MEMORANDUM

To: Board of Directors

Cc: Bill Boyles, Esquire
Aluino Ochoa, M.D.

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – April 3, 2023

Date: March 30, 2023

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

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

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

The Planning Committee meeting has been canceled.

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE
MONDAY, APRIL 3, 2023
12:00 P.M.
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the February 6, 2023 meeting.

II. Vision Statement

III. My Story

IV. Dashboard

V. Pandemic PI

VI. Other

VII. Executive Session (if necessary)

ADJOURNMENT

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE

A regular meeting of the Quality Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 6, 2023 in Conference Room 2/3/4/5, First Floor. The following members were present.

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

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

CALL TO ORDER

Dr. Galfo called the meeting to order at 12:02 p.m.

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **MOVED TO APPROVE THE DECEMBER 5, 2022 MINUTES OF THE QUALITY COMMITTEE, AS PRESENTED.**

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

MY STORY

Mr. Loftin shared the story of JoAnn and the importance of seeing the person, not just the symptoms they present to the provider. PMC's focus continues to be on person centered care.

QUALITY DASHBOARD REVIEW

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

PRESSURE INJURY PREVENTION

Mr. Loftin shared the meaning of Pressure Injury and discussed Pressure Injury Prevention. Mr. Graybill, Ms. Leathers and Ms. Foreman presented the Process Improvement Plan for Pressure Injury Prevention and the demonstrated outcomes PMC has experienced.

OTHER

There was no other business brought before the committee.

ADJOURNMENT

There being no further business, the Quality Committee meeting adjourned at 12:43 p.m.

Elizabeth Galfo, M.D.
Chairperson

PARRISH®
HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Board of Directors

Quality Committee Presentation

PARRISH HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Quality Agenda

April 3, 2023

1. Approval of Minutes
2. Vision Statement
3. My Story
4. Dashboard
5. Pandemic PI
6. Other
7. Executive Session

Quality Committee

Vision Statement

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

My Story

Dashboard

Performance dashboard

Description	Definition	Jan	Nov-Jan	Opportunity
Stroke	Stroke management compliance	94%	95%	Goal: 100%
Sepsis	Severe Sepsis and Septic Shock Management bundle compliance	43%	51%	Goal: 76%
Early Elective Delivery	Percentage of elective deliveries among mothers with uncomplicated pregnancies at 37 and 38 weeks gestation	0%	0%	Goal: 0%
HAI	Hospital onset MRSA bacteremia	0.00	0.00	Goal: 0
Readmission	All cause 30 day readmissions	9.69%	8.74%	Goal: 8.0%
Person Centered flow	Inpatient and outpatient emergency department throughput	644	490	164 *weighted goal

Post Pandemic
PI
(Performance Improvement)

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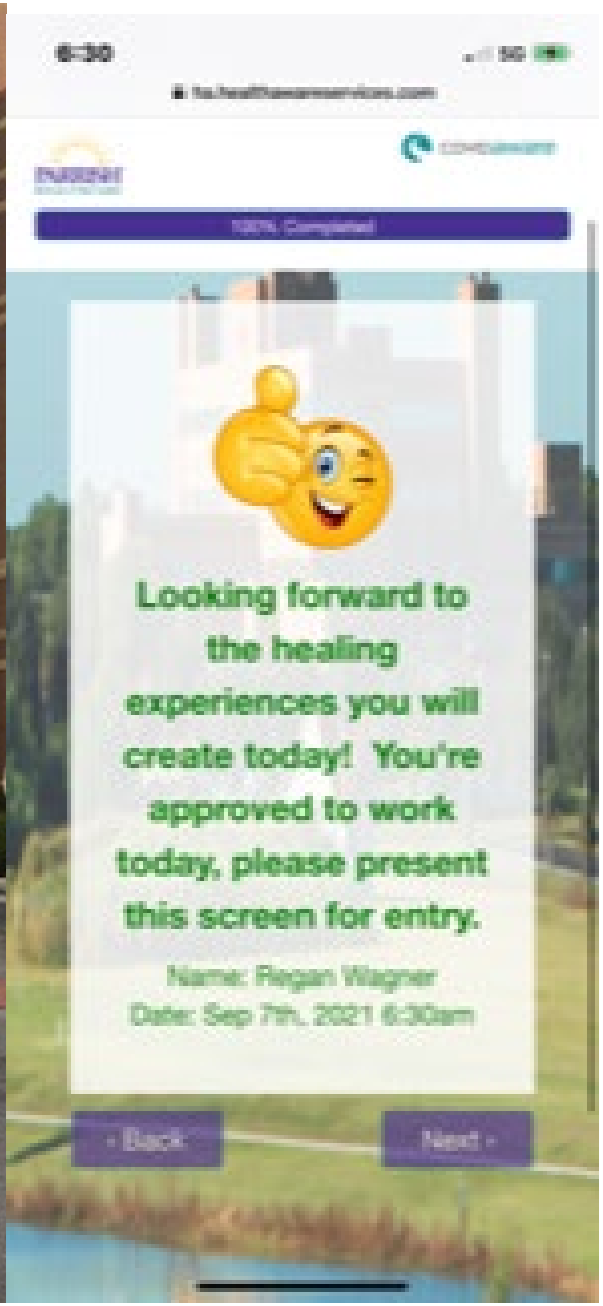
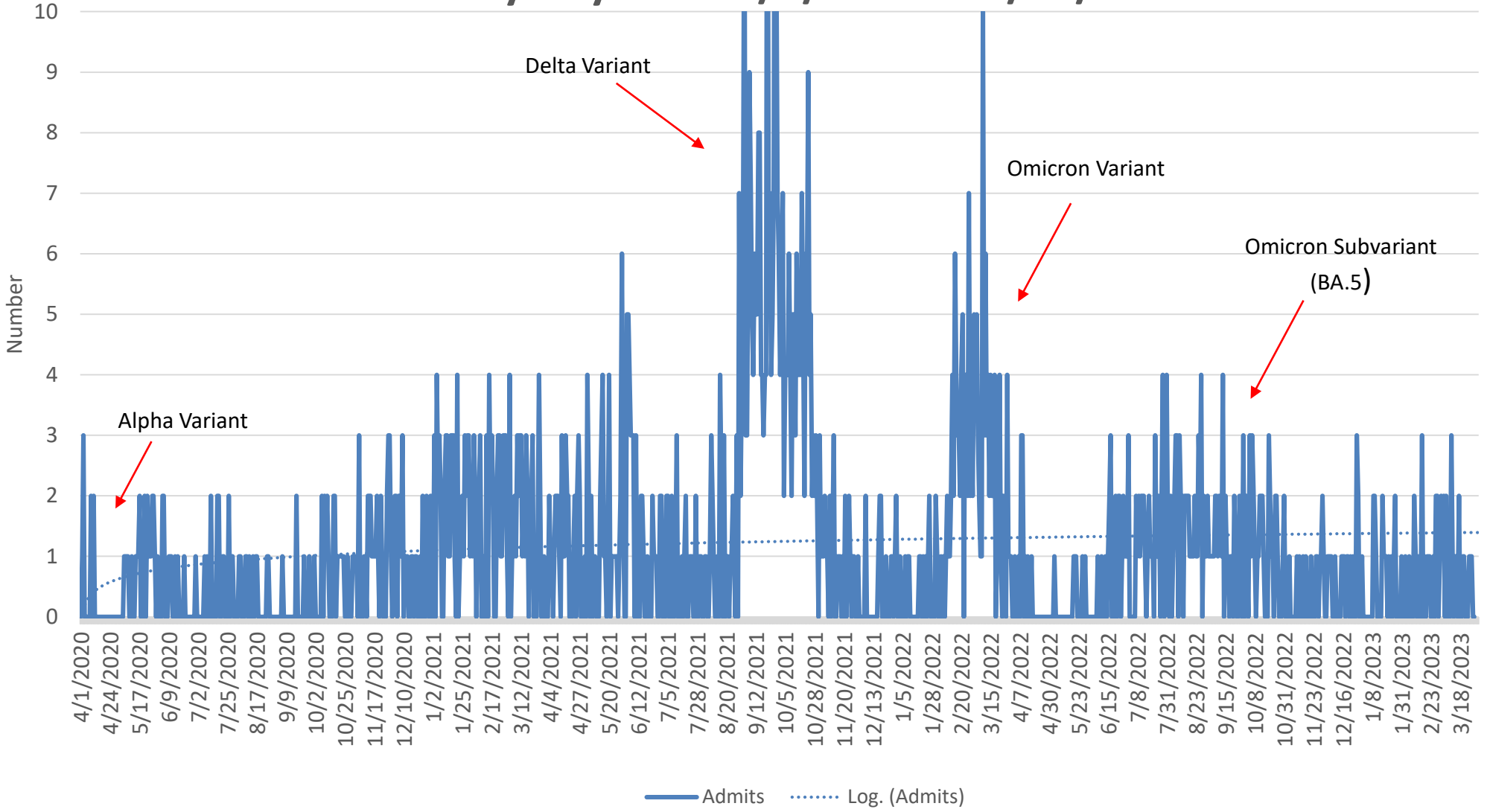
Pre-Pandemic Prep

2020

- January 29 – Document Review & Task team Planning
- February 6 –Deployment of updated screening questions and new isolation signs
- March 2 –Board Education and Care Partner education begins
- March 6 – Incident Command Set Up
- March 9 – Executive Order 2020-52 Declares State of Emergency


6:30
100% Completed
Looking forward to the healing experiences you will create today! You're approved to work today, please present this screen for entry.
Name: Regan Wagner
Date: Sep 7th, 2021 6:30am
‹ Back
Next ›

Admits by Day From 4/1/2020 to 3/31/2023



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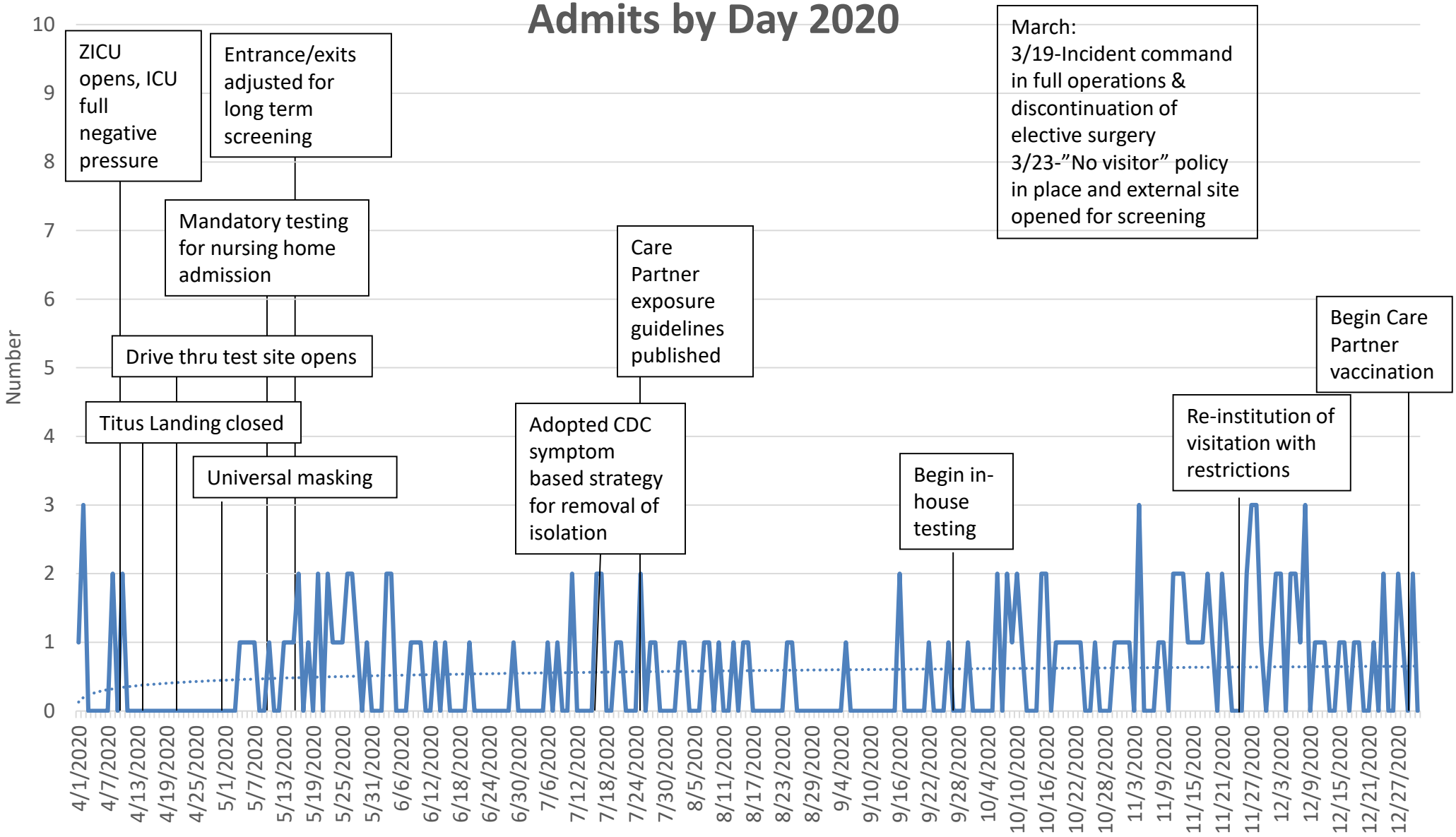
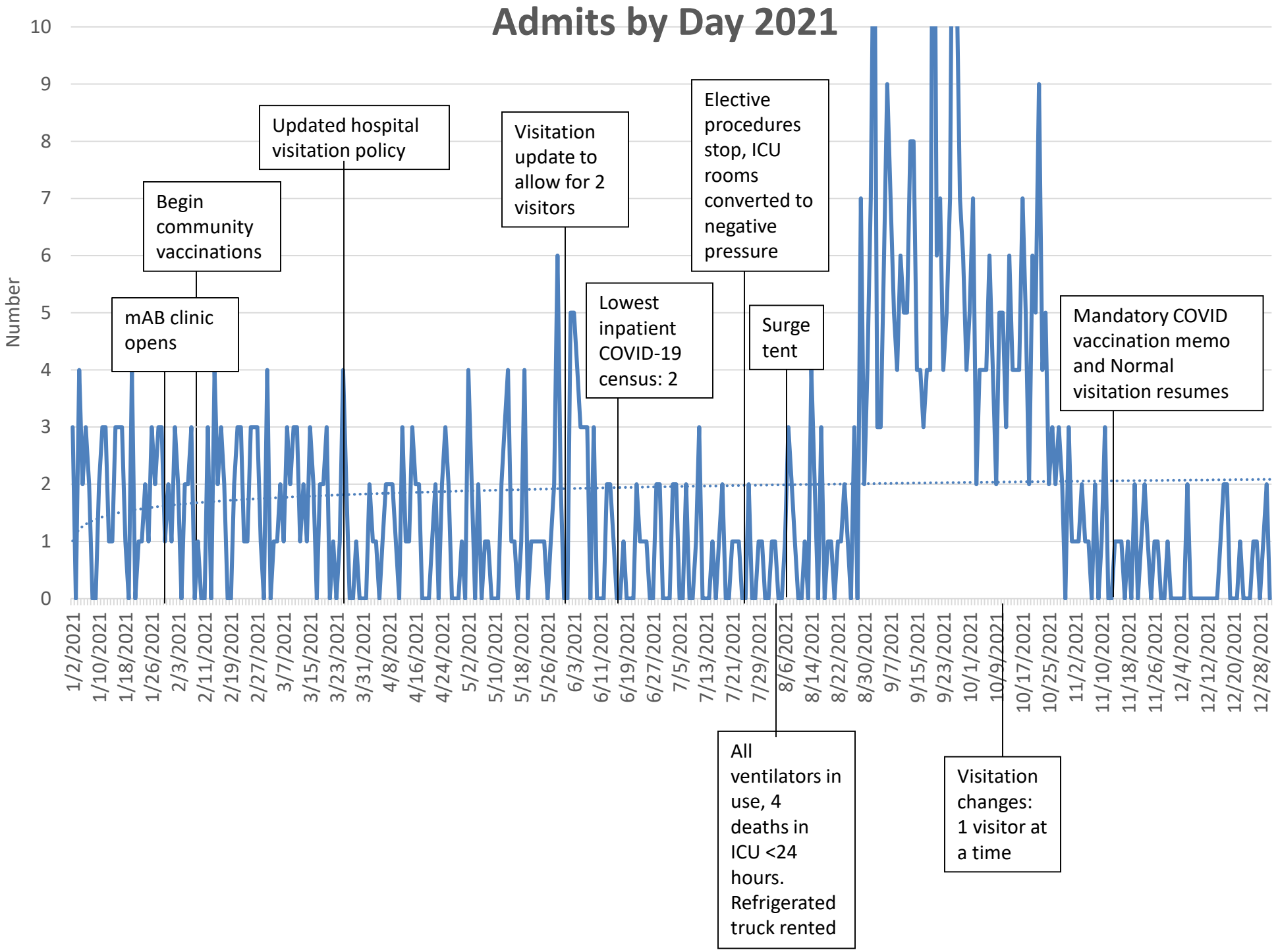
Admits by Day 2020




Admits by Day 2021
Number
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1/2/2021
1/10/2021
1/18/2021
1/26/2021
2/3/2021
2/11/2021
2/19/2021
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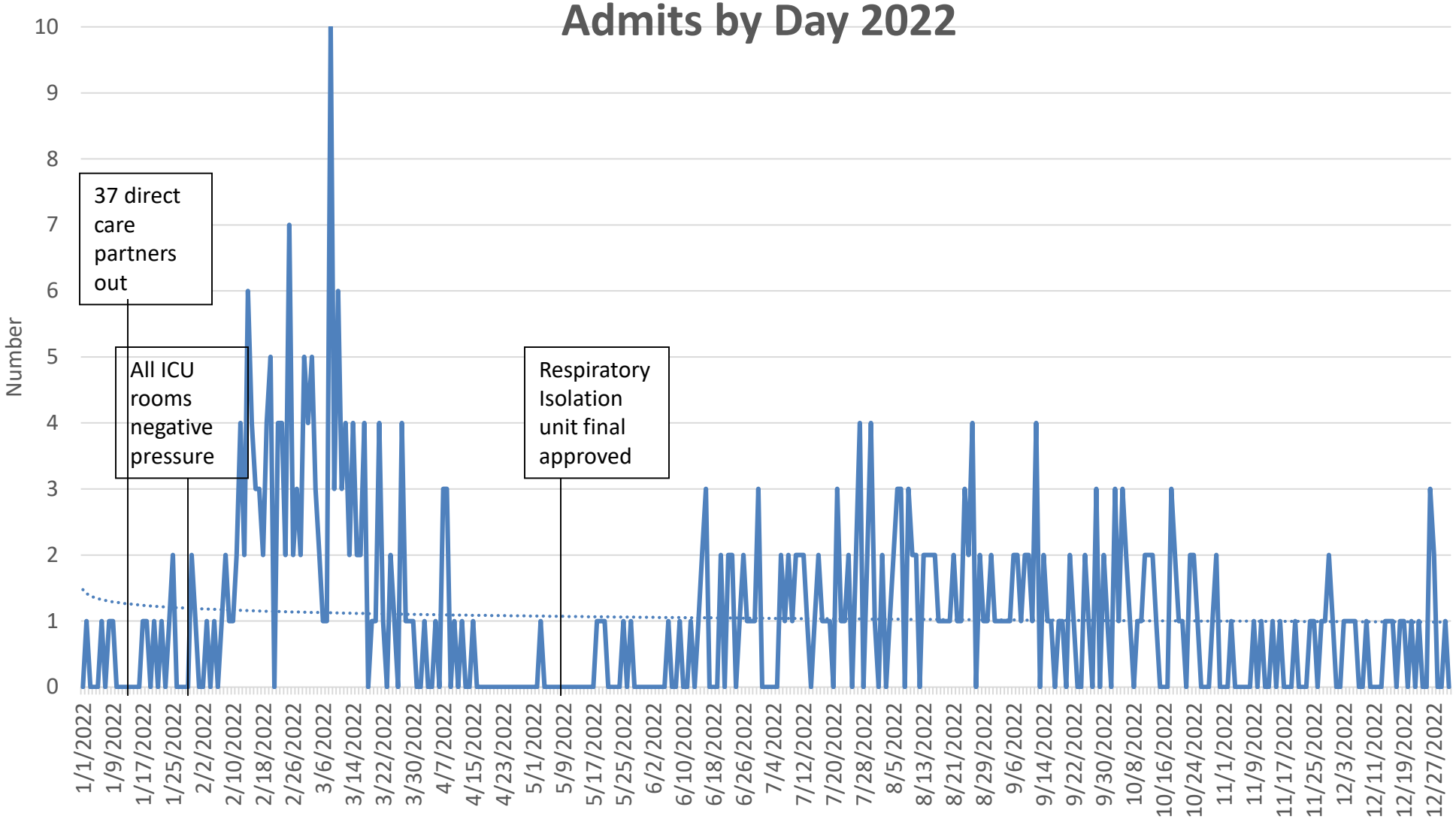
11/10/2021
11/18/2021
11/26/2021
12/4/2021
12/12/2021
12/20/2021
12/28/2021
Begin community vaccinations
mAB clinic opens
Updated hospital visitation policy
Visitation update to allow for 2 visitors
Lowest inpatient COVID-19 census: 2
Elective procedures stop, ICU rooms converted to negative pressure
Surge tent
All ventilators in use, 4 deaths in ICU <24 hours. Refrigerated truck rented
Visitation changes: 1 visitor at a time
Mandatory COVID vaccination memo and Normal visitation resumes

Admits by Day 2022



End of Public Health Emergency

PHE

- End 5/11/2023
- Requesting feedback from care partners

- Board Input:
- Community perception

Future Events

- Updated Emerging Pathogens Policy
- Decontamination team established and trained
- Visitor guidelines review - especially during end-of-life
- Interdisciplinary advisory committee to review “new” medications/devices/techniques/protocols during PHE (includes waiver)
- Remote work options
- Options for employee distancing to minimize cross contamination/exposure
- Establish vendor relationships for quicker delivery of necessary supplies/equipment, etc.
- etc

Questions?

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

FINANCE COMMITTEE MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT OPERATING
PARRISH MEDICAL CENTER
MONDAY, APRIL 3, 2023
FIRST FLOOR CONFERENCE ROOMS 2/3/4/5
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)

CALL TO ORDER

I. Approval of minutes.

Motion: To recommend approval of the February 6, 2023 meeting.

II. Financial Review – Mr. Eljaiek

III. Capital Purchase Request | Nuclear Medicine Camera Replacement – Mr. Loftin

Motion: To recommend to the Board of Directors to approve the purchase of the Replacement of one (1) Nuclear Medicine Camera System at a total cost not to exceed the amount of $381,660.

IV. Investment Fund Signatory Change for Scout Investments – Mr. Eljaiek

Motion: To recommend to the Board of Directors approve the Scout Investments Resolution to add Lester Eljaiek, CFO, as an authorized signer.

V. Emergency Purchase of Capital Equipment | Nihon Koden Sleep Acquiring System – Mr. Loftin

Executive Session (if necessary)

ADJOURNMENT

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

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NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
FINANCE COMMITTEE

A regular meeting of the Finance Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 6, 2023 in Conference Room 2/3/4/5, First Floor. The following members, representing a quorum, were present:

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

Member(s) Absent:
None

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

CALL TO ORDER

Mr. Retz called the meeting to order at 12:44 p.m.

CITY LIAISON

The Finance Committee recessed at 12:44 p.m. and the Executive Committee convened for the purpose of receiving the report from the City Manager. The Finance Committee resumed at 12:52 p.m.

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **MOVED THAT THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS APPROVE THE DECEMBER 5, 2022 MEETING MINUTES OF THE FINANCE COMMITTEE, AS PRESENTED.**

PUBLIC COMMENTS

There were no public comments.

FINANCIAL REVIEW

Mr. Eljaiek summarized the December financial statements of the North Brevard County Hospital District and the year to date financial performance of the Health System.

ANDERSON FINANCIALS

Mr. Anderson gave a brief update on the performance of the retirement plans of the District.

PENSION ACTUARIAL REPORT AS OF OCTOBER 1, 2022

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

ACTION TAKEN: MOTION TO RECOMMEND THE BOARD OF DIRECTORS ACCEPT THE PENSION PLAN ACTUARIAL VALUATION AS OF OCTOBER 1, 2022.

CAPITAL PURCHASE – HEMOCHRON SIGNATURE ELITE INSTRUMENT

Mr. Loftin summarized the memorandum contained in the agenda packet regarding the Hemochron Signature Elite Instrument and its benefits. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Specht and approved (11 ayes, 0 nays, 0 abstentions)

ACTION TAKEN: MOTION TO RECOMMEND THE BOARD OF DIRECTORS TO APPROVE THE PURCHASE OF TWO (2) HEMOCHRON SIGNATURE ELITE INSTRUMENTS FOR THE NEW EP CARDIOLOGY PROGRAM, AT A TOTAL COST OF $27,525.

CAPITAL BUDGET REQUEST – ENDOSCOPE/COLONOSCOPE INSTRUMENTATION AND EQUIPMENT LEASE BUYOUT

Mr. Loftin summarized the memorandum contained in the agenda packet relative to the capital budget request to buyout the lease of the Endoscope/Colonoscope instrumentation and equipment. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Specht and approved (11 ayes, 0 nays, 0 abstentions)

ACTION TAKEN: MOTION TO RECOMMEND THE BOARD OF DIRECTORS TO APPROVE THE BUYOUT OF THE ENDOSCOPE AND COLONOSCOPE INSTRUMENTATION AND EQUIPMENT AT PARRISH MEDICAL CENTER AT FAIR MARKET VALUE (FMV), AT A TOTAL COST NOT TO EXCEED THE AMOUNT OF $187,620.

DISPOSALS

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

ACTION TAKEN: **MOTION TO RECOMMEND THE BOARD OF DIRECTORS TO DECLARE THE EQUIPMENT LISTED IN THE REQUEST FOR DISPOSAL OF OBSOLETE OR SURPLUS PROPERTY AS SURPLUS AND OBSOLETE AND DISPOSE OF SAME IN ACCORDANCE WITH FS274.05 AND FS274.96.**

OTHER

There was no other business to come before the committee.

ADJOURNMENT

There being no further business to come before the committee, the Finance Committee meeting adjourned at 1:34 p.m.

Herman A. Cole, Jr.,
Chairman

MEMORANDUM

To: Finance Committee

From: Matthew F. Graybill, Executive Director of Surgical, Emergency and Critical Care Services

Subject: FY23 Capital Budget Request – Nuclear Medicine Camera System

Date: March 23, 2023

This request is for the budgeted capital replacement of one (1) nuclear medicine camera system at Parrish Medical Center (PMC).

A full assessment of our nuclear medicine camera fleet was performed in 2022. PMC currently owns three (3) nuclear medicine cameras. The first was purchased in 2004, the second in 2007 and the third in 2009. The average was monthly usage in FY 2022 was 152, or a total volume of 1,823. In 2021, exacerbated by the COVID-19 pandemic, PMC our overall volume was 1,890. In the first six (6) months of FY23, we have had five (5) reported requests of downtime for repairs and maintenance.

Based on age, usage, obsolescence and anticipated growth, at this time, we are requesting your approval to replace (1) additional nuclear medicine cameral system now. This year's request is the first year of a multi-year plan to replace our aging fleet.

Representatives from the Diagnostic Imaging, Cardiology, Clinical Engineering, Finance, Administration, and more have been involved in the analysis, evaluation, and the decision and we will continue their involvement as we work through this year's project and due diligence of a future year's needs.

Motion: To recommend to the Board of Directors to approve the purchase of the Replacement of one (1) Nuclear Medicine Camera System at a total cost not to exceed the amount of $381,660.

PARRISH MEDICAL CENTER
PARRISH HEALTHCARE

MEMORANDUM

TO: Finance Committee

FROM: Lester Eljaiek, CFO

SUBJECT: Investment Fund Signatory Change for Scout Investments

DATE: March 13, 2023

Attached is the resolution from Scout Investments requiring a Board resolution to have Lester Eljaiek added as an authorized signer for the investment fund. To make a change in authorized signers, Scout Investments requires a Board resolution. The following motion is recommended for approval.

Motion: ***To recommend the Board of Directors approve the Scout Investments Resolution to add Lester Eljaiek, as an authorized signer.***

If you should have any questions please do not hesitate to contact me at (321) 268-6100 or at lester.eljaiek@parrishmed.com

Attachment

North Brevard County Hospital District d/b/a Parrish Medical Center

SIGNERS' RESOLUTION, Dated: _____

The undersigned, having been authorized by a *Resolution of Board of Directors (attached is the said resolution and meeting minutes)* on _____, hereby authorizes the below signees with authority on behalf of North Brevard County Hospital District dba Parrish Medical Center to conduct business on behalf of the organization and take any actions deemed necessary or desirable to (a) provide instructions to Scout Investments, Inc. with respect to any transactions; and (b) to enter into and carry out any contracts, arrangements, or transactions in connection with any such accounts. As of _____, the following have been approved as signatories:

_____ (Signature)

Printed Name: George Mikitarian

Title: President and Chief Executive Officer

_____ (Signature)

Printed Name: Christopher Mc Alpine

Title: SVP Administration/CTO

_____ (Signature)

Printed Name: Lester Eljaiek

Title: SVP Finance, Chief Financial Officer

_____ (Signature)

Printed Name: _____

Title: _____

I, the undersigned (title) of (entity), hereby acknowledge that the above described signatories are true and correct.

Signed this 3 *day* of April *month*, 2023 *year*

CORPORATE SEAL:

_____ (Signature)

Printed Name: George Mikitarian

Title: President and Chief Executive Officer

PARRISH
MEDICAL CENTER

MEMORANDUM

To: Finance Committee

From: Kristina Weaver, Director of Care Transitions

Subject: Budget Request – Nihon Koden Sleep Acquiring System

Date: February 15th, 2023

This request is for the funding of a replacement of a sleep center acquiring system and data migration for record retention of sleep studies. This is an unexpected need for replacement of this system.

A sleep acquiring systems allows for the sleep center to perform in center sleep testing, treatment of sleep apnea and evaluation of daytime wakefulness disorders.

The current system was purchased in 2014 with an end of life in 2022. The sleep system was planned for replacement in 2024. Due to a new Microsoft security update, the current sleep software will be rendered inoperable earlier than expected (April 14, 2023).

This is a request to replace the current system with The Nihon Koden Sleep System and to migrate the studies on the old sleep system that are needed for record retention to a new compatible server.

A full assessment of this equipment and software was recently performed with considerations given to the equipment quality, service and cost. Representatives from all key stakeholder departments have been involved in the analysis, evaluation, and the decision.

Based on age, usage, obsolescence, and growth of the sleep center, we are requesting your approval to fund the sleep acquiring system with the replacement with the Nihon Koden Sleep System.

Motion: To recommend to the Board of Directors to approve the funding, acquisition and data migration for the Nihon Koden sleep system at a total cost not to exceed the amount of $100,872.

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Finance Committee

FYTD February 28, 2023 – Performance Dashboard

Indicator	FYTD 2023 Actual	FYTD 2023 Budget	FYTD 2022 Actual
IP Admissions	1,873	2,230	2,043
LOS	4.8	4.7	5.6
Surgical Cases	2,229	2,253	2,299
ED Visits	12,577	12,702	11,776
OP Volumes	34,495	32,977	32,385
Hospital Margin %	-0.20%	9.90%	2.95%
Investment Income $	$5.8 Million	$1.4 Million	-$1.5 Million

EXECUTIVE COMMITTEE

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

DRAFT AGENDA
EXECUTIVE COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, APRIL 3, 2023
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5
IMMEDIATELY FOLLOWING FINANCE COMMITTEE

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the February 6, 2023 meeting.

II. Reading of the Huddle

III. ED Update – Mr. Loftin

IV. Email from Dr. Deligdish

V. Attorney Report – Mr. Boyles

VI. Other

VII. Executive Session (if needed)

ADJOURNMENT

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NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EXECUTIVE COMMITTEE

A regular meeting of the Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 6, 2023 in Conference Room 2/3/4/5, First Floor. The following members were present:

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

Members Absent:
None

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

CALL TO ORDER

Mr. Retz called the meeting to order at 12:44 p.m.

CITY LIAISON

The Finance Committee suspended its agenda and the Executive Committee convened at 12:44 p.m. for the purpose of the report from the City Manager, Mr. Scott Larese. Mr. Larese provided the latest edition of Titusville Talking Points, and addressed questions from the committee. The Executive Committee recessed at 12:52 p.m. to resume the Finance Committee.

EVICTION UPDATE AND RULING

The Executive Committee reconvened at 1:44 p.m. to continue its agenda. At this time, Attorney's Joseph Zumpano, Leon Patricios and Nicolette Vilmos joined via phone to provide the committee with the Judge's ruling related to the OMNI eviction from the Cancer Center. Mr. Zumpano noted that the judge ordered OMNI's eviction from the premises for nonpayment of rent under the lease.
Ms. Vilmos indicated that if OMNI does not vacate, she will return to the judge for a writ of possession.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Dr. Galfo and approved (5 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED TO APPROVE THE DECEMBER 5, 2022 MEETING MINUTES OF THE EXECUTIVE COMMITTEE OF THE BOARD, AS PRESENTED.**

READING OF THE HUDDLE

Dr. Galfo read the Weekly Huddle.

ATTORNEY REPORT

Mr. Boyles indicated that he will give his report during the Board meeting.

ER UPDATE

Mr. Loftin updated the committee on upcoming changes surrounding the emergency department. Community complaints regarding PMC result from wait times and length of stay in the Emergency Department. To help resolve this, Space Coast Health Centers, Inc. will be relocating from 836 Century Medical Drive to within the hospital, in the location that is currently the Infusion Center. The Infusion Center will relocate to what was previously the Gift Shop, and Lab services will return to its previous location near the lab. This will allow for patients with non-life-threatening illnesses, when appropriate, to be referred to SCHC where they can be treated. Having the clinic onsite will also allow PMC to meet the criteria for the 340B program, which is a low-cost pharmacy program.
SCHC will remain a separate entity and will have a lease agreement for the space with the District.

OTHER

There was no other business to come before the committee.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 2:26 p.m.

Stan Retz, CPA
Chairman

PARRISH
MEDICAL CENTER
PARRISH HEALTHCARE

MEMORANDUM

TO: Board of Directors

FROM: George Mikitarian, President/CEO

SUBJECT: Email from Dr. Deligdish

DATE: March 29, 2023

Just a short note to inform you that Parrish Medical Center (PMC) will not be responding to yet another email by Dr. Deligdish.

For the record, neither Parrish Medical Center nor its representatives, shall respond to Dr. Deligdish's "off centered" email dated March 28, 2023, titled "Parrish Medical Center Finance and Quality Performance Since 2016." Dr. Deligdish (who as you are aware lost his privileges at PMC, lost his position at the University of Central Florida College of Medicine, was recently subject to a "Temporary No-Contact Order for Stalking or Nonconsensual Sexual Conduct," and whose company was recently evicted from our cancer care premises) has yet again made his false accusations. This time, Dr. Deligdish asks PMC to validate information in his email.

Importantly, and accurately, because PMC is suing Dr. Deligdish and OMNI Healthcare, Inc., on multiple counts relating to his and Omni's breach of financial obligations and fiduciary duties to PMC, NBMS, and/or PMG, PMC shall not be entertaining his antics in this email (which fails to even consider how his and Omni's own behavior affected the very issues he mischaracterizes in his email). As a reminder, the lawsuits are as follows:

North Brevard County Hospital District, d/b/a Parrish Medical Center, North Brevard Medical Support, Inc. v. Omni Healthcare, Inc., Case No. 05-2021-CA-035363 - PMC Plaintiff

Omni Healthcare, Inc. v. North Brevard County Hospital District, d/b/a Parrish Medical Center, North Brevard Medical Support, Inc., Case No. 05-2021-CA-039156 - PMC Counterclaim

Omni Healthcare, Inc. v. North Brevard County Hospital District, d/b/a Parrish Medical Center, North Brevard Medical Support, Inc., Case No. 05-2021-CA-032983 – NBMS Counterclaim

Further, for the record, please see attached Exhibit A, which expresses PMC's position as to monies owed by Dr. Deligdish's accountable care organization – America's MDE, LLC.

From: Craig Deligdish
To: Mikitarian, George; robert.jordan@genesisvii.com; hermancole@hotmail.com; william.boyles@gray-robinson.com; "Elizabeth Galfo"
Cc: Adam Bird; Mark Bobango; Loftin, Edwin; McAlpine, Chris; Sellers, Natalie
Subject: [EXTERNAL Sender] Parrish Medical Center Financial and Quality Performance Since 2016
Date: Tuesday, March 28, 2023 3:25:50 PM

Begin Original Message:

Can you please confirm that the information pulled from public documents and other sources is accurate.

While OMNI reduced financial losses attributable to the Parrish Medical Group from 2017-2021, Parrish increased its overall financial losses. The only two years out of the last seven that Parrish showed a "profit" was in 2020 and 2021, as a result of Cares Act monies and advances from Medicare. https://www.parrishhealthcare.com/about-us/financial-health/

During the last decade the community Parrish serves has grown significantly. Port Canaveral is now the busiest passenger port in the world and the private space program (SpaceX and Blue Origin) has created thousands of jobs. That said, Parrish Medical Center's daily census and annual admissions have been decreasing annually and is now nearly 30% less than it was seven years ago.

While Parrish's financial performance deteriorates annually so do its quality and safety scores. In 2019 Leapfrog, an independent organization which provides Safety Grades to Hospitals gave Parrish an grade of A. However in 2021 and 2022 Parrish received a grade of C for patient safety. Meanwhile CMS gave Parrish a one star grade in 2020 ranking them in the bottom 5% of all hospitals in the country. Currently Parrish has an overall rating of 2 stars by CMS and a 2 star rating by CMS patient surveys. Based on decreasing annual admissions, it would appear that the community is aware of the decreasing quality and safety and is looking for care elsewhere.

Parrish Admissions	Profit/(Loss)	Hospital	
2016	(4,255,236)	6,748	
2017	(2,674.910)	6,194	
2018	(5,688,000)	6,024	
2019	(8,189,000)	5,690	
2020	2,273,000	5,070	Pandemic relief funds $7.5 million
2021	5,714,000	5,389	Pandemic relief funds $6.5 million and advance Medicare payments
2022	(21,170,000)	4,820	

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March 17, 2023

Via Regular Mail and Certified Mail RRR

Craig K. Deligdish, M.D.
Mark Bobango
America's MDE, LLC
1344 S. Apollo Blvd., Suite 406
Melbourne, FL 32901

RE: Monies Owed by America's MDE, LLC ("MDE") to North Brevard Medical Support, Inc. ("NBMS")

Dear Dr. Deligdish and Mr. Bobango:

We represent NBMS.

We have determined that MDE is wrongly and contrary to law withholding a substantial amount of monies due our client. Specifically, for the period beginning April 1, 2021 and ending December 31, 2022, MDE has received payments from CMS which include funds related to medical services provided by NBMS physicians. However, MDE has failed to make any payments to NBMS as it is required to do under its contracts with CMS and also pursuant to Section 9(a) and Schedule 9(a) - 2 of that certain Participation Agreement (the "Participation Agreement," attached as ***Exhibit A***) dated October 23, 2020, between NBMS and Space Coast Independent Practice Association, LLC (which name has since changed to MDE, which is how we will refer to your company in the remainder of this letter). Further, in 2022, as a direct result of MDE's fabricated and fraudulent representation to the Centers for Medicare & Medicaid Services ("CMS") that NBMS was still a participant in MDE's Direct Contracting Entity (a "DCE"), CMS made payments to MDE for medical services rendered that should have been paid directly to NBMS. MDE has not paid those funds to NBMS or even acknowledged receipt.

On behalf of NBMS, we demand that MDE provide, within 30 days of MDE's receipt of this letter, an accounting to NBMS of all funds payable pursuant to the Participation Agreement, and to pay NBMS the full amount to which NBMS is entitled (based on a rate of 110% of the Medicare allowable amount). This accounting should also include a detailed list of claims that NBMS submitted and how CMS handled them. To make our position abundantly clear, we present below a chronology of the shameful history and details of the 2021 and 2022 relationship between MDE and our client, NBMS.

In 2020 MDE entered into an agreement with CMS to become part of a new CMS ACO program called the Global and Professional Direct Contracting Model ("GPDC Model"), beginning April 1, 2021. On October 23, 2020, NBMS and MDE entered into the Participation Agreement, whereby NBMS agreed to provide physician services in support of MDE's GPDC Direct Contracting Entity ("DCE") contract with CMS. The Participation Agreement went "live" on April 1, 2021.

The Participation Agreement utilized CMS' PCC Payment Model. Under that model, primary care services (called "PQEM Services") rendered by NBMS physicians ("Participant Providers") were not fully reimbursed by Medicare because the GPDC Model contemplated that Participant Providers would be subject to at least some reduction for 2021 and thereafter. NBMS elected a 100% reimbursement reduction for its Participant Providers beginning in April 2021.

Under the GPDC Model, Medicare was required to redirect to MDE the reduced payments arising from services (although in a formulaic capitated manner, and not per service), and then, as set forth above, pursuant to the Participation Agreement MDE was to pay NBMS for its PQEM Services rendered. Under Schedule 9(a)-2 of the Participation Agreement, payment by MDE to NBMS for Participant Providers was to be at the rate of 110% of the Medicare allowable fee for service rate. MDE has had the ability throughout the term of the Participation Agreement to calculate what it owes to NBMS, whether through data that CMS provided to MDE under the GPDC program, through data that was available to MDE under the Participation Agreement, or through data that was available to MDE because of the Management Services Agreement executed in February 2018 between NBMS and MDE's affiliate Omni Healthcare, Inc. (until such Management Services Agreement terminated in June 2021).

By letter dated September 10, 2021 (the "Termination Letter"), NBMS notified MDE that, pursuant to the Participation Agreement, NBMS would terminate from the DCE 90 days thereafter (i.e., as of December 9, 2021). The Termination Letter was sent to Mark Bobango of MDE by certified mail, return receipt requested. The signed receipt reflects that MDE received the Termination Letter on September 16, 2021. A copy of the Termination Letter and the signed receipt are attached as ***Exhibit B.***

September 16, 2021 was also the day that MDE was required to certify to CMS its list of Participant Providers for 2022. CMS gave DCEs until 8 PM to provide this information. Once MDE received the Termination Letter, it had sufficient time to remove NBMS' doctors from its provider list. Even if, *in arguendo*, the Termination Letter was not received soon enough on September 16 for MDE to report the termination of NBMS to CMS on that day, MDE nevertheless had ample time to later remove NBMS from MDE's Participant Provider list before the end of 2021. However, we surmise that, without including NBMS as a Participant Provider, MDE would not have had the requisite 5000 assigned Medicare beneficiary lives to allow it to be eligible to participate in the GPDC Program for 2022. In any event, it is abundantly clear that MDE made no attempt to remove NBMS from its Participant Provider list for 2022, even though it knew in mid-September 2021 that NBMS had resigned from the DCE effective December 9, 2021, and would therefore not be available to MDE in 2022.

After receiving the Termination Letter, MDE has never, right up to this moment, commented to NBMS or otherwise communicated with NBMS in any manner about it. MDE has never made any attempt to dissuade NBMS from terminating. MDE has never advised NBMS that, notwithstanding NBMS' termination, MDE did not report NBMS' termination to CMS, and thus CMS considered NBMS to be a Participant Provider of MDE for 2022. Throughout 2022 MDE did not share any performance or quality data with NBMS, nor did NBMS have any reason to ask for such data because NBMS did not consider it or its clinicians to be part of the DCE. The bottom line is that throughout 2022 MDE continued to wrongfully and purposefully collect monies owed to NBMS, but then flagrantly failed to disburse those monies to NBMS.

None of them were aware they were listed on the webpage. Further, we were advised by a CMS representative that CMS listed the NBMS primary care physicians throughout 2022 as part of MDE's Participant Provider list with CMS.

Notwithstanding the benefit that MDE has received from having NBMS' physicians as part of MDE's DCE (or from MDE's representing that to be the case), NBMS has not been paid anything for the claims for PQEM Services provided by its primary care physicians for the period with dates of service from April 1, 2021 through December 31, 2022. Based upon CMS' mistaken belief that NBMS was an MDE Participant Provider, CMS incorrectly made payments to MDE for claims that NBMS filed in 2022. MDE has never notified NBMS that MDE was receiving any payments due to NBMS for 2022. This is all despite the fact that, in 2021, NBMS was a participant in the DCE, and that **in 2022 there was no longer a contractual relationship between MDE and NBMS!**

Summarizing this convoluted and sordid mess, pursuant to the Participation Agreement, NBMS elected for all of the payments it would have otherwise received from Medicare for PQEM Services provided by its physicians for the period April – December 2021 to be paid to MDE. MDE contractually agreed to pay NBMS for such services in an amount equal to 110% of the Medicare allowable rate. MDE did not follow through on this commitment and has never paid anything to NBMS for those services. MDE then purposely failed to advise CMS that NBMS had contractually terminated the Participation Agreement, almost assuredly because doing so would have caused MDE to have insufficient patient beneficiaries assigned to it for 2022, which could have caused MDE to forfeit its status as a DCE. Then for the entirety of 2022 MDE continued to receive all payments for PQEM Services provided by NBMS physicians and, again, never paid anything to NBMS for those services.

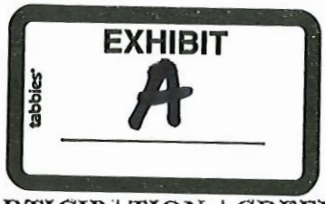
In light of the facts described above, we reiterate our demand that MDE provide the accounting described on page 1, within 30 days of MDE's receipt of this letter. In connection with this demand, NBMS reserves all of its rights to adjust or add to its claims, including the right to resort to all legal measures available to it to collect this debt or to assert any other charges or allegations that it may legally be able to pursue against MDE and any of its principals.

Sincerely,

NELSON MULLINS RILEY & SCARBOROUGH

Mike Segal

Mike Segal, Partner



PARTICIPATION AGREEMENT
[DC Participant Providers and Preferred Providers]

THIS PARTICIPATION AGREEMENT (this "Agreement") is made by and between **SPACE COAST INDEPENDENT PRACTICE ASSOCIATION, LLC**, a Florida limited liability company (the "Company"), and the DC Provider who has executed this Agreement on the signature page hereof.

RECITALS

A. The Company has or will file an application with the Centers for Medicare & Medicaid Services ("CMS") to participate in the direct contracting model ("DCM") established pursuant to Section 1115A of the Social Security Act (the "Act") as a direct contracting entity ("DCE").

B. As a DCE, the Company will, through DC Participant Providers and Preferred Providers, provide medical services for Medicare beneficiaries ("Beneficiaries") who are assigned by CMS to the Company under DCM.

C. The Company must contract with persons or entities that employ or engage DC Participant Providers and Preferred Providers as part of the DCM application process.

AGREEMENT

NOW, THEREFORE, the Company and DC Provider agree as follows:

1. **Definitions.**

(a) When used in this Agreement, the following terms shall have their respective meanings. The singular shall include the plural, the masculine gender shall include the feminine and vice versa, as the context requires.

(i) The "Act" has he meaning set forth in Recital A.

(ii) "Aligned Beneficiaries" means Beneficiaries who have been aligned to the Company by CMS for purposes of determining accountability of the cost of care and determining the Company's historical baseline expenditures to calculate performance year benchmarks.

(iii) "BAA" has the meaning set forth in Section 13.

(iv) "Beneficiary" has the meaning set forth in Recital B.

(v) "CEHRT" has the meaning set forth in Section 6(d).

(vi) "CMS" has the meaning set forth in Recital A.

(vii) "Company" has the meaning set forth in the introductory paragraph.

(viii) "DCE" has the meaning set forth in Recital A.

(ix) "DCM" has the meaning set forth in Recital A.

(x) "DC Participant Provider" means a core provider and supplier in a DCM to whom Beneficiaries are aligned with the Company as a DCE and are responsible for, among other things, reporting quality through the Company and committing to Beneficiary care improvement.

(xi) "DC Provider" means the person or entity executing this Agreement on behalf of DC Participant Providers and Preferred Providers it employs or contracts with to provide medical services to patients of such person or entity.

(xii) "Designated Providers" means DC Participant Providers and/or Preferred Providers that DC Provider employs or contracts with for the performance of medical services and who have agreed to participate in the DCM through DC Provider.

(xiii) "eligible clinician" has the meaning set forth in Section 6(d).

(xiv) "HIPAA" has the meaning set forth in Section 13.

(xv) "PQEM" shall have the meaning set forth in Section 9(a).

(xvi) "Preferred Provider" means a provider or supplier who contributes to DCE goals by extending and facilitating valuable care relationships beyond the DCE. Beneficiaries are not aligned to a DCE through a Preferred Provider.

(xvii) "TIN" has the meaning set forth in Section 3(a).

2. **Compliance with Model Requirements**. DC Provider agrees to participate in and comply with the requirements of the DCM program as promulgated by CMS from time to time. DC Provider shall ensure that its Designated Providers have agreed to comply with the DCM program requirements. DC Provider agrees that it has the obligation to care medically for the population of Aligned Beneficiaries assigned by CMS pursuant to the DCM in order to improve health care for individual Beneficiaries, improve health of the general population and lower the cost of medical care under the Medicare program. DC Provider will work cooperatively with other providers participating with the Company in the DCM to manage and coordinate care for Aligned Beneficiaries.

3. Requirements of DC Provider.

(a) The tax identification number ("TIN") of DC Provider and the names and National Provider Identifier numbers ("NPI") of Designated Providers of DC Provider are set forth on Schedule 3(a). DC Provider must notify the Company within ten (10) days after any change, addition or deletion of the information set forth on Schedule 3(a).

(b) DC Provider shall ensure that each of its Designated Providers make medically necessary coverage services available to Beneficiaries in accordance with applicable laws, regulations and guidance.

(c) DC Provider must permit its Aligned Beneficiaries to maintain the freedom to choose their providers and suppliers, including the ability to select a primary clinician on MyMedicare.gov, even if the provider or supplier is not a Designated Provider. Further, DC Provider must notify its Aligned Beneficiaries that they have the freedom to select their own primary clinician and to receive services from the providers and suppliers of their choice according to traditional Medicare rules.

(d) DC Provider must comply, and ensure that each Designated Provider complies, with the requirements of the DCM and all other applicable laws and regulations, including, but not limited to, (i) federal criminal law, (ii) the False Claims Act (31 U.S.C. §3729 et. seq.), (iii) Medicare Anti-Kickback Statute (42 U.S.C. §1320a-7b(b)), (iv) the Federal Civil Monetary Penalties Law (42 U.S.C. §1320a-7a) and (v) the Physicians Self-Referral Act (42 U.S.C. §1395nn).

4. Representations and Warranties of DC Provider. DC Provider hereby represents and warrants to the Company as follows:

(a) DC Provider is an organization which has been duly organized, validly existing and in good standing under the laws of the State of Florida.

(b) DC Provider has full power and authority to enter into and perform this Agreement and the transactions contemplated hereby have been duly authorized in accordance with the organizational documents of DC Provider. Neither the execution of this Agreement or performance of the transactions contemplated by this Agreement will conflict with or result in a breach of any of the terms, conditions or provisions of the organizational documents of DC Provider, any contract or agreement between DC Provider and any third party, or any statute or administrative regulation, or any order, writ, injunction, judgment or decree of any government authority.

(c) DC Provider possesses all necessary authority and power to cause its Designated Providers to provide the services required to be performed by them pursuant to the terms of this Agreement.

5. **DC Provider TIN**. DC Participant Providers may not use the same TIN for participation in an Accountable Care Organization under the Medicare Shared Savings Program during the term of this Agreement. DC Participant Providers may not simultaneously participate in multiple direct contracting entities in the DCM. These restrictions do not apply to Preferred Providers. DC Participant Providers may not simultaneously participate in direct contracting or another model tested or expanded under Section 1115A of the Act that involves shared savings or any other Medicare initiative that involves shared savings unless otherwise instructed by CMS.

6. **Participation Standards**.

(a) DC Provider must inform Aligned Beneficiaries what that alignment means for the Aligned Beneficiary in terms of the care that they will receive and how to opt-out of CMS sharing certain data about them with the Company as a DCE.

(b) DC Provider must communicate the details of its benefit enhancements (where applicable) to their Aligned Beneficiaries. The Company will furnish written materials for DC Provider to describe to Aligned Beneficiaries benefit enhancements.

(c) The DC Participant Providers of DC Provider are responsible for recording quality measures through the Company and committing to Beneficiary care improvement. DC Participant Providers shall adhere to a quality assurance and improvement program and evidence-based clinical guidelines of CMS as such guidelines exist and are developed by CMS from time to time. Preferred Providers are not responsible for reporting quality measures through the Company. DC Provider and its DC Participant Providers will be subject to Medicare risk scoring which will review the risk coding accuracy of DC Participant Providers. DC Provider agrees to cause its DC Participant Providers to update coding practices in accordance with the results of Medicare risk scoring and to file all future claims in accordance therewith. DC Provider acknowledges and understands that the compensation provided DC Participant Providers in Section 9 it has been determined on the basis that DC Participant Providers will continually increase coding accuracy.

(d) DC Provider shall ensure that its DC Participant Providers are eligible clinicians and use certified electronic health record technology ("CEHRT") to document and communicate clinical care to their patients or other health care providers. The term "eligible clinician" and "CEHRT" are defined at 42 C.F.R. §415.1305. Preferred Providers are not subject to this requirement. DC Provider and its DC Participant Providers shall also comply with all applicable requirements, if adopted, in any final rule on the Interoperability and Patient Access for MA organization and Medicaid Managed Care Plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, Issuers of Qualified Health Plans in the federal-facilitated exchanges and health care providers (https:\\www.federalregister.gov\documents\2019\03\04\2019-02200\Medicare-and-Medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and).

(e) Each Designated Provider will maintain or otherwise become a member in good standing, with unrestricted medical staff privileges, on the medical staff of an acute care hospital or have in force an agreement or arrangement with another physician to provide hospital coverage for the Designated Provider.

(f) Each Designated Provider will provide services to Aligned Beneficiaries on an as-needed basis within the scope of the licensing, training, experience and qualifications of the Designated Provider and consistent with accepted standards of medical practice and the terms and conditions of this Agreement. Each Designated Provider will devote sufficient time, attention and energy necessary for the competent and effective performance of its duties to Aligned Beneficiaries. Each Designated Provider will cooperate with the Company's policies and procedures as to the coordination of the health care of Aligned Beneficiaries by clinically integrating with other providers in the DCM and other components in an Aligned Beneficiary's health delivery system.

(g) Designated Providers will be responsible for responding to emergent needs of Aligned Beneficiaries twenty-four (24) hours per day, seven days per week, including holidays. Unless otherwise approved by the Company, if a Designated Provider is unable to provide coverage for after hour services, he or she will arrange for another equivalently licensed Designated Provider to provide such coverage.

(h) As required by applicable federal, state and local laws, regulations and ordinances, no Designated Provider will discriminate in the treatment of an Aligned Beneficiary based upon physical or medical disability, medical condition, race, color, national origin, ancestry, religion, sex, marital status, veteran status, sexual orientation or age. Designated Providers will provide services to Aligned Beneficiaries in the same manner, in accordance with the same standards and within the same availability, as to non-Aligned Beneficiaries.

(i) Each Designated Provider will determine the method, details and means of performing medical services under this Agreement in accordance with the Company's utilization management, quality assurance and process approval programs. Subject to the terms and conditions of this Agreement, each Designated Provider will be entitled to all usual and customary procedures relative to his or her practice.

(j) Each Designated Provider will cooperate in providing for effective implementation of the provisions of all of the Company's policies and procedures relating to coordination of care, including working cooperatively with other providers in the Company, as well as other components in an Aligned Beneficiary's health care delivery system, to assist in the effective management of the full continuum of Aligned Beneficiary's care, preventive services to hospital-based and nursing home care.

(k) Each Designated Provider will carry out the following activities with respect to health care services provided to Aligned Beneficiaries:

(i) posting notice, provided by the Company in the Designated Provider's office (s) and/or facility informing Aligned Beneficiaries of the Designated Provider's participation in the DCE through the Company;

(ii) providing written notice to Aligned Beneficiaries that the Aligned Beneficiary's health information may be shared with other medical providers and suppliers and that the Aligned Beneficiary has the option to opt-out of such data sharing;

(iii) implementing data systems that are compatible with the data systems used by the Company for collecting and reporting data to the CMS;

(iv) meeting applicable quality performance or reporting requirements (if applicable) in each of the following four (4) domains:

(A) patient/caregiver experience;

(B) care coordination/patient safety;

(C) preventive health; and

(D) at-risk population/frail elderly health.

(v) using only CMS-approved marketing materials for marketing the Company's services to Aligned Beneficiaries;

(vi) complying with the Company's policies and procedures for Aligned Beneficiaries to access their medical records; and

(vii) taking all reasonable actions to transition to an electronic medical records system compatible with the information technology system that will be used by the Company.

(l) DC Provider and each of its Designated Providers will keep confidential all financial, operating, proprietary business information related to the Company that is not otherwise public information.

(m) DC Provider and each of its Designated Providers will comply with the Company's conflict of interest policy.

(n) In the event DC Provider or any of its DC Participant Providers fails to comply with the requirements of the DCM, the Company may take remedial action against DC Provider, including the imposition of a corrective action plan and termination of this Agreement. DC Provider must take similar remedial action against its DC Participant Providers for failure to comply with such requirements.

7. **Professional Requirements.**

(a) At all times during the term of this Agreement, each Designated Provider will:

(i) maintain an unrestricted current license to practice medicine in the State of Florida;

(ii) be enrolled in the Medicare program under Title XVII of the Social Security Act or other applicable state law pertaining to Title XIX of the Social Security Act;

(iii) comply with and be bound by all of the terms and conditions of the Company's clinical integration program as it may be implemented by the Company through its policies and procedures from time to time; and

(iv) notify the Company promptly concerning any denial, modification, reduction, restriction, suspension or termination (either voluntary or involuntary), of a Designated Provider's privileges at any hospital or other facility;

(b) DC Provider will notify the Company promptly of:

(i) any modification, restriction, suspension or revocation of a Designated Provider's license;

(ii) modification restriction, suspension or revocation of a Designated Provider's authorization to prescribe or to administer controlled substances;

(iii) imposition of sanctions against a Designated Provider or DC Provider under the Medicare program or any other governmental health care program;

(iv) other professional disciplinary action or criminal professional liability action of any kind against a Designated Provider or DC Provider which is either initiated, in progress or completed as of the commencement of this Agreement or at any time during the term of this Agreement.

(c) DC Provider will secure, maintain or cause each Designated Provider to secure and maintain, at their expense, throughout the term of this Agreement, professional liability insurance in the minimum amount of not less than the minimum amount required by state law. DC Provider will use its best efforts to obligate its insurance carrier to provide written notices to the Company at least thirty (30) days prior to any cancellation or amendment of a Designated Provider's policy. DC Provider will notify the Company promptly whenever a Designated Provider receives any claim or notice of intent to commence legal action alleging professional negligence against the Designated Provider with respect to treatment or non-treatment of any Aligned Beneficiary, and if a final judgement is rendered against a Designated Provider in any such legal action. If a Designated Provider's professional liability policy is terminated and such policy is provided on a claims made basis, DC Provider or the Designated Provider will immediately purchase at their expense "tail" coverage that meets all the requirements of this Section 7 as necessary to cover any services rendered during the term of this Agreement. The obligations of this Section 7 will survive termination of this Agreement.

8. **Medical Records**.

(a) DC Provider will maintain all usual and customary records, in accordance with all applicable federal and statutory and regulatory requirements. DC Provider will ensure that each Aligned Beneficiary's entire medical record is available for, and properly updated during, each patient encounter, and all that all entries are dated and signed legibly.

(b) CMS has very broad rights to audit the Company and DC Provider. DC Provider shall maintain books, contracts, records, documents and other evidence of participation in the Company for a period of ten (10) years from the date DC Provider's contractual relationship with the Company has terminated or from the date of completion of any audit, evaluation, or inspection, whichever is later, unless:

(i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the Company at least thirty (30) days before the normal disposition date; or

(ii) There has been a termination, dispute, or allegation of fraud or similar fault against the Company, any of its Designated Providers, or any other individuals or entities performing functions or services related to Company activities, in which case the Company must retain records for an additional six (6) years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

(c) DC Provider will indemnify, defend and hold harmless the Company from and against any and all claims, damages, causes of action, sots or expenses, including attorneys' fees, to the extent proximately caused by DC Provider's failure to comply with Section 8(b) above.

(d) Except as otherwise required by applicable law or by this Agreement, DC Provider will keep confidential, and take the necessary precautions to prevent the unauthorized disclosure of, any and all records required to be prepared or maintained by DC Provider under this Agreement.

9. **Compensation**.

(a) DC Participant Providers providing primary care services described on the list of primary care qualified evaluation and management ("PQEM") services attached hereto as Schedule 9(a)-1 shall be compensated for PQEM services in accordance with Schedule 9(a)-2. Preferred Providers who are non-primary care specialists as described on Schedule 9(a)-3 and provide PQEM services shall be compensated for PQEM services in accordance with Schedule 9(b). DC Participant Providers shall bill the Medicare program through DC Provider for PQEM services, but will not receive reimbursement from the Medicare program. The Medicare program will provide an explanation of benefits for services showing zero payment. DC Provider shall provide the Company copies of all billings for PQEM services simultaneously with the submission to the Medicare program. The Company's obligation to pay DC Provider for PQEM services provided by DC Participant Providers is subject to receipt of such copies.

(b) Services other than PQEM services performed by DC Participant Providers and all services provided by Preferred Providers shall be subject to a percentage reduction in the amount of the fee for service claims made to the Medicare program as set forth on Schedule 9(b). DC Provider shall submit billings to the Medicare program at Medicare allowable fee for service rates and provide copies thereof to the Company. The Medicare program will reduce reimbursement to DC Provider by the reduction amounts set forth on Schedule 9(b). The reduction in reimbursement amounts is paid to the Company by CMS and retained by the Company for the management of the DCE.

10. Company Responsibilities.

(a) The Company will maintain an adequate number and types of providers in order to maintain appropriate access to all covered services for Aligned Beneficiaries and have at all times at least five thousand (5,000) Aligned Beneficiaries.

(b) The Company will maintain a web-based directory that includes appropriate and sufficient information so that Aligned Beneficiaries and prospective patients can choose providers participating in the DCM with the Company.

(c) The Company will adopt and periodically review and update a clinical utilization plan which includes (i) a process for verifying Beneficiary eligibility and benefits, (ii) management information system able to track utilization and (iii) a process to conduct on-going monitoring of services rendered and the cost for such services as compared to the revenues received for such services.

(d) The Company will provide DC Provider with written policies and procedures, and appropriate data, to allow Designated Providers to systematically identify Aligned Beneficiaries who are eligible for (i) wellness or preventive care services, (ii) chronic disease management programs and (iii) complex case management.

(e) The Company will provide DC Provider written policies and procedures to provide support to Designated Providers in connection with proactively tracking, identifying and managing patient care needs in connection with the treatment of chronic diseases through the use of patient registries.

(f) The Company will provide DC Provider with written policies and procedures that state the Company's commitment to treating Aligned Beneficiaries in a manner that respects their rights and privacy, does not in any manner restrict dialogue between Aligned Beneficiaries and Designated Providers regarding information of any available treatment options, and facilitates a method for Aligned Beneficiaries to file complaints and grievances about the Company or any Designated Provider.

11. **Data Requirements.**

(a) The Company must submit data on quality measures according to methods established by CMS, and must report data for each quality measure accurately and timely. Thus, it is essential that the DC Provider submit all patient clinical data to the Company as soon as practicable following the date of service, but in all cases within thirty (30) days of the date of service. The Company will collect such patient clinical data from DC Provider's current practice management information system, electronic medical record, or any other mechanism utilized to collect and maintain patient data. DC Provider authorizes the Company to act on their behalf to collect clinical data about the Aligned Beneficiaries from other providers and other sources for purposes of developing a data warehouse and repository, exchanging clinical data between and among DC Provider and other providers, and supporting the other clinical integration, quality management, quality improvement, process improvement, utilization management, and medical management activities and programs of the Company. As required by HIPAA, the privacy and security of all protected health information will be protected through the BAA.

(b) DC Provider will make available all Aligned Beneficiary health data in a format that is consistent with industry accepted standards and compatible with the Company's management information systems. The Company plans to develop a data warehouse and repository, which will maintain and make all health data about the Aligned Beneficiaries available to DC Provider and which may contain information, including, but not limited to, recent diagnoses, inpatient admissions, medication histories, laboratory orders and results, radiology orders and results and compliance with evidence-based clinical protocols. Such access will be subject to procedures established by the Company related to compliance with medical information privacy and security laws. Any claims data remaining in the data warehouse and repository upon termination of this Agreement will be retained by the Company to support on-going trend analyses, for audit and compliance purposes, or any other purposes as may be permitted by law, but any retention will be in compliance with HIPAA, including de-identifying any health data as may be required or appropriate.

(c) DC Provider will permit the Company to access remotely or on-site, on a read-only basis, their electronic medical record, practice management information system or any mechanism utilized to collect and maintain patient data. To ensure that a comprehensive set of data for each Aligned Beneficiary is collected, the data set will include patient data collected from Aligned Beneficiaries for whom Designated Providers have provided medical services for up to three (3) years prior to the execution of this Agreement through the termination of this Agreement.

(d) The data will be collected for purposes of obtaining information about health care services provided to such Aligned Beneficiaries by Designated Providers, so that Company can readily obtain, from governmental entities, quality improvement organizations, health care data collection organizations, malpractice insurers, health plans, laboratory providers, diagnostic imaging providers, pharmacies, pharmacy benefit managers, hospitals, ambulatory surgery centers or other entities relating to (i) patient clinical encounters; (ii) patient pharmaceutical use; (iii) Designated Providers' adherence to quality standards; (iv) DC Participating Providers' attainment of awards, recognition, or special status based on quality measures; (v) quality management and improvement;

(vi) utilization management; (vii) patient satisfaction; (viii) health education for patients; (ix) case management; and (x) disease management.

(e) If DC Provider maintains Beneficiary health data in an electronic format that will permit the direct exchange of Aligned Beneficiary health data with the Company's data warehouse and repository, DC Provider will permit exchange of such health data to occur directly between its information system and the Company's data warehouse and repository. If, however, the Beneficiary's health information is maintained by DC Provider in an electronic format or other format or mechanism utilized to maintain health data that will not permit the direct exchange of such Beneficiary health data with the Company's data warehouse and repository, then the DC Provider will grant the Company access to DC Provider's Beneficiary health data either remotely or on site on a read-only basis, at DC Provider's expense, if any, to permit the copying or otherwise comprehensive transmission of such Beneficiary health data into the Company's data warehouse and repository.

(f) DC Provider will obtain the consent, as may be required by HIPAA, from each Aligned Beneficiary for the collection of health data by Company into its data warehouse and repository for the purpose of developing evidence-based medical practice and clinical guidelines, disease management programs, quality improvement programs, and for any other clinical integration activities and programs that may be engaged in by Company from time to time.

(g) The Company may request and receive health and administrative data from other health plans, laboratory providers, diagnostic imaging providers, pharmacies, pharmacy benefit managers, hospitals, ambulatory surgery centers and other data sources pertaining to health care services provided, or requested, on behalf of an Aligned Beneficiary. Such health and administrative data may be used by the Company to monitor the performance of Aligned Beneficiary, as part of the quality assurance and process improvement activities of the Company.

(h) DC Provider will utilize an information technology solution that accommodates the sharing and reporting of patient data, including providing information to influence care at the point of care, and a mechanism for retrieving information regarding compliance with the clinical protocols and quality programs. Such a solution may include an electronic medical record, a practice management information system, or a mechanism utilized to maintain patient data from which Company can reasonably duplicate records either electronically or manually for submission into the data warehouse and repository. Any platform DC Provider selects must be sufficient to support internet access with high speed connectivity for scanning patient records, including medical records.

(i) The Company is developing a process for the development, implementation and enforcement of evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs. DC Provider will administer the evidence-based medical practice or clinical guidelines, disease management programs, and other quality improvement programs of Company. The Company, through its various committees, will be responsible for monitoring and providing oversight of compliance with such evidence-based medical practice or clinical guidelines, disease management programs, and other quality improvement programs, and will develop and periodically update policies and procedures to ensure achievement

of identified quality benchmarks. The Company may delegate to entities selected by the Company the responsibility to document the pro-competitive effects likely to be achieved by the development, implementation and enforcement of such evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs, and how such programs clearly outweigh any anticompetitive impact that may be enumerated.

(j) A critical component of the Company is participation by DC Provider in the development and implementation of evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs. The Company may call upon DC Provider from time to time to invest a significant amount of time and effort to assist in the development, implementation and enforcement of evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs, in collaboration with the members of the Company. Designated Providers must understand that they may invest a significant amount of time and effort in serving on the various committees of the Company as may be reasonably requested for the purpose of reviewing and updating such evidence-based medical practice or clinical guidelines, disease management programs, and other quality improvement programs from time to time, and in carrying-out the elements of the evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs of the Company.

(k) Designated Providers will be expected to comply with the evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs of the Company. The Company is developing a performance improvement process for Designated Providers to assist with such compliance.

(l) The Company's evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs will be monitored, and the failure of Designated Providers to comply could result in corrective action. The Company is in the process of developing disciplinary measures for Designated Providers who fail to meet performance standards. Persistent non-compliance with the evidence-based medical practice or clinical guidelines, disease management programs and other quality improvement programs or failure to meet minimum performance standards will be a cause for discipline of a Designated Provider, and may be a sufficient basis for termination of the Designated Provider's participation in the Company.

(m) Nothing in this Section 11 or elsewhere in this Agreement is to be construed as requiring sharing of data with any other provider related to services rendered to Aligned Beneficiaries who have elected not to allow their data to be shared.

12. **Term and Termination**.

(a) The term of this Agreement shall commence on the date that the Company is accepted by CMS as a DCE and shall continue until the second anniversary thereof. This Agreement automatically shall terminate if the Company ceases to be a DCE in the DCM.

(b) If there is a material breach of the Agreement by either party, the other party will provide written notice to the defaulting party specifying the nature of the breach. If such breach is not cured to the reasonable satisfaction of the non-defaulting party within thirty (30) days after service of said notice, this Agreement will terminate at the election of the non-defaulting party at the end of said thirty (30) day period. Grounds for material breach of this Agreement against DC Provider may include, among other things, excessive grievances by Aligned Beneficiaries, breach of significant administrative requirements (i.e., maintenance of records), failure to conform with any utilization management and quality management standards established by the Company, or the failure of Designated Provider to comply with the requirements set forth in this Agreement.

(c) If DC Provider fails to follow the policies and procedures of the Company, the Company may provide notice to DC Provider specifying the procedures with which DC Provider did not comply. If, after thirty (30) days, the Company finds that DC Provider has not sufficiently complied with the procedures discussed in the notice, the Company may terminate DC Provider from the Agreement with or without notice.

(d) The Company may terminate the Agreement without cause upon at least thirty (30) days prior notice to DC Provider with an effective date of termination occurring at any time after the first anniversary of the commencement date of this Agreement set forth in Section 12(a).

(e) The Company may terminate the right of a Designated Provider to provide services to DC Provider under this Agreement immediately by notice to DC Provider upon the occurrence of any of the following events:

(i) Designated Provider's medical staff privileges at any licensed general acute care hospital are denied, modified, reduced, restricted, suspended or terminated (either voluntarily or involuntarily), other than temporary suspensions (i.e., of fewer than ten (10) days duration) due solely to Designated Provider's failure to complete medical records on a timely basis;

(ii) Designated Provider's professional liability coverage no longer meets the requirements of Section 7(c) above;

(iii) Designated Provider's license to practice medicine in the State of Florida or authorization to administer controlled substances is denied, modified, reduced, restricted, suspended or terminated (either voluntarily or involuntarily);

(iv) Designated Provider's death or incapacity (as determined by the Company in its reasonable discretion);

(v) The Company makes a reasonable and good faith determination that such termination is necessary in order to protect the health or welfare of an Aligned Beneficiary; or

(vi) Designated Provider (i) loses eligibility to participate in the Medicare Program under Title XVIII of the Social Security Act or other applicable state law pertaining to Title XIX of the Social Security Act, or (ii) is indicted for any felony or of a crime involving moral turpitude.

(f) The DC Provider may terminate its participation under the Agreement immediately by notice to DC Provider upon the occurrence of any of the following events:

(i) The Company fails to fulfill its responsibilities under the Agreement with the Centers for Medicare & Medicaid Services ("CMS") to participate in the direct contracting model ("DCM") established pursuant to Section 1115A of the Social Security Act (the "Act") as a direct contracting entity ("DCE");

(ii) The Company fails to fulfill its responsibilities under the Section 11 entitled Data Requirements;

(iii) The Company's professional liability or errors and omissions coverage is no longer in place;

(iv) The Company's participation in the Medicare or Medicaid program is terminated or it no longer qualifies for participation in the Medicare or Medicaid program;

(v) If Company is in breach of any material provision of this Agreement, provided Company has not cured such breach within sixty (60) days of the receipt of said notice (which shall set forth the facts DC Provider believes show the Company to be in breach). DC Provider shall have no obligation to allow Company to cure any breach or default which has been the subject of an earlier notice of termination given pursuant to this subsection.

(g) The DC Provider may terminate its participation under the Agreement without cause and without penalty upon ninety (90) days prior written notice.

13. **HIPAA Compliance**. DC Provider shall comply in all respects with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and the federal regulations published at 45 C.F.R. Parts 160 to 164 (collectively, "HIPAA"). In accordance therewith, DC Provider shall execute the Business Associate Agreement ("BAA") in the form and content attached hereto as Schedule 13.

14. **Indemnification**.

(a) The Company shall indemnify, defend and hold harmless DC Provider from and against any and all claims, damages, causes of action, cause for expenses, including reasonable attorneys fees, paraprofessional fees and accountant fees to the extent approximately caused by

the negligent act or omission of the Company arising out of or connected with this Agreement.

(b) To the extent permitted under Florida law, DC Provider shall indemnify, defend and hold harmless the Company from and against any and all claims, damages, causes of action, cause for expenses, including reasonable attorneys' fees, paraprofessional fees and accountant fees to the extent approximately caused by the negligent act or omission of DC Provider arising out of or connected with this Agreement.

15. **Governing Law**. This Agreement shall be interpreted in accordance with the laws of the State of Florida and applicable federal laws.

16. **Counterparts**. This Agreement may be signed in counterparts, each of which shall constitute an original and all of which together shall constitute one and the same instrument. An executed counterpart of this Agreement delivered by a party to this Agreement by facsimile or electronic mail shall be considered an original for all purposes.

17. **Execution Authority**. Each person executing this Agreement on behalf of a party represents and warrants that such person has the capacity, power and authority to execute this Agreement on behalf of such party.

18. **Dispute Resolution/Arbitration**. All claims or controversies concerning this Agreement, arising in any way out of the performance or non-performance of this Agreement, will be subject to binding arbitration by a single arbitrator in accordance with the rules of the American Health Lawyers Association, who will have discretion to award to the prevailing party its attorneys' fees and costs or otherwise apportion the parties' attorneys' fees and costs between the parties as part of the arbitrator's position. The single arbitrator shall be appointed by the American Health Lawyers Association. The seat of arbitration shall be in Melbourne, Florida.

IN WITNESS WHEREOF, the parties have executed this Agreement on the dates indicated below.

SPACE COAST INDEPENDENT PRACTICE ASSOCIATION, LLC

By: _____

Print Name: Mark Belanger

Title: CFO

Date Signed: 10/23/2020

DC PROVIDER

North Brevard County Hospital District
dba Parrish Medical Center

By: _____
Print Name: George Mikitarian
Title: President CEO

Date Signed: 10/22/2020

Tax Identification No.: 59-6020427

Schedule 3(a)

DC Provider TIN: 59-3074052

DC Participant Providers

			NPI
Solito	Tricia	APRN	1609105246
Go	Eugene	MD	1528052065
Starkey	Cara	CNM/APRN	1063685774
Hate	Vidya	MD	1043312945
Henry	Roseanne	MD	1508132085
Perez	Dennis	MD	1821190554
Caito	Christina	MD	1821228008
Alder	Toya	APRN	1255819157
Morales	Carmen	MD	1740290246
Kurusanganapalli	Nagamani	MD	1154551992
Galfo	Mark	MD	1326041278
Quintinita	Zarina	APRN	1386850964
Skaden	Jibril	MD	1902281025
Human	Rebecca	APRN	1053937656
Tronetti	Pamela	DO	1649258864

Preferred Providers

			NPI
Lubitz	Jonathan	DPM	1962406348
Allotta	Anthony	DO	1285831743
Licht	Mark	MD	1306841473
Watts	Jennifer	APRN	1699277673
George	Khalid	MD	1275965287
Hart	Jaclyn	APRN	1891217154
Haupt	Julia	APRN	1952637464
Kahrs Bolanos	Rebecca	APRN	1760034334
Manion	Christopher	MD	1104937390
Maynard	Brittany	APRN	1881180503
D'Cruz	Arvid	MD	1154324986
Parrish Medical Center			1053424648

Schedule 9(a)-1

PQEM Services

See attached.

Office or Other Outpatient Services	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Prolonged Care for Outpatient Visit	
99354	Prolonged visit, first hour
99355	Prolonged visit, add'l 30 mins
Telephone Visits – Audio Only	
99421	Online - Digital, Established Patient, 5 - 10 mins
99422	Online - Digital, Established Patient, 10 - 20 mins
99423	Online - Digital, Established Patient, 21+ mins
99441	Phone, Established Patient, 5 - 10 mins
99442	Phone, Established Patient, 10 - 20 mins
99443	Phone, Established Patient, 21+ mins

Chronic Care Management Services	
99490	Comprehensive Care Plan Establishment/Implementation/Revision/Monitoring
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Advance Care Planning	
99497	ACP first 30 mins
99498	ACP add'l 30 mins
Wellness Visits	
G0402	Welcome to Medicare Visit
G0438	Annual Wellness Visit
G0439	Annual Wellness Visit
Virtual Check-Ins	
G2010	Remote Evaluation, Established Patient
G2012	Brief Communication Technology-Based Service, 5 – 10 mins of Medical Discussion

Schedule 9(a)-2

Compensation for PQEM Services

DC Provider shall be compensated at one hundred ten percent (110%) of the Medicare allowable fee for service rate for PQEM services. The Company shall examine patient encounter data for DC Participating Providers providing PQEM services and may make advance payments of the estimated amount of fees DC Participant Providers providing PQEM services would earn a calendar month. The Company shall reconcile actual patient encounters during a calendar month with the actual billing amount for patient encounters during such month. Any billed amount in excess of advance payments will be paid to DC Provider within twenty-one (21) days after the end of the calendar month. Any amount by which actual amounts billed are less than advance payments during the month will reduce the advance payment for subsequent months.

Schedule 9(a)-3

Preferred Providers who are Non-Primary Care Specialists

See attached.

Code	Specialty
6	Cardiology
10	Gastroenterology
12	Osteopathic Manipulative Medicine
13	Neurology
16	Obstetrics/Gynecology
17	Hospice and Palliative Care
23	Sports Medicine
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
29	Pulmonology
39	Nephrology
44	Infectious Disease
46	Endocrinology
66	Rheumatology
70	Multispecialty Clinic or Group Practice
79	Addiction Medicine
82	Hematology
83	Hematology/Oncology
84	Preventative Medicine
90	Medical Oncology
98	Gynecological Oncology
86	Neuropsychiatry

Schedule 9(b)

Percentage Reduction

DC Provider agrees that its Medicare fee for service reimbursement from the Medicare program will be reduced by 100% for non-PQEM services provided by DC Participant Providers and 5% for all services provided by the Preferred Providers.

Schedule 13

Business Associate Agreement

See attached.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is made and entered into as of _____, 2020 by and between _____ ("Covered Entity") and Space Coast Independent Practice Association, LLC ("Business Associate"). This BAA is drafted in accordance with Covered Entity's and Business Associate's obligations under Title II of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-5 Division A Title XIII and Division B Title IV the "HITECH Act"), each as amended from time to time, and the regulations issued and effective thereunder to ensure the integrity and confidentiality of Protected Health Information ("PHI") that the Business Associate may create for or receive from the Covered Entity.

RECITALS

WHEREAS, Business Associate provides certain services to Covered Entity under a separate agreement (the "Services Agreement"); and

WHEREAS, in the course of receiving services from Business Associate, Covered Entity will need to disclose Individually Identifiable Health Information, including Protected Health Information, to Business Associate; and

WHEREAS, pursuant to HIPAA and the HITECH Act, and regulations promulgated pursuant thereto, Covered Entity is required to protect the privacy and security of PHI; and

WHEREAS, in order to protect the privacy and security of PHI created or maintained by or on behalf of Covered Entity, federal law requires Covered Entity to enter into Business Associate Agreements with certain individuals and entities providing services to, for, or on behalf of Covered Entity if such services involve the use or disclosure of Individually Identifiable Health Information; and

WHEREAS, due to the nature and extent of services provided by Business Associate to Covered Entity, Business Associate must access, create, receive, use, disclose, and/or maintain PHI on behalf of Covered Entity; and

WHEREAS, Covered Entity and Business Associate desire to enter into this BAA to allow both parties hereto to meet the aforementioned requirements of federal law.

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the parties, the parties do agree as follows:

1. DEFINITIONS

Capitalized terms used but not otherwise defined in this BAA shall have the same meanings set forth in HIPAA and/or the HITECH Act.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

2.1. Business Associate agrees to comply with the applicable requirements of 45 C.F.R. Part 164 with respect to PHI subject to this BAA. Business Associate agrees not to use or further disclose PHI other than as permitted or required by this BAA or as required by law.

2.2. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this BAA.

2.3. Business Associate agrees to comply with Subpart C of 45 C.F.R. Part 164 and implement administrative, physical, and technical safeguards that reasonably and appropriately protect confidentiality, integrity, and availability of Electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate further agrees to ensure that any agent, including a subcontractor, that creates, receives, maintains or transmits Electronic PHI on behalf of the Business Associate agrees to comply with the applicable requirements of 45 C.F.R. Part 164 by entering into a contract or other arrangement that complies with 45 C.F.R. §164.314(a)(2).

2.4. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply to Business Associate with respect to such information.

2.5. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to provide Covered Entity, upon request, in a reasonable time and manner, PHI maintained or created by Business Associate, so Covered Entity can respond to a request by an individual for access to inspect and obtain a copy of PHI.

2.6. To the extent that Business Associate maintains PHI in a Designated Record Set, Business Associate agrees to provide Covered Entity, upon request, in a reasonable time and manner, PHI maintained or created by Business Associate, so Covered Entity can respond to a request by an individual for amendment to the PHI and if requested by Covered Entity to incorporate any amendments to the PHI maintained by the Business Associate.

2.7. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate available to the U.S. Department of Health and Human Resources ("HHS") within a reasonable time or as designated by HHS, for purposes of the Secretary of HHS determining Covered Entity's compliance with the Privacy Rule.

2.8. 45 C.F.R. §§164.306, 164.308, 164.310, 164.312, and 164.316 shall apply to Business Associate in the same manner that such sections apply to Covered Entity.

2.9. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI.

2.10. Business Associate agrees to provide to Covered Entity or an individual, within a reasonable time from the applicable request, information collected in accordance with section 2.9 of this BAA, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI. Effective as of the date specified by HHS, with respect to disclosures related to an Electronic Health Record, Business Associate shall provide the accounting directly to an individual (in an electronic format, if requested) making such a request, if a direct response is requested by the individual.

2.11. Business Associate will comply with any restriction request under section 4 of this BAA if: (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

2.12. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this BAA as well as any Security Incident of which it becomes aware. In addition, Business Associate shall notify Covered Entity of the discovery of a Breach of Unsecured PHI without unreasonable delay but in no event later than ten (10) calendar days following the discovery of such Breach. Business Associate will treat the Breach as being discovered, and provide any required notification in accordance with 45 C.F.R. §164.410. If a delay is requested by a law-enforcement official in accordance with 45 C.F.R. §164.412, Business Associate may delay notifying Covered Entity for the applicable time period.

2.13. To the extent Business Associate is to carry out one or more of Covered Entity's obligations under Subpart E of 45 C.F.R. Part 164, Business Associate will comply with the requirements of Subpart E that apply to Covered Entity in the performance of the obligations.

3. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

3.1. Except as otherwise limited in this BAA, Business Associate may use

or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity in connection with the performance of the Services Agreement for the Covered Entity, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity. Furthermore, Business Associate may use and disclose PHI received from or created on behalf of Covered Entity only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 C.F.R. Part 164. Business Associate further acknowledges and agrees that Part 164 applies to Business Associate in the same manner that it applies to Covered Entity.

3.2. Except as otherwise limited in this BAA, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the responsibilities of the Business Associate.

3.3. Except as otherwise limited in this BAA, Business Associate may disclose PHI for the proper management and administration of the Business Associate provided that either:

- Such disclosures are Required By Law; or
- Business Associate obtains reasonable assurance from any person or entity to which Business Associate will disclose Covered Entity's PHI that the person or entity will: (1) hold Covered Entity's PHI in confidence and use or further disclose Covered Entity's PHI only for the purpose for which Business Associate disclosed Covered Entity's PHI to the person or entity or as Required by Law; and (2) promptly notify Business Associate of any instance of which the person or entity becomes aware in which the confidentiality of Covered Entity's PHI was breached.

3.4. Except as otherwise limited in this BAA, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B).

3.5. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §164.502(j)(1).

3.6. Business Associate will, in its performance of the functions, activities, services, and operations specified above, limit its use, disclosure and requests of PHI, to the extent practicable, to the Limited Data Set or, if needed by Business Associate, to the minimum necessary to accomplish the intended purposes of the use, disclosure or request, unless an exception under 45 C.F.R. §164.502(b)(2) applies. Business Associate and Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with HIPAA, the HITECH Act, applicable regulations, and government guidance.

3.7. Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI unless the Covered Entity or Business Associate obtained from the individual, in accordance with 45 C.F.R. §164.508, a valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that individual, except as otherwise allowed under the HITECH Act. Business Associate shall not contact any individual to whom PHI pertains without the prior written consent of the Covered Entity.

3.8 Business Associate shall not make any communication set forth in subparagraphs (A), (B) or (C) of paragraph (2)(ii) of the definition of marketing in 45 C.F.R. §164.501, if Business Associate receives or has received direct or indirect payment in exchange for making such communication.

4. OBLIGATIONS OF COVERED ENTITY

4.1. Covered Entity shall provide Business Associate with its Notice of Privacy Practices; notify Business Associate of any limitation(s) in Covered Entity's Notice of Privacy Practices in accordance with 45 C.F.R. §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI and notify Business Associate of any subsequent changes in Covered Entity's Notice of Privacy Practice, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

4.2. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

4.3. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

4.4. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity with the exception of any uses or disclosures allowed by section 3 of this BAA, above.

5. TERM AND TERMINATION

5.1. Term. The term of this BAA shall be effective as of the date first stated above, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this section.

5.2. Termination for Cause. Upon Covered Entity's determination of a material breach by Business Associate of this BAA, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation and terminate this BAA if Business Associate does not cure the breach or end the violation within ten (10) days, or immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible. A breach of this BAA is a breach of the Services Agreement and grounds for termination of the Services Agreement for cause.

5.3. Indemnification. Business Associate shall indemnify, save and hold harmless Covered Entity from and against all losses, costs, damages and expenses (including reasonable attorneys' fees and court costs) arising out of or connected with any breach by Business Associate of any term of this BAA or the unlawful or unauthorized disclosure of PHI by Business Associate.

6. EFFECT OF TERMINATION

6.1. Except as provided in section 6.2 of this BAA, upon termination of this BAA, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

6.2. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this BAA to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. MISCELLANEOUS

7.1. Regulatory References. A reference in this BAA to a section in the Privacy or Security Rule means the section as in effect or as amended, and for which compliance is required.

7.2. Amendment. The Parties agree to take such action as is necessary to amend this BAA from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules, HIPAA, the HITECH Act, and any guidance and regulations promulgated thereunder.

7.3. Survival. The respective rights and obligations of Business Associate under section 3, section 5.3 and section 6 of this BAA shall survive the termination of this BAA.

7.4. Interpretation. Any ambiguity in this BAA shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy and Security Rules, HIPAA, the HITECH Act, and any guidance and regulations promulgated thereunder.

Duly executed by the parties on this 22 day of October, 2020:

"Covered Entity"

By: [signature]

Name: Mark Bolanzo

Title: CFO

Date: 10/22/2020

"Business Associate"

By: [signature]

Name: George Mikitarian

Title: President / COO

Date: 10/22/2020

September 10, 2021

PARRISH
MEDICAL CENTER
PARRISH HEALTHCARE

951 North Washington Ave.
Titusville, FL 32796
P: 321-268-6111
parrishmed.com

Mr. Mark Bobango, COO
Space Coast Independent Practice Association, LLC
1344 S. Apollo Blvd.
Suite 303
Melbourne, FL 32901

Re: Termination of Participation

Dear Mark:

This entity, North Brevard County Hospital District dba Parrish Medical Center ("Parrish"), on October 22, 2020 entered into a Participation Agreement ("Agreement") with Space Coast Independent Practice Association, LLC ("Association"), regarding the formation and operation by the Association of a direct contracting entity. The Agreement describes Parrish as a DC Provider. Section 12 (g) of the Agreement says "[T]he DC Provider may terminate its participation under the Agreement without cause and without penalty upon ninety (90) days prior written notice."

This letter will serve as notice by Parrish to Association that Parrish will terminate its participation under the Agreement on December 9, 2021.

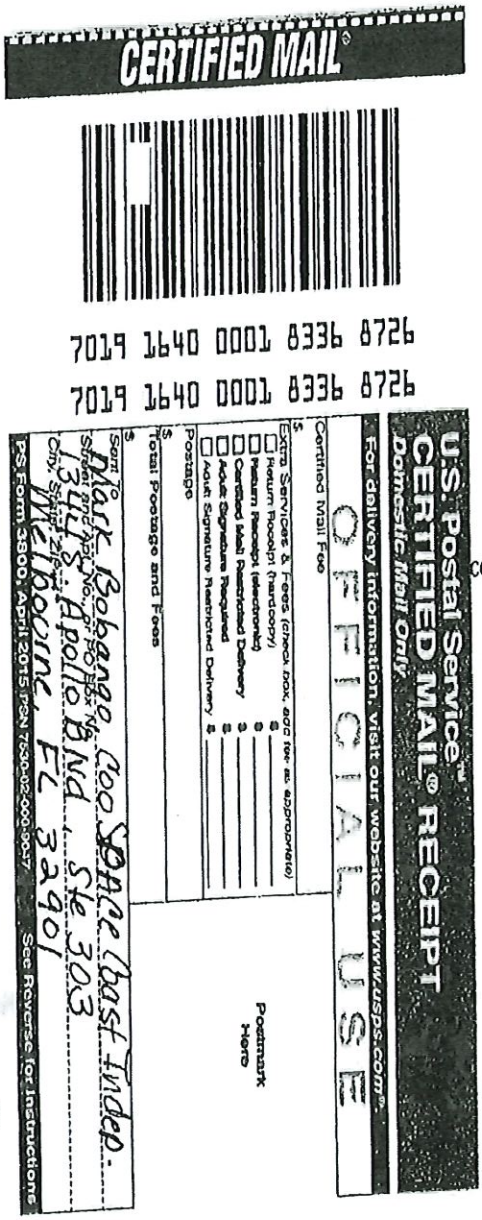
Sincerely,

Chris McAlpine, Sr. Vice President

PARRISH
MEDICAL CENTER

PARRISH HEALTHCARE

951 North Washington Ave.
Titusville, FL 32796



ce Association LLC

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Mark Bobango, COO
Space Coast Independent Practice
Association, LLC
1344 S Apollo Blvd
Suite 303, Melbourne, FL 32901

9590 9402 6286 0274 4283 31

2. Article Number (Transfer from service label)

7019 1640 0001 8336 8726

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X Tim Monroe ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 9/16/21

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☒ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

Restricted Delivery

PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®.

OFFICIAL USE

Certified Mail Fee
$

Extra Services & Fees (check box, add fee as appropriate)

- ☐ Return Receipt (hardcopy) $
- ☐ Return Receipt (electronic) $
- ☐ Certified Mail Restricted Delivery $
- ☐ Adult Signature Required
- ☐ Adult Signature Restricted Delivery $

Postage
$

Total Postage and Fees
$

TITUSVILLE, FL 32780
SEP 14 2021
Postmark
USPS

Sent To: Mark Bobango, COO Space Coast Indep.
Street and Apt. No., or PO Box No.: 1344 S. Apollo Blvd, Ste 303
City, State, ZIP+4®: Melbourne, FL 32901

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7019 1640 0001 8336 8726

WALZ CERTIFIED MAILER® FROM **WALZ**

FORM #45663 VERSION: E0520

Label #1

Craig K. Deligdish, M.D.
Mark Bobango
America's MDE, LLC
1344 S. Apollo Blvd., Suite 406
Melbourne, FL 32901

Label #2

Craig K. Deligdish, M.D.
Mark Bobango
America's MDE, LLC
1344 S. Apollo Blvd., Suite 406
Melbourne, FL 32901

Label #3

Nelson Mullins Riley & Scarborough LLP
2 S. Biscayne Blvd.
Suite 2100
Miami, FL 33131

TEAR ALONG THIS LINE

U.S. Postal Service® CERTIFIED MAIL® RECEIPT

Domestic Mail Only

USPS® ARTICLE NUMBER

9414 7266 9904 2182 6549 91

Certified Mail Fee	$
Return Receipt (Hardcopy)	$
Return Receipt (Electronic)	$
Certified Mail Restricted Delivery	$
Postage	$
Total Postage and Fees	$

Postmark Here

Sent to:
Craig K. Deligdish, M.D.
Mark Bobango
America's MDE, LLC
1344 S. Apollo Blvd., Suite 406
Melbourne, FL 32901

Reference Information
Clt/Mtr# 147891-00013

PS Form 3800, Facsimile, July 2015

A FOLD AND TEAR THIS WAY → OPTIONAL

B

Label #4

Certified Article Number 9414 7266 9904 2182 6549 91

SENDER'S RECORD

Label #5 (OPTIONAL)

Nelson Mullins Riley & Scarborough LLP
2 S. Biscayne Blvd.
Suite 2100
Miami, FL 33131

Label #6 - Return Receipt Barcode (Sender's Record)

9590 9266 9904 2182 6549 94

Label #7 - Certified Mail Article Number

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE

CERTIFIED MAIL®

9414 7266 9904 2182 6549 91

FOLD AND TEAR THIS WAY →

C FOLD AND TEAR THIS WAY →

Thank you for using Return Receipt Service

RETURN RECEIPT REQUESTED
USPS® MAIL CARRIER
DETACH ALONG PERFORATION

Return Receipt (Form 3811) Barcode

9590 9266 9904 2182 6549 94

1. Article Addressed to:

Craig K. Deligdish, M.D.
Mark Bobango
America's MDE, LLC
1344 S. Apollo Blvd., Suite 406
Melbourne, FL 32901

2. Certified Mail (Form 3800) Article Number

9414 7266 9904 2182 6549 91

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent
X ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type:
☒ Certified Mail

Reference Information

Thank you for using Return Receipt Service

PS Form 3811, Facsimile, July 2015 Domestic Return Receipt

EDUCATION COMMITTEE
Billie Fitzgerald, Chairperson
Maureen Rupe, Vice Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Ashok Shah, M.D.
Stan Retz, CPA
Elizabeth Galfo, M.D.
Herman A Cole, Jr.
Jerry Noffel
Billy Specht
Aluino Ochoa, M.D.
George Mikitarian, President/CEO (Non-voting)

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE
MONDAY, APRIL 3, 2023
IMMEDIATELY FOLLOWING EXECUTIVE SESSION
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Review and Approval of Minutes

Motion to approve the minutes of the February 6, 2023 meeting.

II. Brevard Zoo Seagrass Project – Ms. Sellers

III. Healthy People 2030 – Ms. Cottrell

IV. Other

V. Executive Session (if necessary)

ADJOURNMENT

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

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE

A regular meeting of the Educational, Governmental and Community Relations Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 6, 2023 at 2:33 p.m. in Conference Room 2/3/4/5, First Floor. The following members were present:

Billie Fitzgerald, Chairperson
Maureen Rupe, Vice Chairperson
Robert L. Jordan, Jr., C.M.
Ashok, Shah, M.D.
Aluino Ochoa, M.D
George Mikitarian (non-voting)

Member(s) Absent:
None

CALL TO ORDER

Ms. Fitzgerald called the meeting to order at 2:33 p.m.

REVIEW AND APPROVAL OF MINUTES

The following motion was made by Mr. Cole, seconded by Dr. Shah, and approved (5 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED TO APPROVE THE MINUTES OF DECEMBER 5, 2022 EDUCATION COMMITTEE MEETING, AS PRESENTED.**

SIVATS

Dr. Tishko presented his minimally invasive, Single Incision Video Assisted Thoracic Surgery (SIVATS) procedures, explained its benefits and addressed questions from the committee. Copies of the Power Point slides presented are appended to the file copy of these minutes.

OTHER

No other items were presented.

ADJOURNMENT

There being no further business to come before the committee, the Educational, Governmental and Community Relations Committee meeting adjourned at 3:15 p.m.

Billie Fitzgerald
Chairperson

RESTORE OUR SHORES

restoreoureshores.org

BREVARD ZOO

“We Share Our Joy of Nature to Help Wildlife and People Thrive”

RESTORE OUR SHORES

BREVARD ZOO

Brevard COUNTY

ST. JOHNS RIVER WATER MANAGEMENT DISTRICT SJR

Community-Based Indian River Lagoon Habitat Restoration Programs

Oyster Gardening
Shuck & Share
Reef Restoration

Adopt-a-Mangrove
Living Shorelines
Buffer Zones

Clam Restoration Pilot
Clam Gardening

RESTORE OUR SHORES

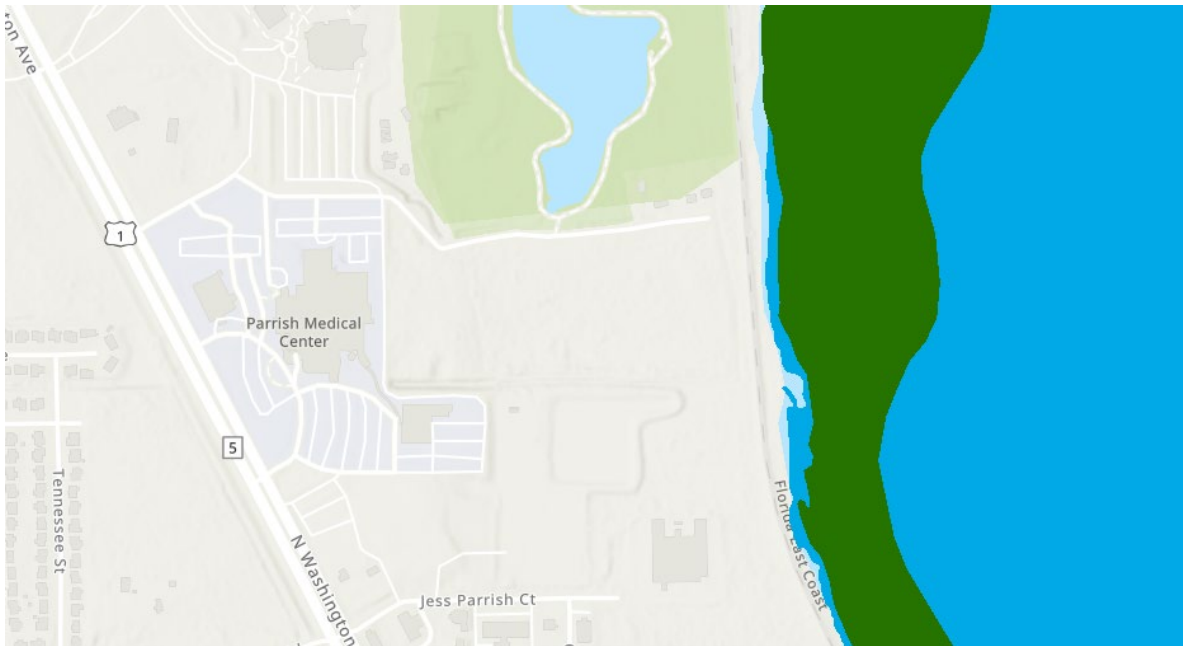
BREVARD ZOO

Diving into Seagrass Restoration

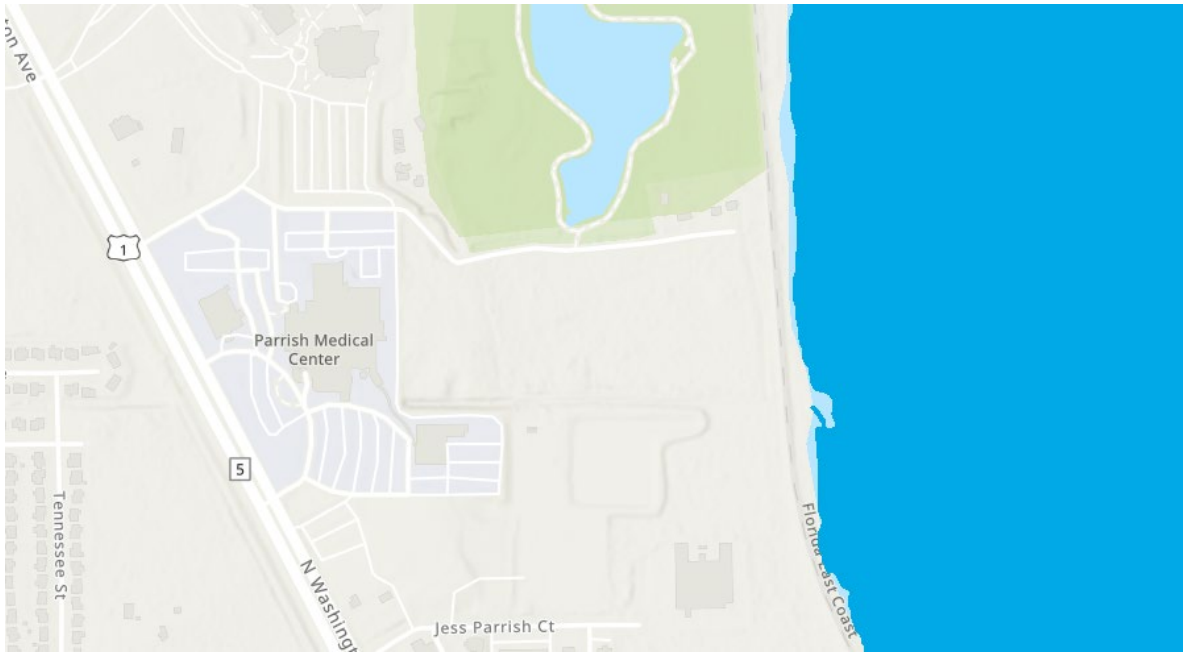
ONE LAGOON
ONE COMMUNITY • ONE VOICE
Indian River Lagoon
National Estuary Program

- Lagoon has lost over 90% seagrass coverage since 2011 (Morris et al. 2022)
- Seagrass nursery at Hubbs Seaworld Research Institute in Melbourne Beach
- Pilot planting project May 2023
  - 17 sites in Brevard
  - Where is the lagoon ready for seagrass restoration?

Seagrass Restoration at Parrish Medical Center



2011 Seagrass Coverage, SJRWMD



2021 Seagrass Coverage, SJRWMD

RESTORE OUR SHORES

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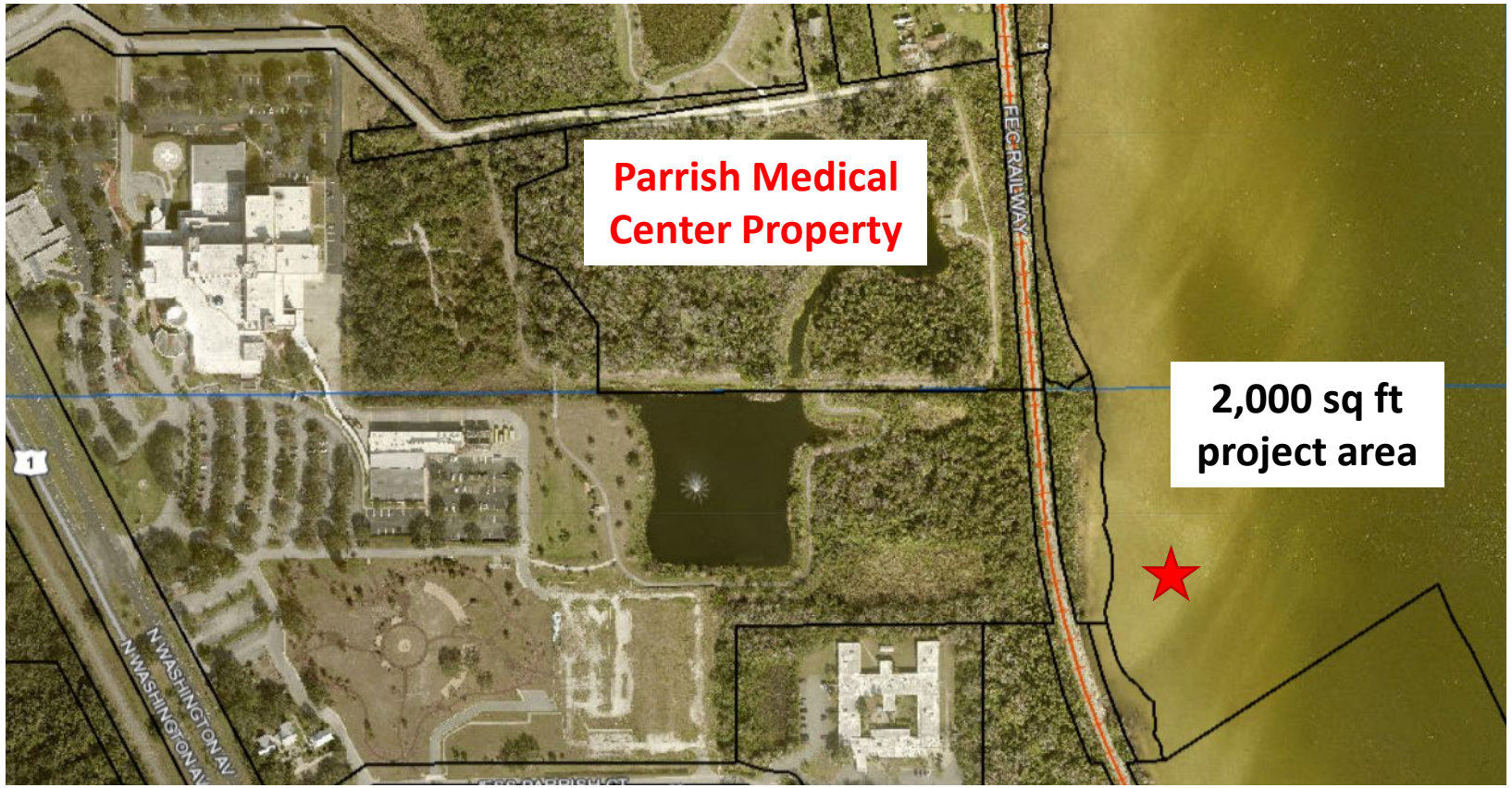


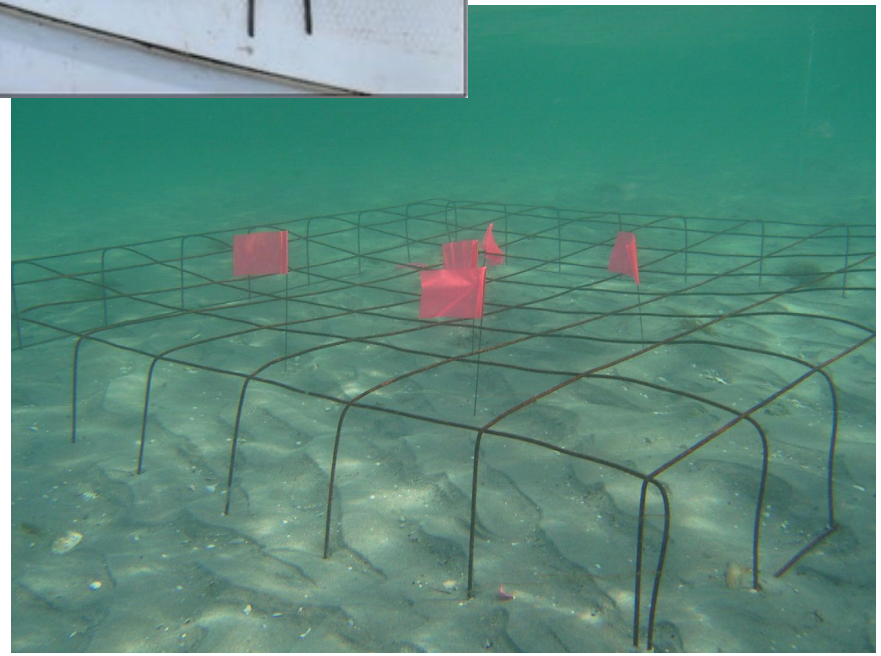
Project Overview

- Planting scheduled early May 2023
- Herbivory exclusion
- Monitoring
- Volunteer engagement
- State permits secured, federal under review

RESTORE OUR SHORES

BREVARD ZOO

Seagrass Planting Unit



Herbivory Exclusion Device

Why is Seagrass so Important?

- Essential habitat
- Food source for manatees, sea turtles, fish, and more
- Coastal resiliency
- Carbon sequestration

RESTORE OUR SHORES

BREVARD ZOO

Thank you!

Keep up with us and sign up for our Restore Our Shores newsletter!

Olivia Escandell

Conservation Manager

Restore Our Shores

oescandell@brevardzoo.org

PARRISH®
HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Health Equity & SDOH

North Brevard

PARRISH HEALTHCARE

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Health Equity

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Health Equity

CMS Framework for Health Equity Priorities

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

Health Equity

CMS Framework for Health Equity Priorities

Priority 3: Build Capacity of Health Care Organizations and the workforce to Reduce Health and Health Care Disparities

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

Health Equity

Priority 1 -CMS new quality measures for 2023

The Hospital Commitment to Health Equity

- 5 Domains
- Each domain is worth 1 point for a total of 5 possible points
- The goal is not to track how equitable your care is; it's simply to understand if your organization has made health equity a strategic priority

- Required to attest once a year in May

Health Equity

The Hospital Commitment to Health Equity

Domain 1: Equity is a strategic priority

Domain 2: Data collection

Domain 3: Data analysis

Domain 4: Quality improvement

Domain 5: Leadership engagement

Health Equity

TJC New NPSG.16.01.01

6 elements of performance

- Identify an individual to lead activities to improve health care equity
- Assess the patient's health-related social needs
- Analyze quality and safety data to identify disparities
- Develop an action plan to improve health care equity
- Take action when the organization does not meet the goals in its action plan
- Inform key stakeholders about progress to improve health care equity

Health Equity

CMS/TJC comparison

			2023	2024
CMS Requirements	**HCHE:** Hospital Commitment to Health Equity Measure	NEW Process Measure with 5 Domains	Mandatory	Mandatory
	SDOH-01: Screening for Social Drivers of Health Measure	NEW Structural Measure	Voluntary	Mandatory
	SDOH-02: Screen Positive Rate for Social Drivers of Health Measure	NEW Structural Measure	Voluntary	Mandatory
TJC Requirements	**Standard LD.04.03.08:** Reducing Health Disparities	NEW Standard with 6 Elements of Performance (EPs)	Mandatory	Mandatory
	Standard RC.02.01.01 EP25: Collecting Race & Ethnicity Data	Existing EP for hospitals	Mandatory	Mandatory
	Standard RI.01.01.01 EP29: Prohibiting Discrimination	Existing EP for hospitals	Mandatory	Mandatory

Social Determinants of Health

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Healing Families – Healing Communities®

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Social Determinants of Health

CMS new quality measures for 2023 and 2024

- SDOH-1, Screening for Social Drivers of Health

- SDOH-2, Screen Positive Rate for Social Drivers of Health

The first measures how many patients were screened and the second measures how many were positive.

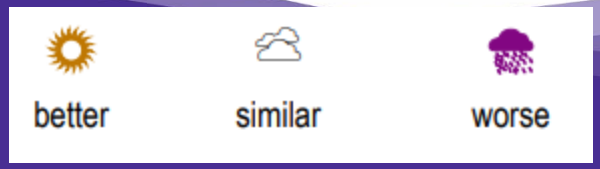
Social Determinants of Health

The 5 Domains of SDOH Screening

- Food Insecurity
- Housing Instability
- Transportation Needs
- Utility Difficulties
- Interpersonal Safety

CHNA

SOCIAL DETERMINANTS	Primary Service Area	PRIMARY SVC AREA vs. BENCHMARKS			
		vs. FL	vs. US	vs. HP2030	TREND
Population in Poverty (Percent)	11.2	13.3	12.8	8.0	
Children in Poverty (Percent)	15.8	18.7	17.5	8.0	
% Worry/Stress Over Rent/Mortgage in Past Year	24.1		32.2		37.0
% Unhealthy/Unsafe Housing Conditions	6.3		12.2		
% Food Insecure	15.2		34.1		
% [Age 18-64] Lack Health Insurance	16.2	22.6	8.7	7.9	8.5



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RECOMMENDATIONS

2022-2025 CHNA Implementation Strategy

Narrowed focus to three areas of priority to develop PMC's 2022-2025 Implementation Strategy:

1. Access to Health Care Services,
2. Heart Disease & Stroke, and
3. Diabetes.

Clinical Alignment 2023 Q1

Focus on 3 main projects

- Access to care:
  - Increase enrollment for dual eligible
  - Reduction of avoidable ER visits
- Chronic disease
  - Implementation of heart disease care map

Questions

DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
APRIL 3, 2023
NO EARLIER THAN 2:00 P.M.,
FOLLOWING THE LAST COMMITTEE MEETING
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Pledge of Allegiance

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

III. Approval of Agenda

IV. Recognitions(s)
A. New Providers (memo included)

V. Review and Approval of Minutes (February 6, 2023 Regular Meeting)

VI. Open Forum for PMC Physicians

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

VIII. Unfinished Business***

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

X. Medical Staff Report Recommendations/Announcements

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

XII. Consent Agenda***

A. Finance
1. **Motion to recommend to the Board of Directors to approve the purchase of the Replacement of one (1) Nuclear Medicine Camera System at a total cost not to exceed the amount of $381,660.**

2. **Motion: To recommend to the Board of Directors approve the Scout Investments Resolution to add Lester Eljaiek, CFO, as an authorized signer.**

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

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

XIII. Committee Reports

A. Quality Committee

B. Finance Committee

C. Executive Committee

D. Educational, Governmental and Community Relations Committee

E. Planning, Physical Facilities & Properties Committee

XIV. Process and Quality Report – Mr. Mikitarian

A. Other Related Management Issues/Information

B. Hospital Attorney - Mr. Boyles

XVI. Other

XVII. Closing Remarks – Chairman

XVIII. Executive Session (if necessary)

ADJOURNMENT

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

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

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

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

A regular meeting of the Board of Directors of the North Brevard County Hospital District operating Parrish Medical Center (the District) was held at 3:18 p.m. on February 6, 2023 in Conference Room 2/3/4/5, First Floor. The following members were present:

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

Member(s) Absent:
Jerry Noffel (excused)

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

CALL TO ORDER

Mr. Jordan called the meeting to order at 3:18 p.m. and determined a quorum was present per Article 1.1.4 of the District Bylaws.

PLEDGE OF ALLEGIANCE

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

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

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

APPROVAL OF MEETING AGENDA

Mr. Jordan requested approval of the meeting agenda in the packet as revised. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (8 ayes, 0 nays, 0 abstentions).

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

RECOGNITIONS

There were no recognitions.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (8 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVE TO APPROVE THE MINUTES OF THE NOVEMBER 7, 2022 REGULAR MEETING, AS PRESENTED.**

OPEN FORUM FOR PMC PHYSICIANS

There were no physician comments.

PUBLIC COMMENTS

There were no public comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

2023 Board of Directors Committee Roster

Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole, and approved (8 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOVE THAT THE BOARD OF DIRECTORS APPROVE THE 2023 BOARD OF DIRECTOR'S COMMITTEE ROSTER, AS PRESENTED.

CONSENT AGENDA

The revised consent agenda was presented, Discussion ensued regarding the consent agenda, and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (8 ayes, 0 nays, 0 abstentions).

ACTION TAKEN**: MOVE THAT THE BOARD OF DIRECTORS APPROVE THE FOLLOWING REVISED CONSENT AGENDA ITEMS:**

Consent Agenda

A. Finance

1. Motion: To recommend to the Board of Directors approve the Pension Plan Actuarial Valuation as of October 1, 2022.

2. Motion: To recommend to the Board of Directors to approve the purchase of two (2) Hemochron Signature Elite Instruments for the new EP Cardiology Program, at a total cost of $27,525.

3. Motion: To recommend to the Board of Directors approve the buyout of endoscope and colonoscope instrumentation and equipment at Parrish Medical Center at fair market value (FMV), at a total cost not to exceed the amount of $187,620.

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

COMMITTEE REPORTS

Quality Committee

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

Finance Committee

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

Executive Committee

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

Educational, Governmental and Community Relations Committee

Ms. Fitzgerald reported all items were covered during the Education, Governmental and Community Relations Committee meeting.

Planning, Physical Facilities and Properties Committee

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

PROCESS AND QUALITY REPORT

No additional information was presented.

Hospital Attorney

Mr. Boyles summarized the memo and resolution previously sent to the Board regarding CEO Compensation.

Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole, and approved (8 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO APPROVE THE RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT APPROVING THE ESSENTIAL TERMS OF THE FIRST AMENDMENT AND DIRECTING THE PREPARATION AND SIGNATURE OF THE FIRST AMENDMENT TO THE CHIEF EXECUTIVE OFFICER EMPLOYMENT AGREEMENT.

Mr. Boyles also noted that the draft Bylaws the Board previously voted on were sent to MEC for their review and comments and will return to the Board for final approval at the March meeting.

COMMUNITY OUTREACH AND INVOLVEMENT

Ms. Sellers reviewed the January community outreach programs and involvement. Copies of the Power Point slides presented are appended to the file copy of these minutes.

OTHER

There was no other business to come before the Board.

CLOSING REMARKS

There were no closing remarks.

ADJOURNMENT

There being no further business to discuss, the Parrish Medical Center Board of Directors meeting adjourned at 3:48 p.m.

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING PARRISH MEDICAL CENTER
MEDICAL EXECUTIVE COMMITTEE MEETING – REGULAR SESSION MINUTES
March 21, 2023 @ 5:30pm

Present: G. Cuculino, MD, V. Williams, MD (for C. Jacobs, MD) L. Stuart, MD, B. Mathews, MD, K. Patel, MD, C. Manion, MD, A. Ochoa, MD, M. Navas, MD P, Carmona, MD K. George, MD,

Absent: C. Rajan, DO, C. Fernandez, MD, G. Mikitarian

The meeting of the Medical Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was called to order on March 21, 2023 at 5:30pm in the Conference Center. A quorum was determined to be present.

CALL TO ORDER.

Dr. Ochoa called the meeting to order at 7:10pm.

I. REVIEW AND APPROVAL OF MINUTES

Motion to approve the Regular Session minutes of February 21, 2023 as written and distributed ***was made by Dr. Mathews, seconded by Dr. Cuculino and unanimously approved.***

2. OLD BUSINESS: None.

3. **NEW BUSINESS:**

1. Policy 9950-23 Department Procedure for Credentialing Criteria for Radio Frequency Ablation. ***Motion to **Retire**as credentialing criteria is contained within Level III privileges of Physiatry and Pain Management, 10 patients/2 years. (Not included in Anesthesiology, Surgery and/or Neurosurgery.*** Motion to ***Retire*** was made by Dr. Carmona, seconded by Dr. Stuart and unanimously approved.

2. Policy 9900-90 Anticoagulation Therapy Monitoring Standards. ***Motion to **Retire** as this is contained within policy 10170297 "Anticoagulation Management Program" assigned to Pharmacy.*** Motion to retire was made by Dr. Cuculino, seconded by Dr. Mathews and unanimously approved.

3. Policy 9900-23 Procedure for Admission/Discharge/Transfer Criteria for ICU. Motion to approve the procedure as written without edit, made by Dr. Mathews, seconded by Dr. Carmona and unanimously approved.

4. Policy "Identifying, Assessing and Managing Possible Abuse Victims" up for review the policy was distributed prior on March 7, 2023 with one respondent noting no edits. Motion to renew the policy without edits was made by Dr. Carmona, seconded by Dr. Stuart and unanimously approved.

5. Policy "Department Procedure for Required Consultations in the ICU" 9900-24. Motion to reassign the policy from Medical Staff Services to ICU (Acute Care Services) was made by Dr. Carmona, seconded by Dr. Stuart and unanimously approved.

6. Policy "Organ, Tissue, and Eye Donation" up for review. The policy was distributed to you on March 7, 2023. Motion to approve without edits was made by Dr. Cuculino, seconded by Dr. Navas and unanimously approved.

7. Policy "Donation after Circulatory Determination of Death". The policy was distributed on March 7, 2023. Motion to approve the policy without edits was made by Dr. R. Patel, seconded by Dr. K. Patel and unanimously approved.

8. Policy "Department Procedure for Scheduling of Elective and Emergency Surgical Cases" 9900-14. Motion to reassign the procedure from Medical Staff Services to Surgical Services was made by Dr. R. Patel, seconded by Dr. C. Manion, and unanimously approved.

9. Policy "Protocol for Birthing Center and Infant Transfers" 9900-37. The policy was distributed on March 17, 2023. Motion to reassign the policy from Medical Staff Services to Women's Center/Nursery was made by Dr. Manion, seconded by Dr. Stuart and unanimously approved.

CONSENT AGENDA - STANDING ORDERS (distributed on 3/17/2023)

Thoracic Surgery Preoperative (E3726) - New Order Set.

Group B Streptococcus Phrophylaxis (E1211) - Added additional Medication Reminders text under
Medications. Added Vancomycin orders. Added Label Comments for ceFAZolin orders. Clarified Clindamycin order for severe PCN allergy.

Orthopedic Standing Orders (E18ab) - Added Consult Physical Therapy and Consult Occupational Therapy orders.

Cesarean Delivery Postoperative - Adult (E178abc) - Removed promethazine IM order and replaced with Prochlorperazine IV. Removed orders for influenza and pneumococcal vaccines. Removed Regular Diet order. Removed comment from Activity order - changed to "assist as needed". Changed medication name to "Hydrocodone/Acetaminophen (Lortab 5 mg/325 mg)". Added Oxytocin 10 mg IM prn X1 order - to match Meditech LIVE. Updated Pitocin Drip orders to Pitocin Drip - Oxytocin infusion 30,000 miliunits/500 ml NS IVINF @ 125 ml/hr PRN after one scheduled bag if persistent bleeding.

The Consent Agenda was approved in block via motion made by Dr. George, seconded by Dr. Manion and unanimously approved.

Report from Administration: None

X. Report from the Board: (entered into the minutes)
The Board of Director's Quality Committee – January 9, 2023
The Board of Director's Regular Meeting – January 9, 2023

XI. Committee Reports: (entered into the minutes)
The Blood Management Committee – March 9, 2023

XII. Lions Eye Institute Report – Donor Contributions thru February 2023 **entered into the minutes**

7. **Open Forum:** None

Adjournment: There being no further business the meeting adjourned at 6:10 pm.

Aluino Ochoa, MD President Medical Staff	Christopher Manion, MD Secretary Treasurer

NEXT MEETING: April 18, 2023

PARRISH®

MEDICAL CENTER

PARRISH HEALTHCARE

Healing Families – Healing Communities®

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Welcome New Provider

Feguens Bataille, MD – Pain Management

Medical School: University of Pittsburgh (Pittsburgh, PA)

Residency: Physical Medicine & Rehabilitation (University of Pittsburgh; Pittsburgh, PA)

Fellowship: Interventional Pain Management with Regional Anesthesia Training (University of Cincinnati; Cincinnati, OH)

Welcome New Provider

Lisa Yamamoto, DO – Primary Care & Occupational Health

Medical School: Touro University (Mare Island, CA)

Residencies: Transitional - Naval Medical Center (San Diego, California); Family Practice – Midwestern University (Glendale, AZ)