approved Emergency Operations Plan, along with relevant regulatory updates established by applicable authoritative agencies;
3. Select and implement procedures and controls to achieve plan objectives; and
4. Review the Utilities Management Plan as deemed necessary, and no less than once annually (see *Section V. Annual Evaluation*).

b. The Risk and Safety Coordinator shall:

1. When necessary, educate staff regarding aspects of the Utility Management Plan applicable to the staff member's scope of work;
2. Work in conjunction with the building's landlords or maintenance

associates to ensure access to a utility system inventory which identifies equipment, location, ownership, emergency power shut-off valves, and a log related to utility failure history is retained in an up-to-date fashion;

3. On a monthly basis, inspect facilities for deficiencies, hazards, unsafe practices, and/or potentially adverse impacts caused by utility mishaps;
4. Investigate, track and report utility related incidents;
~~4.~~5. Ensure generator load tests, performed in accordance with Joint Commission standards, are facilitated and documented monthly; and
~~5.~~6. Present monthly reports concerning significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations regarding utility systems to the Committee.

c. The Fleet and Facilities Coordinator shall:

1. When possible, update or restore utility maintenance systems to proper order;
2. Contact the applicable landlord, maintenance associate (or designee), or third-party service agent when a problem with a utility system at a CHW occupied facility is realized; and
3. Monitor approved policies, procedures, guidelines and recommendations in accordance with the Utilities Management Plan and when applicable, notify the Chief Compliance Officer of recommended procedural revisions.

d. All staff, personnel, and volunteers shall:

1. Follow the policies, procedures, and guidelines approved by the Committee; and
2. Follow safety procedures in accordance with this Plan, the Safety Management Plan, and anything directly or incidentally related to such matters as delineated in the Emergency Operations Plan.

e. Landlord/Maintenance Associates/Contractors

1. Coastal Health & Wellness does not own either of the facilities in which it has a practice; rather, these buildings are both leased. The Texas City site is located at the Mid-County Annex, is owned and operated by the County of Galveston. The Galveston site is located at the Island Community Center, which is owned and operated by the Galveston Housing Authority.

2. Landlords and maintenance associates for these respective properties are responsible for inspecting, testing and retaining a list of utility systems, which include but may not be limited to: electrical power; heating, ventilation and air conditioning; plumbing; and gas. Landlords shall provide any requested documentation of any inspections, maintenance, or tests to the Risk and Safety Coordinator and/or the Fleet and Facilities Coordinator.

f. Battery-Powered Lights

1. Each month, the Risk and Safety Coordinator will test battery-powered lights required for egress at the Galveston location. The test will be performed for a minimum of thirty (30) seconds. Results will be documented and reported to the Committee.
2. Annually, the Risk and Safety Coordinator will test battery-powered lights required for egress for a duration of one-and-a-half (1 ½) hours at the Galveston location. Results shall be documented and reported to the Committee and the CHW Governing Board's Quality Assurance group.
3. All tests performed at the Texas City site will be facilitated by the County of Galveston's Maintenance department. The Risk and Safety Coordinator and/or the Fleet and Facilities Coordinator will work with Galveston County Maintenance personnel to ensure required tests are conducted and subsequent documentation is received.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce utility related safety risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying, and reporting incidents and trends related to utility system failures; and

~~a.~~b. Evaluating the outcomes of the Environment, Risk, Safety and Compliance Assessments ("ERSAs") at both CHW facilities, which are conducted monthly by the Risk and Safety Coordinator.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and to enhance employee education.

b. The Committee keeps the Utility Management Plan current by reviewing the plan at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based upon the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee shall utilize a variety of sources to improve inspection and audit results, accident/incident reports, and other forms of

tracking reports. The Committee may also review and seek input from alternative sources of relevance including leadership, management, staff, personnel, volunteers and third parties.

d. The annual review will include assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE MEASURES: 2021 - 2022

Performance Objective/Goal	Performance Measure/Indicator
Ensuring optimal patient care through stringent utility maintenance	Zero preventable maintenance related injuries incurred by patients, visitors or staff
Effective communication between CHW staff and landlords	100% of problems requiring landlord attention reported by CHW staff to landlord within twenty-four (24) hours of recognition.

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Governing Board
October 2021
Item#8
Consider for Approval the Coastal Health & Wellness Risk Management Report for the Quarter Ending September 30, 2021

Quarterly Risk Management Report
Coastal Health & Wellness Quality Assurance Subcommittee
July - September 2021

Objective	Goal	2020 - 2021 Results	2021 - 2022 Goal	Q1 (07/21-09/21)	Q2 (10/21-12/21)	Q3 (01/22-03/22)	Q4 (04/22-06/22)	Cumulative Total or Average	Comments	Quarterly Goal Met
Customer Service and Patient Satisfaction										
Promote positive patient service experience with all staff, with a particular emphasis on treating patients in a courteous manner.	Reduce grievances by 30% from the previous year.	40	<34	**5** Medical: 4 Patient Serv: 1				**5** Medical: 4 Patient Serv: 1	All clinical complaints were of the same nature, which the CNO and COO have drafted policies addressing.	✓
Offer optimal care for all patients throughout the entirety of their visit.	Increase weighted results of patient satisfaction survey to 4.8.	4.77	4.80	4.50				4.50	Low scores stemming primarily from check-in and wait time feedback, which is being addressed by the QA team.	✗
Promote patient appointment confirmations.	Reduce the cumulative patient no-show rate to 20%.	20.36%	18%	20.00%				20.00%	Updated procedures established to help patients reschedule or cancel appointments, will hopefully lower no-show rate.	✗
Ensure staff always wear their Coastal Health & Wellness issued identification cards in a readily visible manner.	Biennial audits should yield 100% of identification cards being worn appropriately.	100%	100%	N/A	Badge audits performed the second and third and/or fourth quarters of each year			N/A	___	✓
Minimize preventable injuries to all staff, patients and visitors.	Incur zero preventable injuries at all CHW locations.	0	0	0				0	Needlestick prevention course will be administered via Medtrainer this month.	✓
KEY										

COLOR KEY

Missing Measures; Needs Improvement	Trending in Proper Direction; Still Needs Improvement	Compliant with Goals

Quarterly Risk Management Report
Coastal Health & Wellness Quality Assurance Subcommittee
July - September 2021

Objective	Goal	2020 - 2021 Results	2021 - 2022 Goal	Q1 (07/21-09/21)	Q2 (10/21-12/21)	Q3 (01/22-03/22)	Q4 (04/22-06/22)	Cumulative Total or Average	Quarterly Comments	Quarterly Goal Met
Staff Trainings										
Train staff on appropriate responses for different emergency scenarios.	Facilitate at least nine non-required emergency preparedness drills during the year.	9	9	3 trainings and 2 actual emergencies				5 (3 trainings; 2 real COOP activities).	Staff underwent response drills for: - Localized flooding and Continuity of Operations (COOP); - Facility Lockdowns; and - Power Outages. Additionally, Coastal employees assisted in County's mass vaccination/booster clinic and followed hurricane protocols in preparation of Nicholas.	✓
All staff is trained on SDS material pertinent to his/her work area and responsibilities.	Ensure documented training rate of 100% within 30 days of hire.	100%	100%	100%				100%	Coatal hired four new employees during the quarter, all of whom completed their mandatory trainings within the 30-day window.	✓
All staff is trained on equipment critical to his/her job performance.	Ensure documented training rate of 100% within 30 days from hire.	100%	100%	100%				100%		✓
All staff is trained on the Coastal Emergency Operations Plan.	Documentation exhibiting all staff received Emergency Operations training.	N/A	100%	100% for new hires	Training occurs during new-hire orientation and annually in January.			100%	All employees hired by Coastal during the reporting quarter completed the new-hire Emergency Operations Training during the on-boarding process. Annual all-staff training is being conducted in January 2022.	✓

Train staff regarding detection of and follow-up actions for suspected human trafficking victims.	Provide training to 100% of employees about how to report suspected human trafficking.	100%	100% for new hires	100% for new hires	Training occurs during new-hire orientation and annually each November.			100%	All employees hired by Coastal during the reporting quarter completed the new-hire human trafficking training. Annual all-staff training is being conducted in November 2021.	✓
Staff receives safety and incident reporting training.	Documentation exhibiting 100% of staff received Risk Management and Safety Training.	N/A	100% for new hires	100% for new hires	Training occurs during new-hire orientation and annually each July.			100%	All employees hired by Coastal during the reporting quarter completed the new-hire safety and incident reporting training. Annual all-staff training is being conducted in July 2022.	✓
Continue to promote staff knowledge of hand-hygiene practices and policies.	Maintain hand-hygiene score of at least 95%.	98%	98%	97%				97%	Data captured by Infection Control Nurse, who performs hand hygiene audits monthly.	✘

KEY

COLOR KEY

Missing Measures; Needs Improvement	Trending in Proper Direction; Still Needs Improvement	Compliant with Goals

Quarterly Risk Management Report
Coastal Health & Wellness Quality Assurance Subcommittee
July - September 2021

Objective	Goal	2020 - 2021 Results	2021 - 2022 Goal	Q1 (07/21-09/21)	Q2 (10/21-12/21)	Q3 (01/22-03/22)	Q4 (04/22-06/22)	Cumulative Total or Average	Quarterly Comments	Quarterly Goal Met
Maintenance and Reporting										
Protect patients and staff by ensuring incidents and adverse events are promptly reported.	100% of incident reports should be made within two business days of the incident's occurrence.	100%	100%	100%				100%		✓
Protect staff and patients by promptly reporting issues requiring landlord attention.	Report 100% of building and/or maintenance related issues to applicable landlord within 24 business hours of discovery.	100%	100%	100%						✓
Maintain staff and patient safety by keeping equipment properly tested and maintained.	95% of equipment (100% of critical equipment) documented in Equipment Inventory Log should be inspected and calibrated in accordance with manufacturer's recommendations in a timely fashion.	100%	95%	100%					Data captured monthly by the Risk and Safety Coordinator through various means but notably the Environmental Risk, Safety and Compliance audits, which are performed monthly.	✓
Minimize obstruction to fire exit doors.	Achieve a cumulative score for non-obstructed doors of at least 100%.	100%	100%	100%						✓
Maintain at least 18" between storage and top of sprinkler heads.	Achieve a cumulative score of at least 95% when auditing sprinkler head ceiling clearance.	100%	100%	100%						✓
Access to fire extinguishers shall remain clear and unobstructed.	Achieve a cumulative score for non-obstructed pathways to fire extinguishers of at least 95%.	100%	100%	100%						✓
Maintain SDS binders with all applicable material.	Biennial audits should yield at least a 95% level of accuracy.	100%	95%	N/A	SDS audits performed the second and fourth (Risk and Safety) quarters of each year			N/A	100% during the April, May and June auditing periods.	
KEY										

COLOR KEY

Missing Measures; Needs Improvement	Trending in Proper Direction; Still Needs Improvement	Compliant with Goals

Quarterly Risk Management Report Coastal Health & Wellness Quality Assurance Subcommittee July - September 2021										
Objective	**Goal**	**2020 - 2021 Results**	**2021 - 2022 Goal**	**Q1 (07/21-09/21)**	**Q2 (10/21-12/21)**	**Q3 (01/22-03/22)**	**Q4 (04/22-06/22)**	**Cumulative Total or Average**	**Quarterly Comments**	**Quarterly Goal Met**
Suits, Claims and Potentially Compensable Incidents										
Take all necessary precautions to ensure an environment optimally conducive to patient safety	Incur no malpractice or risk management related suits or claims.	0	0	0				0		✓
Retain open communication and promote timely reporting of adverse events	Ensure potentially compensable incidents are reported and deliberated upon by executive management within 72 business hours following their occurrence.	0 incidents	0 incidents	0 incidents				0 incidents	No potentially compesanble incidents (PCIs) incurred during the quarter.	✓
Notes										

Very clean quarter. FTCA, AKB and Stark training to be offered to providers at December in-service. Coastal staff has been instrumental in fulfilling the organization and community's mission of providing COVID vaccines to any and all individuals seeking the immunization.

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Governing Board
October 2021
Item#9
Executive Director will report on Coastal Health & Wellness/COVID-19 Updates Submitted by Dr. Keiser

Coastal Health & Wellness October 2021 Coastal Wave (govdelivery.com)

a) **Executive Director**
b) **Dental Director**

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Governing Board
October 2021
Item#10
Consider for Approval September 2021 Financial Report
Submitted by Marlene Garcia

COASTAL HEALTH & WELLNESS

Governing Board

FINANCIAL SUMMARY

For the Period Ending

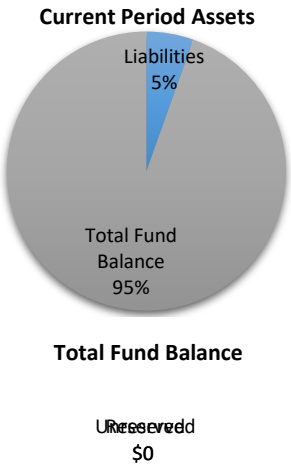
September 30, 2021

October 28, 2021

GCHD Board Room | 9850-A Emmett F. Lowry Expy. | Texas City, TX 77591

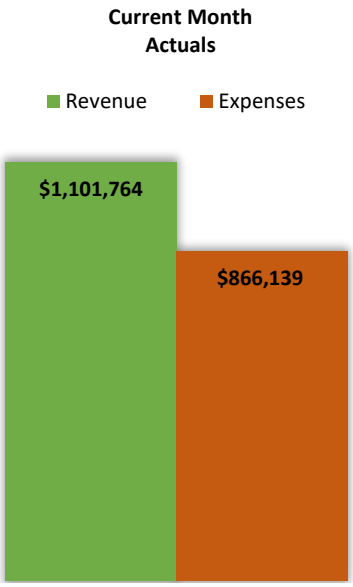
CHW - BALANCE SHEET *as of September 30, 2021*

	Current Month Sep-21	Prior Month Aug-21	Increase (Decrease)
ASSETS			
Cash & Cash Equivalents	$7,167,599	$7,298,239	($130,640)
Accounts Receivable	2,013,533	1,757,258	256,275
Allowance For Bad Debt	(971,778)	(934,745)	(37,033)
Pre-Paid Expenses	135,891	150,874	(14,983)
Due To / From	64,621	(145,550)	210,171
Total Assets	**$8,409,866**	**$8,126,076**	**$283,790**
LIABILITIES			
Accounts Payable	$107,678	$108,484	($805)
Accrued Salaries	308,194	257,873	50,321
Deferred Revenues	42,383	43,734	(1,351)
Total Liabilities	**$458,256**	**$410,091**	**$48,165**
FUND BALANCE			
Fund Balance	$6,426,698	$6,426,698	0
Current Change	1,524,912	1,289,287	235,625
Total Fund Balance	**$7,951,610**	**$7,715,985**	**$235,625**
TOTAL LIABILITIES & FUND BALANCE	**$8,409,866**	**$8,126,076**	**$283,790**



CHW - REVENUE & EXPENSES *as of September 30, 2021*

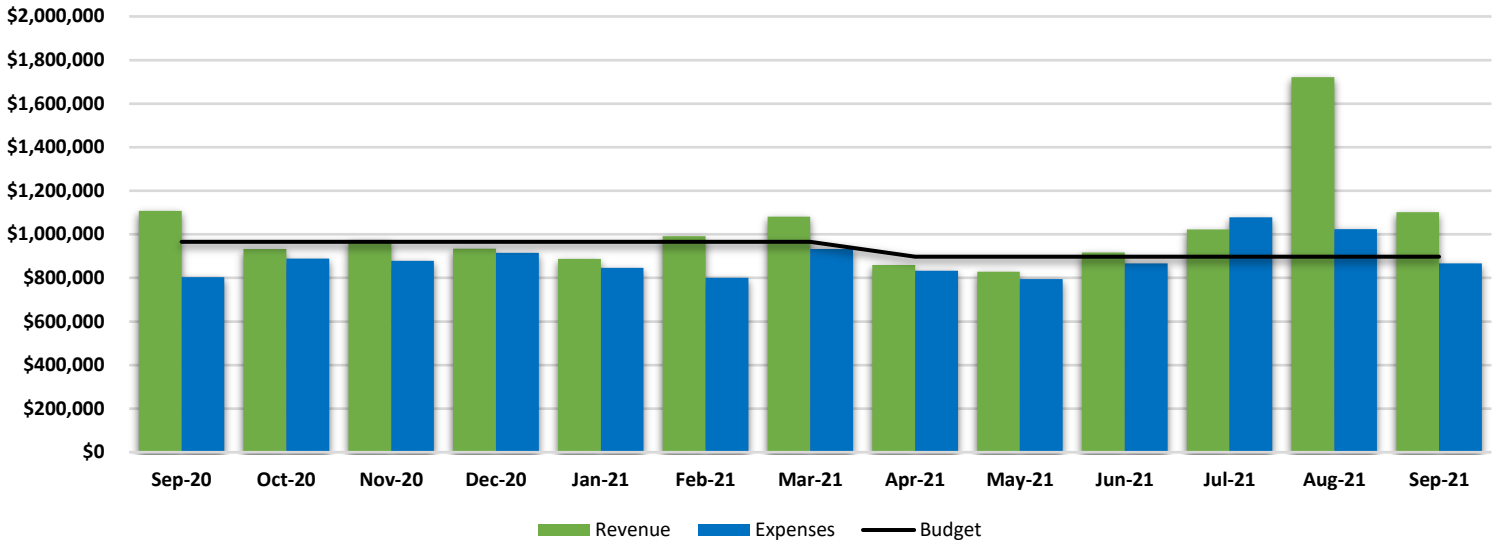
	Actual Sep-21	Budgeted Sep-21	PTD Budget Variance	YTD Budget Variance
REVENUE				
County Revenue	$311,222	$311,222	$0	$0
DSRIP Revenue	0	65,833	(65,833)	549,085
HHS Grant Revenue	548,826	269,783	279,043	560,703
Patient Revenue	234,526	241,682	(7,156)	(52,543)
Other Revenue	7,190	8,851	(1,661)	7,614
Total Revenue	**$1,101,764**	**$897,372**	**$204,392**	**$1,064,860**
EXPENSES				
Personnel	$577,542	$615,556	$38,014	$159,208
Contractual	88,013	57,257	(30,756)	(87,428)
IGT Reimbursement	0	21,666	21,666	(172,018)
Supplies	63,554	80,159	16,606	105,813
Travel	29	2,778	2,749	11,684
Bad Debt Expense	37,033	24,674	(12,359)	(71,900)
Other	99,969	95,283	(4,686)	(21,367)
Total Expenses	**$866,139**	**$897,372**	**$31,233**	**($76,008)**
CHANGE IN NET ASSETS	**$235,625**	**$0**	**$235,625**	**$988,851**



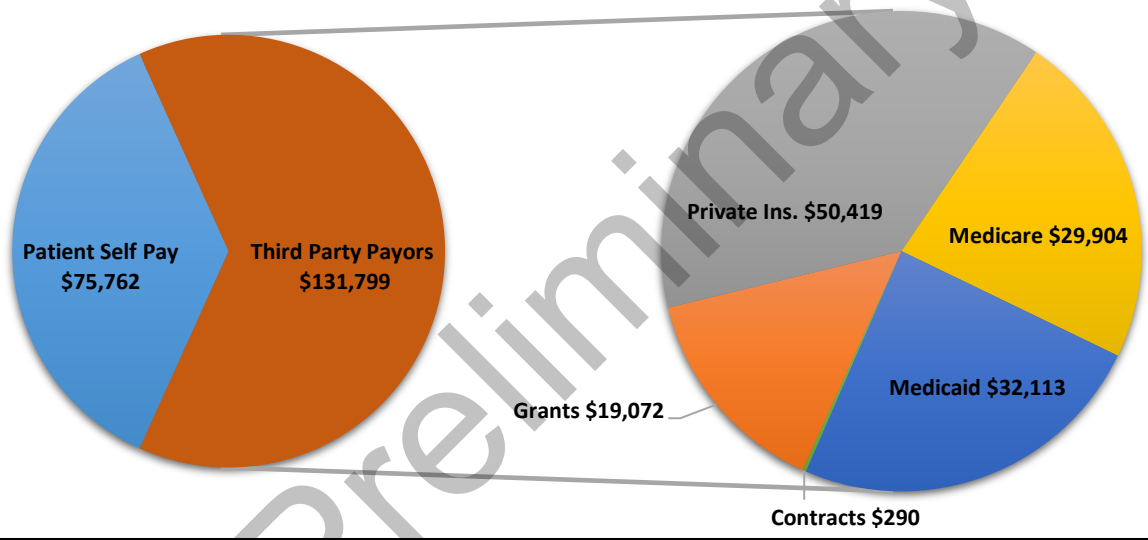
HIGHLIGHTS

- MTD increase in fund balance of $235,625.
- HHS Grant revenues were $279,043 higher than budgeted due to reclass of expenses in Sept 21.
- Total Revenue is pverbudget for the month by $204,392.32. Pharmacy Revenue, Medicaid, Medical Record Revenue , DSRIP Revenue, Interest Income, Contract Revenue an Local Funds/Other Revenue are all underbudget for Sep 21.
- Pharmacy revenue is underbudget for Sep by $48,034.95. The pharmacy revenue (Walgreens) is low due to Lantus manufacture supply change and decrease in prescription orders; including decrease in PrEP and SUD program numbers.
- Total Expense for September 2021 is underbudget by $31,232.96.
- Reserved funds are not available due to annual HRSA 22-23 budget.

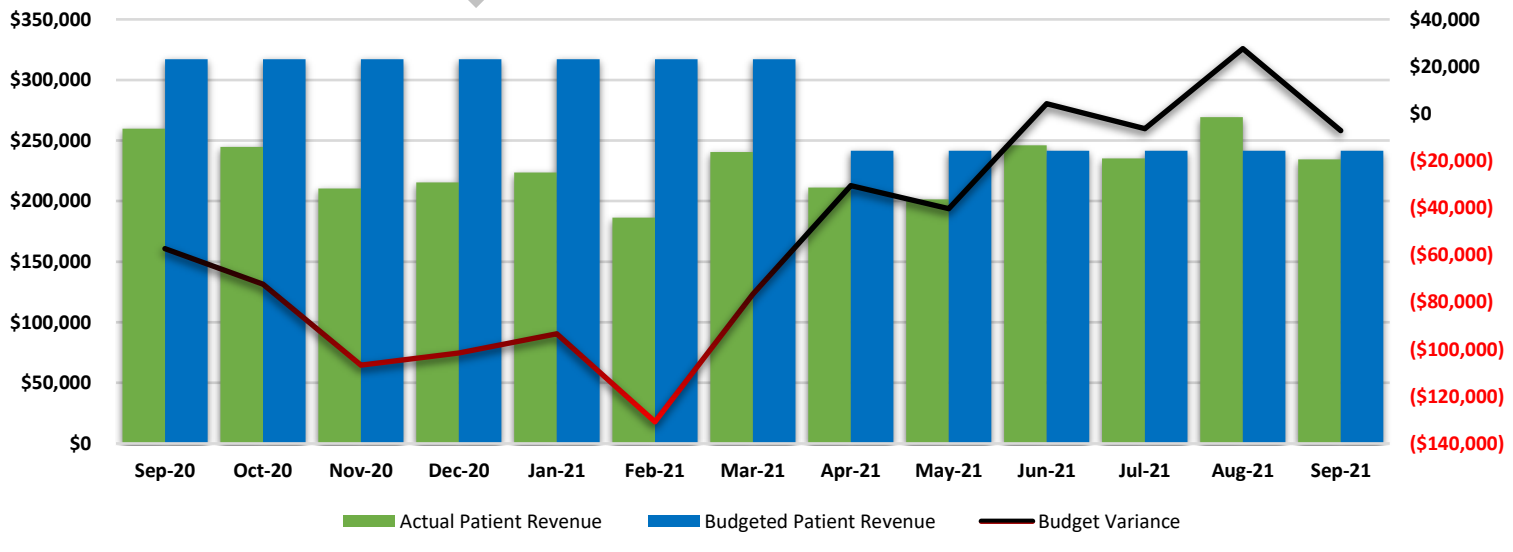
Actual Revenue & Expenses in Comparison to Budget

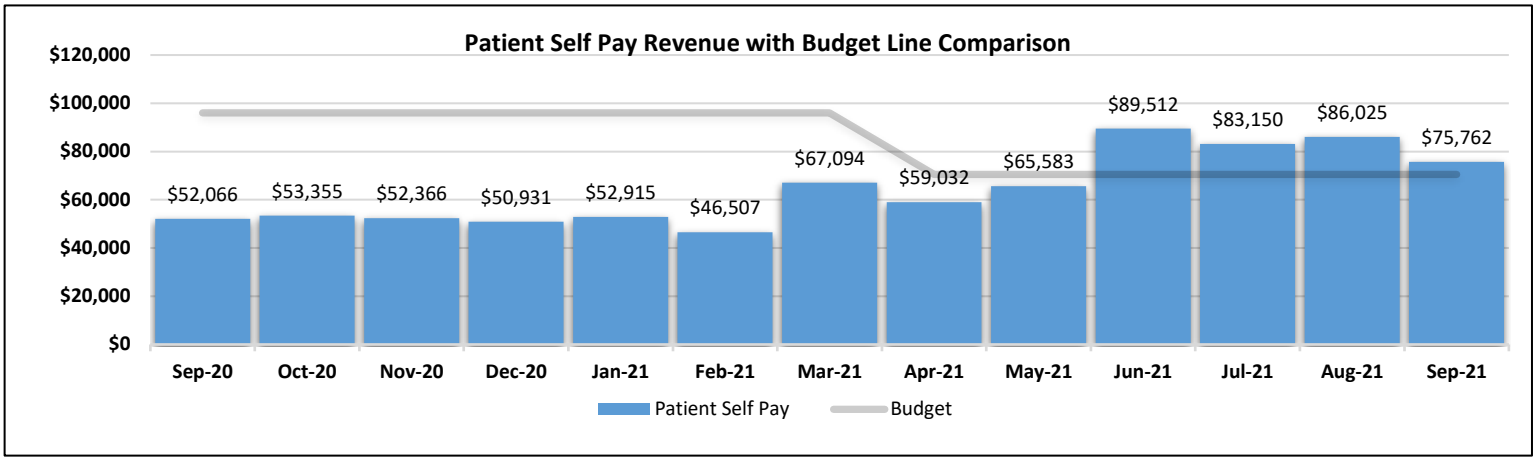


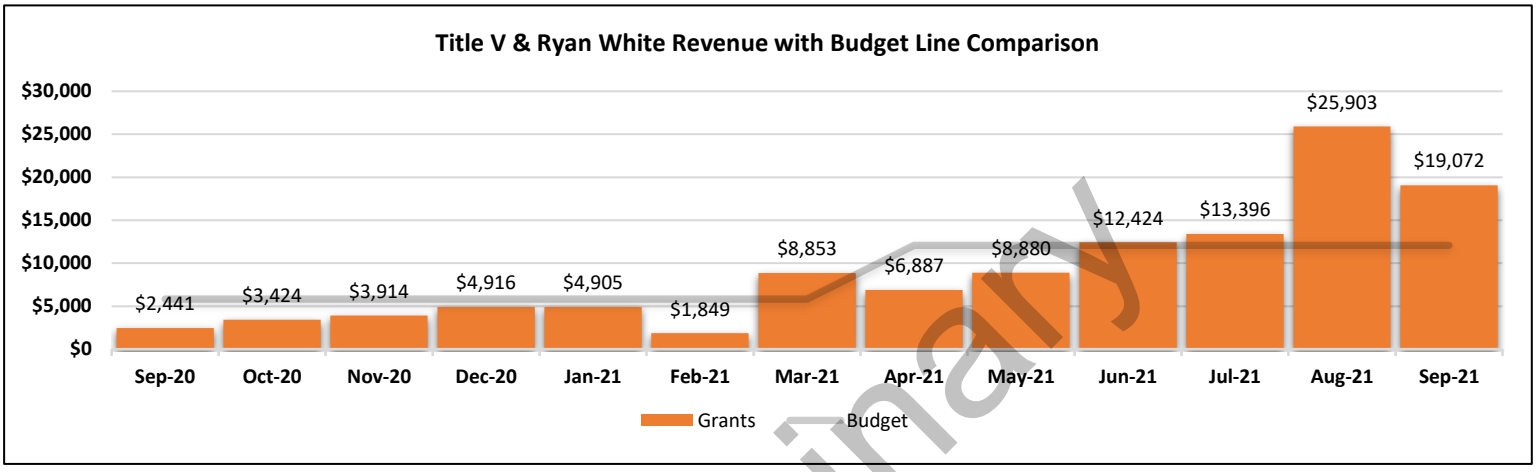
Current Period Patient Revenue with Third Party Payor Contributions Identified

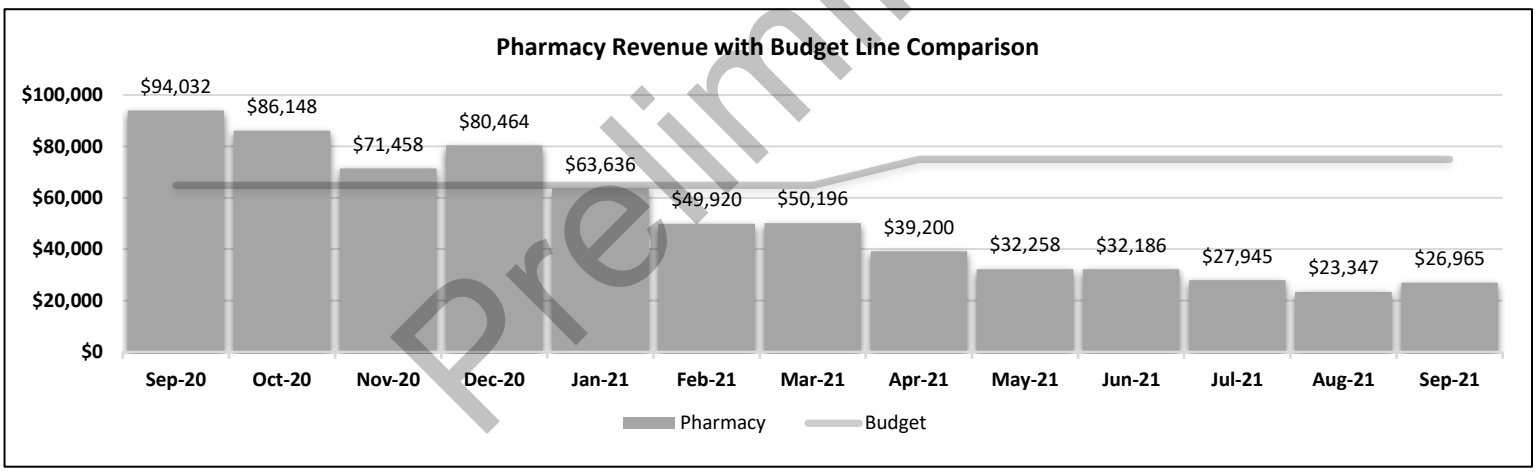


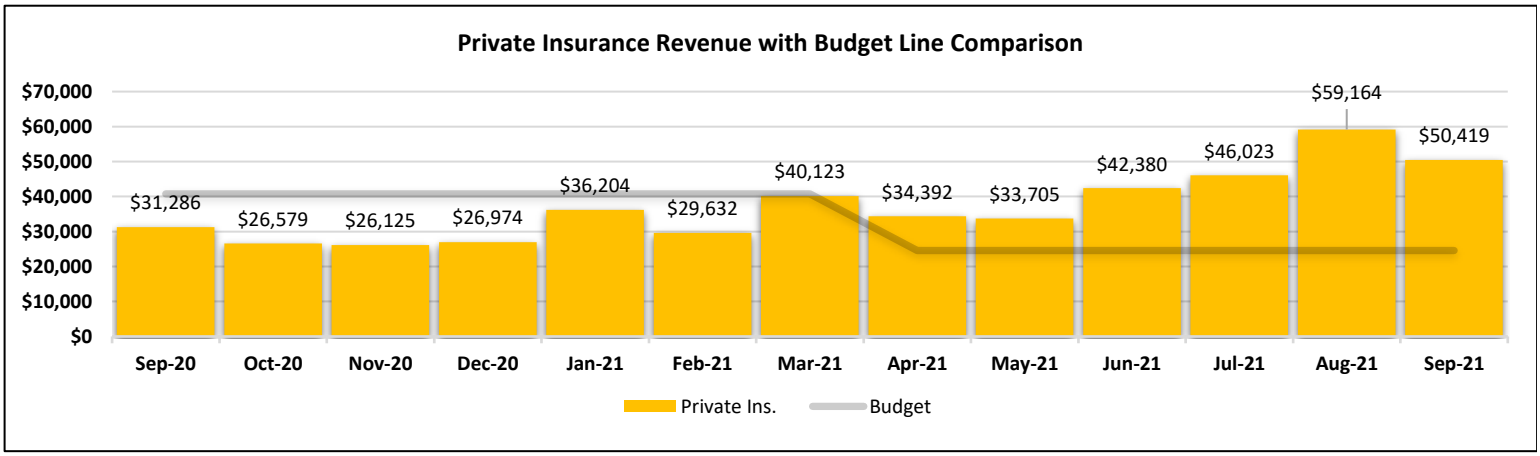
Actual Patient Revenue Rec'd vs Budget with Variance

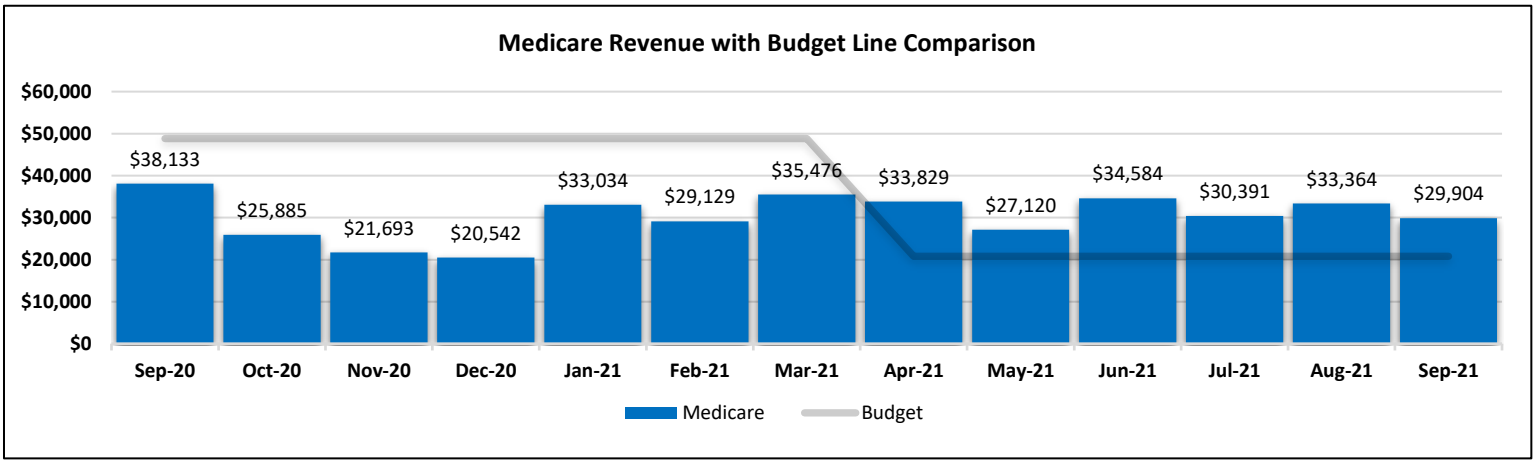


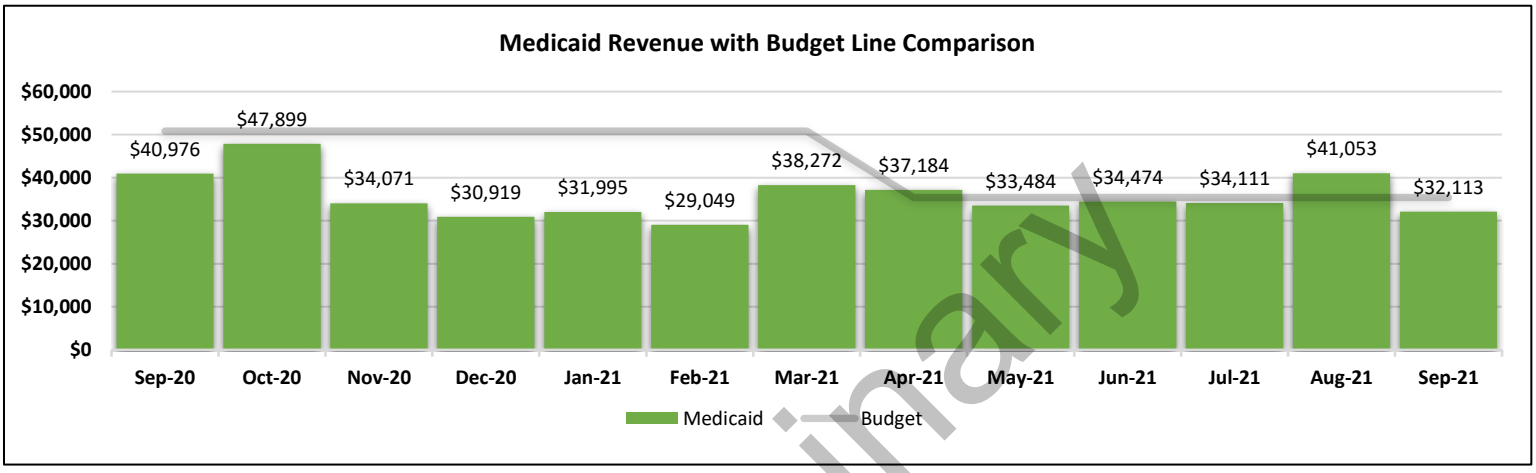


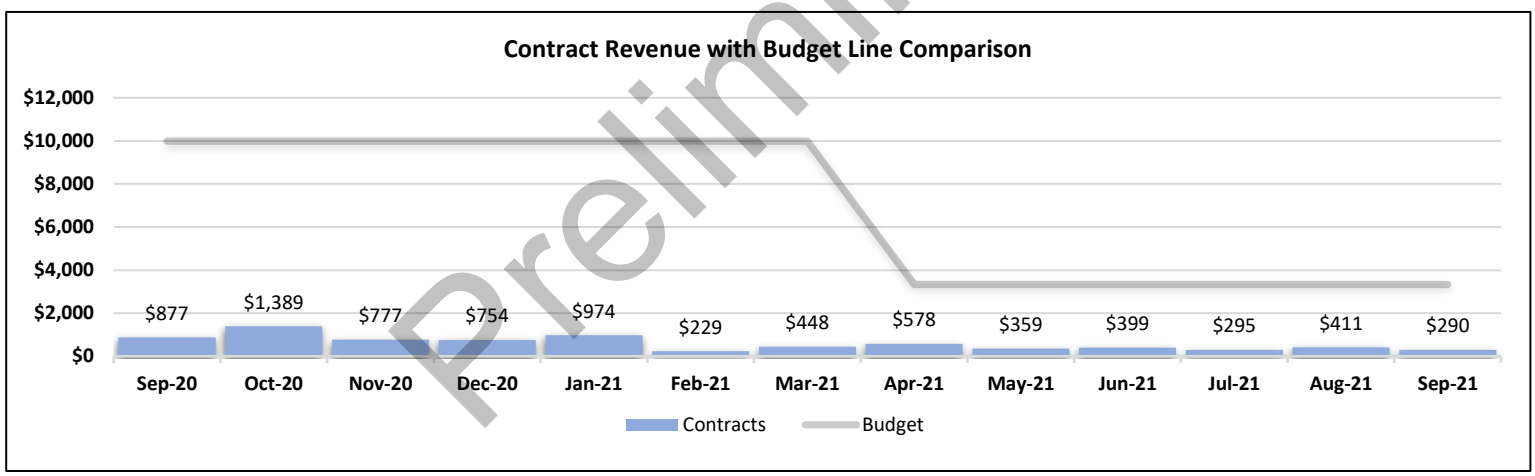


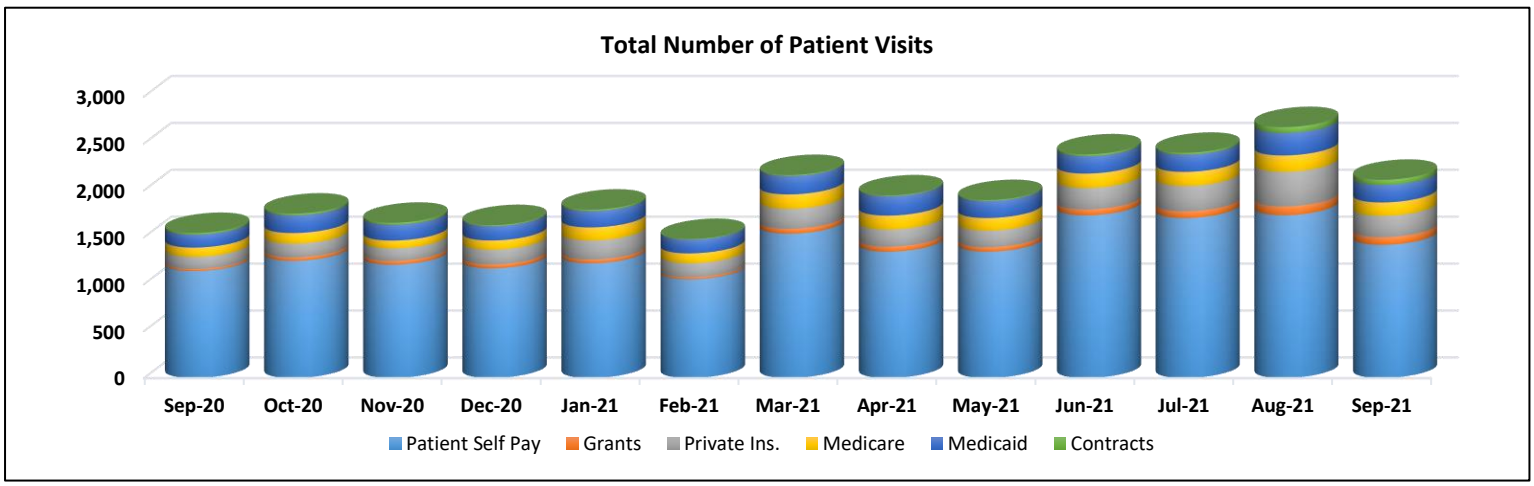












Coastal Health & Wellness
Statement of Revenue and Expenses for the Period ending September 31, 2021

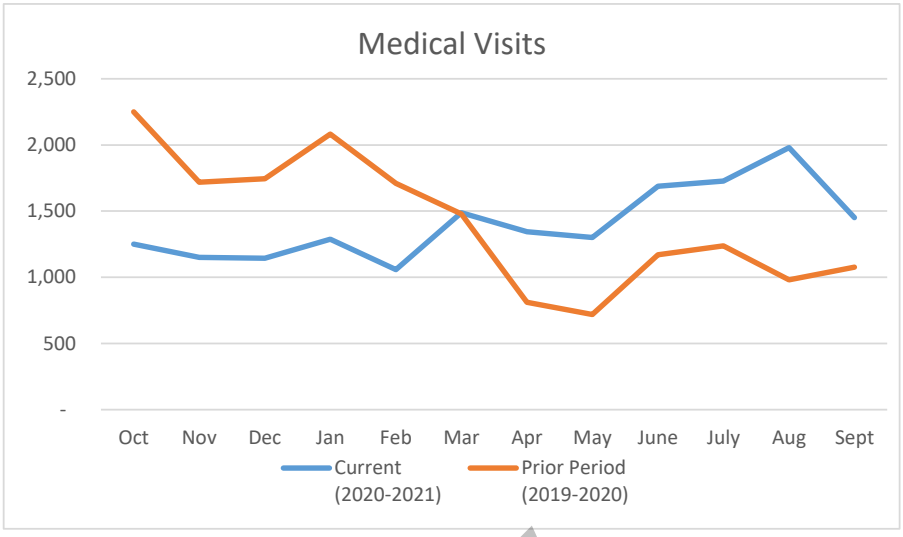
Cost Category	Account Description	Annual Budget	Period Ending 8/31/2021	Period Ending 9/30/2021	MTD Budget	MTD Budget Variance	YTD Actual	YTD Budget	YTD Budget Variance
Grouping	***Revenue***								
HHS	HHS Grant Revenue - HRSA	3,237,400	369,201	548,826	269,783	279,043	2,152,128	1,618,700	533,428
	Base Funding	*3,237,400*	*242,487*	*442,534*	*269,783*	*172,751*	*1,696,809*	*1,618,700*	*78,109*
	HHS QI 19	-			-	-	-	-	-
	COVID Supplemental	-	-	-	-	-	-	-	-
	COVID CARES	-	-	-	-	-	*153,395*	-	*153,395*
	COVID ECT	-	*15,829*	*10,630*	-	*10,630*	*86,449*	-	*86,449*
	HHS QI 20	-	*1,086*		-	-	*8,425*	-	*8,425*
	Hypertension (HTN)	-	-	-	-	-	*1,589*	-	*1,589*
	COVID ARP	-	*109,799*	*95,663*	-	*95,663*	*205,462*	-	*205,462*
HHS	HHS Grant Revenue - Other	-	-	-	-	-	27,275	-	27,275
Patient	Grant Revenue *(Title V, Ryan White)*	144,977	25,903	19,072	12,081	6,991	86,560	72,489	14,072
Patient	Patient Fees	845,950	86,025	75,762	70,496	5,267	459,065	422,975	36,090
Patient	Private Insurance	294,821	59,164	50,419	24,568	25,851	266,083	147,411	118,672
Patient	Pharmacy Revenue - 340b	900,000	23,347	26,965	75,000	(48,035)	181,901	450,000	(268,099)
Patient	Medicare	249,596	33,364	29,904	20,800	9,104	189,192	124,798	64,394
Patient	Medicaid	424,845	41,053	32,113	35,404	(3,291)	212,418	212,423	(4)
Other	Local Grants & Foundations	16,208	1,351	1,351	1,351	0	10,104	8,104	2,000
Other	Medical Record Revenue	15,000	692	99	1,250	(1,151)	4,295	7,500	(3,205)
Other	Medicaid Incentive Payments	-	170	3,043	-	3,043	29,941	-	29,941
County	County Revenue	3,734,667	311,222	311,222	311,222	-	1,867,334	1,867,334	-
DSRIP	DSRIP Revenue	790,000	765,938	-	65,833	(65,833)	944,085	395,000	549,085
Other	Miscellaneous Revenue	-	10	172	-	172	416	-	416
Other	Gain on Fixed Asset Disposals	-	-	-	-	-	656	-	656
Other	Interest Income	70,000	2,349	2,296	5,833	(3,537)	13,022	35,000	(21,978)
Patient	CHW Contract Revenue	40,000	411	290	3,333	(3,043)	2,333	20,000	(17,667)
Other	Local Funds / Other Revenue	5,000	899	229	417	(187)	2,284	2,500	(216)
	Total Revenue	**$ 10,768,464**	**$ 1,721,097**	**$ 1,101,764**	**$ 897,372**	**$ 204,392**	**$ 6,449,092**	**$ 5,384,232**	**$ 1,064,860**
	Expenses								
Personnel	Hourly Pay	5,832,411	476,898	462,477	486,034	23,557	2,827,259	2,916,206	88,946
Personnel	Supplemental/Merit Compensation	-	5,000	-	-	-	5,000	-	(5,000)
Personnel	Provider Incentives	67,000	750	750	5,583	4,833	3,000	33,500	30,500
Personnel	Overtime	42,000	2,360	975	3,500	2,525	14,737	21,000	6,263
Personnel	Part-Time Hourly Pay	202,460	24,665	27,607	16,872	(10,736)	118,055	101,230	(16,825)
Personnel	Comp Pay Premium	-	11	-	-	-	11	-	(11)
Personnel	FICA Expense	470,018	38,058	36,970	39,168	2,198	220,912	235,009	14,097
Personnel	Texas Unemployment Tax (SUTA)	12,759	1,006	868	1,063	195	14,674	6,380	(8,295)
Personnel	Life Insurance Expense	14,961	1,395	1,381	1,247	(134)	8,475	7,481	(994)
Personnel	Long Term Diability Coverage	13,989	1,072	1,051	1,166	114	6,428	6,995	567
Personnel	Employer Paid Health Insurance	494,769	29,686	29,310	41,231	11,921	173,563	247,385	73,822
Personnel	Worker's Comp Insurance	18,437	1,399	(4,262)	1,536	5,798	2,474	9,219	6,744
Personnel	Cobra Expense	-	53	1,120	-	(1,120)	1,368	-	(1,368)
Personnel	Employer Sponsered Healthcare	79,016	6,009	5,087	6,585	1,498	32,051	39,508	7,457
Personnel	Pension/Retirement	138,849	11,598	11,120	11,571	451	67,178	69,425	2,247
Contractual	Outside Lab Contract	146,448	21,607	33,425	12,204	(21,221)	105,152	73,224	(31,928)
Contractual	Outside X-Ray Contract	18,000	1,596	1,380	1,500	120	8,904	9,000	96
Contractual	Misc Contract Services	237,722	27,909	28,636	19,810	(8,826)	174,797	118,861	(55,936)
Personnel	Temporary Staffing	-	4,181	3,086	-	(3,086)	38,942	-	(38,942)
Contractual	CHW Billing Contract Services	72,000	8,669	6,331	6,000	(331)	43,062	36,000	(7,062)
IGT	IGT Reimbursement	259,989	123,865	-	21,666	21,666	302,013	129,995	(172,018)
Contractual	Janitorial Contract	168,780	13,926	16,396	14,065	(2,331)	86,117	84,390	(1,727)
Contractual	Pest Control	960	80	80	80	(0)	481	480	(1)
Contractual	Security	43,176	2,878	1,765	3,598	1,833	12,459	21,588	9,129
Supplies	Office Supplies	82,600	5,085	5,531	6,883	1,352	52,856	41,300	(11,556)
Supplies	Operating Supplies	228,132	29,253	32,675	19,011	(13,664)	167,426	114,066	(53,360)
Supplies	Outside Dental Supplies	40,200	3,699	5,784	3,350	(2,434)	23,130	20,100	(3,030)
Supplies	Pharmaceutical Supplies	600,000	20,350	18,897	50,000	31,103	120,727	300,000	179,273
Supplies	Janitorial Supplies	5,400	-	666	450	(216)	715	2,700	1,985
Supplies	Printing Supplies	5,580	2,072	-	465	465	2,322	2,790	468
Supplies	Uniform Supplies	-	-	-	-	-	-	-	-
Supplies	Controlled Assets *(i.e. computers)*	-	4,606	-	-	-	7,968	-	(7,968)
Other	Postage	9,000	1,176	464	750	286	3,755	4,500	745
Other	Telecommunications	64,500	6,190	6,484	5,375	(1,109)	35,623	32,250	(3,373)
Other	Water	372	31	31	31	1	183	186	3
Other	Electricity	18,000	1,026	1,079	1,500	421	8,062	9,000	938
Travel	Travel, Local	3,200	219	29	267	238	543	1,600	1,057
Travel	Travel, Out Of Town	-	-	-	-	-	-	-	-

Coastal Health & Wellness
Statement of Revenue and Expenses for the Period ending September 31, 2021

Cost Category	Account Description	Annual Budget	Period Ending 8/31/2021	Period Ending 9/30/2021	MTD Budget	MTD Budget Variance	YTD Actual	YTD Budget	YTD Budget Variance
Travel	Training, Local	30,135	135	3,195	2,511	(684)	6,301	15,068	8,767
Travel	Training, Out Of Town	-	1,086	-	-	-	1,335	-	(1,335)
Other	Rentals	39,240	6,078	2,233	3,270	1,037	20,850	19,620	(1,230)
Other	Leases	517,464	43,091	43,091	43,122	31	258,545	258,732	187
Other	Maint/Repair, Equip.	81,844	6,459	9,207	6,820	(2,387)	48,167	40,922	(7,245)
Other	Maint/Repair, Bldg.	2,400	-	49	200	151	5,500	1,200	(4,300)
Other	Maint/Repair, IT Equipment	-	-	-	-	-	-	-	-
Other	Insurance, Auto/Truck	108	9	9	9	0	51	54	3
Other	Insurance, General Liability	11,808	937	937	984	47	5,624	5,904	280
Other	Insurance, Bldg. Contents	18,372	1,149	1,149	1,531	382	6,896	9,186	2,290
Other	Settlements	-	-	-	-	-	-	-	-
Other	IT Equipment	-	-	-	-	-	-	-	-
Other	Operating Equipment	-	-	-	-	-	-	-	-
Other	Building Improvements	-	-	-	-	-	-	-	-
Other	Newspaper Ads/Advertising	23,600	3,323	1,436	1,967	531	9,578	11,800	2,222
Other	Subscriptions, Books, Etc.	18,623	12,295	745	1,552	807	13,209	9,312	(3,898)
Other	Association Dues	34,710	2,792	2,667	2,893	226	16,893	17,355	462
Other	IT Software / Licenses	259,929	22,922	24,756	21,661	(3,095)	139,565	129,965	(9,601)
Other	Prof Fees/Licenses/Inspections	1,670	1,139	-	139	139	1,114	835	(279)
Other	Professional Services	22,800	393	510	1,900	1,390	1,354	11,400	10,046
Other	Med/Hazard Waste Disposal	5,400	390	429	450	21	2,379	2,700	321
Other	Transportation	6,000	237	365	500	135	2,801	3,000	199
Other	Board Meeting Operations	350	-	78	29	(49)	366	175	(191)
Other	Service Charge - Credit Cards	7,200	1,011	1,055	600	(455)	6,074	3,600	(2,474)
Other	Cashier Over/Short	-	-	-	-	-	1	-	(1)
Bad Debt	Bad Debt Expense	296,083	41,543	37,033	24,674	(12,359)	219,941	148,042	(71,900)
Other	Miscellaneous Expense	-	-	-	-	-	3,278	-	(3,278)
	Total Expenses	**$ 10,768,464**	**$ 1,023,367**	**$ 866,139**	**$ 897,372**	**$ 31,233**	**$ 5,460,240**	**$ 5,384,232**	**$ (76,008)**
	Net Change in Fund Balance	***$ -***	***$ 697,730***	***$ 235,625***	***$ -***	***$ 235,625***	***$ 988,851***	***$ -***	***$ 988,851***

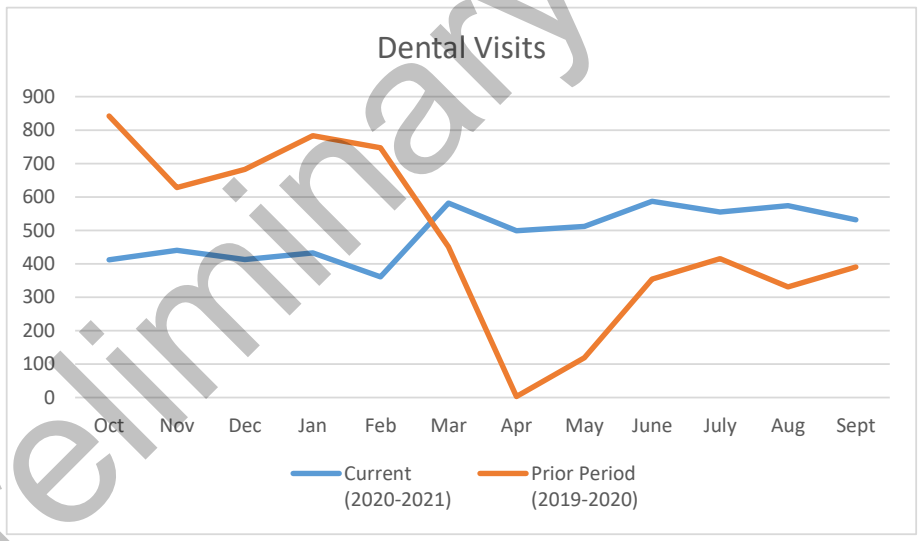
Medical Visits

	Current (2020-2021)	Prior Period (2019-2020)
Oct	1,251	2,250
Nov	1,150	1,719
Dec	1,145	1,745
Jan	1,288	2,082
Feb	1,058	1,710
Mar	1,488	1,480
Apr	1,345	812
May	1,301	719
June	1,689	1,170
July	1,727	1,238
Aug	1,980	981
Sept	1,450	1,077
	16,872	16,983



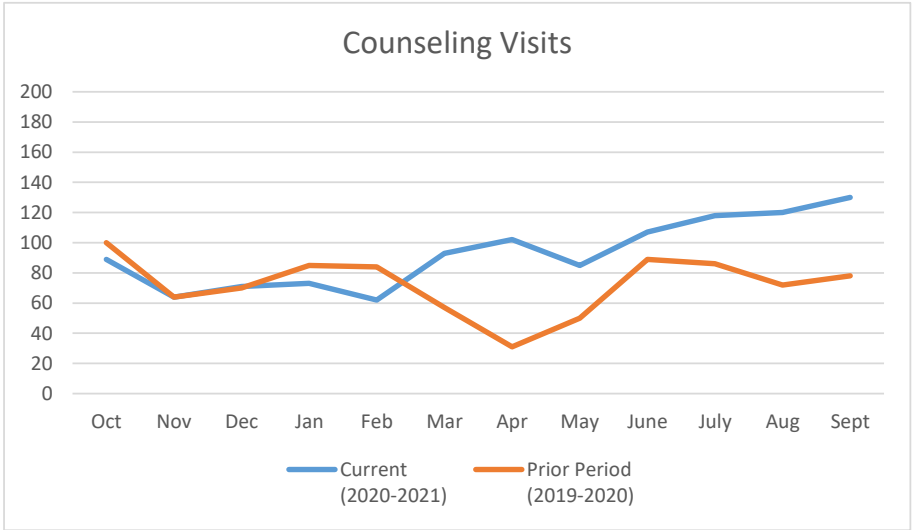
Dental Visits

	Current (2020-2021)	Prior Period (2019-2020)
Oct	412	842
Nov	440	628
Dec	413	682
Jan	433	783
Feb	361	747
Mar	582	451
Apr	499	3
May	512	119
June	587	354
July	555	415
Aug	574	331
Sept	532	390
	5,900	5,745



Counseling Visits

	Current (2020-2021)	Prior Period (2019-2020)
Oct	89	100
Nov	64	64
Dec	71	70
Jan	73	85
Feb	62	84
Mar	93	57
Apr	102	31
May	85	50
June	107	89
July	118	86
Aug	120	72
Sept	130	78
	1114	866



Vists by Financial Class - Actual vs. Budget
As of September 30, 2021 (Grant Year 4/1/2021 -3/31/2022)

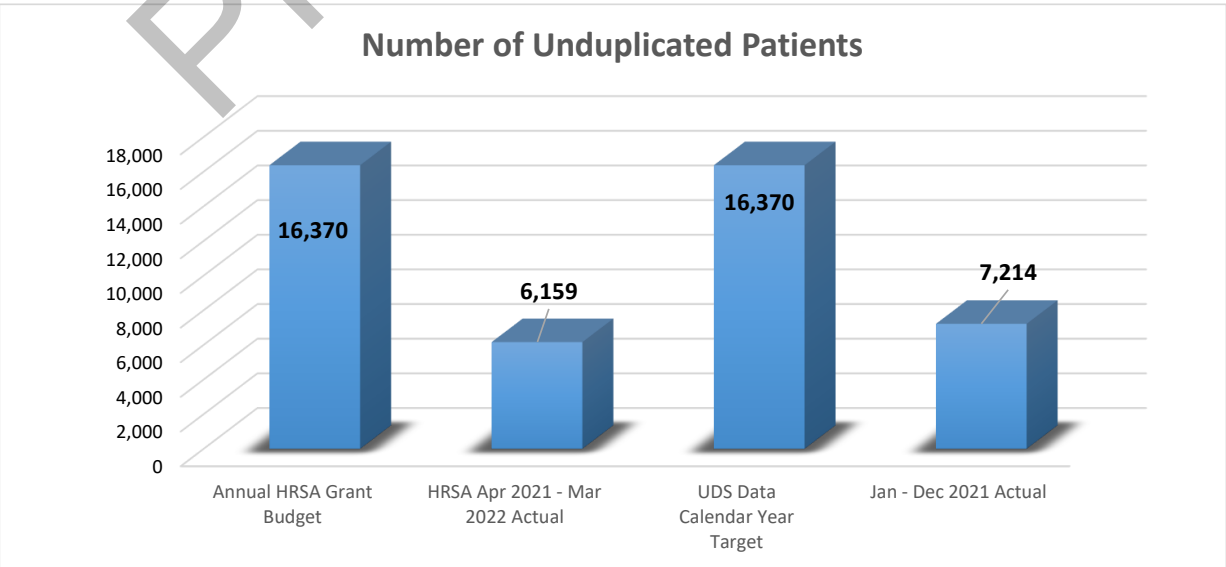
	Annual HRSA Grant Budget	MTD Actual	MTD Budget	Over/(Under) MTD Budget	YTD Actual	YTD Budget	Over/(Under) YTD Budget	% Over/ (Under) YTD Budget
Medicaid	3,147	187	262	(75)	1,280	2,360	(1,080)	-46%
Medicare	2,713	144	226	(82)	913	2,035	(1,122)	-55%
Other Public *(Title V, Contract, Ryan White)*	1,273	136	106	30	596	955	(359)	-38%
Private Insurance	2,941	226	245	(19)	1,461	2,206	(745)	-34%
Self Pay	24,170	1,419	2,014	(595)	9,186	18,128	(8,942)	-49%
	34,244	**2,112**	**2,854**	**(742)**	**13,436**	**25,683**	**(12,247)**	**-48%**

Unduplicated Patients - Current vs. Prior Year
UDS Data Calendar Year
January through December

	Current Year Annual Target	Jan-Sep 2020 Actual	Jan-Sep 2021 Actual	Increase/ (Decrease) Prior Year	% of Annual Target
Unduplicated Patients	16,370	7,023	7,214	191	44%

Unduplicated Patients - Current vs. Prior Year
HRSA Grant Year
April through March

	Annual HRSA Grant Budget	Apr-Sep 2020 Actual	Apr-Sep 2021 Actual	Increase/ (Decrease) Prior Year	% of Annual Target
Unduplicated Patients	16,370	4,410	6,159	1,749	38%



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Governing Board
October 2021
Item#11
Consider for Approval Quarterly Visit and Analysis Report Including Breakdown of New Patients by Payor Source for Recent New Patients Submitted by Marlene Garcia

Coastal Health & Wellness - Quarterly Visit & Analysis Report
for the period ending September 30, 2021
**based on UDS Reporting period (January 1 to December 31) Qualified Encounters*

Total Visits by Financial Class	September 2021	September 2020	% Change	* YTD Average 2021	* YTD Average 2020	% Change		* YTD Payor Mix 2021	* YTD Payor Mix 2020	% Change
Self Pay	1,419	1,149	23%	1,440	1,285	12%		68.6%	73.8%	-5.2%
Medicare	144	102	41%	146	132	11%		7.0%	7.6%	-0.6%
Medicaid	187	138	36%	204	146	40%		9.7%	8.4%	1.4%
Contract	54	17	218%	26	20	25%		1.2%	1.2%	0.0%
Private Insurance	226	130	74%	225	127	78%		10.7%	7.3%	3.4%
Title V	82	21	290%	57	31	82%		2.7%	1.8%	0.9%
Total	**2,112**	**1,557**	**36%**	**2,098**	**1,741**	**21%**		**100%**	**100%**	

Department	* YTD Total Visits 2021	* YTD Total Visits 2020	% Change
Medical	13,326	11,269	18%
Dental	4,635	3,593	29%
Counseling	890	632	41%
Total	**18,851**	**15,494**	**22%**

Unduplicated Visits	* YTD Total Users 2021	* YTD Total Users 2020	% Change
Medical	5,648	5,361	5%
Dental	1,393	1,508	-8%
Counseling	173	150	15%
Total	**7,214**	**7,019**	**3%**

NextGen / Crystal Reports - Summary Aging by Financial Class
for the period ending September 30, 2021 (based on encounter date)

	0-30	31-60	61-90	91-120	121-150	151-180	181-up	Total	%	Days in A/R Current Period	Days in A/R Last Qtr
Self Pay	53,460	48,908	39,187	35,860	29,638	24,300	583,885	$815,238	81%	393	443
Medicare	31,056	6,982	3,514	3,846	1,826	2,407	3,603	$53,234	5%	68	70
Medicaid	24,076	10,817	7,559	6,970	3,330	2,438	12,160	$67,348	7%	61	62
Contract	4,616	4,452	4,623	4,349	-	1,578	12,386	$32,004	3%	90	45
Private Insurance	44,943	16,005	13,824	8,960	6,266	1,748	9,490	$101,236	10%	115	78
Title V	12,991	11,011	3,583	7,379	2,779	477	31,864	$70,083	7%	365	276
Unapplied	(131,175)							($131,175)	-13%	---------	---------
Totals	**$39,966**	**$98,175**	**$72,290**	**$67,365**	**$43,839**	**$32,947**	**$653,388**	**$1,007,969**	**100%**	**182**	**162**

Previous Quarter Balances	**$22,643**	**$87,940**	**$60,781**	**$48,915**	**$39,029**	**$40,409**	**$647,430**	**$947,147**
% Change	77%	12%	19%	38%	12%	-18%	1%	6%

Charges & Collections	September 2021	September 2020	% Change	* YTD 2021	YTD 2020	% Change
Billed	$697,751	$473,798	47%	$3,414,828	$2,464,210	39%
Adjusted	(476,503)	(324,454)	47%	(2,444,804)	(1,846,670)	32%
Net Billed	$221,248	$149,344	48%	$970,024	$617,540	57%
Collected	$207,561	$102,422	103%	740,290	$874,862	-15%
% Net Charges collected	94%	69%	37%	76%	142%	-46%

	YTD Current Period				YTD Prior Year			
Payor	***Visits***	***Payor Mix***	***Net Revenue per Visit***	***(Net Billed) Net Revenue***	***Visits***	***Payor Mix***	***Net Revenue per Visit***	***(Net Billed) Net Revenue***
Self Pay	17,731	66.4%	$21.07	$373,599	14,580	70.2%	$20.40	$297,504
Medicare	2,150	8.0%	$65.66	141,165	1,650	7.9%	$49.97	82,449
Medicaid	2,383	8.9%	$83.33	198,586	1,714	8.2%	$63.81	109,363
Contract	1,189	4.5%	$53.90	64,081	971	4.7%	$41.06	39,869
Private Insurance	2,637	9.9%	$59.91	157,994	1,530	7.4%	$48.76	74,601
Title V	626	2.3%	$55.27	34,599	339	1.6%	$40.58	13,755
Total	26,716	100%	$36.31	$970,024	20,784	100%	$29.71	$617,540

Item	2021	2020
Self Pay - Gross Charges	$3,429,069	$2,858,145
Self Pay - Collections	$459,064	$414,748
% Gross Self Pay Charges Collected	**13.4%**	**14.5%**
% Net Self Pay Charges Collected	**122.9%**	**139.4%**

Coastal Health & Wellness
New Patients By Financial Class
From 1/1/2021 to 9/30/2021

	Current Period		Prior Period 2020	
Summary	**New Patients**	**Current %**	**New Patients**	**%**
Self Pay	1,008	**66.4%**	960	**78.2%**
Medicaid	166	**10.9%**	90	**7.3%**
Medicare	49	**3.2%**	21	**1.7%**
Private Insurance/Commerc.	224	**14.7%**	103	**8.4%**
Title V	64	**4.2%**	39	**3.2%**
Contracts	8	**0.5%**	14	**1.1%**
Total	**1,519**	**100.0%**	**1,227**	**100.0%**

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Governing Board
October 2021
Item#12
Consider for Approval the Quarterly Compliance Report for the Period Ending September 30, 2021 Submitted by Richard Mosquera

Coastal Health & Wellness Governing Board
Quarter 2, FY22 Compliance Report

Internal Audits		
AUDITOR- DATE CONDUCTED	***TYPE OF AUDIT & FINDINGS***	***ACTION TAKEN***
Patient Services Manager - July 1, 2021 – September 30, 2021	**Financial Screening Audit:** • Financial screening audits were performed by randomly pulling ten applications monthly to establish the accuracy and completeness of said applications. • Among the 33 applications reviewed, which collectively encompassed 396 individual fields, two errors were cited.	• The errors, both of which were minor and clerical in nature, were immediately corrected by the Patient Services Manager. • The Patient Services Manager reminded all representatives to remain constantly attentive while completing intake applications, and to review applications in their entirety upon completion to ensure accuracy.
Patient Services Manager - July 1, 2021 – September 30, 2021	**Title V Clerical Audit:** • Title V clerical audits were performed by randomly pulling Title V patient applications and charts to determine accuracy and inclusiveness of the documentation. • Among the 85 applications and charts reviewed, which collectively encompassed 850 individual fields, there were seven errors noted – a decrease of thirteen from the prior quarter.	• Five of the seven errors, all of which were minor, ensued from staff charting incorrect dates. • Errors were corrected immediately by the Patient Services Manager, and all members of the Patient Services staff were reeducated about best practices to mitigate these errors.

Coastal Health & Wellness Governing Board
Quarter 2, FY22 Compliance Report

Nursing Director July 1, 2021 – September 30, 2021	**340B Medication Audit:** • The Nursing Director performed a 340B medication audit to determine the comprehensiveness of charting internally issued 340B meds, which requires documentation reflecting consistency in medication logs, NextGen and billing activities. • Of the 20 charts analyzed (ten from each of the two sites), no errors were identified – yielding a 100% compliance rate.	• Continue operating under current protocol.
Dental Director March 15, 2021 – June 30, 2021 (Audit performed August 30, 2021)	• In accordance with stipulations provided in the Ryan White dental grant, charts for all nine patients receiving services during the denoted period were surveyed to verify provider adherence with appropriate protocols. • Of the 92 analyzed measures, 89 were correctly performed.	• The three non-compliant findings all stemmed from patients not receiving oral health education at least once in the "measurement year" – a HRSA mandate. • These patients have been seen only for their exam, and not yet for their cleaning, at which time this education will be provided.

External Audits

AUDITOR – DATE OCCURRED	*TYPE OF AUDIT & FINDINGS*	*ACTION TAKEN*
NO EXTERNAL AUDITS PERFORMED DURING JULY, AUGUST OR SEPTEMBER OF 2021.		

Warning and Termination Letters

REASON	*TYPE OF LETTER*
Debt Collection Policy	Suspensions 86; Reinstatements: 126
Behavioral Letters Issued	Terminations: 0; Warnings: 0

NOTE: Various issues were discussed in peer review.

Coastal Health & Wellness Governing Board
Quarter 2, FY22 Compliance Report

Incidents involving quality of care issues, in accordance with Section 161 et seq., Health and Safety Code, are reviewed such that proceedings and records of the quality program and committee reviews are privileged and confidential.

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Governing Board
October 2021
Item#13
Consider for Approval the Coastal Health & Wellness Risk Management Training Plan 2021-2022 Submitted by Richard Mosquera

Coastal Health & Wellness
Risk Management Training Plan
2021 – 2022
Approved: October 2021

Article I Risk Management Training Program Goals

Risk Management is the responsibility of all Coastal Heath & Wellness ("CHW") employees, including providers, clinicians, managers, volunteers and staff. Risk management spans the entire operation and most functional areas, and all employees should be trained on risk management functions and responsibilities. CHW's Risk Management Training Program's goals and objectives are to create a culture of safety by:

1. Promoting safe and effective patient care practices;
2. Minimizing errors, events, and system breakdowns;
3. Minimizing effects of adverse events when they occur;
4. Minimizing losses to CHW by being proactive and attentive;
5. Maintaining a safe working environment;
6. Safeguarding protected health information;
7. Facilitating compliance with regulatory, legal, and accrediting agencies;
8. Protecting CHW's financial resources; and
9. Protecting human and intangible resources.

Article II Process for Selection of Training Requirements

1. Using trends and other risk management data (e.g., claims data, patient complaints, incident reports, adverse events, services provided and inherent nature/risk of such services), the areas/activities of highest risk for CHW patient safety and ensuring consistency with CHW's identified scope of project(s).
2. Training courses are then selected to mitigate or minimize the areas identified as highest risk.

Article III Training Courses

1. All staff will be trained on risk management topics applicable to their scope of work upon hire and thereafter on an annual basis. This includes providers, clinicians, managers, volunteers and support staff.
2. CHW has identified required courses for all staff and specialized training to mitigate or minimize risk of injury to patients and potential for liability to CHW, many of which

are predicated upon Coastal Health & Wellness' Environment of Care and Infection Control policies.

3. ***Required Courses for All Staff.*** Applicable staff will be required to complete risk management training about the following topics, and a completion log for these trainings is maintained by the Risk and Safety Coordinator.

    COURSE NAME (TENTATIVE DATE FOR NEXT ANNUAL TRAINING)

    a. Needlestick and Sharps Prevention (October 2021)

    b. Identifying and Reporting Human Trafficking (November 2021)

    c. HIPAA and Patient Confidentiality (December 2021)

    d. Emergency Operations Plan (January 2022)

    e. Anti-Fraud Training (February 2022)

    f. Child, Elderly and Domestic Abuse Reporting Training (March 2022)

    g. Cultural and Linguistic Training (April 2022)

    h. Fire Safety Training (May 2022)

    i. Creating a Culture of Safety (June 2022)

    j. Risk Management and Safety Training (July 2022)

    k. Infection Control: Hand Hygiene (August 2022)

    l. Infection Control: Bloodborne Pathogen Exposure (August 2022)

4. ***Specialized Courses for Select Staff.*** In addition to the required courses outlined above, staff in the following professions/fields will also be required to attend and complete specialized risk management courses applicable to their respective professions and positions in accordance with program, state and federal licensure regulations.

    i. All practitioners must complete their continuing education requirements or other applicable licensure requirements to maintain licensure, registration or certification.

    ii. Dental Instrument Sterilization Training for select staff, as applicable. *CHW exclusively uses disposable instruments for all medical and laboratory procedures, therefore only members of the dental staff are required to undergo instrument sterilization training.*

iii. CHW requires specific risk management trainings for groups of providers that perform various services which may lead to potential risk including:

1. Behavioral Health
2. Dental

iv. Staff who handle hazardous materials must complete Hazardous Waste and Disposal training within thirty (30) days of hire and every three years thereafter.

v. Providers will be trained upon hire and annually thereafter about responding to potential malpractice claims that could invoke litigious action, and in avoiding scenarios that could pose Anti-Kickback and/or Stark claims.

***Please note CHW does not provide prenatal, postpartum or labor/delivery services. Patients are referred to the University of Texas Medical Branch for such procedures.**

5. ***Other Courses/Training.*** The Risk Manager may identify and require additional courses or trainings for some or all staff, as appropriate, to address any incident, identified trend, near miss, patient complaint or any other circumstance.

Article IV Tracking Training Attendance and Completion

1. Tracking Methods

   a. Unless specified otherwise, staff must complete required applicable risk management trainings upon hire and on an annual basis thereafter.

   b. Attendance and/or completion of training courses will be tracked in a manner appropriate to the method by which the course was conducted (e.g., in-service sign-in log for in-person courses; certificates of completion for individual online courses, attestation of review and completion for other courses).

   c. Staff who are unable to attend in-service sessions during which a required training is provided must make-up the training by attending the next New Hire Orientation session, which occur every other week and where the missed training(s) will be offered.

2. Performance Reviews/Credentialing and Privileging

   a. Compliance with training requirements shall be retained in staff personnel records and considered during performance reviews and/or credentialing and privileging determinations.

3. Non-Compliance with Training Requirements

    a. The Risk Manager in conjunction with Human Resources will monitor staff compliance with training requirements. Failure to complete the training may result in the staff member's referral to Human Resources for disciplinary action, up to and including termination.

4. Appropriate Sources of Training/Mode of Delivery

    a. Trainings are facilitated during employee in-service sessions, which are held from 8:00 am-12:00 pm on the second Wednesday of every month.

    b. Training may also be conducted either in person, online, individually or in a group setting utilizing courses developed by CHW or through outside sources (e.g., ECRI Institute; MedTrainer).

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Governing Board
October 2021
Item#14
Consider for Approval Coastal Health & Wellness Performance Improvement Plan Submitted by Ann O'Connell

COASTAL HEALTH & WELLNESS PERFORMANCE IMPROVEMENT PLAN
2021-2022

Introduction

The purpose of this Performance Improvement Plan (PIP) is to outline how Coastal Health & Wellness (CHW) will assure that a meaningful performance improvement program is implemented with continuous monitoring, clear organizational roles and responsibilities for carrying out the Plan, and how performance improvement data will be evaluated and reported to the Governing Board Quality Assurance/Performance Improvement/Risk Management (QA/PI/RM) Committee and the CHW Governing Board (GB).

Responsibilities

Coastal Health & Wellness Governing Board

The CHW Governing Board is the policy-making authority for CHW clinical operations. The Board approves CHW operational policies, ensures CHW's continuing alignment with its vision and mission, and tracks CHW's progress to achieve goals and objectives adopted by the organization and as set forth in accordance with the Healthy People 2020.

As outlined in the Governing Board's bylaws, execution and operational aspects of Board policies are delegated to the Executive Director or his/her designee. The Health Resources and Services Administration (HRSA) mandates that a Quality Assurance/Performance Improvement/Risk Management (QA/PI/RM) Committee comprised of Governing Board members, oversee the progression and effectiveness of Coastal Health & Wellness's overarching initiatives. In doing so, the Governing Board's QA/PI/RM Committee will convene on a quarterly basis to review performance improvement data and priority indicators which shall include CHW's compliance with standards stipulated by CHW accrediting organizations including but not limited to HRSA and The Joint Commission (TJC).

The Governing Board's QA/PI/RM Committee is responsible, when necessary, for requesting that the Executive Director bring pertinent information from these meetings to the Governing Board in its entirety. The Governing Board is subsequently expected to offer feedback to CHW administration regarding these matters.

Coastal Health & Wellness Quality Assurance/Performance Improvement Committee

The Coastal Health & Wellness Quality Assurance/Performance Improvement Committee includes the Executive Director, Chief Compliance Officer, Chief Nursing Officer, Chief Financial Officer, Medical Director, Nursing Director, Dental Director, and all other clinic managers. The Quality Assurance/Performance Improvement Committee meets monthly to evaluate and improve upon current clinical processes as they pertain to patient care, customer service, administrative functions, and adherence to other goals and objectives subject to Governing Board oversight. Minutes from the Quality Assurance/Performance Improvement Committee are distributed to all members within five (5) business days after the meeting and reviewed with all members of the Quality Assurance/Performance Improvement Committee at the start of the subsequent meeting.

Members of the Quality Assurance/Performance Improvement Committee use data presented at these meetings to establish monthly, quarterly, and annual performance matrices. The Executive Director and other designated staff coordinate with the Governing Board's QA/PI/RM Committee to establish organizational responsibilities required to accomplish identified goals and objectives.

Coastal Health & Wellness Supervisors

All Coastal Health & Wellness managers and supervisors are responsible for capturing and tracking data essential to monitoring and evaluating the progress and quality initiatives as they relate to each supervisors' departmental purview, and ensure members of their respective staff are adequately educated about their individual roles and responsibilities, and how these roles and responsibilities fit into CHW's overall objectives. When instructed by the Executive Director, supervisors will coordinate the collection of data and its subsequent aggregation and analysis, including frequency, statistical tools, historical trends, etc.

Approach to Quality Assurance/Performance Improvement

The framework for the Coastal Health & Wellness Performance Improvement Plan is developed in collaboration with a broad and inclusive group of community stakeholders and takes into consideration local morbidity and mortality data. Strategic planning fosters integrated priorities across the entire organization. For 2021 - 2022, data will be collected on:

a. Medical and dental productivity
b. Access to care
c. Patient satisfaction survey results
d. Patient complaint data for unresolved complaints
e. Patients with hypertension
f. Patients with Type 2 diabetes
g. Breast and colon cancer screening initiatives
h. Insurance credentialing
i. Chart audits for quality of care measures
j. Other measures identified by HRSA (clinical measures), TJC, the Department of State Health Services and/or the QA/PI/RM Committee

The 2021 - 2022 Performance Improvement Plan will also mandate that CHW administration continue working to collaborate with Texas Association of Community Health Centers (TACHC) to meet the requirements of the Patient Centered Medical Home credential. Clinic staff will also continue to develop measures over the next year to comply with regulatory changes set forth by any regulatory body.

Measurements for –2021 - 2022

Coastal Health & Wellness is committed to achieving certain goals set forth by HRSA in its Healthy People 2020 initiative. Accordingly, CHW will strive to exceed the following specific measures, which will be reviewed quarterly by the Governing Board's Quality Assurance Committee.

Objectives

1. Implement the new Peer to Peer Clinical Education Initiative to replace the former Peer Review Process for all medical providers
2. Screen at least 50% of all children, adolescents and adults for diabetes and prediabetes with a single hemoglobin A1C using the diagnostic criterion of the American Diabetes Association
3. Provide verbal or written patient education for at least 50% of all children, adolescents and adults who have screened positive for prediabetes
4. Improve by at least 5% the proportion of patients with Type 2 Diabetes who have a hemoglobin A1C less than 9%
5. Increase by 10% the proportion of children, adolescents and adults who have weight screenings and counseling for overweight or obesity

6. Continue the established peer review process for all dental providers
7. Place dental sealants on at least 70% of eligible patients ages 6-9 years old

Measures from the Bureau of Primary Health Care Review

Clinical measures in the Bureau of Primary Health Care grant and mandatory reporting system will be integrated into routine QA monitoring and improvement activities to assure baseline numbers are accurate for the Uniform Data System (UDS) reporting tool.

Dental Peer Review

Dental Peer Review will continue to serve as a vehicle to evaluate and improve the quality of dental health services at Coastal Health & Wellness. Monthly measures for dental are reviewed by audit of individual records or data gathered through electronic reports generated from the system. Currently, Dental Peer Review measures are reviewed monthly by the Coastal Health & Wellness Quality Assurance/Performance Improvement Committee, and feedback from these meetings is presented to all providers by the CHW Dental Director at their department's monthly in-service meeting.

Medical Peer Review

The CHW Medical Team has modified its peer review process and is implementing the peer to peer clinical education initiative for a more comprehensive approach to quality assurance.

Environment of Care and Infection Control Program

The program has predetermined measures for the effectiveness of efforts in safety, life safety, security, hazardous materials, utilities, medical equipment, emergency preparedness and infection control. Improvements are driven by identification of opportunities for enhancement through conformance with the aforementioned measures and data analysis. These are reviewed and approved annually by the QA/PI/RM Committee and follow guidelines set forth by The Joint Commission, OSHA, AAMI and CDC.

Staff Competencies

Licensed independent providers are credentialed and privileged in accordance with the *CHW Credentialing and Privileging Policy for Professional Provider Staff* (attached), which is reviewed and approved annually by the Coastal Health & Wellness Governing Board. Other licensed staff is periodically credentialed and works under the applicable supervision. Providers are subject to review in accordance with the *Clinical Peer/Midlevel Review* (attached). An assessment of all staff competency is made annually as a part of the Coastal Health and Wellness performance evaluation process.

Sentinel Events

A sentinel event is a serious occurrence in CHW that results in the death or serious injury of a patient, staff, or visitor. It also includes an event that causes risk of death or injury, in that if it were repeated, injury or death might occur. Injury may be physical or psychological. It is not related to the course of a patient's illness or condition. Sentinel events are preventable occurrences. Some examples are death or serious injury from a medication error, from transmission of a nosocomial infection, and from breach of a safety measure or avoidable delay in treatment.

Sentinel events shall be reported as incidents and reviewed by the Coastal Health & Wellness Quality Assurance/Performance Improvement Committee. In the rare instance that a sentinel event should occur, a root cause analysis focusing on improving systems and processes will be undertaken by an appropriate multi-disciplinary group assigned by the Quality Assurance/Performance Improvement Committee. Should the event mandate reporting to an external agency, such reports will be prepared by the Chief Compliance Officer, unless directed otherwise by the Executive Director.

Incidents that do not rise to the level of a sentinel event are also thoroughly investigated, and corrective actions, when appropriate, are employed. Such incidents are considered to be important learning and improvement opportunities and are analyzed by the Quality Assurance/Performance Improvement Committee. Process improvements are made based upon Committee recommendations and established procedures for best practices.

Attachments:

a. Patient Safety and Quality of Care Statement

b. Coastal Health & Wellness Clinical Peer/Midlevel Review

c. Galveston County Health District Coastal Health & Wellness Clinic Quality Management Program for DSHS and HHS Funded Programs

d. Coastal Health & Wellness Credentialing and Privileging Policies for Professional Provider Staff

_____ _____

Samantha Robinson, Chair Date
Coastal Health & Wellness Governing Board

Patient Safety and Quality of Care
Coastal Health & Wellness Statement

Patient Safety and excellent quality of care is of the utmost importance to Coastal Health & Wellness staff at all levels. Patients can be assured that Coastal Health & Wellness (CHW) has all the standard systems in place for patient safety, quality assurance, and quality of care improvements.

CHW's goal is to continuously improve health care for the public by evaluating its health care processes and outcomes, and by inspiring a collective sentiment striving for excellence, safety, and the highest quality of care possible among all staff. CHW strives for each of its patients to experience the safest, highest quality, best-value health care available anywhere.

Safety & Quality of Care is addressed in many ways. A few highlights include:

- **Joint Commission Accreditation** (www.jointcommission.org) – The Joint Commission is an independent, not-for-profit organization. The Joint Commission accredits and certifies more than 18,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
- **Risk, Safety, Infection Control and Medication Management** guidelines are annually reviewed, and staff practices are routinely improved and monitored.
- **Investigations** of possible adverse occurrence with root cause analysis are conducted and improvements are implemented when deemed appropriate.
- **Medical Peer Reviews** of patient records are performed as part of the peer-to-peer clinical education initiative and are targeted at discovering ways of improving the quality of care offered.
- **Midlevel Reviews** are conducted by the Medical Director during which time he/she reviews midlevel clinical records. Midlevel providers are typically physician assistants and nurse practitioners employed at Coastal Health & Wellness.
- **Peer Reviews** of patient's dental records are performed as part of the established dental peer review process with the dentists and dental hygienists. These peer reviews are targeted at identifying opportunities for improving the quality of care offered.

Coastal Health & Wellness follows national safety guidelines and standards. Staff routinely manages CHW facilities to optimize security, fire safety, medical equipment safety, reliable power, and utility systems, and maintains a functional clinic environment. Staff also addresses medication and infection control risks, keeps accurate records, continuously ascertains the competency of staff, and provides care in accordance with recognized standards.

As a Coastal Health & Wellness patient, you should speak up if you have questions or if you wish to discuss an issue of safety or the quality of your care. You may contact Clinic Administration at (409) 949-3406. If your concerns are not addressed, you may contact The Joint Commission at (800) 994-6610.
Your health and safety are of the utmost importance to our organization.

COASTAL HEALTH & WELLNESS CLINICAL
PEER/MIDLEVEL REVIEW

A Medical and Dental Quality of Care Improvement Program

These guidelines are an attachment to the approved Coastal Health & Wellness Governing Board's Performance Improvement Plan.

LEGAL FRAMEWORK OF PROGRAM

Pursuant to the *Federal Tort Claims Act*, which provides liability coverage for the Coastal Health & Wellness clinics and its employees, all official Coastal Health & Wellness professional staff are subject to review to evaluate quality of services, provide feedback and be given the opportunity for improvement or corrective action as may be indicated. The *Texas Medicaid Managed Care Program* also requires that providers be subject to review and that quality improvement and corrective actions be taken and monitored, as appropriate.

To qualify for the confidentiality and immunity protections afforded, all Peer/Midlevel Review activities must be carried out pursuant to these guidelines and must be performed at the direction of or on behalf of the Coastal Health & Wellness Quality Assurance Committee comprised of the Executive Director, Chief Nursing Officer, Chief Compliance Officer, Medical Director, Dental Director, Nursing Director, along with other business and clinical staff, as deemed necessary, based upon the issue being addressed.

The evaluation of qualifications, credentials, and privileges of licensed and certified staff are performed in accordance with *Credentialing and Privileging Policy for Professional Provider Staff.*

PEER TO PEER CLINICAL EDUCATIONAL INITIATIVE

Context

Primary health care clinicians are responsible for partnering with our patients to work toward the goals of achieving and maintaining excellent health. This partnership for the purpose of successfully achieving measurable goals is known as value-based care.

The evidence for successful prevention and management of health conditions continues to accumulate and the care we provide needs to evolve as new evidence is obtained. This necessitates a commitment to lifelong learning for all providers and requires ongoing, continuous review and mastery of accepted medical and dental practice.

Peer to Peer Clinical Education Initiative (formerly Peer Review)

CHW's Medical Director strictly monitors the peer review process to ensure that every provider:

- Has access to up-to-date evidence for the most common and impactful health conditions managed in CHW clinics.
- Is aware in a timely fashion of changes in the evidence and the application of evidence as it relates to patient care
- Actively engages with other providers and the health care team as a whole to provide exemplary evidence-based care for our patients.

Content

Taken alone, UDS measures do not indicate whether CHW is upholding appropriate care. However, the data does offer markers for conditions known to impact the health of communities so when followed over time they can help determine if we are on course to effectively manage the care of our patients.

To achieve CHW goals, as well as the HRSA goals identified by UDS, each medical provider will be responsible for championing one or more health conditions (HC) and/or primary prevention screening tools (PST) on an ongoing basis.

- UDS measures are embedded within the identified HC and PSTs.
- Champions are not subject area experts but are responsible for updating colleagues on changes in practice guidelines for their subject.

Tasks for each champion:

- Identify evidence-based resources for managing the HC
- Review these resources on an ongoing basis
    - Provide an initial oral presentation during in service that reviews the acceptable practices for the comprehensive primary care of the HC
        - Provide brief updates at future in service sessions
    - Provide (a) written resource(s) that providers can access when performing clinical duties
        - Titles and links to evidence reviews and summaries that form the basis of acceptable practice
        - Lists/tables for surveillance markers and their frequency for the HC
    - Provide detailed but succinct recommendations for how to document care in NG
        - Work with IT to understand exactly how and where the documentation needs to be put in NG so it can be appropriately accessed for UDS and other statistical summaries and present this to colleagues
- Provide recommendations to improve the achievement of goals for the HC:
    - Specific suggestions to be used in the huddles for capturing data for the HC
    - Specific suggestions for education by nurses and medical assistants before and after the provider visit
        - Succinct, timely handouts
        - Call backs between visits
        - Extended education sessions with nurses

- Provide recommendations for tools for
    - shared decision-making
    - patient goal setting
    - patient education
- Perform focused chart reviews for all providers directed to the HC:
    - Develop in conjunction with the medical director the format for review for the HC that will measure whether providers are appropriately managing the HC
    - All champions will review five charts of every provider and their own once each quarter (four times annually when fully implemented)

The following table lists the health conditions and primary preventive services that will form the basis of our

current peer to peer clinical education initiative. All UDS measures are represented and many are contained within more than one subject area.

Health Condition/Preventive Service	Associated UDS
Asthma management for children and asthma and COPD management for adults	Use of appropriate medications for asthma
	Tobacco use and cessation
Management of Type 2 Diabetes	Hemoglobin A1C at or better than 9%
Primary care management of Coronary Artery Disease and Other Ischemic Vascular Disease	Lipid therapy
	Aspirin or other thrombotics for IVD
	Tobacco use and cessation
Primary care management of hypertension and dyslipidemia	Lipid therapy
	Tobacco use and cessation
	Hypertensive patients with BP < 140/90
Preventive care for infants and children	Childhood immunization status
	Weight assessment and counseling
Preventive care for adult women and adolescent females	Cervical cancer screening
	Prevention/Linkage to care for HIV
	Colorectal cancer screening
	Weight assessment (BMI) and counseling
	Screening and care for clinical depression
	Screening for tobacco use
Preventive care for adult men and adolescent males	Weight assessment (BMI) and counseling
	Screening and care for clinical depression
	Screening for tobacco use
	Colorectal cancer screening
	Prevention/Linkage to care for HIV

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GUIDELINES FOR TYPES OF REVIEWS

Patient Complaints, Adverse Occurrences and Sentinel Events

1. Quality of care concerns and patient complaints that are reported to CHW employees will be thoroughly investigated by the appropriate manager.
2. The appropriate manager will gather and review documentation regarding the incident/complaint including but not limited to, medical records, logs, electronic records, witness written statements, etc.
3. The appropriate manager will draft a chronological report of key findings based on documentation and present the findings to the Executive Director for review.
4. The Executive Director will review for completeness and appropriateness of the findings and formulate recommendations, including, but not limited to, staff and practice expectations, employee corrective actions, training needs, and procedures/guideline development.
5. Depending upon the nature of the infraction, the Chief Compliance Officer may report the incident to

The Joint Commission, National Practitioner Databank, Texas Medical Board, Texas Board of Nursing and/or other appropriate professional licensing boards, as well as to law enforcement if necessary.

6. CHW administration will advise appropriate staff of the incident, and any related policies or procedures implemented as a result.

MIDLEVEL SUPERVISORY REVIEWS

1. On a weekly basis, at least 10% of patient visits with mid-levels are electronically selected.
2. On a weekly basis, the Medical Director or qualified designee reviews these records for appropriate documentation of history, physical exam, diagnosis(es), and plan according to established clinical practice guidelines and evidence-based clinical standards of care.
3. When the Medical Director or designee finds a quality of care concern, he or she will document the concern and recommendation to the appropriate midlevel provider in an email marked "Privileged and Confidential Chart Review Findings." In urgent instances, the Medical Director or designee will consider appropriate clinical or corrective interventions.
4. For most frequent findings, it is expected that the Medical Director or designee provides a brief presentation on the topic during the monthly in-service. An alternative would be to arrange for a topic expert to present on the subject matter.
5. The Dental Director reviews 10% of the dental hygienist's records at least monthly according to an approved review form and gives feedback to the hygienist(s) at least monthly regarding expected improvements in care or documentation.

DENTAL PEER REVIEW PROCEDURE

Dental reviews are conducted by the Dental Director according to measures discussed and approved by the QA/PI Committee according to a review calendar approved by the QA/PI Committee. Dental Peer Review will continue to serve as a vehicle to evaluate and improve the quality of dental health services at CHW. Monthly measures for dental are reviewed by audit of individual records or data gathered through electronic reports generated from the system. Currently, Dental Peer Review measures are reviewed monthly by the CHW Quality Assurance/Performance Improvement Committee, and feedback from these meetings is presented to all providers by the CHW Dental Director at their department's monthly in-service meeting. Dental Peer review includes the evaluation of each type of procedure offered at CHW.

CHW's Dental Director strictly monitors the peer review process to ensure that every provider:

- Has access to up-to-date evidence for the most common and impactful dental conditions managed in CHW clinics;
- Is aware in a timely fashion of changes in evidence, technology and dental materials and the application of these advances as it relates to patient care; and
- Actively engages with other providers and the dental team as a whole to provide exemplary evidence-based care for our patients.

ABOUT CLINICAL PRACTICE GUIDELINES

The QA/PI Committee recommends new and updated Clinical Practice Guidelines that provide an accepted, evidence based, cost-effective standard-of-care for clinical practice at the Coastal Health & Wellness, prioritizing common conditions or prevention. Variations from the standards are acceptable for documented medical reasons.

Recommendations are to be submitted in writing, by the Medical Director or Dental Director to the Coastal Health & Wellness Quality Assurance/Performance Improvement Committee for review and possible action.

Recommended Clinical Practice Guidelines should reflect the most frequently addressed health and medical problems at Coastal Health & Wellness, as well as those for which care is delegated to midlevel practitioners (APN/PA) with prescriptive authority.

GALVESTON COUNTY HEALTH DISTRICT COASTAL HEALTH & WELLNESS
QUALITY MANAGEMENT PROGRAM FOR DSHS AND HHS FUNDED PROGRAMS

Purpose
This guideline is designed to ensure clinic compliance with contract requirements of Department of State Health Services (DSHS), and Texas Health and Human Services (HHS) funded programs and to promote quality healthcare services for clinic patients.

Laws, Regulations and Policies:
All GCHD/CHW programs abide by the *Civil Rights Act*, including Title VI regarding limited English proficiency, *the Americans with Disabilities Act*, including Section 504 – the *Rehabilitation Act*. Policies pertinent to these laws and their applicability at Coastal Health & Wellness are posted on the employee extranet site. Employees are educated about these policies upon initial hire and annually thereafter.

Abortions: No federal or DSHS funds are used for abortion or for abortion-related activities. No abortion-related activities are conducted in the Coastal Health &Wellness Clinics. No members of the Coastal Health & Wellness Governing Board or administrative staff may sit on a board of an organization that performs or endorses abortions.

Child Abuse Screening, Documenting and Reporting Guidelines: Coastal Health & Wellness staff abides by the DSHS Child Abuse Screening, Documenting and Reporting Policy requirements and posts internal procedures on the employee extranet.

Human Trafficking: Coastal Health & Wellness employees are provided with annual training along with a written policy about human trafficking and a resources. The resources are also made available to employees via the extranet.

Domestic and Intimate Partner Violence: Coastal Health & Wellness employees are able to review and obtain written policy/guidelines on Domestic and Intimate Partner Violence on the employee extranet site. The employee extranet also offers staff with patient resources that are transcribed in both English and Spanish.

Cultural and Linguistic Competency: Coastal Health & Wellness receives annual training about requirements for overcoming barriers presented by cultural and linguistic differences, and about best practices when handling such situations.

Clinic Operations
Consent: A general consent for treatment is obtained through the Patient Services area before services are rendered. Patients sign a new general consent each time financial screening is completed. Informed consents are completed by clinical staff before an invasive procedure is performed.

Client Grievance: This procedure is covered in the Coastal Health and Wellness *Operational Policy*, approved annually by the Governing Board. Issues and complaints are addressed and resolved at the lowest possible level, in the most immediate and effective manner. Complaints that are unresolved by staff are addressed by clinic administrative staff, who report the complaint to the department supervisor/manager. The supervisor/manager will then investigate and resolve the complaint in a timely fashion. Those that are not resolved to the patient's satisfaction at the department/manager level are investigated and resolved by the Executive Director or his/her designee. The *Customer Service Policy* also discusses grievance procedures and is available on the employee extranet for review.

Release of Information: The procedures and forms that guide release of patient health information ("PHI") from Coastal Health &Wellness Clinic is posted on the employee extranet site. Fees for documented records are approved by the Governing Board annually and coincide with the fee schedule stipulated by the Texas Medical Association.

Privacy and Confidentiality: Policies that address privacy include the *Work Environment Policy*, *HIPAA Policy*, *Computer and Electronics Usage Policy* and *Employee Ethics and Standards of Conduct Policy*. These policies can be found on the employee extranet.

Format Order Within the Record: Electronic records have specific formats within the medical and dental electronic programs, including templates and summary documents, which are adhered to by default EHR settings.

Record Retention: CHW has a Record Management Program in compliance with Title 6, Subtitle C, Local Government Code (Local Government Records Act), which includes adoption of appropriate records control schedules issued by the Texas State Library and Archives Commission, as well as DSHS and HHS medical record retention schedules. Paper records are retained both on and off-site and are destroyed according to schedule, and only after receiving approval by the Records Management Coordinator and Chief Compliance Officer. Destruction, when appropriate, is accomplished by the outside contractor per contract guidelines.

Infectious Disease Control: Coastal Health & Wellness has an *Infection Control Policy* for all staff that outlines responsibilities for using standard precautions, employee health practices, reporting contagious diseases and how employees are required to handle blood borne pathogen exposures. An *Immunization Policy* also exists for employees and volunteers. The Infection Control Nurse, with assistance from department supervisors, is responsible for the development of procedures for specific components of the infection control program. Coastal Health and Wellness outlines infection control program goals annually, identifies high risk procedures and describes monitoring activities in the *Infection Control Policy*.

Personnel Policies Address:

Job descriptions containing required qualifications and licensure for all personnel including contracted positions: *Hiring Process, Performance Evaluation, Credentialing and Privileging Policy for Professional Staff.*

A written orientation plan for new staff: Orientation Plan for New Staff; Orientation Training PowerPoint presentations on the employee extranet site.

Staff development based on employee needs: Staff development activities are determined by department supervisors or by executive leadership (Executive Director, Medical and Dental Directors) through the process of developing staff in-service agendas on a monthly basis. Activities are determined by standards set forth by regulatory authorities (Joint Commission, Bureau of Primary Care, DSHS, HHS etc.), by results of quality assurance monitoring (chart audits, etc.), by clinical needs (training on new equipment, new processes), compliance with regulatory activities (HIPAA, fraud, etc.) and by organizational needs.

Annual job evaluations of personnel, to include observation of staff/client interactions during clinical, counseling and educational settings: *Performance Evaluation Policy.*

Staff who have contact with clients are appropriately identified (name badge): *Dress Code Policy*

The agency has current Protocols for Physician Assistants (PAs) and Advanced Practice Nurses (APNS), which have been reviewed, agreed upon and signed annually by the physician, PAs and APNs: Well Child Protocols

The agency has current SDOs which have been reviewed, agreed upon and signed annually by the physician that delineates who is authorized to perform specific functions: Medical Director's SDOs for MAs that administer medications

Quality Assurance / Performance Improvement

The agency has a written and implemented internal Performance Improvement Plan used to evaluate services, processes, and operations within the agency. All Coastal Health and Wellness administrative policies and procedures pertinent to federal, state or regulatory stipulations will be reviewed and approved by the Coastal Health & Wellness Quality Assurance/Performance Improvement Committee.

Evaluation of administrative policies and procedures and review of facilities: Approval of administrative policies is the responsibility of the Coastal Health and Wellness Governing Board when applicable and is otherwise tasked to the Galveston County Health District United Board of Health. Policies are reviewed and approved annually by the Board.

Facility Maintenance and Environmental Safety

Review of facilities is accomplished in accordance with the *Safety Manual and Risk Management Policy*, along with Joint Commission Environment of Care policies, *GCHD/CHW Safety Manual* and *Infection Control Plan*. Reports are provided monthly to the Coastal Health & Wellness Infection Control and Joint Commission Committee, and quarterly to the GB Quality Assurance Committee.

Evaluation of eligibility and billing functions: For Title V and other potential DSHS/HHS funded programs, eligibility and billing audits (at least 10 records) are completed at least twice yearly by staff, and results are reviewed by the CHW Quality Assurance/Performance Improvement Committee. When findings fall below 90% compliance per the review tool, quarterly eligibility and billing audits are implemented. On review and recommendation of the Quality Assurance/Performance Improvement Committee, more or less frequent audits may be resumed. It is the responsibility of the CHW Quality Assurance/Performance Improvement Committee to suggest improvement activities when compliance falls below 90%, or whenever such activities are deemed appropriate.

Clinical Record Reviews: For Title V and other potential DSHS/HHS funded programs, data is pulled from the EHR/EDR by the Medical Assistant IV/designated Dental provider and compiled by the Nursing Director and Dental Director. Results are then reviewed and discussed by the CHW Quality Assurance/Performance Improvement Committee. When audit findings demonstrate 90% or more compliance, audits are performed twice yearly with at least five Title V and five Texas Health Steps' medical visits sampled from each clinic site, along with five Title V Dental records sampled from each clinic site. The Title V and Texas Health Step audit tools are utilized for these reviews. When findings demonstrate less than 90% compliance, reviews are conducted quarterly on at least a total of ten Title V and ten Texas Health Steps records that can be from either clinic site. Records chosen for audit are from various providers and selected at random. It is the responsibility of the CHW Quality Assurance/Performance Improvement Committee to suggest improvement activities when compliance falls below 90% or whenever such activities are deemed appropriate. Corrective action may be taken as deemed appropriate.

Adverse Outcomes: Adverse outcomes are broadly defined in the Coastal Health and Wellness *Performance Improvement Plan*. Adverse outcomes include medication errors, delay in addressing lab results or other delay in diagnosis or treatment, or other adverse outcomes due to services provided.

Adverse outcomes are completely investigated by applicable supervisors as designated by the Executive Director or designee. Root causes are determined when possible, and improvement activities and follow up is completed.

Outcomes may be discussed with relevant personnel in the appropriate venue. A discussion of adverse outcomes, to include improvement activities and follow-up, will be addressed in the CHW Quality Assurance/Performance Improvement Committee meetings. If there are no adverse outcomes to report, the minutes will contain documentation of no adverse outcomes.

Client Satisfaction Surveys:–A Governing Board approved survey is given to patients to complete. Survey tallies are reported to the Coastal Health &Wellness Quality Assurance/Performance Improvement Committee on a monthly basis, and to the Governing Board on a quarterly basis.

Prepared for compliance with DSHS/HHS policies and approved by the Quality Assurance Committee on August 10, 2010. Revised per DSHS technical assistance September 3, 2010. Reviewed and approved September 21, 2011; June 14, 2012; July 23, 2013; August 20, 2014; October 21, 2015; December 07, 2017, May 22, 2018; May 18, 2019, July 29, 2020; October 6, 2021.

_____ _____

Philip Keiser, MD Date
Executive Director

_____ _____

Philip Keiser, MD Date
Coastal Health &Wellness Interim Medical Director

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Governing Board
October 2021
Item#15
Consider for Approval Re-Privileging Rights for Emily Bailey, MSW, LCSW, Submitted by Ann O'Connell

Samantha Robinson
Chair, Coastal Health & Wellness Governing Board

Coastal Health & Wellness
Serving, Healing, Caring
www.coastalhw.org

Philip Keiser, MD
Interim Executive Director

Date: October 28, 2021

To: CHW Governing Board

From: Philip Keiser, MD
Interim Medical Director P.K.

Re: Re-Privileging

Emily Bailey, MSW, LCSW is a Licensed Clinical Social Worker requesting counseling privileges. She has been employed part time for two years with Coastal Health and Wellness and will continue to see patients at both clinic sites. Ms. Bailey graduated from the University of Houston.

In addition, after review by Interim Medical Director, Philip Keiser, MD, of the privileging documents submitted by Emily Bailey, we are requesting re-privileging approval by the Governing Board.

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Governing Board
October 2021
Item#16
Consider for Approval Privileging Rights for UTMB Resident Neda Shaghaghi, DO, Submitted by Ann O'Connell

Samantha Robinson, BSN
Chair, Coastal Health & Wellness Governing Board

Coastal Health & Wellness
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www.coastalhw.org

Philip Keiser, MD
Interim Executive Director

Date: October 28, 2021

To: CHW Governing Board

From: Philip Keiser, MD P.K.
Interim Medical Director

Re: Privileging

After review of the standard credentialing documents by a Coastal Health and Wellness Human Resources representative for resident physician Neda Shaghaghi, DO, who will work at all times under the direct supervision of a Board-Certified faculty physician from UTMB, we are requesting credentialing approval by the Governing Board.

In addition, after review by Interim Medical Director, Philip Keiser, MD of the privileging documents submitted by Dr. Shaghaghi, we are requesting privileging approval by the Governing Board.

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Governing Board
October 2021
Item#17
Consider for Approval Privileging Rights for UTMB Resident Sara Hassan-Youssef, MD, Submitted by Ann O'Connell

Samantha Robinson, BSN
Chair, Coastal Health & Wellness Governing Board

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Philip Keiser, MD
Interim Executive Director

Date: October 28, 2021

To: CHW Governing Board

From: Philip Keiser, MD
Interim Medical Director

Re: Privileging

After review of the standard credentialing documents by a Coastal Health and Wellness Human Resources representative for resident physician Sara Hassan-Youssef, MD, who will work at all times under the direct supervision of a Board-Certified faculty physician from UTMB, we are requesting credentialing approval by the Governing Board.

In addition, after review by Interim Medical Director, Philip Keiser, MD, of the privileging documents submitted by Dr. Hassan-Youssef, we are requesting privileging approval by the Governing Board.

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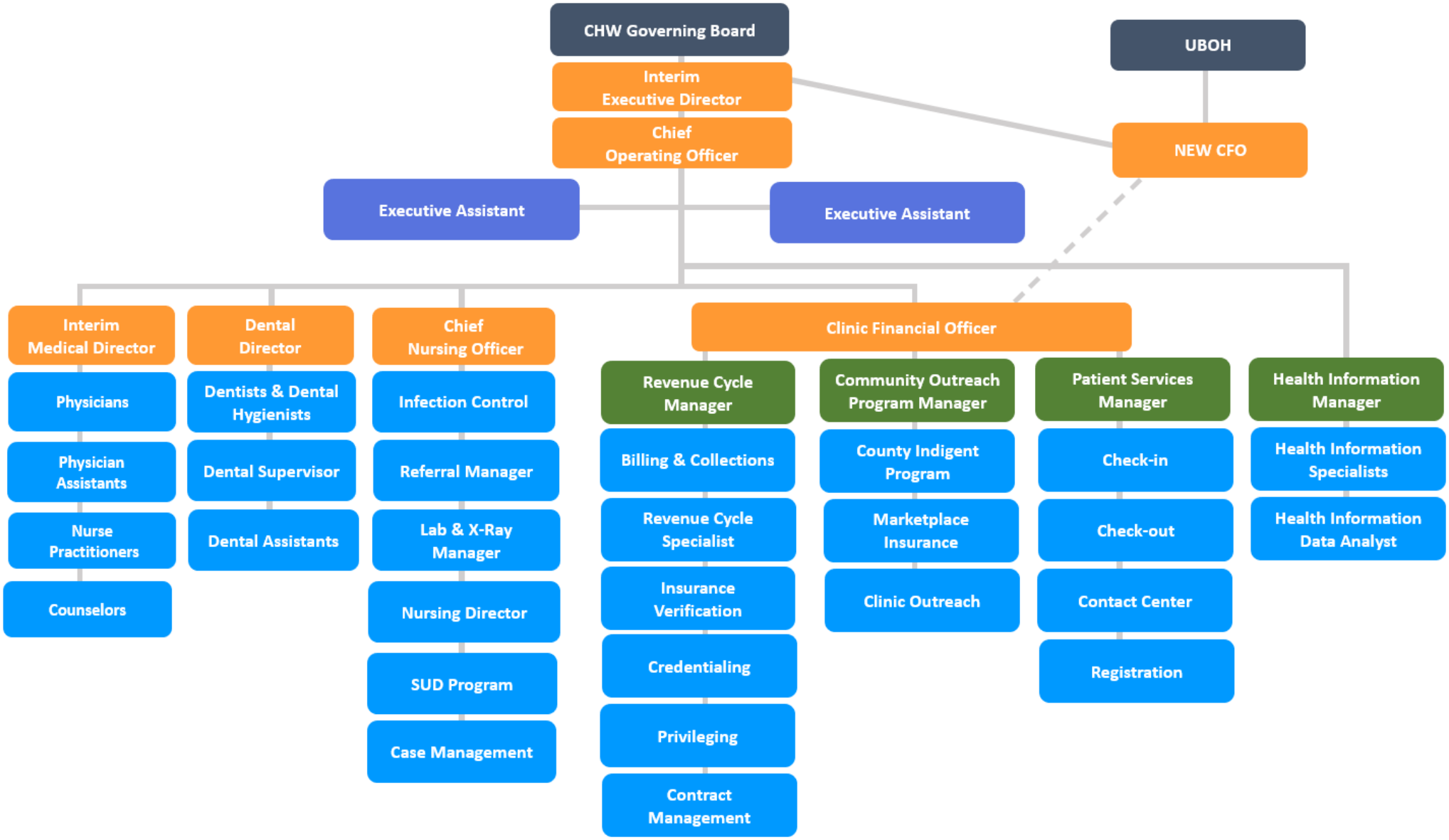
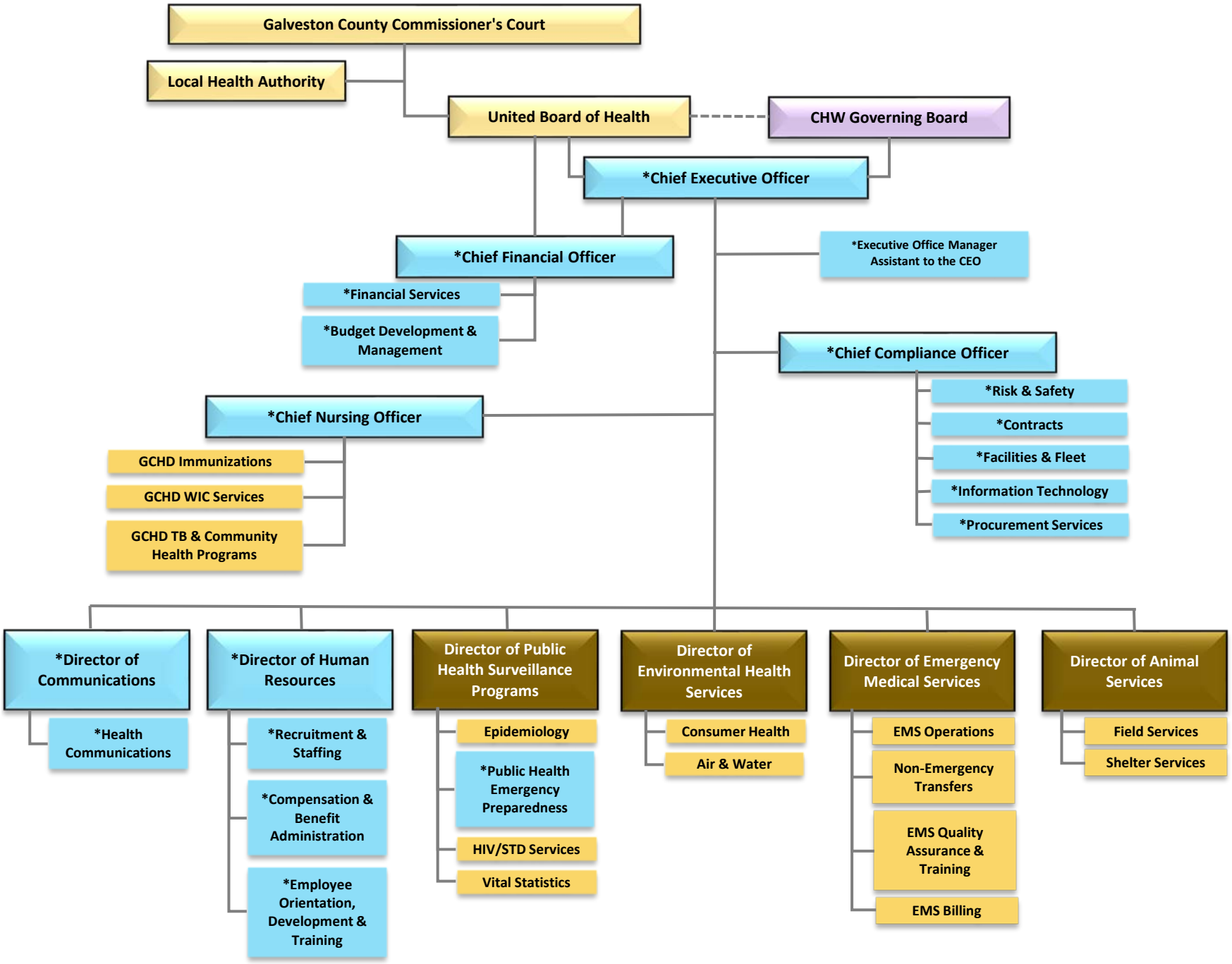
Governing Board
October 2021
Item#18
Review of Coastal Health & Wellness & United Board of Health Organizational Chart

Coastal Health & Wellness

Organizational Chart



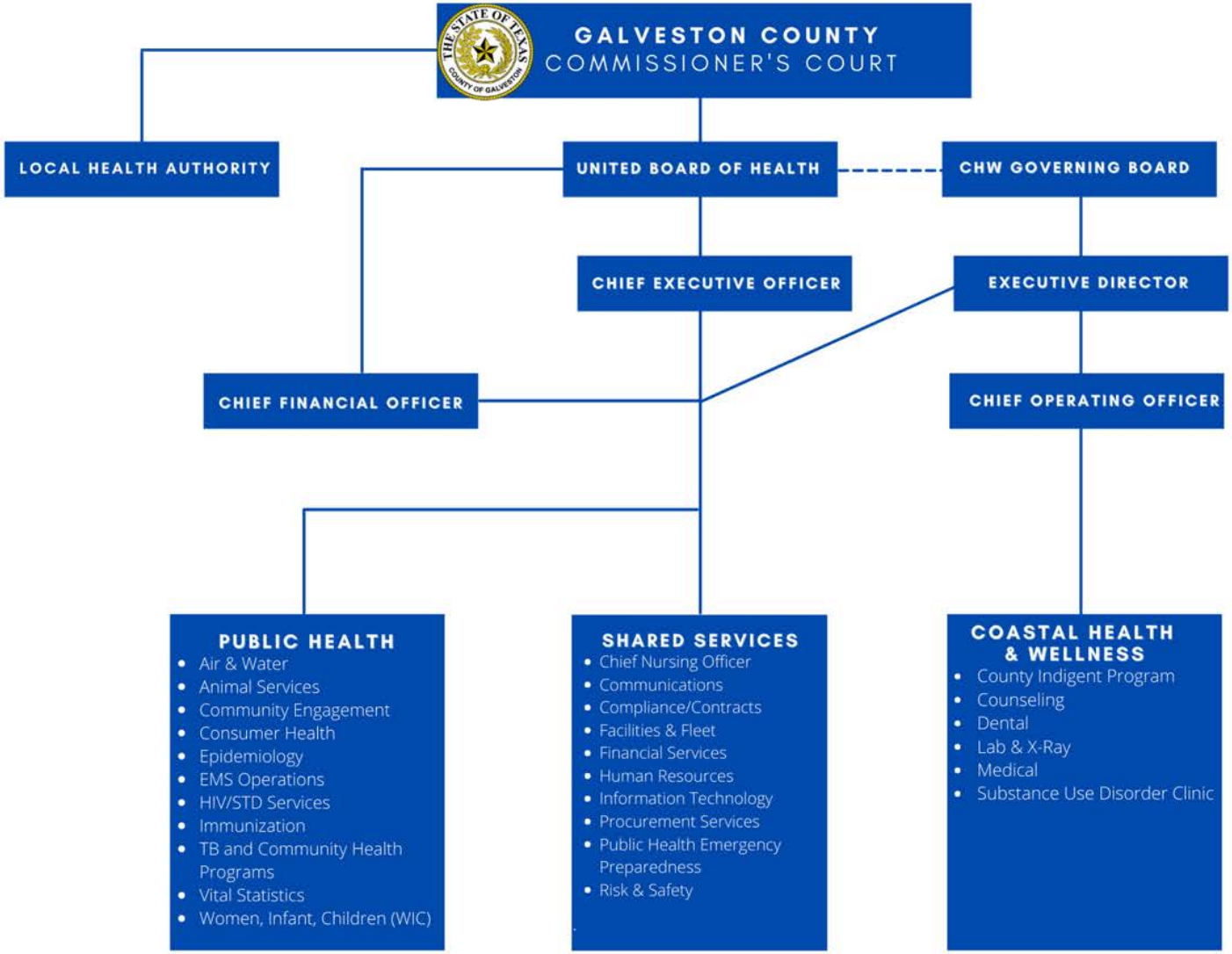
Galveston County Health District Organizational Chart



*Denotes shared service positions with Coastal Health & Wellness

GALVESTON COUNTY HEALTH DISTRICT

ORGANIZATIONAL CHART



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Governing Board
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Item#19

The Governing Board will enter into a closed meeting as permitted under the Section 551.074(b) of the Texas Government Code, Personnel Matters; specifically, to discuss the Executive Director

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Reconvene into Regularly Schedule Meeting

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Possible Action from Executive Session

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Comments from Board Members

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