ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING
DECEMBER 3, 2024 – 5:30 p.m.
MEDICAL CENTER HOSPITAL BOARD ROOM (2ND FLOOR)
500 W 4TH STREET, ODESSA, TEXAS

AGENDA (p.1-2)

I. CALL TO ORDER .....Wallace Dunn, President

II. ROLL CALL AND ECHD BOARD MEMBER ATTENDANCE/ABSENCES .....Wallace Dunn

III. INVOCATION .....Chaplain Doug Herget

IV. PLEDGE OF ALLEGIANCE .....Wallace Dunn

V. MISSION / VISION / VALUES OF MEDICAL CENTER HEALTH SYSTEM .....Bryn Dodd (p.3)

VI. AWARDS AND RECOGNITION

A. December 2024 Associates of the Month ..... Russell Tippin

- Clinical – Tori Yeley
- Non-Clinical – Heather Maddox
- Nurse – Alicia Smith-Furlow

B. Net Promoter Score Recognition ..... Russell Tippin

- Sanchita Yadalla, M.D.

VII. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

VIII. PUBLIC COMMENTS ON AGENDA ITEMS

IX. CONSENT AGENDA ..... Wallace Dunn (p.4-135)
(These items are considered to be routine or have been previously discussed, and can be approved in one motion, unless a Director asks for separate consideration of an item.)

A. Consider Approval of Regular Meeting Minutes, November 5, 2024
B. Consider Approval of Joint Conference Committee, November 26, 2024
C. Consider Approval of Federally Qualified Health Center Monthly Report, October 2024
D. Consider Approval of Compliance Program Resolution
E. Consider Approval of Compliance Program Charter
F. Consider Approval of Compliance Program Manual
G. Consider Approval of MCHS Standards of Conduct

X. COMMITTEE REPORTS

A. Finance Committee ..... Don Hallmark (p.136-181)
1. Financial Report for Month Ended October 31, 2024
2. Consent Agenda
    a. Consider Approval of Cisco SmartNet Hardware/Software Maintenance Support Contract Renewal
    b. Consider Approval of Roche Diagnostics Contract Extension
    c. Consider Approval of NovaRad PACS Agreement
    d. Consider Approval of WebMD Ignite Call Center Contract Renewal
3. Consider Approval of Stryker Surgicount Tablets Purchase

B. Executive Policy Committee..... Don Hallmark

C. Audit Committee ..... Don Hallmark (p.182-268)
    a. Update of Internal Audit Work Performed

XI. TTUHSC AT THE PERMIAN BASIN REPORT..... Dr. Timothy Benton

XII. PRESIDENT/CHIEF EXECUTIVE OFFICER'S REPORT AND ACTIONS
..... Russell Tippin

A. Ad hoc Report(s)

XIII. EXECUTIVE SESSION

Meeting held in closed session involving any of the following: (1) Consultation with attorney regarding legal matters and legal issues pursuant to Section 551.071 of the Texas Government Code; and (2) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code.

XIV. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. CONSIDER APPROVAL OF MCH PROCARE PROVIDER AGREEMENTS

XV. ADJOURNMENT .....Wallace Dunn

If during the course of the meeting covered by this notice, the Board of Directors needs to meet in executive session, then such closed or executive meeting or session, pursuant to Chapter 551, Texas Government Code, will be held by the Board of Directors on the date, hour and place given in this notice or as soon after the commencement of the meeting covered by this notice as the Board of Directors may conveniently meet concerning any and all subjects and for any and all purposes permitted by Chapter 551 of said Government Code.

MISSION

Medical Center Health System is a community-based teaching organization dedicated to providing high quality and affordable healthcare to improve the health and wellness of all residents of the Permian Basin.

VISION

MCHS will be the premier source for health and wellness.

VALUES

I-ntegrity
C-ustomer centered
A-ccountability
R-espect
E-xcellence

Medical Center Health System
Your One Source for Health

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS
REGULAR BOARD MEETING
NOVEMBER 5, 2024 – 5:30 p.m.

MINUTES OF THE MEETING

MEMBERS PRESENT:
Wallace Dunn, President
Don Hallmark, Vice President
Bryn Dodd
Richard Herrera
Will Kappauf
David Dunn
Kathy Rhodes

OTHERS PRESENT:
Russell Tippin, Chief Executive Officer
Matt Collins, Chief Operating Officer
Steve Steen, Chief Legal Counsel
Steve Ewing, Chief Financial Officer
Kim Leftwich, Chief Nursing Officer
Dr. Jeffrey Pinnow, Chief of Staff
Grant Trollope, Assistant Chief Financial Officer
Kerstin Connolly, Paralegal
Lisa Russell, Executive Assistant to the CEO
Various other interested members of the
Medical Staff, employees, and citizens

I. CALL TO ORDER

Wallace Dunn, President, called the meeting to order at 5:32 p.m. in the Ector County Hospital District Board Room at Medical Center Hospital. Notice of the meeting was properly posted as required by the Open Meetings Act.

II. ROLL CALL AND ECHD BOARD MEMBER ATTENDENCE/ABSENCES

Wallace Dunn called roll, and all members were present.

III. INVOCATION

Chaplain Doug Herget offered the invocation.

IV. PLEDGE OF ALLEGIANCE

Wallace Dunn led the Pledge of Allegiance to the United States and Texas flags.

V. MISSION/VISION OF MEDICAL CENTER HEALTH SYSTEM

Kathy Rhodes presented the Mission, Vision and Values of Medical Center Health System.

VI. AWARDS AND RECOGNITION

A. November 2024 Associates of the Month

Russell Tippin, Chief Executive Officer, introduced the November 2024 Associates of the Month as follows:

- Clinical – Virginia Williams
- Non-Clinical – Lina Lerma
- Nurse – Dylan Blackburn

B. Net Promoter Score Recognition

Russell Tippin, Chief Executive Officer, introduced the Net Promoter Score High Performer(s).

- Dr. Jeffrey Freyder
- Dr. Jorge Alamo

VII. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

No conflicts were disclosed.

VIII. PUBLIC COMMENTS ON AGENDA ITEMS

No comments from the public were received.

IX. CONSENT AGENDA

A. Consider Approval of Regular Meeting Minutes, October 1, 2024
B. Consider Approval of Joint Conference Committee, October 29, 2024
C. Consider Approval of Federally Qualified Health Center Monthly Report, September 2024

David Dunn moved, and Kathy Rhodes seconded the motion to approve the items listed on the Consent Agenda as presented. The motion carried unanimously.

X. COMMITTEE REPORTS

A. Finance Committee

1. Quarterly Investment Report – Quarter 4, FY 2024
2. Quarterly Investment Officer's Certificate
3. Financial Report for Month Ended September 30, 2024
4. Consent Agenda
   a. Consider Approval of Texas Healthcare Linens Contract Renewal
   b. Consider Approval of UpToDate – LexiDrug Contract Renewal
   c. Consider Approval of Everbridge Contract Renewal
   d. Consider Approval of Elsevier Clinical Skills and Clinical Key Contract Renewal
   e. Consider Approval of Shimadzu Service Agreement Renewal
   f. Consider Approval of FairWarning Managed Service and License Agreement Renewal
5. Consider Approval of Roche Diagnostics Contract Amendment

6. Consider Approval of LS Point Engagement Letter

Don Hallmark moved, and Richard Herrera seconded the motion to approve the Finance Committee report as presented. The motion carried.

B. Executive Policy Committee

The Executive Policy Committee met on October 31, 2024 to review and approve eight (8) MCH policies meeting the committee guidelines. The committee recommends approval of the submitted policies as presented. To correct the minutes from last month, the committee approved nine (9) policies last month not four (4) as previously reported

Don Hallmark moved, and Richard Herrera seconded the motion to approve the Executive Policy Committee report as presented. The motion carried.

C. Bylaws Committee

a. Consider Approval of Updated Bylaws

Don Hallmark moved, and Richard Herrera seconded the motion to approve the updated Bylaws as were provided to the Board. The motion carried.

XI. TTUHSC AT THE PERMIAN BASIN REPORT

Dr. Timothy Benton provided the TTUHSC at the Permian Basin report for information only. No action was taken.

XII. DNV SURVEY AND STATE SURVEY RESULTS

Russell Tippin, President/CEO, reported that due to the hurricane in Florida the DNV surveyors were redirected to MCH for our survey. We have received their recommendations and will respond as required.

A State surveyor came to investigate 3 issues, all of which were closed and no issues to report. We are waiting for the official report.

These reports were informational only. No action was taken.

XIII. PRESIDENT/CHIEF EXECUTIVE OFFICER'S REPORT AND ACTIONS

A. NICU Survey

Kim Leftwich, Chief Nursing Officer, reported that the NICU Designation survey was completed in mid-October. There were 3 findings, all related to paperwork and policies, not patient care.

B. Ector County Appraisal District – Director Elections

Wallace Dunn explained that ECHD has 260 votes to allocate to the ECAD Director Election and suggested that ECHD allocate all 260 votes to David Dunn.

Don Hallmark moved to allocate ECHD's 260 votes to David Dunn in the ECAD Board election, and Kathy Rhodes seconded the motion. The motion carried.

C. Ad hoc Reports

Russell Tippin, CEO, provided the following updates:

The EMR connection has been terminated, we have received 5 calls about access.

There is a nationwide IV Fluid shortage due to the hurricane disrupting a factory in North Carolina. The factory is now back online. MCH has 12 days of fluids on hand.

The Non-renewal notice has been sent to Humana Advantage.

Dr. Bose will be presenting about Desert Doc at the Chamber's I&D meeting.

The Regional Services Update report was provided in the board packet.

The Community Outreach Report was provided in the board packet.

These reports were informational only. No action was taken.

XIV. EXECUTIVE SESSION

Wallace Dunn stated that the Board would go into Executive Session for the meeting held in closed session involving any of the following: (1) Consultation with attorney regarding legal matters and legal issues pursuant to Section 551.071 of the Texas Government Code; (2) Deliberation regarding Real Property pursuant to Section 551.072 and (3) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code..

ATTENDEES for the entire Executive Session: ECHD Board members, Bryn Dodd, Will Kappauf, Richard Herrera, David Dunn, Don Hallmark, Wallace Dunn, Kathy Rhodes and Russell Tippin, Chief Executive Officer, Steve Steen, Chief Legal Counsel, Matt Collins, Chief Operating Officer, and Kerstin Connolly, Paralegal.

Adiel Alvarado, President of ProCare, presented the ProCare provider agreement to the ECHD Board of Directors during Executive Session, and then was excused from the remainder of Executive Session.

Matt Collins, Chief Operating Officer, presented the MCHS Lease Agreements to the ECHD Board of Directors during Executive Session.

Russell Tippin, Chief Executive Officer, provided an update on the Chief Medical Officer position.

Steve Steen, Chief Legal Counsel, led the Board in discussion about using PBHN funds to help with the EMR Access Integration.

Executive Session began at 6:05 p.m.
Executive Session ended at 6:52 p.m.

No action was taken during Executive Session.

XV. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreements.

Wallace Dunn presented the following renewal:

- Benedict Novicio, CRNA– This a three (3) year Anesthesia Contract.

Wallace Dunn presented the following amendments:

- Vijay Borra, M.D. – This is an amendment to an Orthopedics Contract.
- Sam Kim, M.D. - This is an amendment to a Internal Medicine Contract.
- Antonyos Mahfoud, M.D. – This is an amendment to a Critical Care Contract.
- Benedict Novicio, CRNA – This is an amendment to an Anesthesia Contract.
- Jennie Wolfram, CRNA – This is an amendment to an Anesthesia Contract.
- Marivic Salarda, CRNA – This is an amendment to an Anesthesia Contract.
- Samsadeen Issah, CRNA – This is an amendment to an Anesthesia Contract.
- Mary Jane Dunaway, CRNA – This is an amendment to an Anesthesia Contract.

Wallace Dunn presented the following new contracts:

- Gonzalo Lievano, M.D. – This a three (3) year Urology Contract.
- Leonardo Zelaya Castillo, M.D. – This is a three (3) year Hospitalist Contract.
- Thomas Byrne, M.D. – This is a three (3) year OB/GYN (MFM) Contract.
- Sheharyar Merwat, M.D. – This is a two (2) year Gastroenterology Contract.

Kathy Rhodes moved, and Bryn Dodd seconded the motion to approve the MCH ProCare Provider Agreements as presented. The motion carried.

B. Consider Approval of MCHS Property Leases

Wallace Dunn presented the following MCHS Property Leases:

- MCH TraumaCare – This is a three (3) year property lease.
- MCH ProCare Infectious Disease – This is a three (3) year property lease.

Bryn Dodd moved, and Kathy Rhodes seconded the motion to approve the MCHS Property Leases as presented. The motion carried.

XVI. ADJOURNMENT

There being no further business to come before the Board, Wallace Dunn adjourned the meeting at 6:53 p.m.

Respectfully submitted,

David Dunn, Secretary
Ector County Hospital District Board of Directors

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Medical Staff and Allied Health Professionals Staff Applicants

Statement of Pertinent Facts:
Pursuant to Article 7 of the Medical Staff By laws, the application process for the following Medical Staff and Allied Health Professional applicants is complete. The Joint Conference Committee and the Medical Executive Committee recommend approval of privileges or scope of practice and membership to the Medical Staff or Allied Health Professionals Staff for the following applicants, effective upon Board Approval.

Medical Staff:

Applicant	Department	Specialty/Privileges	Group	Dates
Maleeha Basham, MD	Hospitalist	Hospitalist	ProCare	12/03/2024-12/02/2025
Gonzalo Lievano, MD	Surgery	Urology	ProCare	12/03/2024-12/02/2025
Gia Marotta, MD	Surgery	Otolaryngology	ProCare	12/03/2024-12/02/2025
Sheharyar Merwat, MD	Medicine	Gastroenterology	ProCare	12/03/2024-12/02/2025
Jack Shakarshy, MD	Radiology	Telemedicine	VRAD	12/03/2024-12/02/2026

Allied Health:

Applicant	Department	AHP Category	Specialty/Privileges	Group	Sponsoring Physician(s)	Dates
Mackenzie Allen, PA	Emergency Medicine	AHP	Physician Assistant	BEPO	Dr. Rolando Diaz	12/03/2024-12/02/2026
**Megan Riegle, PA	Surgery	AHP	Physician Assistant		Dr. John Dorman	12/03/2024-12/02/2026

*Please grant temporary Privileges

Advice, Opinions, Recommendations and Motions:

If the Hospital District Board of Directors concurs, the following motion is in order: Accept the recommendation of the Medical Executive Committee and the Joint Conference Committee and approve privileges and membership to the Medical Staff as well as scope of practice and Allied Health Professional Staff membership for the above listed applicants.

Jeffrey Pinnow, MD Chief of Staff
Executive Committee Chair
/MM

Medical Center Hospital
A Member of Medical Center Health System

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Reappointment of the Medical Staff and/or Allied Health Professional Staff

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommends approval of the following reappointments of the Medical Staff and Allied Health Professional Staffa's submitted. These reappointment recommendations are made pursuant to and in accordance with Article 5 of the Medical Staff Bylaws.

Medical Staff:

Applicant	Department	Status Criteria Met	Staff Category	Specialty/Privileges	Group	Changes to Privileges	Dates
Aseem Bhandari, MD	Radiology	Yes	Associate	Radiology	ProCare	None	02/01/2025-01/31/2026
Justin Brown, DPM	Surgery	Yes	Affiliate	Podiatry		None	02/01/2025-01/31/2026
Ramachandra Chemitiganti, MD	Internal Medicine	Yes	Active	Internal Medicine	TTUHSC	None	01/01/2025-12/31/2026
Ronald Dillee, MD	Radiology	Yes	Telemedicine	Telemedicine	VRAD	None	02/01/2025-01/31/2027
Sridhar Enuganti, MD	Hospitalist	Yes	Active	Hospitalist	ProCare	None	02/01/2025-01/31/2027
Jeffrey Freyder, MD	Surgery	Yes	Active	Orthopedic	ProCare	None	02/01/2025-01/31/2027
Stefan Meyering, DO	Emergency Medicine	Yes	Active	Emergency Medicine	BEPO	None	02/01/2025-01/31/2027
Vipul Mody, MD	Hospitalist	Yes	Associate	Hospitalist	ProCare	None	02/01/2025-01/31/2026
John Molland, MD	OB/GYN	Yes	Associate	OB/GYN		None	02/01/2025-01/31/2026
Lisa Moore, MD	OB/GYN	Yes	Associate to Active	Maternal & Fetal Medicine	TTUHSC	None	12/03/2024-12/02/2026
Scott Peterson, MD	Surgery	Yes	Active	Trauma Surgery	MCH Trauma Care	None	02/01/2025-01/31/2027
Heather Webb, MD	Radiology	Yes	Active	Telemedicine		None	02/01/2025-01/31/2026

Allied Health Professionals:

Applicant	Department	AHP Category	Specialty / Privileges	Group	Sponsoring Physician(s)	Changes to Privileges	Dates
Courtney Barner, NP	Surgery	AHP	Nurse Practitioner	MCH Trauma care	Dr. York, Dr. Peterson, Dr. Grove, Dr. Wiltse, Dr. Choi	None	03/01/2025-02/28/2027
Hugh Cochran, CRNA	Anesthesia	AHP	CRNA	Midwest Anesthesia	Dr. Putta Shankar Bangalore, Dr. Abhishek Jayadevappa, Dr. Marlys Munnell, Dr. Hwang, Dr. Skip Batch, Dr. Joe Bryan, Dr. Jannie Tang, Meghana Gillala, Dr. P. Reddy	None	02/01/2025-01/31/2027
Janelle Fabia, NP	Pediatrics	AHP	Nurse Practitioner	TTUHSC	Dr. Robert Bennett	None	03/01/2025-02/28/2027
Jammie Holland, LVN	Medicine	AHP	LVN	TTUHSC	Dr. Timothy Benton		02/01/2025-01/31/2027
Katrina Loera, NP	Medicine	AHP	Nurse Practitioner	ProCare	Dr. Sindhu Kaitha, Dr. Kalyan Chakrala	None	02/01/2025-01/31/2027
Edelmiro Morales, CRNA	Anesthesia	AHP	CRNA	Midwest Anesthesia	Dr. Putta Shankar Bangalore, Dr. Abhishek Jayadevappa, Dr. Marlys Munnell, Dr. Hwang, Dr. Skip Batch, Dr. Joe Bryan, Dr. Jannie Tang, Meghana Gillala, Dr. P. Reddy	None	02/01/2025-01/31/2027
Courtney Meyers, PA	Cardiology	AHP	Physician Assistant	ProCare	Dr. Adam Farber	None	03/01/2025-02/28/2027
Irene Vera, NP	Family Medicine	AHP	Nurse Practitioner	ProCare	Dr. Aberra	None	02/01/2025-01/31/2027

Advice, Opinions, Recommendations and Motions:

If the Hospital District Board of Directors concurs, the following motion is in order Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee relating to the reappointment of the Medical Staff and/or Allied Health Professional Staff.

Jeffrey Pinnow, MD Chief of Staff
Executive Committee Chair
/MM

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Change in Clinical Privileges

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommends the request below on change in clinical privileges. These clinical changes in privileges are recommendations made pursuant to and in accordance with Article 4 of the Medical Staff Bylaws.

Additional Privileges:

Staff Member	Department	Privilege
Nathanael Longacre, PA	Surgery	**REMOVE: ACLS from Privilege Form**
Jemimah Omavuezi, PA	Cardiology	**ADD: Exercise Stress ECG Testing**

Advice, Opinions, Recommendations and Motions:

If the Hospital District Board of Directors concurs, the following motion is in order: Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee relating to the change in clinical privileges of the Allied Health Professional Staff.

Jeffrey Pinnow, MD Chief of Staff
Executive Committee Chair
/MM

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

Change in Medical Staff or AHP Staff Status–Resignations/Lapse of Privileges

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommends approval of the following changes in staff status. These resignations/lapses of privileges are recommendations made pursuant to and in accordance with Article 4 of the Medical Staff Bylaws.

Resignation/Lapse of Privileges:

Staff Member	Staff Category	Department	Effective Date	Action
Madison Flores, PA	AHP	Medicine	04/04/2024	Resignation
Michele Foster, NP	AHP	Medicine	11/22/2024	Resignation
Sarah Kiani, MD	Active	Medicine	11/01/2024	Resignation

Advice, Opinions, Recommendations and Motion:

If the Hospital District Board of Directors concurs, the following motion is in order: Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee to approve the Resignation/Lapse of Privileges.

Jeffrey Pinnow, MD Chief of
Staff
Executive Committee Chair
/MM

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Change in Medical Staff or AHP Staff Category

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommend approval of the following changes in staff status category. The respective departments determined that the practitioners have complied with all Bylaws requirements and are eligible for the changes noted below.

Staff Category Change:

Staff Member	Department	Category
Lisa Moore, MD	OB/GYN	Associate to Active

Changes to Credentialing Dates:

Staff Member	Staff Category	Department	Dates
None			

Changes of Supervising Physician(s):

Staff Member	Group	Department
None		

Leave of Absence:

Staff Member	Staff Category	Department	Effective Date	Action
None				

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Removal of I-FPPE

Staff Member	Department	Removal/Extension
Abidemi Adeniran, NP	Hospitalist	**I-FPPE Removal**
Jennifer Adkins, NP	Surgery	**I-FPPE Removal**
Adam De Fazio, MD	Surgery	**I-FPPE Removal**
Angela Green, NP	Surgery	**I-FPPE Removal**
Alma Hernandez, NP	Family Medicine	**I-FPPE Removal**
Lucas Jacomides, MD	Surgery	**I-FPPE Removal**
Omer Kineish, MD	Surgery	**I-FPPE Removal**
John Molland, MD	OB/GYN	**I-FPPE Removal**
Hannah Yee, NP	Medicine	**I-FPPE Removal**
Jose Vilaro, MD	Surgery	**I-FPPE Removal**

Change in Privileges

Staff Member	Department	Privilege
None		

Proctoring Request(s)/Removal(s)

Staff Member	Department	Privilege(s)
None		

Advice, Opinions, Recommendations and Motion:

If the Hospital District Board of Directors concurs, the following motions in order: Accept and approve the recommendations of the Medical Executive Committee and the Joint Conference Committee to approve the staff category changes, changes to the credentialing dates, changes of supervising physicians, leave of absence, removal of -FPPE, proctoring requests/removals, and change in privileges.

Jeffrey Pinnow, MD Chief of Staff
Executive Committee Chair
/MM

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

Statement of Pertinent Facts:

The Medical Executive Committee recommends approval of the following new delineation of privilege forms:

- Pain Management
- Hospitalist IM/FM
- Internal Medicine
- Podiatry
- Dentistry
- Dermatology
- Ophthalmology
- Urology
- General Surgery

Advice, Opinions, Recommendations and Motion:

- Pain Management
- Hospitalist IM/FM
- Internal Medicine
- Podiatry
- Dentistry
- Dermatology
- Ophthalmology
- Urology
- General Surgery

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Advice, Opinions, Recommendations and Motion:

- If the Joint Conference Committee concurs, the following motion is in order: Accept the recommendation of the Medical Executive Committee to approve the Delineation of Privilege forms and forward this recommendation to the Ector County Hospital District Board of Directors.

Jeffrey Pinnow, MD, Chief of Staff
Executive Committee Chair
/MM

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

Statement of Pertinent Facts:

The Medical Executive Committee recommends approval of the following Additional Surgery Department Chairman Criteria:

Item to be considered:

Statement of Pertinent Facts:

The Medical Executive Committee recommends approval of the following:

- Additional Surgery Department Chairman criteria

Advice, Opinions, Recommendations and Motion:

- Additional Surgery Department Chairman criteria

Advice, Opinions, Recommendations and Motion:

- If the Joint Conference Committee concurs, the following motion is in order: Accept the recommendation of the Medical Executive Committee to approve the additional surgery department chairman criteria.

Forward this recommendation to the Ector County Hospital District Board of Directors.

Jeffrey Pinnow, MD, Chief of Staff
Executive Committee Chair
/MM

December 3, 2024

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

Statement of Pertinent Facts:
The Medical Executive Committee recommends approval of the following Radiology OPPE Plan:

Statement of Pertinent Facts:

The Medical Executive Committee recommends approval of the following:

- Radiology Department OPPE Plan

Advice, Opinions, Recommendations and Motion:

- Radiology Department OPPE Plan

Advice, Opinions, Recommendations and Motion:

- If the Joint Conference Committee concurs, the following motion is in order: Accept the recommendation of the Medical Executive Committee to approve the Radiology Department OPPE Plan
-

Forward this recommendation to the Ector County Hospital District Board of Directors.

Jeffrey Pinnow, MD, Chief of Staff
Executive Committee Chair
/MM

Medical Center Health System

Your One Source for Health

Pain Medicine

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of an ACGME-accredited residency training program in pain medicine.
Certification	Current certification in Pain Medicine from an American Board of Medical Specialties or American Osteopathic Association board. **OR** Within five years of completion of an approved residency in pain medicine, certification in pain medicine by the American Board of Anesthesiology, the American Board of Physical Medicine and Rehabilitation, or the American Board of Psychiatry and Neurology, or in pain management by the American Osteopathic Board of Anesthesiology. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	Should demonstrate provision of inpatient, outpatient or consultative services to at least 30 patients in the past 12 months. This can be demonstrated in one of the following ways: An applicant who has just completed a residency shall provide his/her residency log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his or her clinical activity for the past 12 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 12 months.
	If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications	

Primary Privileges
Pain medicine is the discipline of medicine that specializes in the management of patients suffering from acute or chronic pain, or pain in patients requiring palliative care. The management of acute and chronic pain syndromes is a complex matter involving many areas of interest and different medical disciplines. Clinical and investigative efforts are vital to the progress of the specialty. Fellows may originate from different disciplines and approach the field with varying backgrounds and experience. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation, and coordination of a multiple modality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team

Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Management and Evaluation
☐	Admit to inpatient or appropriate level of care
☐	Perform history and physical examination
☐	Evaluate, diagnose, provide consultation, medically manage, and provide invasive and/or non-invasive treatments to patients presenting with acute or chronic pain syndromes, pain requiring palliative care, or pain related to cancer
	Procedures
☐	Arthrocentesis, aspiration and/or injection, with or without image guidance
☐	Cervical nerve root injections
☐	Cervical or paravertebral sympathetic (autonomic) nerve blocks
☐	Chemical neuromuscular denervation (e.g., Botox injection)
☐	Discography and intradiscal/percutaneous disc treatments
☐	Differential spinals and epidurals
☐	Epidural and intrathecal injections
☐	Facet and medial branch blocks, with or without imaging guidance
☐	Intradiscal electrothermal therapy (IDET) or Intradiscal electrothermal annuloplasty (IDTA)
☐	Lumbar and thoracic nerve root injections
☐	Minimally Invasive Lumbar Decompression (MILD) procedure
☐	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter)
☐	Percutaneous radiofrequency ablation (thermal destruction) of basivertebral nerve, including imaging guidance
☐	Peripheral nerve blocks (plexus, nerve, or branch)

☐	Percutaneous therapeutic discal injections including allograft injection
☐	Percutaneous discectomy
☐	Trigger point injection(s)
☐	Use of radiofrequency ablation (all modes) in an interventional procedural area where the applicant is a concurrent privilege holder
☐	Sacroiliac joint infusion (si joint)

Privilege Cluster: Vertebroplasty and Kyphoplasty

Vertebroplasty and kyphoplasty are minimally invasive procedures for the treatment of vertebral compression fractures (VCF), which are fractures involving the vertebral bodies that make up the spinal column.

Qualifications

Education/Training	Confirmation from pain medicine fellowship program director that applicant successfully completed training in the privileges requested including supervised experience on human subjects. **OR** Confirmation that the applicant completed manufacturer designated training in the specific procedure requested with human subjects experience under the supervision of a qualified physician preceptor.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of clinical services representative of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the privileges requested during the past 24 months.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Procedures
☐	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including imaging guidance
☐	Percutaneous sacral augmentation (sacroplasty) (with cement)
☐	Percutaneous vertebral augmentation (kyphoplasty)
☐	Percutaneous vertebroplasty (with cement)

Privilege Cluster: Pain Medicine Device Implantation

A specialized device which delivers medication directly to the area where pain can be managed. Patients who suffer from neuropathic pain, especially in the limbs, failed back surgery syndrome, complex regional pain syndrome, and sometimes chronic back pain, refractory angina pectoris, peripheral vascular disease may be candidates for spinal cord stimulation therapy. Patients with severe pain related to malignancy and patients with spascity as a result of multiple sclerosis, spinal cord injury, cerebral palsy and other neurologic disorders are candidates for intrathecal infusion pumps.

Qualifications

Education/Training	Confirmation from pain medicine fellowship program director that applicant successfully completed training in the privileges requested including supervised experience on human subjects. **OR** Confirmation that the applicant completed manufacturer designated training in the specific procedure requested with human subjects experience under the supervision of a qualified physician preceptor.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of clinical services representative of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the privileges requested during the past 24 months.

Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Procedures
☐	Analysis, reprogramming, and refilling of implanted devices
☐	Implantation and management of spinal cord stimulator
☐	Implantation and management of peripheral nerve stimulator
☐	Implantation and management of intrathecal programmable pump

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges	
I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:	
Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System

Your One Source for Health

Hospitalist - Family Medicine

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Completion of an ACGME or AOA accredited Residency training program in Family Medicine.
Certification	Current certification in Family Medicine by the American Board of Family Medicine or in Family Practice by the American Osteopathic Board of Family Physicians or its equivalent. **OR** Within five years of completion of an approved residency in Family medicine certification by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	An applicant who has just completed a residency shall provide his/her residency or fellowship log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his/her clinical activity for the past 12 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 12 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Primary Privileges

Description: A Hospitalist is a physician whose primary professional focus is the general medical care of hospitalized patients.

Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Admit and/ or Discharge to inpatient or appropriate level of care
☐	Ambulatory blood pressure monitoring
☐	Central venous catheter
☐	Perform history and physical examination
☐	Evaluate, diagnose, provide generalist/primary care consultation, medically manage and provide treatment to adult patients with a wide variety of medical conditions, illnesses, diseases, injuries or disorders.
	Procedures
☐	Abdominal paracentesis
☐	Arterial puncture
☐	Arthrocentesis
☐	Distal nerve block and trigger point injection
☐	Electrocardiogram (EKG) interpretation
☐	Epistaxis (nasal hemorrhage) management, posterior, including nasal packs and/or cautery
☐	Incision and drainage or aspiration of abscess
☐	Lumbar Puncture
☐	Nasogastric intubation
☐	Skin excision, including biopsy and lesion removal
☐	Trephination of nail (evacuation of subungal hematoma)
☐	Transurethral Catheterization
☐	Wound care management, including local anesthetic techniques, superficial debridement, placement and removal of drains, selection of specialized dressings, including liquid or spray occlusive materials as well as soft or rigid immobilizing dressings, and wound closure

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which

would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges	
I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:	
Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System

Your One Source for Health

Hospitalist - Internal Medicine

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of a residency training program in internal medicine accredited by the ACGME, AOA, or equivalent Canadian training.
Certification	Current certification in Internal Medicine by the American Board of Internal Medicine or in Internal Medicine by the American Osteopathic Board of Internal Physicians or its equivalent. **OR** Within five years of completion of an approved residency in Internal medicine certification by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine Physicians. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	An applicant who has just completed a residency shall provide his/her residency or fellowship log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his/her clinical activity for the past 12 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 12 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Primary Privileges

A Hospitalist is a physician whose primary professional focus is the general medical care of hospitalized patients.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Admit and/ or Discharge to inpatient or appropriate level of care
☐	Ambulatory blood pressure monitoring
☐	Central venous catheter
☐	Evaluate, diagnose, provide generalist/primary care consultation, medically manage and provide treatment to adult patients with a wide variety of medical conditions, illnesses, diseases, injuries or disorders.
☐	Perform history and physical examination
	Procedures
☐	Abdominal paracentesis
☐	Arterial puncture
☐	Arthrocentesis
☐	Distal nerve block and trigger point injection
☐	Electrocardiogram (EKG) and imaging studies, preliminary interpretation
☐	Epistaxis (nasal hemorrhage) management, posterior, including nasal packs and/or cautery
☐	Incision and drainage or aspiration of abscess
☐	Lumbar puncture
☐	Nasogastric intubation
☐	Skin excision, including biopsy and lesion removal
☐	Trephination of nail (evacuation of subungal hematoma)
☐	Transurethral Catheterization
☐	Wound care management, including local anesthetic techniques, superficial debridement, placement and removal of drains, selection of specialized dressings, including liquid or spray occlusive materials as well as soft or rigid immobilizing dressings, and wound closure

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which

would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System
Your One Source for Health

Podiatry

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of a residency training program in Podiatric Medicine and Surgery - 24 months; **OR** Successful completion of a residency training program in Podiatric Medicine and Surgery - 36 months
Certification	Current certification in foot surgery by the American Board of Foot and Ankle Surgery (ABFAS) or The American Board of Podiatric Medicine (ABPM) **OR** Within five years of completion of an approved residency in podiatric medicine, certification by the American Board of Podiatric Surgery (ABPS) and the American Board of Podiatric Medicine(ABPM). 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	An applicant who has just completed a residency shall provide his/her residency log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his or her clinical activity for the past 12 month, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 12 months. Page 33 of 268 If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the past 24 months.

Primary Privileges	
Podiatric Medicine and Surgery (Podiatry) is focused on the study, prevention, and treatment of diseases, disorders and injuries of the foot, ankle, and their governing and related structures by medical, surgical, and physical methods.	
Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Co-admit to inpatient or appropriate level of care
☐	Evaluate, diagnose, provide consultation, medically and/or surgically manage, and provide surgical and/or non-surgical treatment to patients presenting with podiatric injuries, diseases, disorders, or conditions of the forefoot, midfoot, and hindfoot.
☐	Perform history and physical examination
	General Procedures
☐	Administration of peripheral nerve blocks
☐	Onychoplasty
☐	Soft tissue surgery involving a nail, plantar wart excision, avulsion of toenail, excision or destruction of nail matrix, removal of foreign body
	Surgical Privileges for the Forefoot, Midfoot and Non-reconstructive Hind Foot
☐	Ankle arthroplasty, including prosthesis revision, replacement or removal
☐	Arthroplasty, forefoot, including implant
☐	Incision/Drainage/Debridement of ulcer
☐	Digital surgery including, digital exostectomy, digital fusions, tenotomy/capsulotomy, open/closed reduction of digital fracture, simple digital amputation, syndactylization and polydactylism, digital tendon transfers, lengthening, and repair
☐	Excision of benign bone cysts and bone tumors, forefoot
☐	Excision of accessory ossicles
☐	Excision of soft tissue mass (neuroma, ganglion, fibroma)
☐	Excision of sesamoids
☐	Hallux valgus repair with or without metatarsal osteotomy (including 1st metatarsal cuneiform joint)
☐	Metatarsal excision
☐	Metatarsal surgery including open/closed reduction of fractures, metatarsal exostectomy, metatarsal osteotomy, or metatarsal arthrodesis excluding calcaneal fracture
☐	Midtarsal and tarsal ostectomy, including posterior calcaneus spur
☐	Moderate Sedation

☐	Neurolysis or nerve decompression, rearfoot, tarsal tunnel
☐	Plantar fasciotomy with or without excision of calc spur to include endoscopic
☐	reduction of foot fracture, other than digital or metatarsal
☐	Tenotomy/capsulotomy, metatarsal, phalangeal joint
☐	Treatment of deep wound infections, osteomyelitis
☐	Tendon lengthening
☐	Tendon transfers
☐	Tenodesis

Privilege Cluster: Reconstructive Rearfoot and Ankle Surgery

Reconstructive rearfoot and ankle surgery are procedures focused on the surgical reconstruction of bones, joints, ligaments, tendons, muscles and related structures of the foot and ankle. Foot and ankle surgery may be performed for injuries, arthritis, infection, birth defects, or diseases that cause severe foot and ankle deformities.

Qualifications

Education/Training	Successful completion of a 36 month residency program in podiatric medicine and surgery (post completion of a four year college/school of podiatric medicine) in a program approved by the Council on Podiatric Medical Education (CPME).
Certification	Current certification in Reconstructive Rearfoot/Ankle Surgery by the American Board of Foot and Ankle Surgery (ABFAS). **OR** Must be Board Certified in "Reconstructive Rearfoot/Ankle (RRA) Surgery" or in "Foot and Ankle Surgery" if Certified prior to 1991 by the American Board of Foot and Ankle Surgery.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of podiatric services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the past 24 months.
Additional Qualifications	Must qualify for and be granted primary privileges in podiatry.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Procedures

☐	Arthrotomy
☐	Excision of accessory ossicles, midfoot and rearfoot
☐	Excision of benign bone cyst or bone tumors, rearfoot
☐	External fixation (multiplane) confined to the foot
☐	Grafts and flaps
☐	Neurolysis or nerve decompression, rearfoot
☐	Open/closed reduction of foot fracture, other than digital or metatarsal, excluding calcaneal
☐	Open/closed reduction of talus or calcaneus bone fracture
☐	Ostectomy, excision of tarsal coalition
☐	Osteotomies of the midfoot and rearfoot
☐	Rearfoot arthrodesis (fusion)
☐	Repair, primary, open or percutaneous, ruptured Achilles tendon, including graft
☐	Tendon lengthening
☐	Tendon transfers
☐	Tenodesis
	Ankle procedures
☐	Arthroscopy, diagnostic
☐	Arthroscopy, therapeutic, including debridement and soft tissue repair
☐	Tendon and ligament repair
☐	Treatment of fractures, including with or without instrumentation

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System

Your One Source for Health

Dentistry

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of accredited dental program recognized by the American Dental Association. Successfully pass Parts I and II of the written National Board Dental Examination. **AND** Completion of a one (or two) year residency program (approved by ADA CODA) in general dentistry. **AND** Successfully pass the Clinical Examination Requirement. Clinical examinations are conducted by individual state boards of dentistry or by regional dental testing agencies. NOTE: Candidates for dental licensing in most U.S. licensing jurisdictions are subject to the clinical examination requirement, with the exception of New York, who requires completion of an accredited postgraduate dental education program of at least 1 year in length. California, Connecticut, Minnesota, and Washington offer the option of completing an accredited postgraduate education program, at least 1 year in length, in lieu of a clinical examination. **AND** Current state license to practice dentistry. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of general dentistry services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year). An applicant who has just completed a training program shall provide his/her training program log. **OR** An applicant who is not applying directly out of a training program shall provide a quality profile from facilities where the applicant currently has privileges showing his/her clinical activity for the past 12 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the facilities where the applicant currently has privileges, documentation of the applicant's clinical activity for the past 24 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience -	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Renewal of
Privileges

Primary Privileges	
Provision of primary oral health care, including performing restorative, prosthetic, routine endodontic therapy, routine periodontal therapy, and simple exodontia, as well as performing examinations. Direct health promotion and disease prevention activities. Plan and coordinate multidisciplinary oral health care for a wide variety of patients including patients with special needs.	
Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Consult of patients that require hospitalization/one-day surgery for dental procedures
☐	Perform history and physical examination
☐	Provide general dental diagnostic, preventive, and therapeutic oral health care to correct or treat various routine conditions of the oral cavity, dentition and related structures. Privileges include the use and interpretation of dental radiology.
	Procedures
☐	Administration of nitrous oxide (anxiety control)
☐	Administration of dental nerve blocks
☐	Alveoloplasty
☐	Carious teeth, restoration of, includes: - amalgam; - composite; - cast restoration
☐	Dental prostheses, construction of fixed
☐	Dental prostheses, construction of removable
☐	Emergent treatment of traumatic dental injuries
☐	Erupted teeth, removal of
☐	Gingivectomy
☐	Gingivoplasty
☐	Infected teeth, emergency treatment of
☐	Local anesthesia in the oral cavity
☐	Moderate Sedation, administer
☐	Non-complex implant restoration
☐	Palliative dental treatment
☐	Restorative dentistry, including crown and bridge preparation

☐	Scaling and root planning
☐	Simple extractions
☐	Soft tissue surgery (minor)
☐	Splinting of mobile teeth, temporary
☐	Traumatized teeth, emergency treatment of

Privilege Cluster: Dental Subspecialty Procedures

Qualifications

Education/Training	Requires certification of completion of the applicable CODA approved subspecialty program.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Procedures
☐	Endodontics Specialist. Provide expert consultative evaluation and perform procedures including apicoectomy with or without root canal therapy and/or retrograde fillings; and use of operating microscope for endodontic therapy.
☐	Maxillo-facial Prosthodontics
☐	Orthodontics Specialist. Including minor tooth movement for tooth guidance; treatment to control para-functional habits; interceptive orthodontic treatment, treatment of the transitional dentition; treatment of permanent dentition, treatment of atypical or extended skeletal case; post treatment stabilization; splint therapy.
☐	Periodontics Specialist. Provide expert consultative evaluation and perform procedures including osseous surgery (including flap entry and closure); free gingival grafts; pedicle grafts; osseous grafts (one or multiple sites) in conjunction with peridontal surgery; root resections, hemisections in conjunction with peridontal surgery.

Privilege Cluster: Oral Medicine and/or Orofacial Pain

Oral Medicine is focused on the oral health care of medically complex patients, including the diagnosis and management of medical conditions that affect the oral and maxillofacial region. Orofacial pain is focused on the diagnosis, management and treatment of pain disorders of the jaw, mouth, face, head and neck.

Qualifications

Education/Training	Completion of a 12 month residency or fellowship in Oral Medicine and/or Orofacial Pain as applicable to the privileges requested. The applicant must submit a letter from the board attesting to such qualification.
Certification	Current certification by the American Board in Oral Medicine and/or Orofacial Pain as applicable to privileges requested.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Request

☐ - Newly Requested privileges ☐ - Currently Granted privileges

	Procedures
☐	Biopsy and management of oral lesions
☐	Complex appliance therapy
☐	Evaluation and treatment of headache and orofacial pain
☐	Dental nerve blocks
☐	Trigger point injection
☐	Temporomandibular joint injection

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges	
I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:	
Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System
Your One Source for Health

Dermatology

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of a residency training program in dermatology accredited by the ACGME or approved by the AOA.
Certification	Within five years of completion of an approved residency in dermatology, certification by the American Board of Dermatology or the American Osteopathic Board of Dermatology. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	Should demonstrate provision of inpatient, outpatient or consultative services to at least 25 patients in the last 12 months. This can be demonstrated in one of the following ways: An applicant who has just completed a residency shall provide his/her residency log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his or her clinical activity for the past 12 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 12 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session

Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Primary Privileges

Description: Dermatology is the specialty focused on the recognition, evaluation, diagnosis, treatment, and management of benign and malignant conditions and disorders of the skin, hair and nails, and adjacent mucous membranes.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Admit to inpatient or appropriate level of care
☐	Evaluate, diagnose, provide consultation, medically manage and provide treatment to patients presenting with dermatologic diseases, disorders, or conditions of the skin, hair, nails, and mucous membranes. Privileges include medical management of general medical conditions that may be encountered during the course of care to dermatology patients.
☐	Perform history and physical examination
	Procedures
☐	Adjacent tissue transfer
☐	Skin excision, including debridement, biopsy, excision of benign or malignant lesions, including repair
☐	Botulinum toxin injection, chemodenervation
☐	Hair transplantation, punch or strip
☐	Injection of dermal fillers
☐	Lip excision, including biopsy, vermilionectomy, wedge excision, and lip resection
☐	Nail procedures
☐	Scar revision
☐	Split or full-thickness grafts
☐	Use of energy sources (lasers, cryo, radiofrequency) as an adjunct to any privileged procedure

Privilege Cluster: Dermatopathology

Description: Dermatopathology is the subspecialty of Dermatology and Pathology that is concerned with the study and diagnosis of diseases of the skin and adjacent mucous membranes, cutaneous appendages, hair, nails, and subcutaneous tissues by histological, histochemical, immunological, ultrastructural, molecular, and microbiological techniques.

Qualifications

Education/Training	Completion of an ACGME accredited Fellowship training program in Dermatopathology
Certification	Current certification in Dermatopathology by the American Board of Dermatology or Dermatopathology by the American Osteopathic Board of Dermatology or its equivalent. Board certification must be achieved within five years of completion of training and must be continuously maintained.
Clinical Experience - Initial Privileges	Applicant must be actively practicing in this subspecialty and exercising the full range of privileges requested during the previous year. This requirement is waived for applicants who completed training in dermatopathology during the previous year.
Clinical Experience - Renewal of Privileges	Actively practicing in this subspecialty and exercising the full range of privileges requested in the previous 24 months.
Additional Qualifications	Must qualify for and be granted primary privileges in Dermatology

Request

☐ - Newly Requested privileges ☐ - Currently Granted privileges

	Procedures
☐	Examination and interpretation of specially prepared tissue sections, including interpretation of MOHS micrographic frozen sections, cellular scrapings and smears of skin lesions by means of routine and special microscopes (electron and fluorescent)
☐	Interpretation of immunologic analysis of tissue cells and body fluids

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges	
I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:	
Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System
Your One Source for Health

Ophthalmology

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of a residency program in ophthalmology accredited by the ACGME or approved by the AOA.
Certification	Current certification in Ophthalmology by the American Board of Ophthalmology or in Ophthalmology by the American Osteopathic Board of Ophthalmology and Otolaryngology or its equivalent. **OR** Within five years of completion of an approved residency, certification in ophthalmology by the American Board of Ophthalmology or the American Osteopathic Boards of Ophthalmology and Otolaryngology / Head and Neck Surgery. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience-Initial Privileges	An applicant who has just completed a residency shall provide his/her residency log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his or her clinical activity for the past 24 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 24 months. Applicant should demonstrate performance of a minimum of 100 Ophthalmology surgery procedures in the past 12 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience-Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.
Additional	Documentation of performance of supervised cases on human subjects after completion of

Qualifications for Ocular Brachytherapy Placement	manufacturer designated training or training by a recognized expert in ocular brachytherapy placement.

Primary Privileges

The specialty of Ophthalmology is focused on comprehensive eye and vision care. Ophthalmologists prescribe glasses and contacts, provide treatment and manage prevention of medical disorders of the eye, and perform all types of eye surgery. Ophthalmologists have expertise in optics, visual physiology, and corrections of refractive errors; retina, vitreous, and uvea; neuro-ophthalmology; pediatric ophthalmology and strabismus; external disease and cornea; glaucoma, cataract, and anterior segment; oculoplastic surgery and orbital diseases; and ophthalmic pathology.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Admit to inpatient or appropriate level of care
☐	Evaluate, diagnose, provide consultation, order diagnostic studies, and provide surgical and/or non-surgical treatment to patients presenting with ocular and visual injuries, diseases, disorders, and conditions, of the eye and its component structures, eyelids, the orbit, and the visual pathways
☐	Perform history and physical examination
	Procedures
☐	Cataract surgery, discission of secondary membranous cataract (opacified posterior lens capsule and/or hyaloid); stab incision technique and extracapsular cataract removal with insertion of intraocular lens prosthesis, manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)
☐	Dacryocystorhinostomy (fistulation of lacrimal sac to nasal cavity)
☐	Evisceration of ocular contents or enucleation of eye, with or without implant
☐	Glaucoma procedures
☐	Goniotomy
☐	Insertion of anterior segment aqueous drainage device
☐	Insertion of iris prosthesis, including suture fixation and repair or removal of iris
☐	Intraocular foreign body removal, intraocular; from anterior chamber of eye or lens or from posterior segment
☐	Injection of vitreous substitute (fluid-gas exchange), with or without aspiration; Implantation of intravitreal drug delivery system (eg, ganciclovir implant) with concomitant removal of vitreous, or intravitreal injection of pharmacologic agent
☐	Ophthalmic plastic and reconstructive surgery, functional or aesthetic
☐	Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)

☐	Photodynamic therapy (PDT)
☐	Placement of ocular brachytherapy in collaboration with a Radiation Oncologist
☐	Refractive eye surgery procedures
☐	Removal of vitreous, anterior approach (open sky technique or limbal incision); partial or subtotal removal with mechanical vitrectomy
☐	Surgical procedures involving the cornea, sclera, and conjunctiva, including removal of foreign body, excision, and repair (excludes refractive eye surgery)
☐	Surgical procedures involving the orbit, including orbital exenteration, orbitotomy, orbital implant insertion, and orbital reconstruction or repair
☐	Strabismus surgery, recession or resection procedure, transposition, exploration and/or repair of detached extraocular muscles, release of scar tissue, chemodenervation, or biopsy
☐	Temporal artery, ligation or biopsy
☐	Use of lasers as an adjunctive tool in a procedural area where the applicant is a concurrent privilege holder
☐	Use of an ophthalmic endoscope in a procedural area where the applicant is a concurrent privilege holder

Privilege Cluster: Retina and Vitreous Surgery

Diagnosis and management of medical and surgical disorders of the retina and vitreous, including treatment of patients with vitreoretinal diseases by initial evaluation and long term follow-up of outpatients; pre, intra-, and post-operative care of patients.

Qualifications

Education/Training	Completion of a two-year vitreo-retinal training program. The fellowship program must be based in an organization that also sponsors an ACGME residency program in Ophthalmology.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months or completion of a vitreo-retinal fellowship in the previous year with documented experience in the specific privileges requested.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications	Must qualify for and be granted primary privileges in Ophthalmology.

Request

☐ - Newly Requested privileges ☐ - Currently Granted privileges

	Procedures
☐	Destruction of retinal lesion (eg, macular edema, tumors); cryotherapy, diathermy, or photocoagulation
☐	Intraocular tamponade (i.e., air, gas, silicone oil)
☐	Pneumatic retinopexy (repair of retinal detachment)
☐	Scleral buckling (repair of retinal detachment)
☐	Vitrectomy, mechanical, pars plana approach

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System

Your One Source for Health

Urology

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of an ACGME-accredited residency training program in clinical urology or an AOA-approved training program in urological surgery.
Certification	Current certification in Urology by the American Board of Urology or in Urological Surgery by the American Osteopathic Board of Surgery or its equivalent. **OR** Within five years of completion of an approved residency, certification in urology by the American Board of Urology or in urological surgery by the American Osteopathic Board of Surgery. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	Can be demonstrated in one of the following ways: An applicant who has just completed a residency shall provide his/her residency log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where the applicant currently has privileges showing his/her clinical activity for the past 12 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant?s hospital-based clinical activity for the past 12 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Primary Privileges

Urology evaluates and treats patients with disorders of the genitourinary tract, including the adrenal gland and external genitalia. Specialists in this discipline demonstrate knowledge of the basic and clinical sciences related to the normal and diseased genitourinary system, as well as attendant skills in medical and surgical therapy.

Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Admit and/or Discharge to inpatient or appropriate level of care
☐	Evaluate, diagnose, provide consultation, medically and/or surgically manage, and provide surgical and/or non-surgical treatment to patients presenting with congenital or acquired diseases, disorders, injuries, and conditions of the genitourinary tract, including the adrenal gland and external genitalia
☐	Perform history and physical examination
	Kidney Procedures
☐	da Vinci Surgical System **Please contact the Medical Staff Office for criteria**
☐	Extracorporeal Shock Wave Lithotripsy (ESWL)
☐	Nephrectomy, open renal biopsy, excision or marsupialization of renal cyst
☐	Open kidney procedures, including perirenal or renal abscess drainage, nephrostomy, nephrotomy, nephrolithotomy, pyelotomy, pyelostomy, pyeloplasty, and nephrorrhaphy
☐	Percutaneous renal biopsy including fine needle aspiration
☐	Placement and management of percutaneous nephrostomy catheter and renal endoscopy, including biopsy, foreign body or calculus removal, and tumor resection
☐	Renal endoscopy through nephrotomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography with endopyelotomy (includes cystoscopy, urteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)
	Ureteral Procedures
☐	Ureteroscopy, including catheterization, biopsy, fulguration or incision, foreign body or calculus removal
☐	Ureteral procedures, including ureterotomy, ureter stent placement and management, ureterolithotomy, ureterectomy, ureteroplasty, ureterolysis, ureterostomy and laser lithotripsy
☐	Ureteral anastomosis procedures
	Bladder Procedures
☐	Bladder procedures, including cystolithotomy, cystotomy for bladder neck or diverticula excision, cystectomy, pelvic exenteration, cystourethroplasty, including bladder neck suspension procedures, cystourethroscopy procedures, transurethral bladder neck procedures in males, insertion and management of bladder neck sphincter
☐	Cutaneous appendico-vesicostomy
☐	Cystocele repair
☐	Cystectomy Robotic

☐	Enterocystoplasty (bladder augmentation)
☐	Implantation and management of neuromodulation device (e.g., InterStim) for bladder control
☐	Incontinence surgery, including endoscopic urethral bulking, bladder neck or urethral suspension procedures, sling operations, urethral/bladder neck sphincter insertion and management, periurethral transperineal adjustable balloon continence device insertion
☐	Insertion and management of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
☐	Percutaneous and cystourethroscopic bladder procedures
	Urethral Procedures
☐	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch), with or without endoscopic control (eg, Stamey, Raz, modified Pereyra)
☐	Cystourethroscopic and open urethral biopsy and excision or fulguration of urethral lesions, tumors, polyps, caruncles, prolapse or Skene's glands
☐	Distal hypospadias repair (1-stage), with or without chordee or circumcision; with simple meatal advancement (eg, Magpi, V-flap), with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)
☐	Urethroplasty
☐	Urethrotomy, urethrectomy, and urethral diverticulectomy, including urethroplasty
	Prostate Procedures
☐	Prostate biopsy, prostatectomy, open or transurethral
☐	Radical prostatectomy
☐	Transurethral lifting or repositioning of the prostate
	Genital Surgery
☐	Erectile dysfunction procedures, including revascularization and prothesis insertion and management
☐	Penectomy; partial or complete
☐	Performance of circumcision, using clamp or other device with regional dorsal penile or ring block
☐	Scrotal procedures, including inguinal hernia repair, testicular biopsy, orchiectomy, testicular torsion reduction, orchiopexy, spermatocele, hydrocele, or varicocele excision, epididymectomy, scrotal abscess drainage, vasectomy, and vasovasostomy
☐	Surgical correction for Peyronie's Disease or Chordee
☐	Surgical intervention for priapism, including irrigation, fistulization, or shunt placement
	Miscellaneous Procedures
☐	Abdominal (ventral) hernia repair incidental to a urological procedure
☐	Ablation, all modes
☐	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy
☐	Basic diagnostic laparoscopy, including ligation of spermatic veins for varicocele, lymphadenectomy, biopsy, or tissue removal

☐	Lymphadenectomy, inguinal, retroperitoneal, or pelvic
☐	Urinary diversion (eg, taking down of ureteroileal conduit, ureterosigmoidostomy or ureteroenterostomy with ureteroureterostomy or ureteroneocystostomy)

Privilege Cluster: Advanced Laparoscopic and Robotic Procedures

Minimally invasive surgery

Qualifications

Education/Training	Formal training during urology residency in advanced laparoscopy. Program Director must validate training and competency. **OR** Post residency training supervised by an experienced advanced laparoscopic surgeon. **AND** Must have da Vinci Surgical System privileges
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of advanced laparoscopic procedures representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications	Applicant must qualify for and be granted primary privileges in Urology.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Procedures
☐	da Vinci Surgical System **contact the Medical Staff Office for Criteria**
☐	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy
☐	Lymphadenectomy, retroperitoneal
☐	Nephrectomy, radical (for cancer), partial, hand-assisted
☐	Nephrectomy, simple
☐	Nephroureterectomy
☐	Pyeloplasty
☐	Reconstructive bladder surgery
☐	Renal cyst ablation
☐	Ureteroneocystostomy; with vesico-psoas hitch or bladder flap

☐	Ureterolysis
☐	Ureterolithotomy
☐	Ureteroneocystostomy with or without cystoscopy and ureteral stent placement
☐	Ureteral reimplantation
☐	Prostatectomy
☐	Ureterostomy

Privilege Cluster: Female Pelvic Medicine and Reconstructive Surgery (Urogynecology)

Female pelvic medicine and reconstructive surgery physicians provide specialized services and comprehensive management of women with pelvic floor disorders. Comprehensive management includes the preventive, diagnostic, and therapeutic procedures necessary for the total care of the female patient, including complications and sequelae resulting from pelvic floor disorders

Qualifications

Education/Training	Completion of an ACGME accredited fellowship in Female Pelvic Medicine and Reconstructive Surgery. **OR** Completion of American Urology Association approved fellowship in female urology or evidence of prior training and experience in the specific procedure during ACGME or AOA accredited urology residency.
Certification	Current certification in Female Pelvic Medicine and Reconstructive Surgery by the American Board of Urology.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of urolgynecology surgery services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Request

☐ - Newly Requested privileges ☐ - Currently Granted privileges

	Procedures
☐	Perineoplasty, anteroposterior colporrhaphy or colpopexy (i.e., vaginal vault repair), and/or enterocele repair
☐	Repair of the urethral diverticulum
☐	Sacrocolpopexy

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

Medical Center Health System

Your One Source for Health

General Surgery

Delineation of Privileges

Applicant's Name: Test, Provider

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Facilities

☑ **MCH**

Required Qualifications

Education/Training	Successful completion of a residency training program in surgery accredited by the ACGME or approved by the AOA.
Certification	Within five years of completion of an approved residency in General Surgery certification by the American Board of General Surgery or the American Osteopathic Board of Surgery. 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	Should demonstrate performance of at least 250 major operations in the past 12 months. This can be demonstrated in one of the following ways: An applicant who has just completed a residency shall provide his/her residency log. **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his or her clinical activity for the past 24 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 24 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Primary Privileges

The practice of surgery encompasses the provision of comprehensive care to the patient with surgical disorders of the abdomen and its contents, the alimentary tract, skin, soft tissues, and breast, endocrine organs, and trauma. The practice of surgery also encompasses the surgical evaluation and management of patients with oncologic, vascular, pediatric, and intensive care disorders. Furthermore, the practice of surgery entails adequate knowledge and experience for the assessment and requisite emergency surgical stabilization and management of severe conditions of the cardiothoracic, urologic, gynecologic, neurologic, and otolaryngologic systems and indications for specialty consultations. Comprehensive care includes (but is not limited to) the evaluation, diagnosis, and treatment (both operative and non-operative) of surgical disorders, as well as the appropriate disposition and follow-up of the patients with those disorders. To include open or Laparoscopic

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Admit and/or Discharge to inpatient or appropriate level of care
☐	Evaluate, diagnose, provide consultation, medically and/or surgically manage, and provide surgical and/or non-surgical treatment to patients presenting with various injuries, diseases, disorders, and conditions affecting the abdomen, digestive tract, endocrine system, breast, skin and blood vessels
☐	Perform history and physical examination
	Vascular Access Procedures
☐	Insertion and management of central venous catheters, arterial lines, pulmonary artery catheters, pumps and ports, and transvenous intrahepatic portosystemic shunts
	Alimentary Tract procedures
☐	Abdominoperineal resection
☐	Abdominal procedures
☐	Gastric procedures, including gastrotomy, total or partial gastrectomy, gastric intubation or aspiration, gastric bypass, and gastric repair procedures (non-bariatric)
☐	Ileo-anal pull-through procedure (J Pouch creation)
☐	Rectal and anal procedures, including hemorrhoidectomy, rectal prolapse repair, proctectomy, anoplasty, fistula and fissure repair, and abscess incision, Proctoscopy, anoscope and drainage.
☐	Small and large bowel procedures, including biopsy, enterolysis, bowel resections, stoma creations, diverticulectomy, and appendectomy
	Abdominal and Pelvic Procedures
☐	Abdominal wall hernia repair, epigastric, incisional, spigelian, or umbilical, with or without mesh
☐	Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy
☐	Biliary tract procedures, including cholecystectomy with and without common duct exploration, biliary-gastrointestinal tract anastomosis
☐	Drainage of intra-abdominal abscess
☐	Drainage of pancreatic abscess

☐	Fine needle aspiration (FNA)
☐	Inguinal hernia repair, with or without mesh
☐	Incidental hysterectomy or incision and drainage of genital abscess or Oophorectomy
☐	Paraesophageal hiatal hernia repair, with or without mesh, including fundoplication and Linxs
☐	Pancreatectomy, with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure)
☐	Pancreatectomy, with or without splenectomy; with pancreaticojejunostomy; with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy, including anastomosis
☐	Resection or debridement of pancreas, including peripancreatic tissue
☐	Retroperitoneal transabdominal lymphadenectomy, including pelvic, aortic, and renal nodes
☐	Splenic procedures including splenectomy and repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy
	Liver Procedures
☐	Hepatotomy, drainage of abscess or cyst
☐	Hepatectomy, resection of liver
☐	Insertion and management of transvenous intrahepatic portosystemic shunts, including venous access.
☐	Liver biopsy, percutaneous or excisional
	Skin/Soft Tissue Procedures
☐	Head and neck surgery, including tracheostomy creation, revision, and closure; biopsy and excision of oral, tongue, or floor of mouth lesions; thyroidectomy, and parathyroidectomy
☐	Lymphatic biopsy, excision, and lymphadenectomy
☐	Skin and soft tissue procedures, including debridement, skin and muscle biopsy, benign and malignant skin lesion excision, wound repair, grafts and flaps, and burn management
	Additional thoracic procedures available to the general surgeon
☐	Sympathectomy, thoracic or thoracolumbar
☐	Thoracostomy, including tube thoracostomy placement (i.e., chest tube) and thoractomy procedures
☐	Thoracentesis, needle or catheter, with or without imaging guidance
☐	Vagotomy

Privilege Cluster: Bariatric Surgery

Bariatric surgery is a type of procedure performed on people who are morbidly obese, for the purpose of losing weight. This weight loss is usually achieved by restrictive or malabsorptive operations.

Qualifications	
Education/Training	Concurrent privileges to perform advanced laparoscopic surgery. **AND** Formal didactic training in bariatric surgery, including preoperative evaluation and patient selection, operative techniques, and postoperative follow-up consistent with ACS requirements. **OR** Participation in a structured bariatric program with long-term follow-up if training occurred greater than 12 months ago.
Continuing Education	Participation in 6 hours of bariatric specific CME every 24 months. Evidence of continuing medical education related to bariatric surgery privileges.
Clinical Experience - Initial Privileges	Evidence of the performance of 50 bariatric operations with satisfactory outcomes in the past 12 months OR evidence of completion of formal Residency/fellowship training in bariatric procedures that included supervised training on human subjects in the past 12 months. An evaluation from the director of the applicant's residency/ fellowship training program that included laparoscopic bariatric surgery OR from the director of another appropriate training program in bariatric surgery. **AND** An evaluation from the department chief at another hospital where the applicant is/was granted privileges to perform bariatric surgery or from another professional colleague who has direct knowledge of the applicant's competence to perform bariatric surgery.
Clinical Experience - Renewal of Privileges	Evidence of the performance of 75 bariatric operations in the previous 24 months reflective of the scope and complexity and privileges requested. **AND** Evidence of continuing medical education related to bariatric surgery privileges.

Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Procedures
☐	Gastric restrictive procedure, with gastric bypass;
☐	Gastric-restrictive procedure; placement and management of adjustable gastric restrictive device (gastric band and subcutaneous port components)
☐	Bariatric procedures involving transection of the gastrointestinal tract, sleeve gastrectomy, duodenal switch and other similar procedures included in bariatric reconstruction of the gastrointestinal tract
☐	Gastric restrictive procedure revisions
☐	Endoluminal therapy, deployment of bariatric balloon

Privilege Cluster: Endoscopic Procedures

Use of an endoscope to look inside the body to make a diagnosis or to treat abnormalities. The endoscope has a tiny camera on the tip of a long tube that is passed through an opening, such as the mouth or anus, or through a small incision in the abdomen or joint. Various kinds of endoscopy include laparoscopy for the abdomen, colonoscopy for the large intestine, bronchoscopy for the lungs and cystoscopy for the urinary system.

Qualifications

Education/Training	Successful completion of a residency training program in surgery accredited by the ACGME or approved by the AOA. **OR** Documentation that the specific endoscopy procedure requested was taught by an experienced endoscopic practitioner post residency training. Documentation must include a detailed description of the nature of the training, the number of procedures performed with and without supervision and the actual observed competency of the applicant for each endoscopic procedure for which privileges are requested. **OR** If training occurred greater than 12 months ago the applicant must provide evidence of ongoing clinical practice in each procedural privilege requested.
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of surgical services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year). If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications	Must qualify for and be granted primary privileges in General Surgery

Request	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Procedures
☐	Colonoscopy, with or without biopsy; polyp removal, any method; and colonic dilation with or without stent placement **Please contact the Medical Staff Office for criteria**
☐	Diagnostic bronchoscopy, including biopsy and aspiration or removal of foreign body
☐	ERCP with sphincterotomy, stent placement and management, stone extraction or destruction and balloon dilation **Please contact the Medical Staff Office for criteria**
☐	Esophagogastroduodenoscopy (EGD), with or without biopsy **Please contact the Medical Staff Office for criteria**
☐	Laryngoscopy
☐	Percutaneous Endoscopic Gastrostomy (PEG) tube placement **Please contact the Medical Staff Office for criteria**
☐	Sclerotherapy of esophageal/gastric varices

☐	Sigmoidoscopy with or without biopsy or polypectomy **Please contact the Medical Staff Office for criteria**

Privilege Cluster: Breast Disease and Surgical Oncology
Diagnosis and preoperative, operative, and postoperative management of patients with diseases, injuries, and disorders of the breast.

Qualifications

Education/Training	Completion of an ACGME or AOA accredited Residency training program in Surgery-General
Clinical Experience - Initial Privileges	Applicant must provide documentation of provision of breast disease and surgery services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Evaluate, diagnose, provide consultation, medically and/or surgically manage, provide surgical and/or non-surgical treatment to patients presenting with injuries, diseases, disorders, and conditions of the breast and the surrounding tissues and interdisciplinary treatment planning with multiple disciplines (radiology, plastic and reconstructive surgery, medical oncology, radiation oncology and pathology)
	Procedures
☐	Biopsy, ultrasound guided, vacuum assisted, rotational cutting biopsy
☐	Biopsy, including stereotactic core and percutaneous core, with or without imaging guidance
☐	Breast reconstruction
☐	Chest wall resection
☐	Duct exploration and excision; central, major, or terminal
☐	Lymphadenectomy
☐	Percutaneous ultrasound-guided breast cryoablation or radiofrequency ablation
☐	Sentinel lymph node mapping, biopsy and dissection
☐	Mastectomy procedures; complete or partial, with or without axillary lymph node dissection, radical, modified radical, subcutaneous, or skin-sparing, including immediate or delayed insertion of breast implant

☐	Placement of breast localization devices (wires, clips) or radiotherapy afterloading catheters, with or without imaging guidance

Privilege Cluster: Trauma Surgical

Surgical critical care is the subspecialty of surgery that focuses on the management of complex surgical and medical problems in critically-ill surgical patients.

Qualifications

Education/Training	Successful completion of an ACGME-General Surgery Residency Certified by the ABMS or AOA.
Certification	Within five years of completion of an approved residency in anesthesiology, certification by the American Board of Surgery or the American Osteopathic Board of Surgery 2.A.1 THRESHOLD ELIGIBILITY CRITERIA The applicant is board certified as that term is defined in the Article 2.A.1.(q) of the Medical Staff Bylaws, and pursuant to any other applicable Medical Staff Bylaws provision, by a board recognized by the American Board of Medical Specialties or the American Bureau of Osteopathic Specialties 6/11/13.
Clinical Experience - Initial Privileges	An applicant who has just completed a residency shall provide his/her residency log. Should demonstrate performance of at least 250 major operations in the past 12 months. This can be demonstrated in one of the following ways: **OR** An applicant who is not applying directly out of a residency shall provide a quality profile from hospital(s) where he/she currently has privileges showing his or her clinical activity for the past 24 months, including numbers of procedures performed, morbidity, mortality, infection rates and other complications. **OR** If a quality profile is not available from the hospital(s) where the applicant currently has privileges, documentation of the applicant's hospital-based clinical activity for the past 24 months. If applicant is not able to demonstrate the minimum requirements the application will be reviewed by the department in Executive Session.
Clinical Experience - Renewal of Privileges	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Request	
	☐ - Newly Requested privileges ☐ - Currently Granted privileges
	Evaluation and Management
☐	Evaluate, diagnose, provide consultation, medically and/or surgically manage, and provide surgical and/or non-surgical treatment to patients presenting with traumatic injury or with various injuries, diseases, and disorders that lead to life threatening conditions, such as severe or multiple organ dysfunction that requires critical care intervention
☐	Airway management

☐	Computed tomography, interpretation of
☐	DVT prophylaxis, management of
☐	Fluid resuscitation of trauma victims, management of
☐	Life-threatening trauma, initial management of
☐	Nutritional maintenance, enteral/parenteral
☐	Pediatric trauma, evaluation and management of
☐	Radiographic studies of trauma patients, interpretation of
☐	Sepsis, treatment of
☐	Surgical management of traumatic injuries (penetrating or crush injuries), including soft tissue, bone, or organ trauma (excludes head/neck)
☐	Ventilator Management
	Procedures
☐	Abdomen, open dressing changes
☐	Acute thoracic injury, operative procedures
☐	Aortic cross-clamping
☐	ATLS (Advanced Trauma Life Support)
☐	Bronchoscopy
☐	Cardiopulmonary resuscitation
☐	Cardiorraphy
☐	Cricothyroidotomy
☐	Debridement and repair of complex injuries
☐	Intubation, oral/nasal/tracheal
☐	Extensor tendon repair
☐	Fasciotomy
☐	Feeding tubes, endoscopic placement
☐	Focused Assessment with Sonography in Trauma (FAST), investigational or focused ultrasound
☐	Insertion and management of temporary transvenous pacemaker
☐	Joint dislocations, reduction and immobilization of
☐	Laparotomy, trauma
☐	Local wound exploration
☐	Moderate Sedation Level 4
☐	Open cardiac/massage defibrillation
☐	Penetrating abdominal trauma, operative care

☐	Pericardiotomy
☐	Peripheral venous cut-down
☐	Peritoneal lavage, diagnostic
☐	Soft-tissue, operative procedures
☐	Spine immobilization
☐	Swan-Ganz catheter, insertion and management
☐	Urethral catheterization
☐	Ultrasound, abdominal/thoracic
☐	Vascular injury repair
☐	Venous cut-down
☐	Ventilator management (all modes), including intubation
☐	Vessel ligation
☐	Visceral rotation maneuvers

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I have no mental or physical condition which would limit my clinical abilities. I wish to exercise at Medical Center Hospital, and I understand that: A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation. B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

MCH

Department Chair/Designee Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

Medical Center Hospital

Memorandum

Date: 11/20/2024

To: Physicians, Allied Health, and Residents

From: Medical Staff Office

Cc: Dr. Jeff Pinnow Chief of staff

Re: Consent to treat and Operative Note Education

Effective immediately all surgical consents must contain the name of the attending surgeon/surgeon's responsible for the procedure.

Additionally, all operative notes must include the names and the specific tasks completed by any residents and or assistants involved in the case.

Finally, an immediate post-operative note or full operative note must be fully visible and **authenticated by the attending surgeon** prior to the patient moving from PACU to the floor. The patients that are directly moved from the OR to the critical care areas are excluded.

Beginning December 1st, 20 random chart audits will be performed monthly. They will be specifically checking that the operative report includes the names and specific tasks completed by the residents and or allied health professionals. As well as verifying that the consents completed have the name of the attending/surgeon who completed the procedure. Additionally, verifying whether there was an immediate post-operative note or full operative note in the chart prior to the patient moving to the next level of care (PACU to the floor).

The chart audits will be done until we have 100% compliance for 90 days and reported as our action plan to DNV.

Attached are educational documents that were presented at the department meetings.

Please contact the medical staff office if you have any questions or concerns.

Medical Staff Office
432-640-1116
medstaff@echd.org

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Eligibility Criteria – Department Chair

Pursuant to the Medical Staff Bylaws Article 3.B. Eligibility Criteria

Physician Name: Benjamin Cunningham **Department:** Ortho.

INITIAL each BOX

- BC be certififed by an appropriate speciality board and main certification as defined in the Credentials Policy;
- BC have served on the Active Staff for at least three years.
- BC have no pending adverse recommendations concerning appointment or clinical privielges;
- BC not presently be serving as a Medical Staff officer, board member, or department chairperson at any other hosptial and will not serve during their terms of office
- BC be willing to faithfully discharge the duties and responsbilities of the position;
- BC have some experience in a leadership position or other involvement in performance improvement function for at least two years;
- BC participate in Medical Staff Leadership training as determined by the Medical Executive Committee; and
- BC Disclose any financial conflict of intrest(ie. an ownership or investment intrest in or compensation arragement) with a hosptial or hospital-affilaited entity within Ector County or within 100 miles of the hosptial c;ampus to the nominating committee for evaluation. This does not apply to services provided wthin a practitioner's office and billed under the same provider number used by the practitioner.

Signature X _____ **Date:** 11/15/24

MEDICAL STAFF ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2024

DEPARTMENT/SERVICE:	Radiology Department
RESPONSIBILITY:	The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.
SCOPE OF CARE:	Management of patients utilizing radiological services.
DATA SOURCES:	The patient's health care record.
SAMPLE:	A representative sample of the patients receiving radiologic services will be screened, as indicated.
METHODOLOGY:	Data is collected by appropriate personnel through established screening criteria. The data collected will correspond to identify performance standards. When indicated, the department member assigned that responsibility evaluates care. The chairman and the clinical staff of the Radiology Department review findings. The chairman authorizes actions for cases in which opportunities to improve care are present.
REPORTING:	The results of all assessment activities will be reported to the Radiology Department and Quality Monitoring Department, as appropriate. Reports will also be submitted to the Medical Staff Office and Quality Analytics Department for inclusion in the reappointment file and designated reports.

RADIOLOGY DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2024

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month (interventional radiology if applicable)** • When > 2.0 twice in 1 quarter provider will receive notification letter from BUC. • When > 2.0 for four months in 2 quarters, BUC will refer provider to PPEC.
SR.4 Specific department indicators that have been identified by the medical staff;	• **I-FPPE:** Initial focused professional practice evaluation for each practitioner who has been granted privileges. Minimum of 5 cases. • **OPPE:** Individual case review for clinical concerns (See SR.11) and (proactive) Retrospective QA review will be performed. • Chair will review 100% of individually received quality concerns brought to medstaff by MCH patient impact form as well as retrospective QA. • Retrospective QA consists of average 5 x-rays per month and 1% of cases representative of all other modalities per month for first 1000 cases, then 0.5% thereafter. • Individual case and Retrospective QA Data is collected each month by radiology administration, shared with medstaff office monthly, and presented at quarterly Radiology Dept meeting; Chair or designee will assess trends monthly. • MCH Patient Impact QA Benchmark (Levels 0-3); if >or = 3 major (Level 2 or 3) negative patient impact effects are found in < 1 year period by one radiologist; *radiologist referral is made to PPEC.* The radiology chair will notify the PPEC chair when a radiologist has 2 major discrepancies in a <1 year period. • Radiologists that read remotely and are part of a hospital-contracted remote radiology reading service will receive QA comparison through their corporate QA process. The contracted company will notify MCH medstaff when one of their radiologists is terminated for quality concerns.

SR.5 Moderate Sedation Adverse Events;	**Adverse Events 100% Chart Review by chair or designee:** • Failure to return to baseline consciousness. • Refractory bradycardia / tachycardia due to sedation • Airway compromise needing airway rescue. • Unplanned admission related to moderate sedation. • Mortality within 24 hours • All code blue and rapid responses in Radiology department are reviewed; *any identified concerning trend reported to PPEC.*
SR.9 Significant deviations from established standards of practice (American College of Surgeons Levels 1-3 designation and DNV Accreditations)	• DNV Primary stroke center accreditation requirement: vRad and ProCare MCH Radiologists review CTs for Stroke interpretation in turnaround time less than or equal to 45 minutes AND provide Intracranial Hemorrhage Dimension/ Volume within Radiology report findings section within 6 hours of CVA patient entering MCH ED OR provided before surgical bleed evacuation (ED providers do ICH calculation in their notes). 100% compliance ICH volume documentation in radiology final report; *any identified concerning trend reported to PPEC.* • ACS Trauma accreditation requirements for designated Levels 1-3: vRad/ ProCare MCH Radiologists will be available for in-house or have remote accessibility for imaging interpretation within 30 minutes of trauma surgeon request; Radiologists will document dates/times and contents of verbal communications of preliminary and final findings chronologically in the final radiology report; Final CT trauma radiology reports will be available in the EMR within 12 hours of the completion of imaging; Some of this information is reported monthly in trauma committee; *any identified concerning trend reported to PPEC* • ACS Trauma Accreditation requirements for designated Levels 1-2: Interventional radiology (and endovascular) services will be available for hemorrhage control patient needs either as in-person procedure or phone discussion of remote imaging interpretation within 60 minutes of trauma surgeon request; *any identified concerning trend reported to PPEC.*

SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • Full operative report must be authenticated by attending proceduralist within 24 hours after an operative procedure and entered into the record before the patient is transferred to the next level of care. • If a full operative report cannot be entered into the record within a reasonable amount of time after the operation or procedure, a postop procedure note must be entered prior to the patient being transferred to the next level of care. • Suspensions- 3 or more suspensions in a consecutive 6-month period will receive an automatic referral to PPEC.
SR. 11 Any variant that should be analyzed for statistical significance.	• For clinically significant discrepancies or quality issues identified in SR.4 that will affect patient management, the ordering clinical provider will be notified verbally of the discrepancy and a written addendum/revision describing discrepancy will be documented in original report; *any identified concerning trend reported to PPEC.* • 100% chart review by Chair or designee for significant complications post radiology procedure or imaging adverse event (unexpected transfer to ICU as direct complication of procedure, stroke, bleeding requiring transfusion, code blue/death); *any identified concerning trend reported to PPEC.* • Wrong site/wrong side incidences reviewed, all reported to risk mgmt.; *any identified concerning trend reported to PPEC.* • Patient Grievances/ORTS/Risk Management cases that have potential negative impact on patient will be reviewed by med staff and Chair or designee; *case referred to PPEC as needed.*

Family Health Clinic
December 2024
ECHD Board Update

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CENTERS COMBINED - OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 1,895,010	$ 1,721,178	10.1%	$ 1,493,355	26.9%	$ 1,895,010	$ 1,721,178	10.1%	$ 1,493,355	26.9%
TOTAL PATIENT REVENUE	$ 1,895,010	$ 1,721,178	10.1%	$ 1,493,355	26.9%	$ 1,895,010	$ 1,721,178	10.1%	$ 1,493,355	26.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 1,117,087	$ 809,030	38.1%	$ 732,680	52.5%	$ 1,117,087	$ 809,030	38.1%	$ 732,680	52.5%
Self Pay Adjustments	73,473	81,445	-9.8%	40,796	80.1%	73,473	81,445	-9.8%	40,796	80.1%
Bad Debts	10,543	60,407	-82.5%	34,683	-69.6%	10,543	60,407	-82.5%	34,683	-69.6%
TOTAL REVENUE DEDUCTIONS	$ 1,201,103	$ 950,882	26.3%	$ 808,159	48.6%	$ 1,201,103	$ 950,882	26.3%	$ 808,159	48.6%
	63.38%	55.25%		54.12%		63.38%	55.25%		54.12%	
NET PATIENT REVENUE	$ 693,907	$ 770,296	-9.9%	$ 685,197	1.3%	$ 693,907	$ 770,296	-9.9%	$ 685,197	1.3%
OTHER REVENUE										
FHC Other Revenue	$ 27,482	$ 39,174	-29.8%	$ 55,568	-50.5%	$ 27,482	$ 39,174	-29.8%	$ 55,568	-50.5%
TOTAL OTHER REVENUE	$ 27,482	$ 39,174	-29.8%	$ 55,568	-50.5%	$ 27,482	$ 39,174	-29.8%	$ 55,568	-50.5%
NET OPERATING REVENUE	$ 721,389	$ 809,470	-10.9%	$ 740,765	-2.6%	$ 721,389	$ 809,470	-10.9%	$ 740,765	-2.6%
OPERATING EXPENSE										
Salaries and Wages	$ 188,822	$ 190,583	-0.9%	$ 215,967	-12.6%	$ 188,822	$ 190,583	-0.9%	$ 215,967	-12.6%
Benefits	30,949	28,041	10.4%	31,857	-2.9%	30,949	28,041	10.4%	31,857	-2.9%
Physician Services	554,614	498,196	11.3%	403,953	37.3%	554,614	498,196	11.3%	403,953	37.3%
Cost of Drugs Sold	112,946	61,422	83.9%	55,935	101.9%	112,946	61,422	83.9%	55,935	101.9%
Supplies	20,472	19,898	2.9%	7,253	182.2%	20,472	19,898	2.9%	7,253	182.2%
Utilities	5,054	7,382	-31.5%	5,874	-14.0%	5,054	7,382	-31.5%	5,874	-14.0%
Repairs and Maintenance	1,382	2,099	-34.2%	1,038	33.1%	1,382	2,099	-34.2%	1,038	33.1%
Leases and Rentals	1,123	1,212	-7.4%	1,833	-38.7%	1,123	1,212	-7.4%	1,833	-38.7%
Other Expense	1,000	1,427	-29.9%	1,000	0.0%	1,000	1,427	-29.9%	1,000	0.0%
TOTAL OPERATING EXPENSES	$ 916,363	$ 810,260	13.1%	$ 724,711	26.4%	$ 916,363	$ 810,260	13.1%	$ 724,711	26.4%
Depreciation/Amortization	$ 21,844	$ 25,319	-13.7%	$ 24,971	-12.5%	$ 21,844	$ 25,319	-13.7%	$ 24,971	-12.5%
TOTAL OPERATING COSTS	$ 938,208	$ 835,579	12.3%	$ 749,682	25.1%	$ 938,208	$ 835,579	12.3%	$ 749,682	25.1%
NET GAIN (LOSS) FROM OPERATIONS	**$ (216,818)**	**$ (26,109)**	**730.4%**	**$ (8,917)**	**2331.6%**	**$ (216,818)**	**$ (26,109)**	**730.4%**	**$ (8,917)**	**2331.6%**
Operating Margin	-30.06%	-3.23%	831.8%	-1.20%	2396.9%	-30.06%	-3.23%	831.8%	-1.20%	2396.9%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	4,504	3,935	14.5%	3,770	19.5%	4,504	3,935	14.5%	3,770	19.5%
Average Revenue per Office Visit	420.74	437.40	-3.8%	396.12	6.2%	420.74	437.40	-3.8%	396.12	6.2%
Hospital FTE's (Salaries and Wages)	43.8	43.5	0.6%	49.8	-12.1%	43.8	43.5	0.6%	49.8	-12.1%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - SOUTH - OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 196,379	$ 155,755	26.1%	$ 173,439	13.2%	$ 196,379	$ 155,755	26.1%	$ 173,439	13.2%
TOTAL PATIENT REVENUE	$ 196,379	$ 155,755	26.1%	$ 173,439	13.2%	$ 196,379	$ 155,755	26.1%	$ 173,439	13.2%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 64,077	$ 54,235	18.1%	$ 87,119	-26.4%	$ 64,077	$ 54,235	18.1%	$ 87,119	-26.4%
Self Pay Adjustments	62,365	15,229	309.5%	15,545	301.2%	62,365	15,229	309.5%	15,545	301.2%
Bad Debts	2,991	8,710	-65.7%	8,607	-65.2%	2,991	8,710	-65.7%	8,607	-65.2%
TOTAL REVENUE DEDUCTIONS	$ 129,433	$ 78,174	65.6%	$ 111,271	16.3%	$ 129,433	$ 78,174	65.6%	$ 111,271	16.3%
	65.9%	50.2%		64.2%		65.9%	50.2%		64.2%	
NET PATIENT REVENUE	$ 66,946	$ 77,581	-13.7%	$ 62,167	7.7%	$ 66,946	$ 77,581	-13.7%	$ 62,167	7.7%
OTHER REVENUE										
FHC Other Revenue	$ 27,482	$ 39,174	0.0%	$ 55,568	-50.5%	$ 27,482	$ 39,174	0.0%	$ 55,568	-50.5%
TOTAL OTHER REVENUE	$ 27,482	$ 39,174	-29.8%	$ 55,568	-50.5%	$ 27,482	$ 39,174	-29.8%	$ 55,568	-50.5%
NET OPERATING REVENUE	$ 94,428	$ 116,755	-19.1%	$ 117,736	-19.8%	$ 94,428	$ 116,755	-19.1%	$ 117,736	-19.8%
OPERATING EXPENSE										
Salaries and Wages	$ 56,556	$ 50,229	12.6%	$ 63,294	-10.6%	$ 56,556	$ 50,229	12.6%	$ 63,294	-10.6%
Benefits	9,270	7,390	25.4%	9,336	-0.7%	9,270	7,390	25.4%	9,336	-0.7%
Physician Services	91,187	69,696	30.8%	61,016	49.4%	91,187	69,696	30.8%	61,016	49.4%
Cost of Drugs Sold	37,612	8,901	322.6%	9,361	301.8%	37,612	8,901	322.6%	9,361	301.8%
Supplies	3,037	6,228	-51.2%	1,835	65.5%	3,037	6,228	-51.2%	1,835	65.5%
Utilities	2,091	3,595	-41.8%	2,512	-16.8%	2,091	3,595	-41.8%	2,512	-16.8%
Repairs and Maintenance	531	1,278	-58.5%	527	0.8%	531	1,278	-58.5%	527	0.8%
Leases and Rentals	1,037	606	71.1%	542	91.5%	1,037	606	71.1%	542	91.5%
Other Expense	1,000	1,427	-29.9%	1,000	0.0%	1,000	1,427	-29.9%	1,000	0.0%
TOTAL OPERATING EXPENSES	$ 202,320	$ 149,350	35.5%	$ 149,422	35.4%	$ 202,320	$ 149,350	35.5%	$ 149,422	35.4%
Depreciation/Amortization	$ 4,048	$ 4,083	-0.8%	$ 4,071	-0.6%	$ 4,048	$ 4,083	-0.8%	$ 4,071	-0.6%
TOTAL OPERATING COSTS	$ 206,369	$ 153,433	34.5%	$ 153,494	34.4%	$ 206,369	$ 153,433	34.5%	$ 153,494	34.4%
NET GAIN (LOSS) FROM OPERATIONS	**$ (111,941)**	**$ (36,678)**	**-205.2%**	**$ (35,758)**	**-213.1%**	**$ (111,941)**	**$ (36,678)**	**-205.2%**	**$ (35,758)**	**-213.1%**
Operating Margin	-118.55%	-31.41%	277.4%	-30.37%	290.3%	-118.55%	-31.41%	277.4%	-30.37%	290.3%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	755	558	35.3%	614	23.0%	755	558	35.3%	614	23.0%
Average Revenue per Office Visit	260.10	279.13	-6.8%	282.47	-7.9%	260.10	279.13	-6.8%	282.47	-7.9%
Hospital FTE's (Salaries and Wages)	9.6	9.5	1.0%	11.6	-17.5%	9.6	9.5	1.0%	11.6	-17.5%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WEST UNIVERSITY - OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 218,793	$ 211,614	3.4%	$ 214,762	1.9%	$ 218,793	$ 211,614	3.4%	$ 214,762	1.9%
TOTAL PATIENT REVENUE	$ 218,793	$ 211,614	3.4%	$ 214,762	1.9%	$ 218,793	$ 211,614	3.4%	$ 214,762	1.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 90,578	$ 157,432	-42.5%	$ 112,584	-19.5%	$ 90,578	$ 157,432	-42.5%	$ 112,584	-19.5%
Self Pay Adjustments	39,738	37,317	6.5%	14,905	166.6%	39,738	37,317	6.5%	14,905	166.6%
Bad Debts	3,000	11,360	-73.6%	3,804	-21.1%	3,000	11,360	-73.6%	3,804	-21.1%
TOTAL REVENUE DEDUCTIONS	$ 133,316	$ 206,109	-35.3%	$ 131,293	1.5%	$ 133,316	$ 206,109	-35.3%	$ 131,293	1.5%
	60.93%	97.40%		61.13%		60.93%	97.40%		61.13%	
NET PATIENT REVENUE	$ 85,478	$ 5,505	1452.7%	$ 83,469	2.4%	$ 85,478	$ 5,505	1452.7%	$ 83,469	2.4%
OTHER REVENUE										
FHC Other Revenue	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
TOTAL OTHER REVENUE	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
NET OPERATING REVENUE	$ 85,478	$ 5,505	1452.7%	$ 83,469	2.4%	$ 85,478	$ 5,505	1452.7%	$ 83,469	2.4%
OPERATING EXPENSE										
Salaries and Wages	$ 22,166	$ 34,283	-35.3%	$ 25,828	-14.2%	$ 22,166	$ 34,283	-35.3%	$ 25,828	-14.2%
Benefits	3,633	5,044	-28.0%	3,810	-4.6%	3,633	5,044	-28.0%	3,810	-4.6%
Physician Services	56,827	57,658	-1.4%	51,449	10.5%	56,827	57,658	-1.4%	51,449	10.5%
Cost of Drugs Sold	4,966	4,045	22.8%	0	12416050.0%	4,966	4,045	22.8%	0	12416050.0%
Supplies	843	1,879	-55.1%	1,026	-17.8%	843	1,879	-55.1%	1,026	-17.8%
Utilities	2,964	3,787	-21.7%	3,362	-11.9%	2,964	3,787	-21.7%	3,362	-11.9%
Repairs and Maintenance	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Leases and Rentals	86	40	114.7%	40	114.7%	86	40	114.7%	40	114.7%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 91,485	$ 106,736	-14.3%	$ 85,516	7.0%	$ 91,485	$ 106,736	-14.3%	$ 85,516	7.0%
Depreciation/Amortization	$ 17,721	$ 21,161	-16.3%	$ 20,824	-14.9%	$ 17,721	$ 21,161	-16.3%	$ 20,824	-14.9%
TOTAL OPERATING COSTS	$ 109,206	$ 127,897	-14.6%	$ 106,340	2.7%	$ 109,206	$ 127,897	-14.6%	$ 106,340	2.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (23,729)**	**$ (122,392)**	**-80.6%**	**$ (22,871)**	**3.7%**	**$ (23,729)**	**$ (122,392)**	**-80.6%**	**$ (22,871)**	**3.7%**
Operating Margin	-27.76%	-2223.29%	-98.8%	-27.40%	1.3%	-27.76%	-2223.29%	-98.8%	-27.40%	1.3%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	758	698	8.6%	722	5.0%	758	698	8.6%	722	5.0%
Average Revenue per Office Visit	288.65	303.17	-4.8%	297.45	-3.0%	288.65	303.17	-4.8%	297.45	-3.0%
Hospital FTE's (Salaries and Wages)	8.2	8.5	-3.2%	8.1	1.0%	8.2	8.5	-3.2%	8.1	1.0%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - JBS - OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 461,259	$ 376,968	22.4%	$ 331,033	39.3%	$ 461,259	$ 376,968	22.4%	$ 331,033	39.3%
TOTAL PATIENT REVENUE	$ 461,259	$ 376,968	22.4%	$ 331,033	39.3%	$ 461,259	$ 376,968	22.4%	$ 331,033	39.3%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 291,964	$ 188,955	54.5%	$ 163,308	78.8%	$ 291,964	$ 188,955	54.5%	$ 163,308	78.8%
Self Pay Adjustments	4,563	8,445	-46.0%	4,062	12.3%	4,563	8,445	-46.0%	4,062	12.3%
Bad Debts	8,743	11,851	-26.2%	9,419	-7.2%	8,743	11,851	-26.2%	9,419	-7.2%
TOTAL REVENUE DEDUCTIONS	$ 305,270	$ 209,251	45.9%	$ 176,789	72.7%	$ 305,270	$ 209,251	45.9%	$ 176,789	72.7%
	66.18%	55.51%		53.41%		66.18%	55.51%		53.41%	
NET PATIENT REVENUE	$ 155,988	$ 167,717	-7.0%	$ 154,244	1.1%	$ 155,988	$ 167,717	-7.0%	$ 154,244	1.1%
OTHER REVENUE										
FHC Other Revenue	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
TOTAL OTHER REVENUE	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
NET OPERATING REVENUE	$ 155,988	$ 167,717	-7.0%	$ 154,244	1.1%	$ 155,988	$ 167,717	-7.0%	$ 154,244	1.1%
OPERATING EXPENSE										
Salaries and Wages	$ 23,550	$ 37,571	-37.3%	$ 34,322	-31.4%	$ 23,550	$ 37,571	-37.3%	$ 34,322	-31.4%
Benefits	3,860	5,528	-30.2%	5,063	-23.8%	3,860	5,528	-30.2%	5,063	-23.8%
Physician Services	70,119	63,193	11.0%	52,171	34.4%	70,119	63,193	11.0%	52,171	34.4%
Cost of Drugs Sold	34,160	21,316	60.3%	30,858	10.7%	34,160	21,316	60.3%	30,858	10.7%
Supplies	6,741	3,445	95.7%	731	822.1%	6,741	3,445	95.7%	731	822.1%
Utilities	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Repairs and Maintenance	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 138,430	$ 131,053	5.6%	$ 123,145	12.4%	$ 138,430	$ 131,053	5.6%	$ 123,145	12.4%
Depreciation/Amortization	$ 75	$ 75	-0.2%	$ 75	0.0%	$ 75	$ 75	-0.2%	$ 75	0.0%
TOTAL OPERATING COSTS	$ 138,505	$ 131,128	5.6%	$ 123,220	12.4%	$ 138,505	$ 131,128	5.6%	$ 123,220	12.4%
NET GAIN (LOSS) FROM OPERATIONS	**$ 17,483**	**$ 36,589**	**-52.2%**	**$ 31,024**	**-43.6%**	**$ 17,483**	**$ 36,589**	**-52.2%**	**$ 31,024**	**-43.6%**
Operating Margin	11.21%	21.82%	-48.6%	20.11%	-44.3%	11.21%	21.82%	-48.6%	20.11%	-44.3%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	1,102	902	22.2%	779	41.5%	1,102	902	22.2%		0.0%
Average Revenue per Office Visit	418.56	417.92	0.2%	424.95	-1.5%	418.56	417.92	0.2%	424.95	-1.5%
Hospital FTE's (Salaries and Wages)	6.8	10.2	-34.0%	9.9	-31.5%	6.8	10.2	-34.0%	9.9	-31.5%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WOMENS CLINIC- OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 1,018,580	$ 976,841	4.3%	$ 774,122	31.6%	$ 1,018,580	$ 976,841	4.3%	$ 774,122	31.6%
TOTAL PATIENT REVENUE	$ 1,018,580	$ 976,841	4.3%	$ 774,122	31.6%	$ 1,018,580	$ 976,841	4.3%	$ 774,122	31.6%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 670,468	$ 408,408	64.2%	$ 369,669	81.4%	$ 670,468	$ 408,408	64.2%	$ 369,669	81.4%
Self Pay Adjustments	(33,193)	20,454	-262.3%	6,284	-628.2%	(33,193)	20,454	-262.3%	6,284	-628.2%
Bad Debts	(4,191)	28,486	-114.7%	12,852	-132.6%	(4,191)	28,486	-114.7%	12,852	-132.6%
TOTAL REVENUE DEDUCTIONS	$ 633,084	$ 457,348	38.4%	$ 388,805	62.8%	$ 633,084	$ 457,348	38.4%	$ 388,805	62.8%
	62.15%	46.82%		50.23%		62.15%	46.82%		50.23%	
NET PATIENT REVENUE	$ 385,496	$ 519,493	-25.8%	$ 385,317	0.0%	$ 385,496	$ 519,493	-25.8%	$ 385,317	0.0%
OTHER REVENUE										
FHC Other Revenue	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
TOTAL OTHER REVENUE	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
NET OPERATING REVENUE	$ 385,496	$ 519,493	-25.8%	$ 385,317	0.0%	$ 385,496	$ 519,493	-25.8%	$ 385,317	0.0%
OPERATING EXPENSE										
Salaries and Wages	$ 86,551	$ 68,500	26.4%	$ 92,524	-6.5%	$ 86,551	$ 68,500	26.4%	$ 92,524	-6.5%
Benefits	14,186	10,079	40.7%	13,648	3.9%	14,186	10,079	40.7%	13,648	3.9%
Physician Services	336,481	307,649	9.4%	239,316	40.6%	336,481	307,649	9.4%	239,316	40.6%
Cost of Drugs Sold	36,208	27,160	33.3%	15,716	130.4%	36,208	27,160	33.3%	15,716	130.4%
Supplies	9,850	8,346	18.0%	3,661	169.0%	9,850	8,346	18.0%	3,661	169.0%
Utilities	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Repairs and Maintenance	851	821	3.7%	511	66.5%	851	821	3.7%	511	66.5%
Leases and Rentals	-	566	-100.0%	1,251	-100.0%	-	566	-100.0%	1,251	-100.0%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 484,127	$ 423,121	14.4%	$ 366,628	32.0%	$ 484,127	$ 423,121	14.4%	$ 366,628	32.0%
Depreciation/Amortization	$ -	$ -	0.0%	$ -	100.0%	$ -	$ -	0.0%	$ -	100.0%
TOTAL OPERATING COSTS	$ 484,127	$ 423,121	14.4%	$ 366,628	32.0%	$ 484,127	$ 423,121	14.4%	$ 366,628	32.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (98,632)**	**$ 96,372**	**-202.3%**	**$ 18,689**	**-627.8%**	**$ (98,632)**	**$ 96,372**	**-202.3%**	**$ 18,689**	**-627.8%**
Operating Margin	-25.59%	18.55%	-237.9%	4.85%	-627.5%	-25.59%	18.55%	-237.9%	4.85%	-627.5%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	1,889	1,777	6.3%	1,655	14.1%	1,889	1,777	6.3%	1,655	14.1%
Average Revenue per Office Visit	539.22	549.71	-1.9%	467.75	15.3%	539.22	549.71	-1.9%	467.75	15.3%
Hospital FTE's (Salaries and Wages)	19.3	15.3	25.6%	20.2	-4.8%	19.3	15.3	25.6%	20.2	-4.8%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC COMBINED
OCTOBER 2024

	MONTHLY REVENUE						YTD REVENUE					
	Clements	**West**	**JBS**	**Womens**	**Total**	**%**	**Clements**	**West**	**JBS**	**Womens**	**Total**	**%**
Medicare	$ 66,383	$ 47,134	$ -	$ 49,149	$ 162,666	8.6%	$ 66,383	$ 47,134	$ -	$ 49,149	$ 162,666	8.6%
Medicaid	29,174	30,892	315,026	312,267	687,358	36.3%	29,174	30,892	315,026	312,267	687,358	36.3%
FAP	-	-	-	-	-	0.0%	-	-	-	-	-	0.0%
Commercial	26,343	80,893	124,584	607,051	838,872	44.3%	26,343	80,893	124,584	607,051	838,872	44.3%
Self Pay	71,972	54,130	18,077	30,537	174,714	9.2%	71,972	54,130	18,077	30,537	174,714	9.2%
Other	2,507	5,745	3,572	19,576	31,400	1.7%	2,507	5,745	3,572	19,576	31,400	1.7%
Total	**$ 196,379**	**$ 218,793**	**$ 461,259**	**$ 1,018,580**	**$ 1,895,010**	**100.0%**	**$ 196,379**	**$ 218,793**	**$ 461,259**	**$ 1,018,580**	**$ 1,895,010**	**100.0%**

	MONTHLY PAYMENTS						YEAR TO DATE PAYMENTS					
	Clements	**West**	**JBS**	**Womens**	**Total**	**%**	**Clements**	**West**	**JBS**	**Womens**	**Total**	**%**
Medicare	$ 17,107	$ 21,668	$ -	$ 17,567	$ 56,341	8.0%	$ 17,107	$ 21,668	$ -	$ 17,567	$ 56,341	8.0%
Medicaid	8,349	14,653	151,584	$ 103,742	278,328	39.5%	8,349	14,653	151,584	103,742	278,328	39.5%
FAP	-	-	-	$ -	-	0.0%	-	-	-	-	-	0.0%
Commercial	8,501	28,111	80,924	$ 159,062	276,598	39.3%	8,501	28,111	80,924	159,062	276,598	39.3%
Self Pay	10,191	12,355	9,665	$ 54,057	86,269	12.3%	10,191	12,355	9,665	54,057	86,269	12.3%
Other	105	2,142	928	$ 3,241	6,416	0.9%	105	2,142	928	3,241	6,416	0.9%
Total	**$ 44,253**	**$ 78,929**	**$ 243,101**	**$ 337,669**	**$ 703,952**	**100.0%**	**$ 44,253**	**$ 78,929**	**$ 243,101**	**$ 337,669**	**$ 703,952**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
OCTOBER 2024

REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 66,383	33.8%	$ 53,416	30.8%	$ 66,383	33.8%	53,416	30.8%
Medicaid	29,174	14.9%	31,433	18.1%	29,174	14.9%	31,433	18.1%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	26,343	13.4%	31,095	17.9%	26,343	13.4%	31,095	17.9%
Self Pay	71,972	36.6%	58,171	33.6%	71,972	36.6%	58,171	33.6%
Other	2,507	1.3%	(676)	-0.4%	2,507	1.3%	(676)	-0.4%
TOTAL	**$ 196,379**	**100.0%**	**$ 173,439**	**100.0%**	**$ 196,379**	**100.0%**	**173,439**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	17,107	38.7%	$ 19,970	35.9%	$ 17,107	38.7%	19,970	35.9%
Medicaid	8,349	18.9%	18,322	32.8%	8,349	18.9%	18,322	32.8%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	8,501	19.2%	9,641	17.3%	8,501	19.2%	9,641	17.3%
Self Pay	10,191	23.0%	7,836	14.0%	10,191	23.0%	7,836	14.0%
Other	105	0.2%	9	0.0%	105	0.2%	9	0.0%
TOTAL	**$ 44,253**	**100.0%**	**$ 55,778**	**100.0%**	**$ 44,253**	**100.0%**	**55,778**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
OCTOBER 2024

REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 47,134	21.5%	$ 53,225	24.8%	$ 47,134	21.5%	$ 53,225	24.8%
Medicaid	30,892	14.1%	$ 39,167	18.2%	30,892	14.1%	39,167	18.2%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	80,893	37.1%	$ 63,546	29.6%	80,893	37.1%	63,546	29.6%
Self Pay	54,130	24.7%	$ 48,547	22.6%	54,130	24.7%	48,547	22.6%
Other	5,745	2.6%	$ 10,278	4.8%	5,745	2.6%	10,278	4.8%
TOTAL	**$ 218,793**	**100.0%**	**$ 214,762**	**100.0%**	**$ 218,793**	**100.0%**	**$ 214,762**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 21,668	27.5%	$ 18,963	27.1%	$ 21,668	27.5%	$ 18,963	27.1%
Medicaid	14,653	18.6%	16,858	24.1%	$ 14,653	18.6%	16,858	24.1%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	28,111	35.5%	18,894	27.0%	28,111	35.5%	18,894	27.0%
Self Pay	12,355	15.7%	11,726	16.7%	12,355	15.7%	11,726	16.7%
Other	2,142	2.7%	3,597	5.1%	2,142	2.7%	3,597	5.1%
TOTAL	**$ 78,929**	**100.0%**	**$ 70,039**	**100.0%**	**$ 78,929**	**100.0%**	**$ 70,039**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC JBS
OCTOBER 2024

REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ -	0.0%	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	315,026	68.3%	$ 241,794	73.0%	315,026	68.3%	241,794	73.0%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	124,584	27.0%	$ 73,639	22.2%	124,584	27.0%	73,639	22.2%
Self Pay	18,077	3.9%	$ 11,918	3.6%	18,077	3.9%	11,918	3.6%
Other	3,572	0.8%	$ 3,681	1.1%	3,572	0.8%	3,681	1.1%
TOTAL	**$ 461,259**	**100.0%**	**$ 331,033**	**100.0%**	**$ 461,259**	**100.0%**	**$ 331,033**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ -	0.0%	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	151,584	62.3%	98,772	70.6%	151,584	62.3%	98,772	70.6%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	80,924	33.3%	32,181	23.0%	80,924	33.3%	32,181	23.0%
Self Pay	9,665	4.0%	8,484	6.1%	9,665	4.0%	8,484	6.1%
Other	928	0.4%	527	0.4%	928	0.4%	527	0.4%
TOTAL	**$ 243,101**	**100.0%**	**$ 139,964**	**100.0%**	**$ 243,101**	**100.0%**	**$ 139,964**	**100.0%**

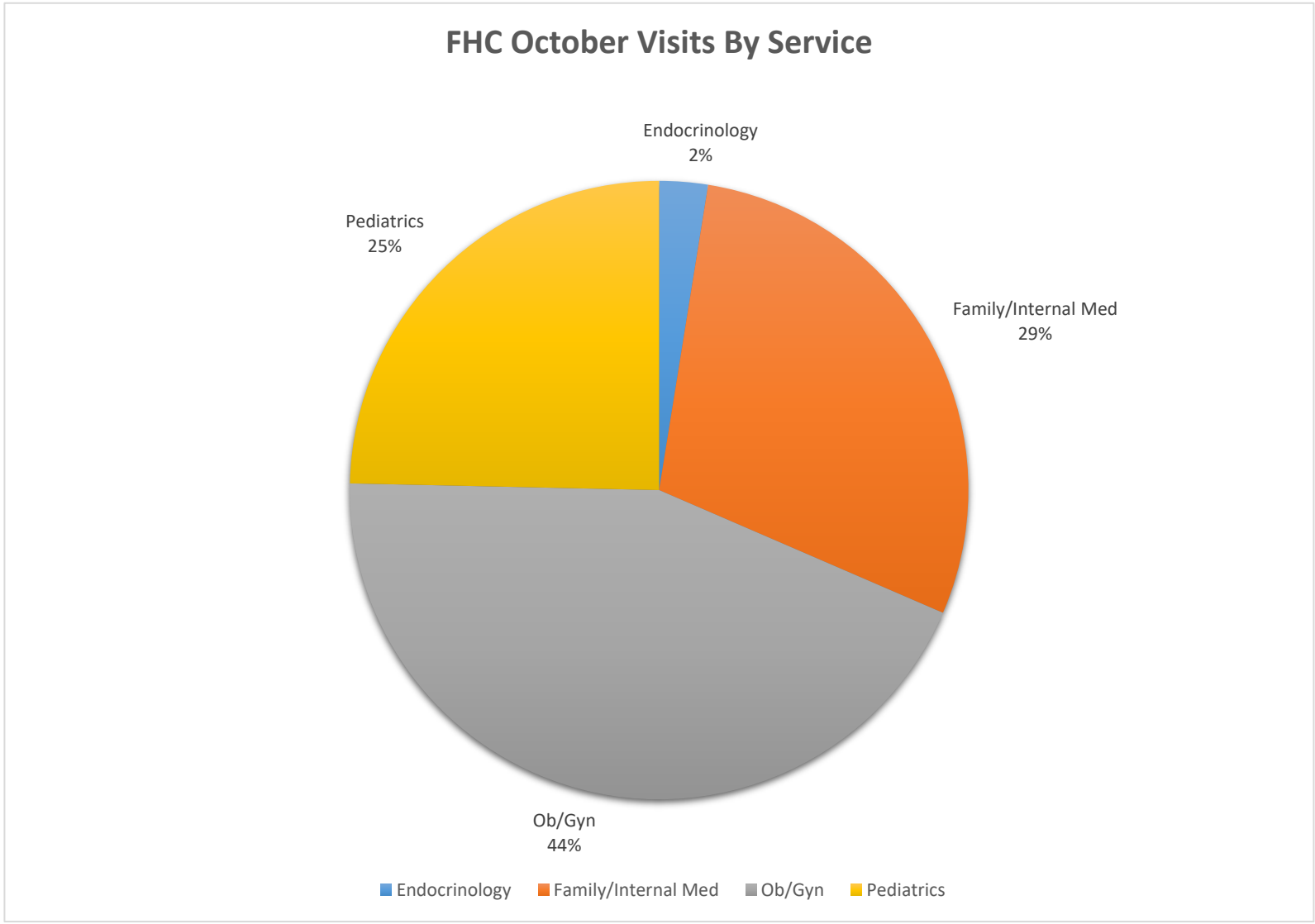
ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WOMENS CLINIC
OCTOBER 2024

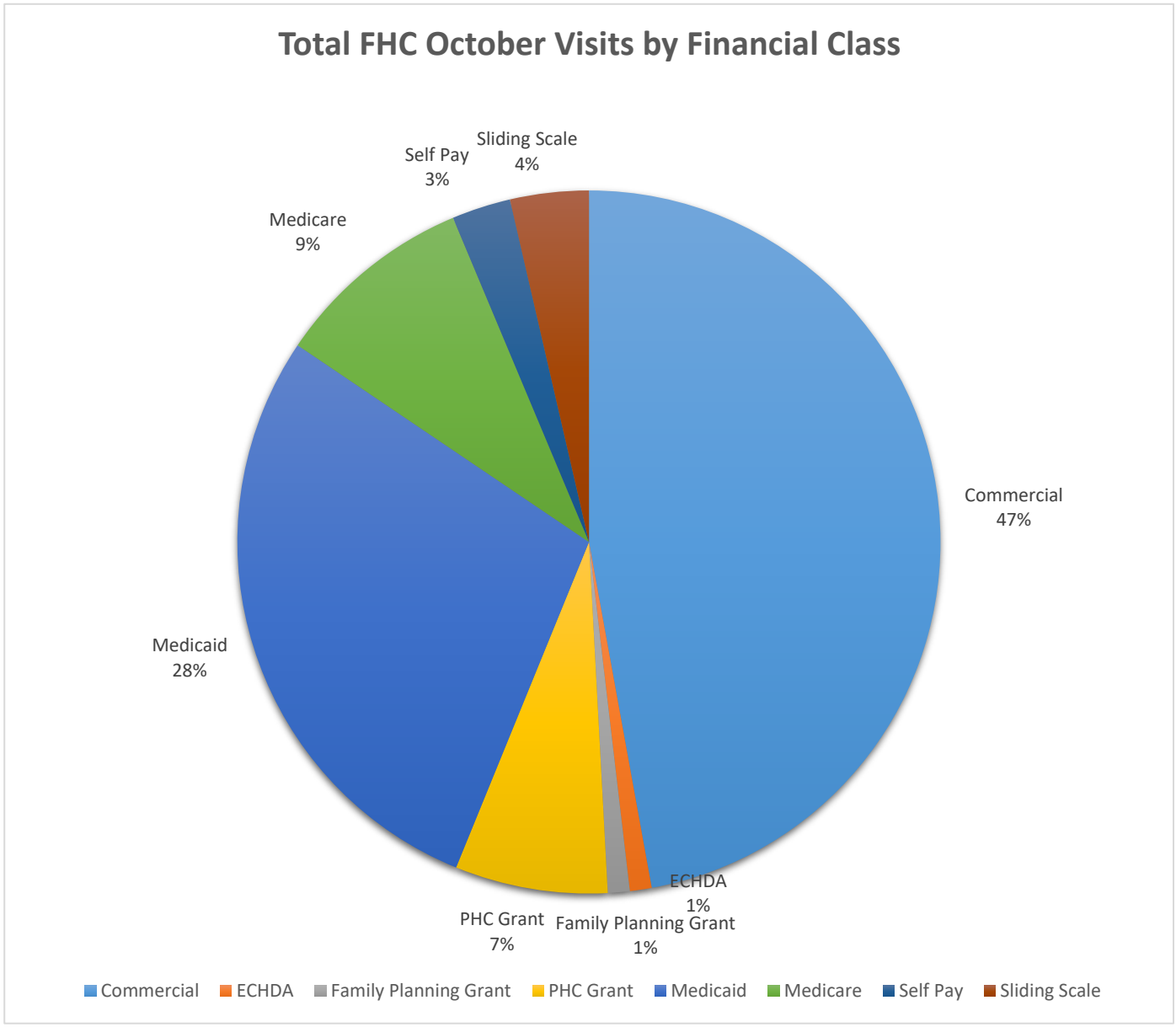
REVENUE BY PAYOR

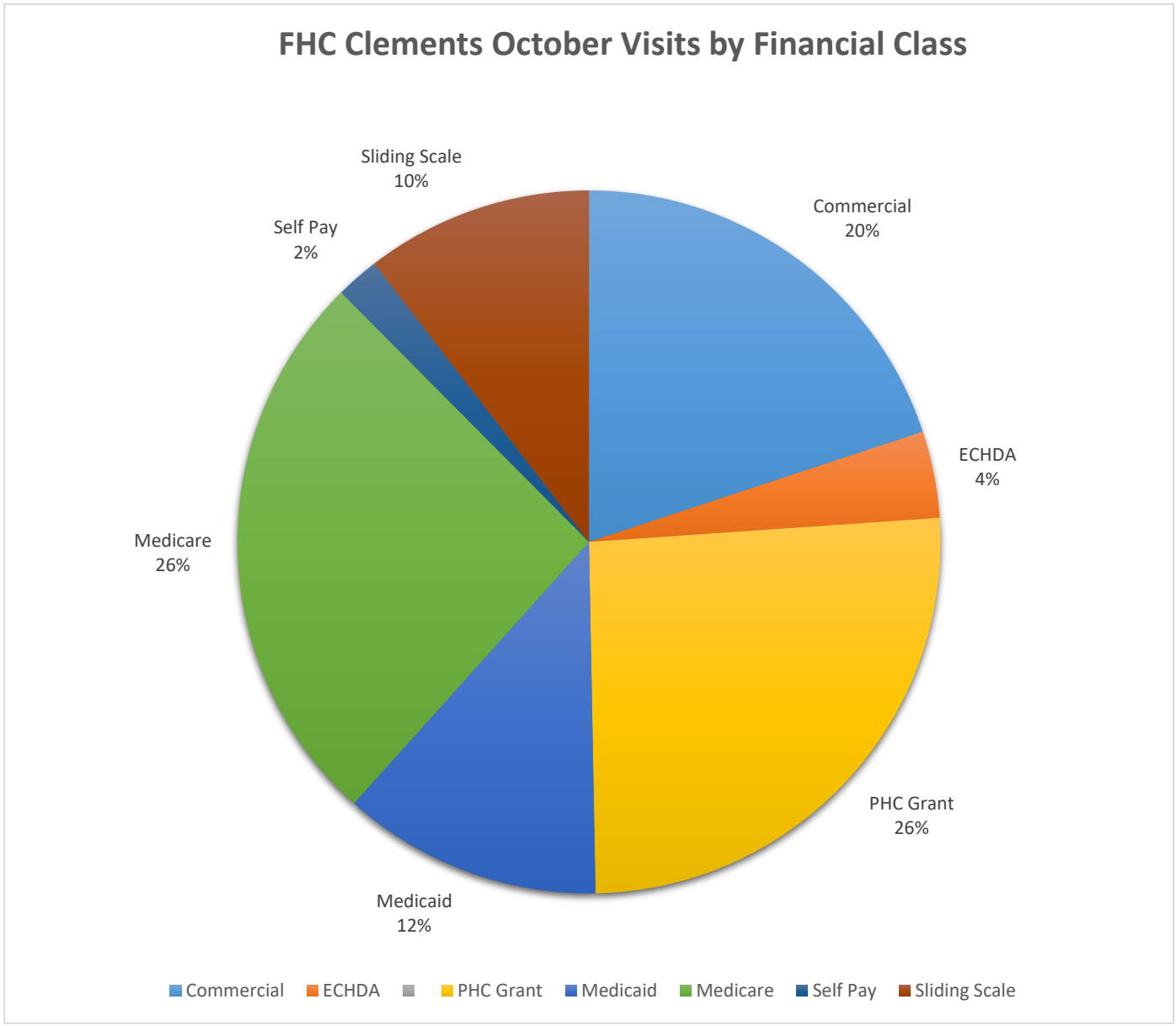
	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 49,149	4.8%	$ 39,717	5.1%	$ 49,149	4.8%	$ 39,717	5.1%
Medicaid	312,267	30.7%	$ 257,966	33.3%	312,267	30.7%	257,966	33.3%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	607,051	59.6%	$ 431,979	55.8%	607,051	59.6%	431,978	55.8%
Self Pay	30,537	3.0%	$ 25,645	3.3%	30,537	3.0%	25,645	3.3%
Other	19,576	1.9%	$ 18,815	2.4%	19,576	1.9%	18,815	2.4%
TOTAL	**$ 1,018,580**	**100.0%**	**$ 774,122**	**100.0%**	**$ 1,018,580**	**100.0%**	**$ 774,122**	**100.0%**

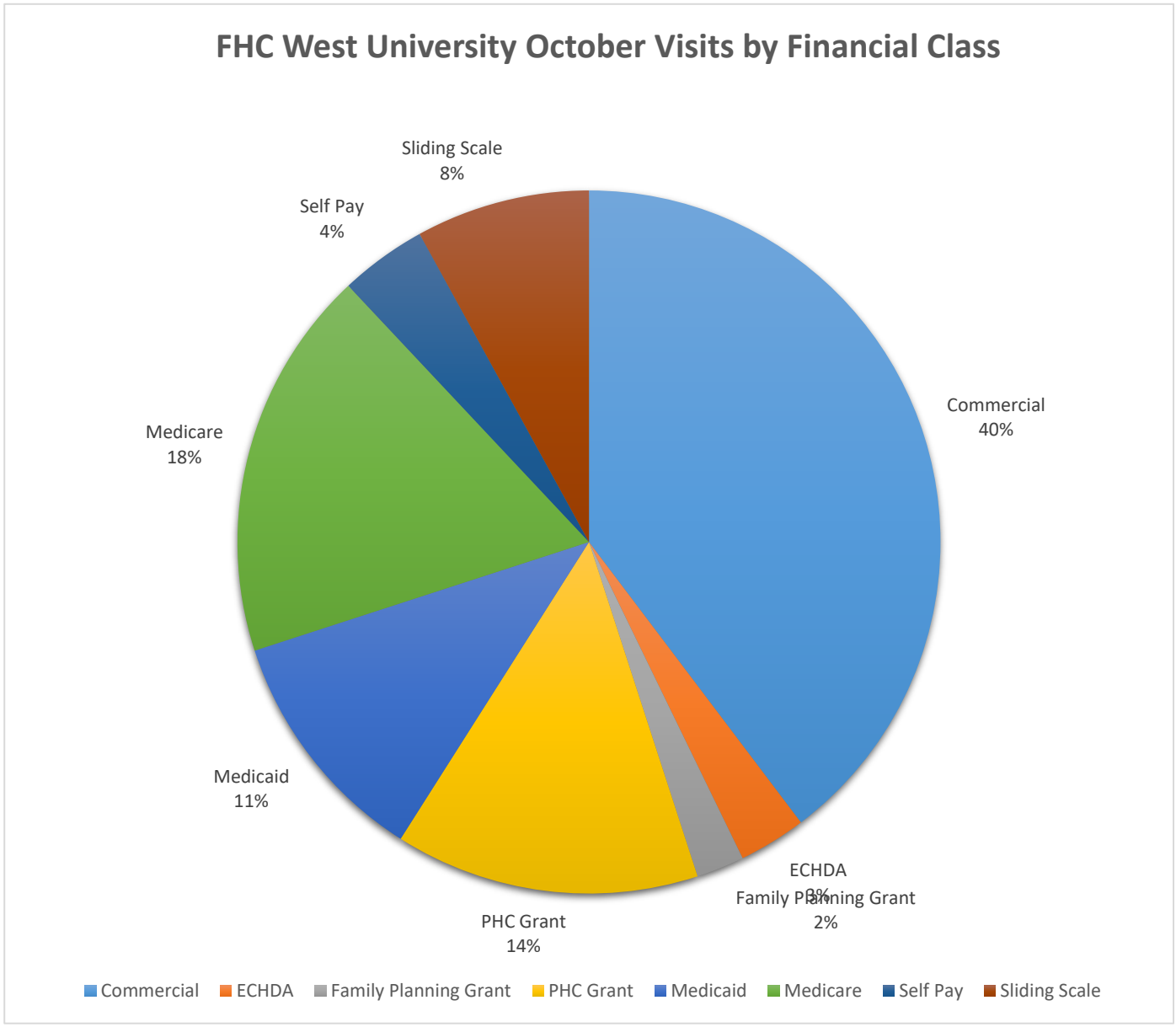
PAYMENTS BY PAYOR

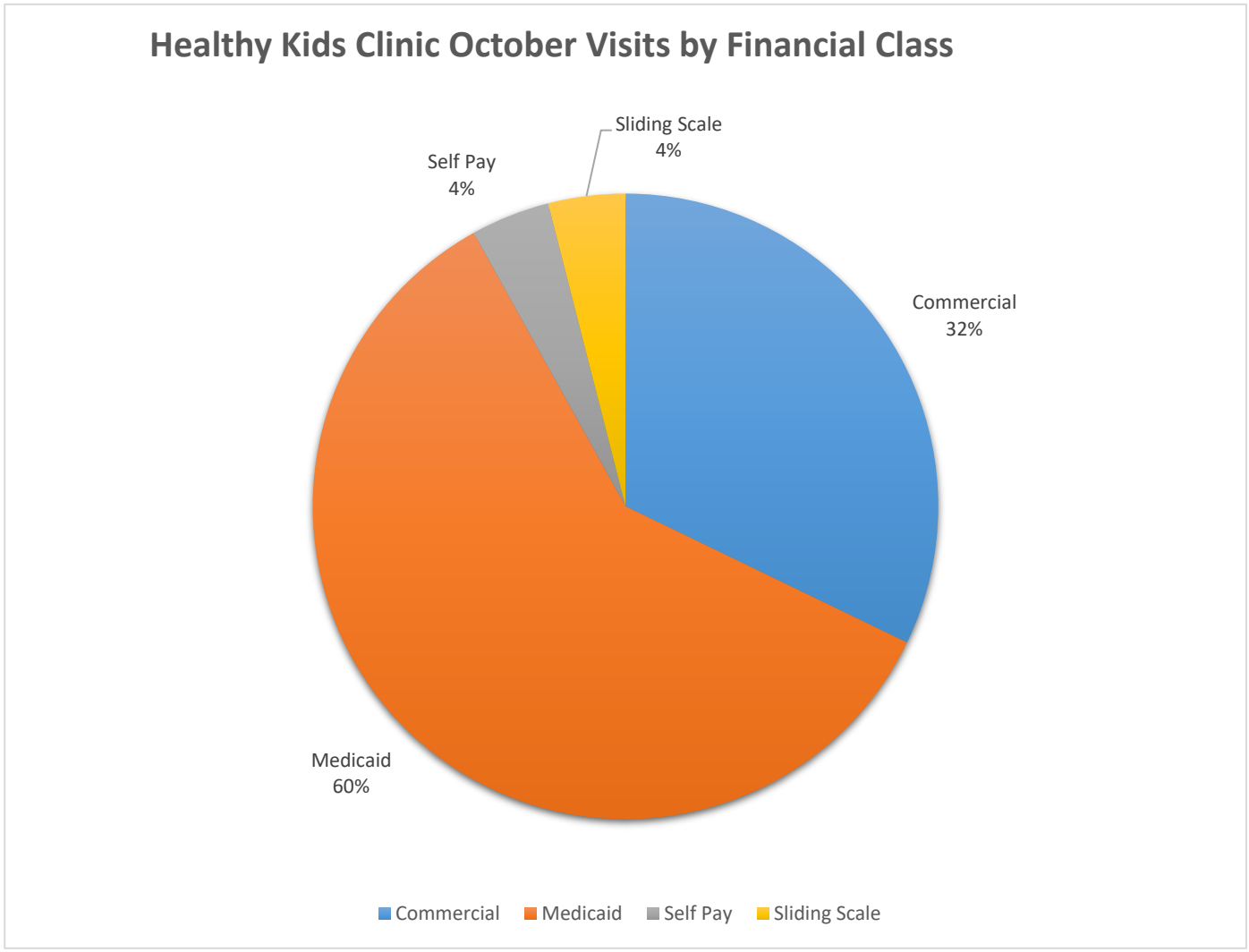
	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 17,567	5.2%	$ 3,682	2.2%	$ 17,567	5.2%	$ 3,682	2.2%
Medicaid	103,742	30.7%	27,631	16.5%	103,742	30.7%	27,631	16.5%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	159,062	47.1%	71,553	42.7%	159,062	47.1%	71,553	42.7%
Self Pay	54,057	16.0%	64,329	38.4%	54,057	16.0%	64,329	38.4%
Other	3,241	1.0%	347	0.2%	3,241	1.0%	347	0.2%
TOTAL	**$ 337,669**	**100.0%**	**$ 167,541**	**100.0%**	**$ 337,669**	**100.0%**	**$ 167,541**	**100.0%**

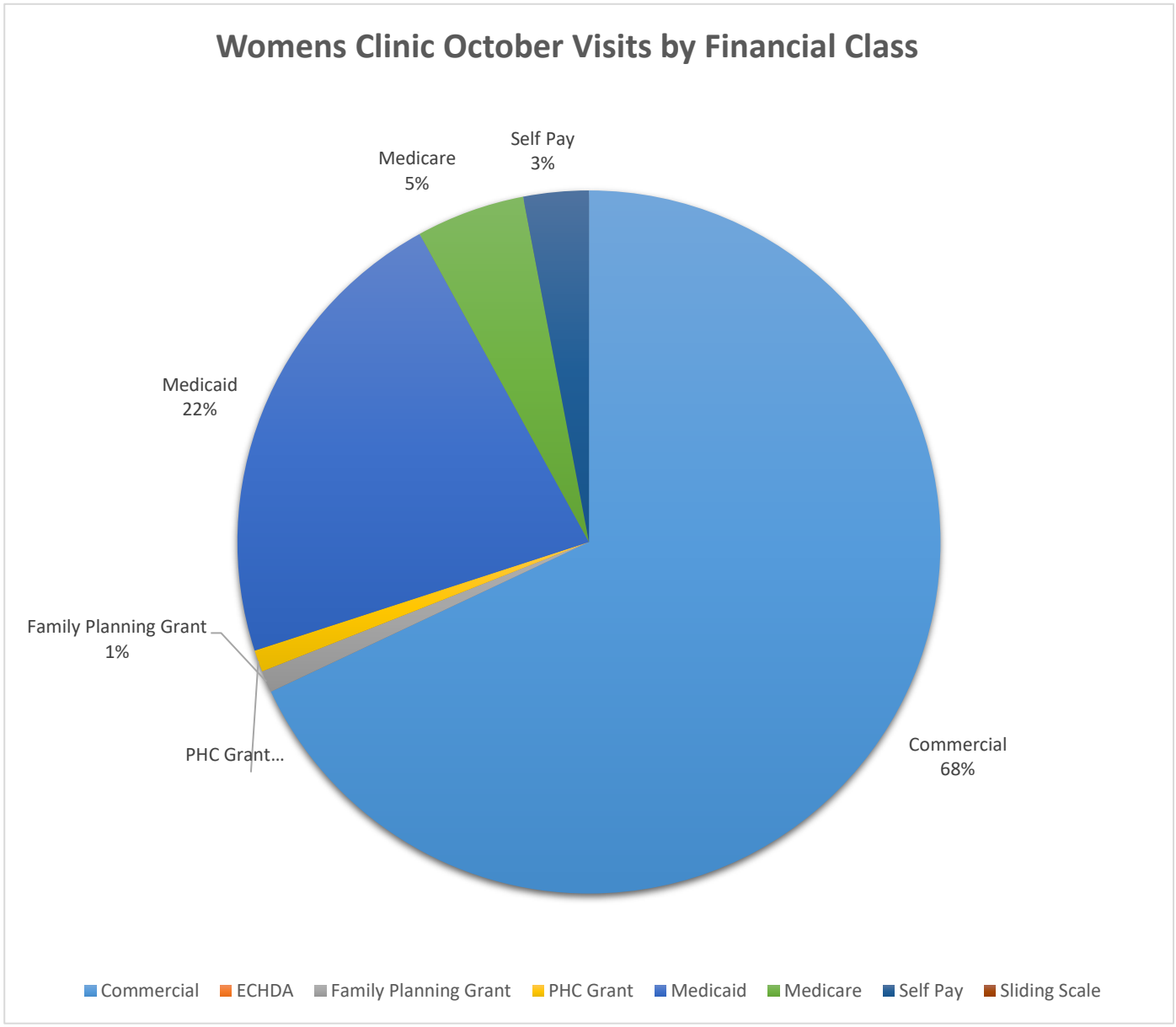

FHC October Visits By Service
Endocrinology
2%
Family/Internal Med
29%
Ob/Gyn
44%
Pediatrics
25%
Endocrinology
Family/Internal Med
Ob/Gyn
Pediatrics


Total FHC October Visits by Financial Class
Sliding Scale 4%
Self Pay 3%
Medicare 9%
Commercial 47%
Medicaid 28%
ECHDA 1%
PHC Grant 7%
Family Planning Grant 1%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC Clements October Visits by Financial Class
Sliding Scale
10%
Commercial
20%
Self Pay
2%
ECHDA
4%
Medicare
26%
PHC Grant
26%
Medicaid
12%
Commercial
ECHDA
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC West University October Visits by Financial Class
Sliding Scale 8%
Self Pay 4%
Medicare 18%
Medicaid 11%
PHC Grant 14%
ECHDA 3%
Family Planning Grant 2%
Commercial 40%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


Healthy Kids Clinic October Visits by Financial Class
Sliding Scale
4%
Self Pay
4%
Commercial
32%
Medicaid
60%
Commercial
Medicaid
Self Pay
Sliding Scale


Womens Clinic October Visits by Financial Class
Self Pay
3%
Medicare
5%
Medicaid
22%
Family Planning Grant
1%
PHC Grant...
Commercial
68%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale

FHC Executive Director's Report-December 2024

- **Staffing Update**:
  - **Women's Clinic**: The Women's Clinic is currently in search of an LVN, FT Ultrasound Tech, and PT Ultrasound Tech.
  - **Family Health Clinic**: FHC West University is currently searching for a PT LVN. FHC Clements is in search of an LVN.
  - **Healthy Kids Clinic**: The Healthy Kids Clinic is currently in search of a FT LVN, a PT LVN, and a Medical Assistant.

- **Provider Update:**
  - **West University**: We are currently searching for an additional Family Medicine physician for our West University location. Merritt Hawkins is assisting in the search. We have hired an additional Nurse Practitioner for West University, Alona Roldan, FNP. Alona is expected to start early 2025.
  - **Women's Clinic**: The Women's Clinic is currently searching for two OB/Gyns. Both Merritt Hawkins and Curative are assisting with the search. The Women's Clinic has added a Maternal Fetal Medicine physician, Dr. Thomas Byrne. He will start February 1, 2025.

THE BOARD OF DIRECTORS OF THE
ECTOR COUNTY HOSPITAL DISTRICT
MEDICAL CENTER HEALTH SYSTEM

WHEREAS: The Ector County Hospital District/Medical Center Health System (ECHD/MCHS), is committed to ethical and legal business practices as essential to the advancement of its Mission of service to the Ector County community**.**

WHEREAS: Pursuant to this commitment, as set forth in the minutes of July 14, 1998 and subsequent minutes, the Board of Directors of ECHD/MCHS has previously directed the establishment and maintenance of a Corporate Compliance Program as a continuous process for the improvement of its business policies and practices, and oversight of its responsibilities under local, state and federal rules, laws, and regulations.

WHEREAS: It is the policy of the ECHD/MCHS that the implemented Corporate Compliance Program assure a collaborative participation of all elements of the hospital in the prevention of violations of Medical Center Health System's policies, local, state and federal laws. The expectations of this policy are to:

- Reaffirm this hospital's commitment to its stated principles and beliefs.
- Assure the hospital acts in a manner consistent with its Mission and Values.
- Have the hospital meet its ethical and legal requirements.
- Decrease the risk of inappropriate behavior.

RESOLVED: That the Board of Directors, ECHD/MCHS reaffirms its commitment to the expectations of ethical and legal conduct stated herein, and to the continuous effective monitoring of the hospital's responsibilities and business practices by its leadership, managers, and employees, and through the processes and procedures of the Corporate Compliance Program.

FURTHER RESOLVED: To assure that the Board's expectations are adhered the Board directs that:

- That the Audit Committee monitor the performance of the Corporate Compliance Program and receive regular reports in Executive Session, but no less than quarterly in each calendar year, from the Chief Compliance Officer, on the program's initiatives, training, education, audits and reviews, and such other matters as should be brought to the Board's attention.
- That the Chief Executive Officer and the Chief Compliance Officer jointly report to the full Board on the status and effectiveness of the Corporate Compliance Program on no less than an annual basis.
- That the Chief Executive Officer establishes such policies and procedures as necessary to accomplish the goals and objectives stated herein.

Passed and Approved this day 3 of December 2024

_____	_____
Wallace Dunn, President	Richard Herrera
_____	_____
Don Hallmark, Vice President	Will Kappauf
_____	_____
Bryn Dodd	Kathy Rhodes
_____	
David Dunn	

December 2024

MEDICAL CENTER HEALTH SYSTEM

COMPLIANCE COMMITTEE CHARTER

I. PURPOSE

As an expression of our commitment to act with integrity and ethics and to institute a program to ensure compliance with all applicable laws, Medical Center Health System ("MCHS") has created a Board approved Compliance Committee to (i) oversee the implementation, operation, and effectiveness of MCHS's Compliance Program and the performance of the Compliance Officer in effectuating the Compliance Program, and (ii) assist the Board in fulfilling its fiduciary responsibility and accountability relating to its compliance oversight responsibilities, the Mission and Values of MCHS and the MCHS Compliance Standards of Conduct.

II. AUTHORITIES AND RESPONSIBILITIES

The Compliance Committee is continuously composed of representatives from multiple disciplines. At a minimum, the Compliance Committee will include the Chief Compliance and Privacy Officer, President and Chief Executive Officer (Pres./CEO), Chief Legal Counsel, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, Chief Information Officer and two Ector County Hospital District Board Members. The Pres./CEO shall also appoint such ex officio members of the Compliance Committee as he or she deems necessary or advisable to assist the committee in the performance of its duties. Ex officio members of the committee may not vote on matters before the committee.

The Compliance Committee will receive reports from ad-hoc guests which will be related to Human Resources, Information Technology/Security, Revenue Cycle/Integrity, or others as deemed necessary.

III. DUTIES OF THE COMPLANCE COMMITTEE

The duties of the Compliance Committee shall include:

1. Advising the Chief Compliance Officer and assisting in the implementation and maintenance of the Compliance Program;
2. Working with appropriate departments of the Health System to develop standards of conduct and policies and procedures to promote adherence to the Compliance Program;

3. Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out MCHS's standards, policies and procedures;
4. Determining the appropriate strategy and/or approach to promote adherence to the Compliance Program and the detection of potential violations;
5. Developing a system to solicit, evaluate and respond to complaints and problems;
6. Overseeing the education and training of employees and systems for communication with and by employees;
7. Analyzing the legal requirements with which MCHS must comply and locating and analyzing specific risk areas within the Health System; and
8. Establishing confidentiality standards and requirements for committee members and those persons requested to provide assistance to the committee.

IV. MEETINGS

The Committee shall meet at least quarterly in order to perform its responsibilities. The Committee shall keep agendas, minutes and attendance of its meetings.

MEDICAL CENTER HEALTH SYSTEM

COMPLIANCE PROGRAM MANUAL 2024

CREATED: AUGUST 1998

REVIEWED AND REVISED:
OCTOBER 2001
DECEMBER 2002
APRIL 2004
OCTOBER 2005
DECEMBER 2007
NOVEMBER 2010
DECEMBER 2011
JANUARY 2013
SEPTEMBER 2014
JANUARY 2016
FEBRUARY 2017
APRIL 2018
SEPTEMBER 2024

MEDICAL CENTER HEALTH SYSTEM

COMPLIANCE PROGRAM

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MEDICAL CENTER HEALTH SYSTEM

COMPLIANCE PROGRAM

Introduction

Agencies and departments of the U.S. Government have publicized a number of instances of fraud, abuse and waste in federally funded health care programs including Medicare and Medicaid. The Board of Directors of the Ector County Hospital District and the Executive Team of Medical Center Health System recognize the seriousness of the issues raised by the Government and recognize that failure to comply with applicable laws and regulations could threaten MCHS's continuing participation in these health care programs.

The Ector County Hospital District (ECHD) Board, therefore, has directed that Medical Center Health System undertake an integrity program to continue MCHS's commitment to high standards of conduct, honesty and reliability in its business practices. This integrity program is called a Compliance Program. The purpose of the Compliance Program is to promote understanding of and adherence to applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse, or waste in Medical Center Health System in connection with federally funded health care programs and private health plans. There are several parts to the Compliance Program, each of which is important. The Program applies to all employees, medical staff, contractors, vendors, and volunteers.

I.

CHIEF COMPLIANCE & PRIVACY OFFICER AND COMPLIANCE COMMITTEE

A. **Officer.** The President/Chief Executive Officer (CEO) shall appoint a high-level employee as Chief Compliance & Privacy Officer. Chief Financial Officer (CFO) or Chief Legal Officer (CLO) shall not be appointed.

B. **Duties.** The Chief Compliance & Privacy Officer and the Compliance Committee shall prepare, and revise as necessary, a job description for the Chief Compliance & Privacy Officer. The Chief Compliance & Privacy Officer's primary responsibilities set out in the job description shall include:

1. Overseeing and monitoring the implementation of the Compliance Program for the Health System;

2. Reporting on a regular basis to the Health System's Boards of Directors, the President/CEO, and the Compliance Committee on the progress of implementation, and assisting the Boards, the President/CEO and the committee in establishing methods to improve MCHS's efficiency and quality of services, and to reduce the Health System's vulnerability to fraud, abuse and waste;

3. Periodically revising the Compliance Program as required by changes in the law and policies and procedures of government and private payor health plans;

4. Developing, coordinating, and participating in an educational and training program that focuses on the elements of the Compliance Program for the Health System, and seeks to ensure that all appropriate employees, medical staff, vendors and volunteers are knowledgeable of, and comply with, pertinent federal and state standards;

5. Ensuring that independent contractors and agents who furnish medical services to the Health System are aware of the requirements of the Health System's Compliance Program with respect to coding, billing, and marketing, among other things;

6. Coordinating personnel issues with the Chief Human Resources Officer, through IT Support, Volunteer Services Manager, Assistant Chief Financial Officer or designees and the Medical Staff Office to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been checked with respect to all employees, volunteers, medical staff and independent contractors;

7. Assisting in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments and audits;

8. Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all MCHS departments, Clinics, providers and sub-providers, agents and, if

   appropriate, independent contractors; and

9. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

C. **Authority.** The Chief Compliance & Privacy Officer shall have direct access to the President/CEO and to the Health System's Boards of Directors. The Chief Compliance & Privacy Officer shall have access to all documents and information relevant to compliance activities including but not limited to patient records, billing records, marketing records, contracts and written arrangements or agreements with others. The Chief Compliance & Privacy Officer may seek advice from legal counsel and may retain necessary consultants or experts.

D. **Reports.** The Chief Compliance & Privacy Officer shall report to the Health System's Boards at least annually on the status of compliance in the Health System. Such reports may be written or oral.

E. **Compliance Committee.**

The Compliance Committee **is continuously composed of representatives from multiple disciplines**. At a minimum, the Compliance Committee will include the Chief Compliance and Privacy Officer, President and Chief Executive Officer (Pres./CEO), Chief Legal Counsel, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, Chief Information Officer and two Ector County Hospital District Board Members. The Pres./CEO shall also appoint such ex officio members of the Compliance Committee as he or she deems necessary or advisable to assist the committee in the performance of its duties. Ex-officio members of the committee may not vote on matters before the committee.

The Compliance Committee will receive reports from ad-hoc guests which will be related to Human Resources, Information Technology/Security, Revenue Cycle/Integrity, or others as deemed necessary.

F. **Duties.** The duties of the Compliance Committee shall include:

1. Advising the Chief Compliance & Privacy Officer and assisting in the implementation and maintenance of the Health System's Compliance Program;

2. Working with appropriate departments of the Health System to develop policies and

procedures to promote adherence to laws and regulations;

3. Recommending and monitoring, in conjunction with the relevant departments & Clinics, the development of internal systems and controls to carry out MCHS's standards, policies and procedures;

4. Determining the appropriate strategy and/or approach to promote adherence to the Health System's Compliance Program and the detection of potential violations;

5. Developing a system to solicit, evaluate and respond to complaints and problems;

6. Overseeing the education and training of employees and systems for communication with and by employees;

7. Analyzing the legal requirements with which MCHS must comply and locating and analyzing specific risk areas within the Health System; and

8. Establishing confidentiality standards and requirements for committee members and those people requested to provide assistance to the committee.

G. **Guidelines.** The Compliance Committee may adopt written guidelines for holding meetings and conducting the activities and operations of the committee.

II.
TRAINING AND EDUCATION

A. **Necessity.** It is imperative that coding and billing of federal health care claims be truthful and accurate and within appropriate guidelines. Not only are there severe penalties payable to the government for improper coding and billing, but honesty and integrity, in MCHS's operations, are the right and proper thing to do. Sometimes conduct undertaken without wrongful intent but with inadequate knowledge may violate applicable laws and regulations. Proper and continuing training and education of employees at all levels is, therefore, a significant element of an effective compliance program.

B. **Initial Education.** Mandatory Compliance, HIPAA Privacy and HIPAA Security education for all new employees, physicians, vendors and volunteers and the employee handbook will provide an overview of fraud and abuse laws, a copy of MCHS Compliance Standards of Conduct, and an explanation of the elements of the Compliance Program, including the reporting process and highlight the Health System's commitment to integrity in its business operations and compliance with applicable laws and regulations. Annual Compliance, HIPAA Privacy and HIPAA Security education is also required for all employees, vendors as applicable, and volunteers. Physicians receive

Compliance, HIPAA Privacy and HIPAA Security education at credentialing and re-credentialing.

C. **General Rules**. Periodically, as necessary, appropriate employees & volunteers will be retrained (i) in the Health System's Compliance Program; (ii) the fraud and abuse laws as they relate to the claim development and submission process and MCHS's business relationships; (iii) relevant Medicare and other federal and state requirements; and (iv) the consequences both to MCHS and individuals of failing to comply with applicable laws and regulations. Such training must emphasize the importance of the Compliance Program and the Health System's commitment to honesty and integrity in its business dealings.

D. **Substantive Rules**. Involved employees will be trained and retrained in the specific federal health care program rules (e.g., Medicare) that relate to their job function. By way of example:

1. Admitting personnel will receive training to ensure they are asking the necessary questions and obtaining the necessary information to comply with Medicare and Medicaid requirements.

2. Coding personnel will be taught current reimbursement principles, proper coding, the impact of coding on the DRG, and how to avoid the areas of concern applicable to the coding process described in Section II.

3. Patient care personnel will be instructed in charge entry and coding, and the importance of documenting services and supplies which will later be billed to Medicare or Medicaid.

4. Billing personnel will be instructed in Medicare requirements applicable to the preparation of claims for services, the distinction between covered and non-covered services and the importance of listing those services in the proper section of the claim forms and how to avoid the areas of concern applicable to the billing process described in Section II.

Such employees may be trained individually or as a group.

E. **Department Training and Education.** Department directors or managers shall periodically identify and advise the Chief Compliance & Privacy Officer of training and education necessary or advisable for all or any employees of his or her department. The Chief Compliance & Privacy Officer and the director or manager shall promptly arrange for such training and education.

F. **Types.** Training and education may occur in sessions with individual employees, in mandatory in-service meetings or incorporated into special or regular departmental meetings or in some other effective manner. Training may consist of live presentations, videos, question and answer sessions and written material and may occur in-house or through attendance at external workshops and seminars.

G. **Amount of Training.** All employees need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all employees. Targeted training and education will be provided to employees whose actions may affect the accuracy of claims submitted to the government. The actual amount of training should reflect necessity, an analysis of risk areas or areas of concern identified by the Health System or the Office of the Inspector General, the Health System's compliance experience and the results of periodic audits or monitoring.

H. **Documentation.** The training provided to each employee shall be documented. The documentation shall include the date and a brief description of the subject matter of the training activity or program. Documentation is important.

I. **Failure to Attend.** Failure to comply with training requirements or to attend scheduled training sessions of the Health System or of each department may result in disciplinary action.

J. **Evaluation.** There should be periodic evaluations of training and education programs to determine, and if necessary, improve, the value, effectiveness, and appropriateness of any such program.

III.
COMMUNICATION

A. **Reason.** Open communications between employees and the Chief Compliance & Privacy Officer or the Compliance Committee are important to the success of this Compliance Program and to the reduction of any potential for fraud, abuse, and waste. Without help from employees it may be difficult to learn of possible compliance problems and make necessary corrections.

B. **Questions.** At any time, any employee or physician may seek clarification or advice from the Chief Compliance & Privacy Officer or members of the Compliance Committee in the event of any confusion or question regarding this Program or any element of this Program or any MCHS policy or

procedure related to this Program. Questions and responses should be documented and, if appropriate, shared with other employees for informational and educational purposes. Employees should be encouraged to contact the Chief Compliance & Privacy Officer and any member of the

committee and for this purpose the Chief Compliance & Privacy Officer will develop or cause to be developed publicity and notices regarding his or her name, location and e-mail address and the names of members of the committee and their location.

C. **Reporting.** Employees or physicians who are aware of or suspect acts of fraud, abuse or waste or violations of MCHS Compliance Standards of Conduct should report such acts or violations. Several independent reporting paths are available:

1. Employees may report concerns/violations directly to their supervisor or department director or manager. Supervisors and managers will thereafter promptly pass on the report to the Chief Compliance & Privacy Officer or member of the committee.

2. An employee or physician may report directly to the Chief Compliance & Privacy Officer or to a member of the compliance committee. The Compliance Office Hotline can be reached at 432-640-1900 during normal business hours.

3. MCHS has contracted with Navex/Ethics Point to operate a 24-hour, 365-day hotline known as the "Compliance Line" (1-800-805-1642). Employees and physicians may use this line anonymously at any time, day, or night. The phone number of the Compliance Line has been posted at various places throughout the Health System and employees will be reminded of the number and of their duty to report actual or suspected wrongdoing through the Health System newsletter, MCHS Intranet, unit meetings and other methods. Employees should be encouraged to use this line.

4. On each floor/unit in the Health System, in many cases next to a time clock, is a Hotline Poster with a QR Code that can be scanned into phones or other smart devices to take you directly to an online reporting form. Additionally, there are "Integrity Boxes" with blank forms and a pen located at key locations on the main hospital campus. The forms may be completed anonymously and dropped in the box. The Integrity Boxes are located on the first floor of the main building in the central hallway at the main entrance and the far West hallway near the basement elevator, and in the Annex building main entrance outside of Human Resources. These boxes are checked each week by the Compliance Office.

5. Concerns may also be placed online from the MCHS Intranet under the Employee Links section labeled Compliance Hotline.

D. **Confidentiality.** Reports received will be treated confidentially to the extent possible under applicable law. However, there may be a time when an individual's identity may become known or must be revealed if governmental authorities become involved or in response to subpoena or other legal proceeding.

E. **Non-Retaliation.** There will be no retaliation against any employee who in good faith reports acts or suspected acts of fraud, abuse or waste or violations or suspected violations of MCHS Compliance Standards of Conduct or other wrongdoing or misconduct. However, an employee who

makes an intentional false report or a report not in good faith may be subject to disciplinary action.

F. **Documentation.** Reports that suggest substantial violation of this Program, violation of MCHS's Compliance Standards of Conduct or violation of relevant law or regulation should be documented by the Chief Compliance & Privacy Officer. Information about such reports should be furnished periodically to the Board and the President/CEO and to the Compliance Committee at its regular meetings.

IV.
INVESTIGATION

A. **Requirement and Purpose.** Reports or reasonable indications of fraud, abuse or waste, violations of the MCHS Compliance Program and/or violations of MCHS's Compliance Standards of Conduct, violations of MCHS's policy or procedure or violations of applicable law or regulation will be promptly investigated. The purpose of the investigation shall be to identify those situations involving fraud, abuse or waste or relevant violations or unacceptable conduct; to identify individuals who may have knowingly or inadvertently caused or participated in such situations or may need further training and education; to facilitate corrective action; and to implement procedures necessary to ensure future compliance.

B. **Control of Investigation.** The Chief Compliance & Privacy Officer shall be responsible for directing the investigation of the alleged situation or problem. In undertaking investigations, the Chief Compliance & Privacy Officer may utilize other MCHS employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.

C. **Process.** Because of the many situations or problems which are possible, the process and method of investigation is left to the sound judgment and discretion of the Chief Compliance & Privacy Officer, including when appropriate, pursuant to the advice of legal counsel. The Chief Compliance & Privacy Officer or his or her designee, may conduct interviews with any MCHS employee and with other persons and may review any MCHS document including but not limited to those related to the claim development and submission process, patient records, e-mail and the contents of computers.

D. **Documentation.** The Chief Compliance & Privacy Officer shall include in his or her investigation event files, as applicable, the following types of information: (i) define the nature of the situation or problem (ii) summarize the investigation process (iii) identifies any person whom the investigator believes may have violated MCHS's Compliance Standards of Conduct, MCHS's policy or procedure or violations of applicable law or regulation and (iv) if possible, as applicable, estimate the nature and extent of any resulting overpayments.

E. **Response.**

The following actions may be taken as a result of an investigation:

1. Billing involved in the situation or problem may be discontinued until such time as appropriate corrections are made.

2. If duplicate or improper payments have been paid by Medicare/Medicaid or other health care program or excessive payments made because of coding or other MCHS errors or mistakes (i) the defective practice or procedure will be corrected; (ii) the duplicate or improper payments will be calculated and repaid to the appropriate payor; and (iii) a program of education will be undertaken with appropriate employees to prevent future similar problems.

3. A summary of the results of the investigation may be sent for appropriate disciplinary action to the department director or manager (or the appropriate executive staff member if the director or manager is implicated). Pending disciplinary action, any such employee may be removed from any position with oversight of or impact upon the claim's development and submission process.

4. State and federal agencies will be notified as deemed appropriate by the Chief Compliance & Privacy Officer in coordination with legal counsel, the President/CEO, and the ECHD Board.

Voluntary Disclosures. Any voluntary self-disclosures may be guided by the OIG's Health Care Fraud Self-Disclosure Protocol 63 Fed. Reg. 58399 (October 21, 1998); (updated April 17, 2013: FR Doc.2013.11050, and amended November 8, 2021, updates and renames the Provider Self-Disclosure Protocol).

F. **Reports by Chief Compliance & Privacy Officer.** The Chief Compliance & Privacy Officer periodically shall furnish information (bearing in mind issues of confidentiality) about such investigations to the Board and the President & CEO and to the Compliance Committee at its regular meetings.

V.

AUDITS

A. **Process.** Periodic audits will be undertaken to identify deficiencies in the claim development

and submission process. MCHS will devote such resources as are reasonably necessary to ensure that audits are adequately staffed by people with appropriate knowledge and experience.

B. **Time.** The Compliance Committee shall designate the time for audits and the departments and functions to be audited.

C. **New Employees.** It is the responsibility of each department manager to ensure that employees who are new to a position, which have a direct impact on the claim development and submission process, are provided adequate and appropriate training and education. To verify that each new employee understands the essential elements of his or her job function, the work of such new employees should be audited or reviewed until the director or manager is satisfied that the accuracy of the employee's work is adequate to justify cessation of the audit or review. Directors or managers may rely on other competent and experienced employees to assist in such reviews. New employees whose work does not meet the necessary quality or standard within a reasonable time after employment may be transferred to another job in or out of the department and such transfer shall not be considered disciplinary action for any purpose or reason.

D. **Periodic Tests and Audits.** MCHS, under the direction of the Chief Compliance & Privacy Officer, will conduct periodic tests of claims submitted to Medicare, Medicaid and other federal health care plan and audits of the claim's development and submission process. The audits shall include reviewing the work of coders, billers, admitting and registration clerks, patient care providers (including physicians where reasonably possible) ancillary departments such as laboratory and diagnostic imaging and risk areas identified by the OIG or fiscal intermediaries. Audits shall also cover MCHS's relationship with third party contractors, including physicians on its medical staff, and compliance with laws governing kickback arrangements. The Compliance Office may request that the director or manager of each affected department prepare and submit testing, audit, and monitoring plans for his or her department.

E. **Access.** Auditors and reviewers shall have access to all necessary documents including those related to claim development and submission, patient records, e-mail and the contents of computers. Auditors and reviewers shall always bear in mind confidentiality requirements.

F. **Action.** The Chief Compliance & Privacy Officer will be notified of the results of all audits. Further action, if any, by the Chief Compliance & Privacy Officer with respect to any deviation or discrepancy revealed by an audit will be taken under the provisions of Section VI.

G. **Documents.** All audits shall be thoroughly documented. Such documents shall be maintained in the permanent files of the Chief Compliance & Privacy Officer and adequately secured.

VI.
SCREENING

A. **New Employees.** MCHS will conduct a reasonable background investigation of all new employees, or applicants for employment, who have or will have discretionary authority to make decisions that, or whose job function may, materially impact the Medicare/Medicaid claim development and submission process or MCHS's relationship with physicians on its medical staff. The purpose of the background investigation is to determine whether any such employee or applicant has been (i) convicted of a criminal offense related to health care or (ii) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation. All employees and volunteers will be screened monthly.

B. **Providers.** A similar reasonable background investigation will be undertaken for providers who do or will possess an individual Medicare or Medicaid provider number. Such providers will be screened monthly.

C. **Vendors and Contractors.** Reasonable background investigations will be conducted for vendors and contractors to determine if any such vendor or contractor has a criminal conviction related to health care or has been disbarred or excluded by a federal agency. For the vendors we contract with Vendor Credentialing Service to perform this function.

D. **Process.** The Chief Compliance & Privacy Officer, in consultation as necessary with the Chief Human Resources Officer, The ECHD Police Dept., the Director of Medical Staff Services, MCH ProCare Administrative Staff and other employees, will implement and maintain policies and procedures for developing relevant applications for employment and for conducting such background investigations. The application for employment should require the applicant to disclose

any criminal conviction related to health care programs or exclusion action. The background investigations should utilize the OIG Cumulative Sanction Report, the General Services Administration list of debarred contractors of, the Specially Designated Nationals (SDN) and the National Practitioner Data Bank.

E. **Prohibition.** MCHS will not hire or retain an employee in a position which has or will have discretionary authority to make decisions or whose job functions may materially impact the Medicare/Medicaid claim development and submission process or MCHS's relations with its staff physicians if such prospect or employee has been convicted of a crime related to health care or has been excluded or debarred. MCHS will not contract with any person or entity which has been so convicted, excluded, or debarred and will attempt to terminate its contract arrangements with any such person or entity, subject to legal constraints such as damages for breach of contract. MCHS will make reasonable and prudent effort not to submit any claim for service ordered or furnished by any person or entity, including physicians, excluded from participation.

VII.
EVALUATIONS

Adherence to and promotion of this Program will be a factor in evaluating the performance of employees, including supervisory, managerial, and administrative personnel.

VIII.
REPORTS

The Chief Compliance & Privacy Officer shall make written evaluation reports on compliance activities including reports or complaints received from employees, investigations, auditing, and monitoring, to the system's Boards of Directors, the President/CEO, and members of the Compliance Committee on a regular basis. Reports to the Health System's Boards shall be at least annually or more often as necessary or advisable.

IX.
RESPONSE TO GOVERNMENTAL INQUIRIES

A. **Cooperation.** Federal agencies have available several investigation tools including search

warrants, subpoenas and civil investigation demands. Actions also may be brought against MCHS to exclude it from participating in Medicare/Medicaid if MCHS fails to grant immediate access to agencies conducting surveys or reviews. It is, therefore, the policy of Medical Center Health System to cooperate with and properly respond to all governmental inquiries and investigations.

B. **Process.** Employees who receive a search warrant, subpoena or other demand or request for investigation, or if approached by a federal agency, should attempt to identify the investigator, if any, and immediately notify the Chief Compliance & Privacy Officer or, in that Officer's absence, a member of the Compliance Committee or the employee's supervisor. Employees should request the government representative to wait until the Chief Compliance & Privacy Officer or his or her designee arrives before conducting any interview or reviewing documents. The Chief Compliance & Privacy Officer in consultation with outside legal counsel is responsible for coordinating MCHS's response to warrants, subpoenas, inquiries, and investigations by federal agencies. If appropriate, MCHS also may provide legal counsel to employees.

C. **Documents.** MCHS's response to any warrant, subpoena, investigation, or inquiry must be complete and accurate. No employee shall alter or destroy any document or record or alter, delete, or download any material from any computer. Documents and records must be preserved in their original form.

X.
DISCIPLINE AND DISCLAIMER

A. **Other Reasons:** In addition to possible disciplinary action mentioned elsewhere in this Program, employees may be subject to disciplinary action for:

1. Failure to perform any obligation or duty required of employees relating to compliance with this Program or applicable laws or regulations.

2. Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements and this Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.

B. **Procedure**. Possible disciplinary action will follow MCHS's existing disciplinary policies and procedures. Progressive discipline is not required.

C. **Disclaimer.** Nothing in this Program shall (i) constitute a contract of or agreement for

employment; or (ii) modify or alter in any manner any employee's at-will employment status. Any part of this Program may be changed or amended at any time without notice to any employee.

XI.
Employee Guidelines

All Medical Center Health System's business affairs must be conducted in accordance with federal, state, and local laws, professional standards, applicable federally funded health care program regulations and policies and with honesty, fairness, and integrity. Employees should perform their duties in good faith, in a manner that he or she reasonably believes to be in the best interest of Medical Center Health System and its patients and with the same care that a reasonably prudent person in the same position would use under similar circumstances. To further these overall goals, several policies or Compliance Standards of Conduct have been adopted by MCHS.

A. **EMPLOYEE HANDBOOK.** The handbook given to each employee sets out several types of conduct, which are unacceptable. These include:

1. Intentionally or knowingly making false or erroneous entries on reports, patient charts or other MCHS records.
2. Dishonesty.
3. Unauthorized alteration or destruction of MCHS records including patients' charts.
4. Coding or billing which violates Medicare or Medicaid rules or regulations or other federal rules or regulations.
5. Behavior detrimental to the operation of MCHS.

Other unacceptable conduct may be found in the handbook.

B. **CONFLICT OF INTEREST.** To perform their duties with honesty and fairness and in the best interest of the Ector County Hospital District and Medical Center Health System, employees must avoid conflicts of interest in their employment. Conflicts of interest may arise from having a position or interest in or furnishing managerial or consultative services to any concern or business from which MCHS obtains goods or services or with which it competes or does business, from soliciting or accepting gifts, excessive entertainment or gratuities from any person or entity that does or is seeking to do business with the Health System and from using MCHS property for personal or private purposes. Conflicts also may arise in other ways. If an employee has any doubt or any

question about any of his or her proposed activities, guidance or advice should be obtained from the Chief Compliance & Privacy Officer, Chief Human Resource Officer, or the employee's manager. MCHS's policy on and prohibiting conflicts of interest may be found in Policy Number MCH-3016. A copy may be obtained from MCHS Intranet under the MCH policies.

C. **HIPAA / CONFIDENTIALITY OF INFORMATION.** A patient's health record is the property of Medical Center Health System and shall be maintained to serve the patient, necessary health care providers, the institution and third-party payors such as Medicare in accordance with legal, accrediting, and regulatory agency requirements. The information contained in the health care record belongs to the patient and the patient is entitled to the protection of that information as mandated under the Health Insurance Portability and Accountability Act also known as HIPAA. All patient care information is regarded as confidential and available only to authorized users such as treating or consulting physicians, employees who may be providing patient care and to third party payors to facilitate reimbursement. The operations, activities, business affairs and finances of the Health System should also be kept confidential and discussed or made available only to authorized users.

D. **WORKPLACE ADMINISTRATIVE SEARCHES.** To assist in providing a reliable, efficient and productive work force for the proper care of patients, to assist in providing employees with a safe working environment, to assist in the effective operation of the Compliance Program and to supplement the Drug and Alcohol Policy, MCH-3033, supervisors may conduct unannounced administrative searches of Health System premises, offices, work areas, property and equipment and the contents of such property and equipment. No employee should have any expectation of privacy on MCHS property or in their offices or work areas including lockers, desks, cabinets, drawers, shelves, or trash cans or in folders, envelopes or packages located on MCHS premises. Any data on any MCHS device or in any of MCHS' systems is property of the hospital and subject to search/review. Personal possessions or materials should not be brought to work if they are of a sensitive or confidential nature. MCHS's policy on Workplace Administrative Searches is Policy Number MCH-3043. MCH-1046 Computer Security Policy also states that the use of computer systems at MCHS signifies consent to monitoring and monitoring does occur. A copy may be

obtained from the MCHS Intranet under the MCH policies. Other policies permit monitoring of and access to computers by supervisors. The use of computers, e-mail and access to the Internet must be reasonable and responsible.

E. **FRAUD AND ABUSE.** Employees shall refrain from conduct, which may violate the fraud and abuse laws. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered or claims which do not otherwise comply with applicable program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment or excessive payment for any service.

F. **BUSINESS ETHICS.** Employees must accurately and honestly represent MCHS and should not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

G**. FINANCIAL REPORTING.** All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is not only contrary to MCHS policy, but it may also be in violation of applicable laws. Sufficient and competent evidential matter or documentation shall support all cost reports.

H**. PROTECTION OF ASSETS.** MCHS will make available to employee's assets and equipment necessary to conduct MCHS business including such items as computer hardware and software, billing, and medical records, both hardcopy and in electronic format, fax machines, office supplies and various types of medical equipment. Employees should strive to use MCHS assets in a prudent and effective manner. MCHS property should not be used for personal reasons or be removed from Medical Center Health System without approval from a departmental manager. An employee who believes that any medical equipment is not operating properly or has an inaccurate calibration should immediately report the problem to his or her supervisor.

I. **ANTI-COMPETITIVE CONDUCT.** Medical Center Health System will not engage in anti-

competitive conduct that could produce an unreasonable restraint of trade or a substantial lessening of competition. Evaluation of anti-competitive conduct requires legal guidance. Communication by employees with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

J. **CREDIT BALANCES.** MCHS will comply with Federal and state laws and regulations governing credit balance reporting and refund all overpayments in a timely manner.

K. **FINANCIAL INDUCEMENTS.** No employee shall offer any financial inducement, gift, payoff, kickback, or bribe intended to induce, influence or reward favorable decisions of any government personnel or representative, any customer, contractor or vendor in a commercial transaction or any person in a position to benefit Medical Center Health System or the employee in any way. Employees are strictly prohibited from engaging in any corrupt business practice either directly or indirectly. No employee shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful or improper purpose. Appropriate commissions, rebates, discounts, and allowances are customary and acceptable business inducements provided that they are approved by Administration and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to whom the original agreement or invoice was made or issued. Such payments should not be made to individual employees or agents of business entities.

L. **ADDITIONAL STANDARDS.** MCHS has adopted several other System-wide policies and procedures. Employees may obtain copies from the MCHS Intranet web page under MCHS policies. Additional standards and policies may be applicable only to particular departments and copies may be obtained from supervisors or directors in those departments. It is particularly important that coding, billing, and submission of claims to Medicare, Medicaid and other third-party payors, be appropriate, accurate and in compliance with applicable laws and regulations. Standards relating to billing will be found in a later section of this document.

M.**. ADMINISTRATION AND APPLICATION OF MCHS COMPLIANCE STANDARDS**

MCHS Compliance Standards of Conduct apply to ***all*** MCHS employees, including supervisors, managers, directors, and the Executive team. They also apply to temporary and contract employees, as well as independent contractors doing business with Medical Center Health System, vendors, contractors, volunteers and to the physicians on the Medical Staff

MCHS Compliance Standards of Conduct are not intended to cover every situation which may be encountered, and employees should comply with all applicable laws and regulations whether or not specifically addressed in the Standards.

Questions about the existence, interpretation or application of any law, regulation, policy, or standard should be directed, without hesitation, to an employee's supervisor, manager/director or to the Chief Compliance & Privacy Officer. Because laws, regulations and policies are constantly evolving, this Compliance Program Manual will be revised and updated as needed. Revisions will be communicated timely to MCHS employees through administrative notification, as applicable, and changes will be posted to the Compliance Web page.

Failure to comply with MCHS Compliance Standards of Conduct or to conduct business in an honest, ethical, reliable manner can result in civil fines or criminal penalties against MCHS and its employees or disciplinary action by MCHS, including termination. Supervisors are responsible for ensuring that their new employees receive education on the MCHS Compliance Program and then participate in mandatory training related to the Program. Compliance with and promotion of MCHS Compliance Standards of Conduct will be a factor in evaluating the performance of MCHS employees.

XII.

BILLING AND AREAS OF CONCERN

A. **Prohibited Billing Practices.** Generally, federal laws and regulations provide civil and criminal penalties for individuals and hospitals that submit claims for services which were: (i) not provided; (ii) billed in a manner other than as actually provided; (iii) not medically necessary; or (iv) billed in a manner that did not comply with applicable government requirements. Examples of prohibited practices include:

1. Submitting a claim that represents that MCHS performed a service all or part of which was simply not performed;

2. Upcoding, that is, using a billing code that provides a higher payment rate than the billing code that actually reflects the services furnished to a patient;

3. DRG creep. Like upcoding, DRG creep is the practice of billing using a DRG code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient;

4. Duplicate billing, that is, submitting more than one claim for the same service or submitting a bill to more than one primary payor at the same time;

5. Misrepresenting the qualifications of the person rendering the service or representing that supervision requirements were met when they were not;

6. Billing separately for diagnostic services provided to a patient in the three calendar days preceding hospital admission rather than rolling such claims into the diagnosis related group;

7. Billing for discharge in lieu of transfer;

8. Billing for services which are not covered; and

9. Unbundling, that is, submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.

B. **Non-Covered Services.** Some services are not covered under Medicare. Examples include:

1. Services which are medically unnecessary. That is, items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or which are not medically necessary for the health of the patient;

2. Routine screening services;

3. Services considered by Medicare to be experimental in nature or not medically

effective; and

4. Services that are considered not reasonable and appropriate or necessary for the diagnoses.

When a Medicare patient requests that a known non-covered service be performed and billed, an Advanced Beneficiary Notice should be obtained from the patient explaining that the service is non-covered and will be the patient's responsibility.

C. **Kickbacks.** Federal law prohibits the MCHS from paying a physician or anyone else for the referral of a patient for services which might be covered by Medicare or Medicaid. Illegal payments may be subtle. Examples include (i) payment to a heavy admitter for "Medical Director" fees in excess of the value of the work the physician actually performs as a medical director; (ii) providing reduced rate rent; (iii) paying excessive travel fees. All payments from MCHS to a physician and all leasing arrangements with physicians should be carefully examined to ensure that such payments or arrangements comply with applicable statutes and regulations and are not inducements to refer patients.

D. **Accurate Bills and Records.** Bills to Medicare and other federally funded health care programs, as well as to other payors, must be true, accurate and complete and for services believed to be medically necessary, and that were ordered by a physician or other appropriately licensed person. All physicians and other professional services should be documented timely, correctly, and properly. Patient records and other documentation which support the bills should also be true, accurate and complete in accordance with professional standards and available for audit and review. The diagnoses and procedures reported on the reimbursement claim must be based on the patient record and other relevant documentation.

E. **Training and Incentives.** Training, education, and documents necessary for accurate code assignment is and will continue to be made available to employees involved in coding. Billing department coders and billing consultants will not be provided with any financial incentive to improperly up-code claims or otherwise improperly increase MCHS revenue.

F. **Cost Reports.** The Chief Financial Officer shall prepare or cause to be prepared policies and procedures ensuring against submission of false or inaccurate cost reports and ensuring that:

1. Costs are not claimed unless based on appropriate and accurate documentation;

2. Allocation of costs to various cost centers are accurately made and supportable by verifiable and auditable data;

3. Unallowable costs are not claimed for reimbursement;

4. Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;

5. Costs are properly classified;

6. Fiscal intermediary prior year audit adjustments are implemented and are either not claimed for reimbursement or claimed for reimbursement and clearly identified as protested amounts on the cost report;

7. All related parties are identified on Form 339 submitted with the cost report and all related party charges are reduced to cost;

8. Requests for exceptions to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data;

9. MCHS's procedures for reporting of bad debts on the cost report are in accordance with federal statutes, regulations, guidelines and policies;

10. Procedures are in place and documented for notifying promptly the Medicare fiscal intermediary (or any other applicable payor, e.g. TRICARE and Medicaid) of errors discovered after the submission of the hospital's cost report.

G. **Bad Debts.** The Chief Financial Officer (CFO) shall develop or cause to be developed a mechanism to review, at least annually: (i) whether MCHS is properly reporting bad debts to Medicare and (ii) all Medicare bad debt expenses claimed, to ensure that MCHS's procedures are in accordance with applicable federal and state statutes, regulations, guidelines and policies. In addition, such a review should ensure that MCHS has appropriate and reasonable mechanisms in place regarding beneficiary deductible or co-payment collection efforts and has not claimed as bad debts any routinely waived Medicare co-payments and deductibles, which waiver also constitutes a violation of the anti-kickback statute. The CFO or his or her designee may consult with the appropriate fiscal intermediary if there are questions relating to bad debt reporting requirements.

H. **Credit Balances.** The CFO shall develop or cause to be developed policies and procedures providing for the timely reporting of Medicare and other federal health care program credit balances. The CFO shall designate appropriate employees to (i) review reports of credit balances and

reimbursements or adjustments monthly and (ii) be responsible for tracking, recording, and reporting credit balances.

I. **Retention of Records.** The Chief Compliance and Privacy Officer shall prepare or cause to be prepared policies and procedures regarding the creation, distribution, retention, storage, retrieval, disclosure and destruction of records and documents. Such records and documents shall include: (i) all records for the local government that have retention schedules (ii) clinical and medical records and claims documentation required by federal or state law for participation in federal health care programs; and (iii) records relating to the Compliance Program such as documentation related to employee training, reports from the hotline, the nature and results of any investigations, and results of MCHS's auditing and monitoring efforts.

COMPLIANCE STANDARDS OF CONDUCT

Originally Created 6-1-98
Last Revised 9-26-2024

MEDICAL CENTER HEALTH SYSTEM
INTRODUCTION TO THE STANDARDS OF CONDUCT

The purpose of Medical Center Health System's **Compliance Standards of Conduct** is to define the principles and guidance on ethical business practice by which we perform our daily duties. These Standards apply to the Ector County Hospital District Board of Directors, Medical Center Health System employees, medical staff, volunteers, contractors, vendors and agents, and anyone doing business with Medical Center Health System (MCHS). Each associate is expected to demonstrate behaviors that reflect ethical, respectful, honorable, honest and truthful performance on our job as we treat others with fairness, respect, and commit to "doing the right thing."

We each have the responsibility to conduct ourselves in a manner that assures we comply with all policies, procedures, laws and regulations which relate to Medical Center Health System. Also, each of us is expected to report any concerns that we may have in connection with our responsibilities. The failure to report suspected improper activity may constitute a violation which could result in disciplinary action, which may range from a warning up to termination. In addition, referral of the matter may be made to the appropriate government agencies. MCHS has set up a toll-free Compliance Line (1-800-805-1642) for this purpose, and callers may remain anonymous. Confidentiality is guaranteed to the limit of the law. You may also file a complaint via the MCHS Intranet under the "*Employee Links*" click on "*Compliance Hotline*" or by using any PC with internet access at ***www.mch.ethicspoint.com.*** Each floor on the main campus and in exterior buildings and clinics have a poster with a QR code that can be scanned with a Smart Phone or tablet to submit a concern online. If you prefer to leave a note to submit your concern, we have placed Integrity Boxes at select locations, including two on the first floor of the main campus and one at the entrance of the Annex building next to Human Resources. Again, there will be no retaliation or retribution against any employee for reporting a concern to management, Human Resources, the Compliance Line, the website or through the Integrity Boxes.

It is of utmost importance that each of us reads and understands the principles, guidance and ethical guidelines defined in the MCHS Compliance Standards of Conduct. Together we will continue to provide quality services to our patients and our community, through upholding our "**I CARE**" values: **I**ntegrity, **C**ustomer Centered, **A**ccountability, **R**espect, and **E**xcellence.

Should you have questions about these Standards or any MCHS policies or practices, please feel free to raise your concern with any member of management or with Human Resources without any fear of retaliation or reprisal. You may also contact the MCHS Compliance and Privacy Officer.

Sincerely,

Russell Tippin, President/CEO

MISSION STATEMENT

Medical Center Health System is a community-based teaching organization dedicated to providing high-quality and affordable healthcare to improve the health and wellness of all residents of the Permian Basin.

VISION STATEMENT

MCHS will be the premier source for health and wellness

VALUES

"I CARE"

Integrity • Customer Centered • Accountability • Respect • Excellence

QUALITY OF CARE AND PATIENT RIGHTS

Medical Center Health System (MCHS) is committed to providing the highest quality of care and delivering services in an ethical, professional and cost-effective manner, and shall not ignore any actual or perceived quality-of-care issues. Each MCHS workforce member has a duty to ensure that all such matters are brought to the attention of management, Human Resources or the Compliance Office. Members of the MCHS workforce will:

- Treat every patient with dignity, respect, and compassion at all times. We will demonstrate sensitivity and responsiveness to patients' needs by listening attentively and patiently to their comments and concerns.

- Recognize the rights of all patients to receive high-quality care without discrimination due to race, creed, gender, religion, national origin, disability, age, payer source or ability to pay.

- Provide patients with a written statement of their rights and responsibilities and ensure that they understand their rights and responsibilities in a manner that will be understood by them and obtain informed consent for treatment.

- Determine, upon admission, whether or not the patient has made or wishes to make advance directives and properly document in the health record any such directives. All directives will be followed as long as they fall within the limits of ethical standards and the law.

- Have a written process to address an employee's request to not participate in an aspect of patient care because of the employee's cultural, ethical, or religious beliefs; ensure that a patient's care will not be affected negatively if such a request is granted; and maintain guidelines and procedures stating those aspects of care which might conflict with an employee's cultural values, ethical or religious beliefs.

- Ensure that patients are fully informed and involved in resolving questions or concerns about their care decisions, the health care facility providing care, and any involved decision-makers and that they are treated in a manner that preserves their privacy, dignity, self-esteem, civil and legal rights and involvement in their own care.

- Ensure that clinical decisions are based on identified patient health needs, regardless of how the facility compensates or shares financial risk with its management or clinical staff, and licensed independent practitioners. Guidelines and procedures, which address the relationship between use of services and financial incentives, are available on request for review by patients, clinical staff, licensed independent practitioners and hospital employees.

- Consider all patient information to be private and strictly confidential.

- Protect the confidentiality of a patient's health care information and discuss only with those directly involved in the patient's care, or with those whose duties and responsibilities require access to such information, or as otherwise required by laws and regulations. We will protect and maintain the confidentiality of all patient records as required by applicable laws regulations, policies and procedures.

- Ensure that patients presenting themselves for emergency medical treatment will be provided treatment or care, without regard to their ability to pay, and within the service capability of the facility, in accordance with the Emergency Medical Treatment and Active Labor Act (**EMTALA**) and other laws, regulations and policies or procedures.

  Anyone with an emergency medical condition will be evaluated, treated, stabilized and admitted based on medical necessity. Financial information will be obtained only after the patient's immediate needs are met. Patients will only be transferred to another facility if their medical needs cannot be met at the receiving facility (MCHS) and then only to a facility that can provide the necessary treatment. Patients may only be transferred after they have been stabilized and accepted by the receiving facility. Patients or someone authorized to act in their behalf will be involved in any transfer decision and the informed consent for such a transfer.

- Conduct effective collaboration among departments and hospital/physician staff, contributing to patient care and organizational vitality.

- Engage the services of only professionals with proper credentials,

experience and expertise in meeting the needs of our patients.

- Screen all our medical professionals against duly authorized licensing and disciplinary authorities for any sanctions for performance or conduct.

- Provide medical services, which comply with all applicable laws, regulations and professional standards.

- Take all reasonable steps to ensure the safety and security of patients, visitors and employees. We will operate as efficiently as possible, but will not compromise quality of care, safety or service to reduce cost.

- Honor the rights of patients, or their legal designees, to participate in decision-making regarding their health care, to include refusing treatment to the extent permitted by law and to inform the patient of the consequences of such action.

- Ensure that patients are provided needed protective services, and we will provide procedures for an independent assessment of the patients' best interests and inform them of their right to file grievances with the proper agencies.

- Recognize that patients have a right to pain management and have established guidelines and protocols to properly assess and to effectively manage pain. We will ensure that appropriate employees are properly trained in the initial and periodic assessment of pain and sensitivity in communicating with the patient about pain management.

- Ensure that patients who are asked to participate in a research project or clinical trial are provided sufficient information to make an informed decision and we will obtain an informed consent.

- Ensure that long-term care patients will be informed of their right to perform or refuse to perform tasks in or on behalf of the facility.

- Ensure All MCHS communications and any promotional or marketing activities will be conducted in accordance with ethical standards and guidelines, and applicable laws, regulations, policies and

procedures to protect patient rights.

- Comply with all standards and procedures set forth in the accreditation certification body guidelines to remain accredited by the accrediting certification body.

COMPLIANCE WITH LAWS AND REGULATIONS

MCHS is subject to a number of state and federal laws and regulations pertaining to all aspects of its operation. Compliance with these laws and regulations is the basis for establishing and publishing our MCHS Compliance Standards of Conduct. Compliance with applicable laws and regulations is of the utmost importance to our health system. MCHS workforce members are all required to understand and abide by those laws and regulations, which are applicable to each employee in the performance of their different roles. Employees have the duty to report any actual or perceived violation of applicable laws, regulations and professional standards to management, Human Resources or the Compliance Office. Each workforce member will **NOT**:

- Pursue any business opportunity or personal matter that requires engagement in unethical or illegal activity or that we believe may be in violation of any law, rule, and regulation or MCHS policy.

- Solicit, receive, or offer to give anything of value to employees, physicians, or other health care professionals for referrals of patients. Kickbacks, bribes, rebates or flow of any kind of benefits intended to induce referrals are strictly prohibited.

Furthermore, each workforce member **WILL**:

- Provide payments or other benefits at fair market value to clinicians and potential or actual referral sources only for the services rendered.

- Maintain complete and accurate patient health records to support all medical decisions including the medical necessity of all diagnostic testing.

- Adhere to sound environmental and safety practices, as well as the proper handling of medical or hazardous waste, including radioactive materials.

- Commit to training employees to carry out their work in a manner that is safe for them, their coworkers and the patients they serve.

- Ensure that our contracts conform to all applicable laws and regulations by having them reviewed and approved in accordance with MCHS's Policy.

- Ensure that all drugs or other controlled substances used in treatment of patients are maintained, dispensed, and transported in conformance with all applicable laws and regulations.

- Take issues regarding false claims, fraud and abuse seriously and encourage all Ector County Hospital District Board of Directors, MCHS employees, medical staff, volunteers, contractors, vendors and agents to be aware of the laws regarding detection and prevention of fraud and abuse and false claims and to identify and resolve any issues immediately.

    - These laws can be searched on the Internet. The Federal False Claims Act, includes information on what defines a false claim, the enforcement for violation, penalties, Qui Tam provisions, and protections for Whistleblowers.

    - The Program Fraud Civil Remedies Act authorizes certain federal agencies, including the Department of Health and Human Services to investigate and assess civil penalties against persons who make or cause to be made false claims or false written statements to Medicare and Medicaid. Enforcement is provided by the Attorney General.

    - Texas has their own False Claims Act of 1995 which adds another support for enforcing fraudulent claims.

Reporting Fraud and Abuse: Issues are resolved faster and most effectively when given prompt attention. Anyone can report suspected fraud concerns through the MCHS Compliance Office, the internal hot line at 640-1900, or by submitting a concern through the MCHS Intranet under the Employee Links and clicking on Compliance Hotline. Also, one can access the Internet search engine and type in the address www.mch.ethicspoint.com to access the MCHS external hotline. A written concern can be placed in one of the Integrity boxes located on the

first floor of the main campus near the main entrance and the far west hallway near the basement elevator, or on the first floor of the annex building near the time clock, or a concern can be called in to the MCHS external Compliance Line at 1-800-805-1642. Callers can and may remain anonymous. Please provide as much information as possible to help with the investigation of the concern.

CONFLICTS OF INTEREST

MCHS will take all necessary steps to avoid conflicts or the appearance of conflicts between private interests and the official responsibilities of our duties. These Standards are not intended to extend to the ordinary courtesies of business life, such as token gifts of minimal value, modest entertainment incidental to a business relationship or the giving or receipt of normal hospitality of a social nature. Employees have a duty to report any actual or perceived conflicts of interest to management, Human Resources or the Compliance Office. MCHS employees will:

- Avoid engaging in any activity, practice or act that is disloyal, competitive or violates the MCH-3016 Conflict of Interest Policy.

- Ensure that all statements, communications and representations are accurate, complete and truthful and that they comply with applicable laws and regulations.

- Not accept gifts provided in connection with employment that exceed $50 in value unless reported and approved in writing by the Compliance Officer. Gifts of nominal value, such as meals and entertainment, are not prohibited, but should comply with the MCH-3016 Conflict of Interest Policy.

- Engage in outside employment only after ensuring that it does not conflict with employment at MCHS.

- Not engage in any outside employment or activity that would require extra hours and effort to such an extent that it would be detrimental to the employee's satisfactory performance or detrimental to the interests of MCHS.

- Not do business with any firm in which we, our families, or our close business and personal associates have a direct or indirect interest without

disclosure and proper written approval.

- Make no investment nor engage in any business transaction with an organization that is a potential competitor, supplier or customer of MCHS without disclosure and proper written approval.

- Not own, directly or indirectly, a financial interest in a business entity that does or seeks to do business with or is in competition with MCHS without disclosure and proper written approval.

- Utilize fair and competitive pricing for our services and products.

HIPAA, PRIVACY RULE & SECURITY RULE

Medical Center Health System (MCHS) recognizes the rights of all patients to have their health information protected from review, viewing and disclosure. To this end MCHS has specific policies addressing all aspects of the HIPAA rules for Protected Health Information (PHI). These policies may be found on the hospital Intranet under the POLICIES tab by searching for HIPAA under the "search by department" search option. They may also be searched by word or topic. (HIPAA-5001 to HIPAA-6022) We are all held accountable for respecting the rights of all patients to privacy of their health information, which is protected by a Federal Law referred to as HIPAA. All new MCHS employees are trained upon hire, annually and periodically throughout the year on the HIPAA policies and their responsibility to protect the patient's health information.

The HIPAA Privacy Rule deals with Protected Health Information (PHI) in general and gives patients an array of rights with respect to that information. The Privacy Rule provides a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

The HIPAA Security Rule deals with electronic Protected Health Information (ePHI) and requires implementation of three types of safeguards:1) administrative, 2) physical, and 3) technical.

- Medical Center Health System (MCHS) shall implement reasonable and appropriate controls to govern the receipt, use and removal of hardware and software that could possibly contain electronic protected health information (ePHI) in any form. (See MCH-1100)

- A device is any device capable of recording and/or storing ePHI and

should be used as a means to access data on the MCHS network, not to store ePHI. Because technology continues to evolve, MCH-1100 Electronic Computing Devices and Media Control, is considered to cover any future storage technology. All devices containing ePHI must be encrypted and password protected.

- MCHS shall employ technical safeguards to verify that a person or entity seeking access to ePHI is the one claimed.

- Use of a computer at MCHS means the user assumes personal responsibility for appropriate use and agrees to comply with Information Technology (IT) policy, other applicable MCH policies as well as city, state and federal laws and regulations.

- MCHS contracts with FairWarning to monitor all access to PHI on a daily basis for improper access.

- Improper access will be reported to the Privacy Officer and the workforce member's supervisor.

- Any Breach of PHI will be reported to the patient and to the Secretary of Health and Human Services Office for Civil Rights (HHS OCR) at least annually, or as required based on the number of individuals involved.

- We are prohibited from taking pictures of patients, employees or visitors with any device capable of taking pictures.

- Abuse of these Standards through personal use or use in violation of the law or MCH policies will result in disciplinary action, up to and including termination of employment and for non-employees, severance of the business association.

HIPAA PRIVACY BREACH NOTIFICATION

Following a breach of unsecured protected health information, the MCHS must provide notification of the breach to affected individuals, the HHS Secretary, and, in certain circumstances, to the media. In addition, business associates must notify the Medical Center Health System if a breach occurs at or by the business associate in accordance with the American Recovery and Reinvestment

Act of 2009 and the HITECH Act 2013.

PROTECTION OF PROPERTY

We are committed to protecting MCHS's assets and the property of patients, employees, and visitors against loss, theft, and misuse. In the course of their duties, we may have access to the proprietary information of MCHS, its patients or employees. Proprietary information is information that is confidential, privileged, or protected by law.

MCHS also is committed to respecting the intellectual property rights of others. Moreover, all software used in connection with MCHS's business will be properly licensed and used in accordance with that license. Employees are also required to respect the patent trademark rights of others. Employees have a duty to report any actual or perceived misuse, loss or theft of property to management, Human Resources or the Compliance Office. MCHS workforce will:

- Not reproduce, distribute, or alter copyrighted material from books, trade journals, computer software, or magazines or any other items without permission of the copyright holder or his or her agent.

- Be responsible for protecting the confidentiality of patient records and information and shall not use or reveal any such information outside the context of our official duties and MCHS policy.

- Have an affirmative duty to preserve MCHS's assets, property, facilities, equipment and supplies and their loss, theft or unauthorized use.

- Take all reasonable steps to safeguard the property of patients, employees and visitors.

- Be responsible and accountable for the proper expenditure of MCHS funds and for the proper use of its equipment.

- Follow established internal control procedures in handling and recording all funds.

- Not use hospital assets for unlawful purposes or unauthorized personal benefit or fail to keep accurate and complete records of all assets, liabilities,

revenues, and expenses.

- Ensure that drugs are safely stored, secured and inventoried and that missing supplies are promptly reported to supervisors and the Director of Nursing.

- Dispose of surplus or obsolete property in accordance with MCHS procedures.

WORKPLACE ADMINISTRATIVE SEARCHES

To assist in providing a reliable, efficient and productive work force for the proper care of patients, to assist in providing employees with a safe working environment, to assist in the effective operation of the Compliance Program and to supplement the Drug and Alcohol Policy, MCH-3033, supervisors may conduct unannounced administrative searches of Health System premises, offices, work areas, property and equipment and the contents of such property and equipment. **No employee should have any expectation of privacy on MCHS property** or in their offices or work areas including lockers, desks, cabinets, drawers, shelves, or trash cans or in folders, envelopes or packages located on MCHS premises. Any data on any MCHS device or in any of MCHS' systems is property of the hospital and subject to search/review. Personal possessions or materials should not be brought to work if they are of a sensitive or confidential nature. MCHS's policy on Workplace Administrative Searches is Policy Number MCH-3043. **MCH-1046 Computer Security Policy also states that the use of computer systems at MCHS signifies consent to monitoring and monitoring does occur.** A copy of the policies referenced may be obtained from the MCHS Intranet under the MCH policies. Other policies permit monitoring of and access to computers by supervisors. The use of computers, e-mail and access to the Internet must be reasonable and responsible.

PROPER CONSIDERATION OF HUMAN RESOURCES

MCHS is committed to protecting and supporting all employees, as well as, helping them to achieve their fullest potential in a fair and equitable manner. Employees have a duty to report any actual or perceived mistreatment, discrimination or hostile activity occurring in the workplace. Employees will:

- Assure that everyone is afforded equal employment and advancement opportunities regardless of gender, age, disability, race, creed, religion

or national origin.

- Treat one another with respect, dignity and fairness, appreciating the diversity of our work force and the uniqueness of each employee.

- Show proper consideration and respect to one another. Sexual harassment, such as sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature that would create a hostile work environment is strictly prohibited.

- Encourage and support each other in the development of individual skills, talents, knowledge and understanding of our jobs in order to deliver the highest quality of service and benefit to our patients.

- Encourage and recognize creativity and appropriate risk taking at all levels of MCHS in order to achieve innovation and excellence.

- Use our time productively during work hours spent at MCHS.

- Observe the standards of our professions and exercise judgment and objectivity in our practices.

- Maintain a high standard of confidentiality relating to employees of MCHS concerning salary, benefits, disciplinary and other personal information.

- Limit the number of employees who have access to confidential information to those individuals in MCHS who need the information to perform their job, and each employee shall exercise due care in protecting such information.

- Maintain a drug-free workplace and smoke-free workplace.

- Take all reasonable precautions to ensure our safety as well as the safety of patients, visitors and other personnel.

COMMUNICATION

We will encourage open, timely and candid communication, as well as collaboration among employees, departments, and physicians. **WE ALL have a duty to openly communicate and maintain an environment founded on teamwork**. Therefore,

members of the workforce will:

- Be responsible to share ideas, resolve problems or concerns and treat all opinions with respect and consideration.

- Strive to understand the duties, responsibilities and challenges that face our fellow workers.

- Raise legitimate questions or concerns without fear of retribution, report concerns in the workplace, including violations of laws, regulations and MCHS policies, and seek clarification and guidance whenever there is doubt.

- Be honest and forthright in any representations made to patients, vendors, payers, other employees and the community.

- Recognize that patients have the right to receive information regarding MCHS's policies, procedures and charges.

- Recognize that patients have the right to know the identity and qualifications of all MCHS personnel who provide services to them.

- Ensure the right of patients to voice their complaints/concerns about care and services provided without fear of retaliation or retribution.

- Ensure that patients are fully informed of their options with respect to any outside referral, such as a home health agency.

BILLING AND CODING

MCHS is committed to honesty, accuracy and integrity in all of its billing, coding and documentation activities. MCHS workforce has **a duty to report any actual or perceived false, fraudulent, inaccurate or fictitious claims or documentation to management, Human Resources or the Compliance Office**. MCHS workforce members will:

- Submit for payment or reimbursement only claims for services actually rendered that are fully documented in patients' medical records and use billing codes that accurately describe the services provided.

- Ensure that all claims submitted for payment are supported by

documentation of medical necessity.

- Commit to engaging in accurate and truthful billing practices. The submission of any claims for payment of any kind that are false, fraudulent, inaccurate, incomplete or fictitious is strictly prohibited.

- Take immediate steps to alert appropriate MCHS staff if inaccuracies are discovered in claims that have been submitted for payment or reimbursement and will promptly submit a corrected claim, refunding any money that is not due us.

- Always document physician information in the health record to ensure that all claims are submitted with the proper provider number.

- Ensure that physicians and MCHS employees are properly licensed and credentialed, and are not sanctioned or excluded from the Medicare, Medicaid or any other federal healthcare programs. (MCH-1057)

- Submit to governmental authorities only accurate reports and we shall not make false or deceptive statements.

ADDRESSING ISSUES AND CONCERNS

Any workforce members who raise concerns or allegations of possible violations of the Compliance Standards of Conduct, policies/procedures, laws, or regulations will be received openly and courteously. MCHS will not tolerate any direct or indirect retaliation or retribution against anyone who, in good faith, raises problems or concerns.

If a member of the workforce has a serious concern regarding conduct that is suspected to be illegal or fraudulent occurring in any of the MCHS facilities, they should report this to their supervisor, director or executive staff member immediately. An individual may call the toll-free Compliance Line at 1-800-805-1642 if you are not comfortable discussing the matter directly with someone in the chain of command. The Compliance Line is available to any anyone to report problems or concerns in good faith; however, it is not intended to replace the normal chain of command.

This Compliance Line is intended to identify and address fraudulent and illegal conduct as quickly and effectively as possible. If an individual calls the Compliance Line to report fraud or

illegal conduct by others, they should do so without fear of retaliation or reprisal.

"Integrity Boxes" are located in on the first floor of the main hospital campus near the main entrance and in the far west hallway, and on the first floor of the Annex building. The Integrity Boxes have proven to be an effective means for individuals to report concerns in the past and the Compliance Department continues to maintain them as a reporting mechanism in addition to the Compliance Line, as referred to in policy MCH-1064.

OTHER CONCERNS

For other concerns that do not involve fraud or violations of law, the following procedures should be utilized until resolution of the concern is achieved:

- First, workforce members are encouraged to contact their direct supervisor/manager unless there are circumstances that preclude them from doing so. The workforce member's supervisor/manager is in a good position to listen to and understand the concerns one may have and should be given the opportunity to resolve the issue. The supervisor/manager has access to resources throughout the hospital to assist in upholding the Compliance Standards of Conduct.

- Second, if a workforce member has raised an issue and does not think it is getting proper attention, or if the supervisor/manager cannot find the appropriate answer, the workforce member may relate their concerns to the next level of management.

- Third, the workforce member may seek guidance from the Human Resources Department, and/or the appropriate executive staff member.

If assistance is still needed, call the MCHS Compliance Line at 1-800-805-1642.

Before calling the Compliance Line, the workforce member should ask oneself the following questions:

- Do I have all the facts?

- If I need more information, where do I find it?

- Are there any laws, regulations, policies or procedures that apply to the situation?

- Have I followed normal procedures to try to resolve my concern?

In addition, the Compliance Officer may be reached at (432) 640-1900 or (432) 640-1106, or you may write to the Compliance Officer at:

Chief Compliance and Privacy Officer
Medical Center Health System
P. O. Box 7239
Odessa, Texas 79760

MCHS
COMPLIANCE STANDARDS OF CONDUCT

CERTIFICATION OF RECEIPT AND UNDERSTANDING

I, _____
(Print Name)

_____
(Position)

_____
(Employee/Medical Staff/ MCHS Board of Directors Member/
Volunteer/Contractor/Vendor/Agent)

I hereby certify that I have received the MCHS Compliance Standards of Conduct and participated in Compliance Standards of Conduct Training and understand that compliance with the provisions of the Standards of Conduct is mandatory. If I have any question concerning the principles in the Compliance Standards of Conduct or any other MCHS policy or procedure, I will discuss my questions with my supervisor or other appropriate resource to obtain a clear understanding of my responsibilities.

I also certify that I have been informed that all Protected Health Information (PHI) in the systems at MCHS will be monitored for access and all inappropriate access will be reported to the Chief Compliance and Privacy Officer and my supervisor.

_____
(Signature)

_____
(Date)

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
OCTOBER 2024

	CURRENT MONTH					YEAR-TO-DATE				
		BUDGET		PRIOR YEAR			BUDGET		PRIOR YEAR	
	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%
Hospital InPatient Admissions										
Acute / Adult	1,120	1,272	-11.9%	1,092	2.6%	1,120	1,272	-11.9%	1,092	2.6%
Neonatal ICU (NICU)	22	19	15.8%	24	-8.3%	22	19	15.8%	24	-8.3%
Total Admissions	1,142	1,291	-11.5%	1,116	2.3%	1,142	1,291	-11.5%	1,116	2.3%
Patient Days										
Adult & Pediatric	4,238	4,662	-9.1%	4,165	1.8%	4,238	4,662	-9.1%	4,165	1.8%
ICU	427	464	-8.0%	407	4.9%	427	464	-8.0%	407	4.9%
CCU	426	450	-5.3%	401	6.2%	426	450	-5.3%	401	6.2%
NICU	498	302	64.9%	283	76.0%	498	302	64.9%	283	76.0%
Total Patient Days	5,589	5,878	-4.9%	5,256	6.3%	5,589	5,878	-4.9%	5,256	6.3%
Observation (Obs) Days	754	697	8.2%	739	2.0%	754	697	8.2%	739	2.0%
Nursery Days	276	304	-9.2%	331	-16.6%	276	304	-9.2%	331	-16.6%
Total Occupied Beds / Bassinets	6,619	6,879	-3.8%	6,326	4.6%	6,619	6,879	-3.8%	6,326	4.6%
Average Length of Stay (ALOS)										
Acute / Adult & Pediatric	4.55	4.38	3.7%	4.55	-0.2%	4.55	4.38	3.7%	4.55	-0.2%
NICU	22.64	15.89	42.4%	11.79	92.0%	22.64	15.89	42.4%	11.79	92.0%
Total ALOS	4.89	4.55	7.5%	4.71	3.9%	4.89	4.55	7.5%	4.71	3.9%
Acute / Adult & Pediatric w/o OB	5.60			5.46	2.7%	5.60			5.46	2.7%
Average Daily Census	180.3	189.6	-4.9%	169.5	6.3%	180.3	189.6	-4.9%	169.5	6.3%
Hospital Case Mix Index (CMI)	1.8768	1.7180	9.2%	1.6714	12.3%	1.8768	1.7180	9.2%	1.6714	12.3%
CMI Adjusted LOS	2.61	2.65	-1.6%	2.82	-7.5%	2.61	2.65	-1.6%	2.82	-7.5%
Medicare										
Admissions	429	519	-17.3%	431	-0.5%	429	519	-17.3%	431	-0.5%
Patient Days	2,472	2,682	-7.8%	2,349	5.2%	2,472	2,682	-7.8%	2,349	5.2%
Average Length of Stay	5.76	5.17	11.5%	5.45	5.7%	5.76	5.17	11.5%	5.45	5.7%
Case Mix Index	2.1983	1.9465	12.9%	1.9497	12.8%	2.1983	1.9465	12.9%	1.9497	12.8%
Medicaid										
Admissions	96	129	-25.6%	123	-22.0%	96	129	-25.6%	123	-22.0%
Patient Days	543	499	8.8%	491	10.6%	543	499	8.8%	491	10.6%
Average Length of Stay	5.66	3.87	46.2%	3.99	41.7%	5.66	3.87	46.2%	3.99	41.7%
Case Mix Index	1.3853	1.1174	24.0%	1.0622	30.4%	1.3853	1.1174	24.0%	1.0622	30.4%
Commercial										
Admissions	399	408	-2.2%	339	17.7%	399	408	-2.2%	339	17.7%
Patient Days	1,670	1,690	-1.2%	1,376	21.4%	1,670	1,690	-1.2%	1,376	21.4%
Average Length of Stay	4.19	4.14	1.0%	4.06	3.1%	4.19	4.14	1.0%	4.06	3.1%
Case Mix Index	1.6875	1.6559	1.9%	1.6952	-0.5%	1.6875	1.6559	1.9%	1.6952	-0.5%
Self Pay										
Admissions	182	203	-10.3%	191	-4.7%	182	203	-10.3%	191	-4.7%
Patient Days	747	854	-12.5%	864	-13.5%	747	854	-12.5%	864	-13.5%
Average Length of Stay	4.10	4.21	-2.4%	4.52	-9.3%	4.10	4.21	-2.4%	4.52	-9.3%
Case Mix Index	1.7396	1.5885	9.5%	1.3947	24.7%	1.7396	1.5885	9.5%	1.3947	24.7%
All Other										
Admissions	36	32	12.5%	32	12.5%	36	32	12.5%	32	12.5%
Patient Days	157	153	2.6%	176	-10.8%	157	153	2.6%	176	-10.8%
Average Length of Stay	4.36	4.78	-8.8%	5.50	-20.7%	4.36	4.78	-8.8%	5.50	-20.7%
Case Mix Index	2.0806	2.0742	0.3%	1.5152	37.3%	2.0806	2.0742	0.3%	1.5152	37.3%
Radiology										
InPatient	4,420	4,902	-9.8%	4,274	3.4%	4,420	4,902	-9.8%	4,274	3.4%
OutPatient	9,605	9,109	5.4%	8,799	9.2%	9,605	9,109	5.4%	8,799	9.2%
Cath Lab										
InPatient	609	700	-13.0%	668	-8.8%	609	700	-13.0%	668	-8.8%
OutPatient	486	574	-15.3%	423	14.9%	486	574	-15.3%	423	14.9%
Laboratory										
InPatient	78,228	84,121	-7.0%	73,190	6.9%	78,228	84,121	-7.0%	73,190	6.9%
OutPatient	77,305	74,111	4.3%	69,652	11.0%	77,305	74,111	4.3%	69,652	11.0%
Other										
Deliveries	181	179	1.1%	202	-10.4%	181	179	1.1%	202	-10.4%
Surgical Cases										
InPatient	264	260	1.5%	228	15.8%	264	260	1.5%	228	15.8%
OutPatient	664	557	19.2%	536	23.9%	664	557	19.2%	536	23.9%
Total Surgical Cases	928	817	13.6%	764	21.5%	928	817	13.6%	764	21.5%
GI Procedures (Endo)										
InPatient	133	151	-11.9%	173	-23.1%	133	151	-11.9%	173	-23.1%
OutPatient	214	198	8.1%	214	0.0%	214	198	8.1%	214	0.0%
Total GI Procedures	347	349	-0.6%	387	-10.3%	347	349	-0.6%	387	-10.3%

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
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	CURRENT MONTH					YEAR-TO-DATE				
		BUDGET		PRIOR YEAR			BUDGET		PRIOR YEAR	
	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%	ACTUAL	AMOUNT	VAR.%	AMOUNT	VAR.%
OutPatient (O/P)										
Emergency Room Visits	5,498	5,406	1.7%	5,297	3.8%	5,498	5,406	1.7%	5,297	3.8%
Observation Days	754	697	8.2%	739	2.0%	754	697	8.2%	739	2.0%
Other O/P Occasions of Service	21,484	20,579	4.4%	20,980	2.4%	21,484	20,579	4.4%	20,980	2.4%
Total O/P Occasions of Svc.	27,736	26,682	4.0%	27,016	2.7%	27,736	26,682	4.0%	27,016	2.7%
Hospital Operations										
Manhours Paid	299,213	299,169	0.0%	285,112	4.9%	299,213	299,169	0.0%	285,112	4.9%
FTE's	1,689.1	1,688.9	0.0%	1,609.5	4.9%	1,689.1	1,688.9	0.0%	1,609.5	4.9%
Adjusted Patient Days	11,371	11,315	0.5%	10,533	8.0%	11,371	11,315	0.5%	10,533	8.0%
Hours / Adjusted Patient Day	26.31	26.44	-0.5%	27.07	-2.8%	26.31	26.44	-0.5%	27.07	-2.8%
Occupancy - Actual Beds	49.0%	54.3%	-9.8%	46.1%	6.3%	49.0%	54.3%	-9.8%	46.1%	6.3%
FTE's / Adjusted Occupied Bed	4.6	4.6	-0.5%	4.7	-2.8%	4.6	4.6	-0.5%	4.7	-2.8%
Family Health Clinic - Clements										
Total Medical Visits	755	558	35.3%	614	23.0%	755	558	35.3%	614	23.0%
Manhours Paid	1,695	1,678	1.0%	2,054	-17.5%	1,695	1,678	1.0%	2,054	-17.5%
FTE's	9.6	9.5	1.0%	11.6	-17.5%	9.6	9.5	1.0%	11.6	-17.5%
Family Health Clinic - West University										
Total Medical Visits	758	698	8.6%	722	5.0%	758	698	8.6%	722	5.0%
Manhours Paid	1,453	1,502	-3.2%	1,439	1.0%	1,453	1,502	-3.2%	1,439	1.0%
FTE's	8.2	8.5	-3.2%	8.1	1.0%	8.2	8.5	-3.2%	8.1	1.0%
Family Health Clinic - JBS										
Total Medical Visits	1,102	902	22.2%	779	41.5%	1,102	902	22.2%	779	41.5%
Manhours Paid	1,197	1,814	-34.0%	1,748	-31.5%	1,197	1,814	-34.0%	1,748	-31.5%
FTE's	6.8	10.2	-34.0%	9.9	-31.5%	6.8	10.2	-34.0%	9.9	-31.5%
Family Health Clinic - Womens										
Total Medical Visits	1,889	1,777	6.3%	1,655	14.1%	1,889	1,777	6.3%	1,655	14.1%
Manhours Paid	3,411	2,715	25.6%	3,584	-4.8%	3,411	2,715	25.6%	3,584	-4.8%
FTE's	19.3	15.3	25.6%	20.2	-4.8%	19.3	15.3	25.6%	20.2	-4.8%
Total ECHD Operations										
Total Admissions	1,142	1,291	-11.5%	1,116	2.3%	1,142	1,291	-11.5%	1,116	2.3%
Total Patient Days	5,589	5,878	-4.9%	5,256	6.3%	5,589	5,878	-4.9%	5,256	6.3%
Total Patient and Obs Days	6,343	6,575	-3.5%	5,995	5.8%	6,343	6,575	-3.5%	5,995	5.8%
Total FTE's	1,732.9	1,732.4	0.0%	1,659.3	4.4%	1,732.9	1,732.4	0.0%	1,659.3	4.4%
FTE's / Adjusted Occupied Bed	4.7	4.7	-0.5%	4.9	-3.3%	4.7	4.7	-0.5%	4.9	-3.3%
Total Adjusted Patient Days	11,371	11,315	0.5%	10,533	8.0%	11,371	11,315	0.5%	10,533	8.0%
Hours / Adjusted Patient Day	27.00	27.12	-0.5%	27.91	-3.3%	27.00	27.12	-0.5%	27.91	-3.3%
Outpatient Factor	2.0345	1.9250	5.7%	2.0039	1.5%	2.0345	1.9250	5.7%	2.0039	1.5%
Blended O/P Factor	2.2401	2.1174	5.8%	2.2151	1.1%	2.2401	2.1174	5.8%	2.2151	1.1%
Total Adjusted Admissions	2,323	2,485	-6.5%	2,236	3.9%	2,323	2,485	-6.5%	2,236	3.9%
Hours / Adjusted Admisssion	132.12	123.48	7.0%	131.44	0.5%	132.12	123.48	7.0%	131.44	0.5%
FTE's - Hospital Contract	47.2	56.8	-17.0%	49.7	-5.1%	47.2	56.8	-17.0%	49.7	-5.1%
FTE's - Mgmt Services	54.9	53.7	2.2%	50.1	9.7%	54.9	53.7	2.2%	50.1	9.7%
Total FTE's (including Contract)	1,835.0	1,842.9	-0.4%	1,759.1	4.3%	1,835.0	1,842.9	-0.4%	1,759.1	4.3%
Total FTE'S per Adjusted Occupied Bed (including Contract)	5.0	5.0	-0.9%	5.2	-3.4%	5.0	5.0	-0.9%	5.2	-3.4%
ProCare FTEs	208.1	237.8	-12.5%	199.9	4.1%	208.1	237.8	-12.5%	199.9	4.1%
TraumaCare FTEs	8.4	8.7	-3.9%	9.5	-11.6%	8.4	8.7	-3.9%	9.5	-11.6%
Total System FTEs	2,051.4	2,089.4	-1.8%	1,968.4	4.2%	2,051.4	2,089.4	-1.8%	1,968.4	4.2%
Urgent Care Visits										
JBS Clinic	1,459	1,374	6.2%	1,414	3.2%	1,459	1,374	6.2%	1,414	3.2%
West University	938	922	1.7%	879	6.7%	938	922	1.7%	879	6.7%
Total Urgent Care Visits	2,397	2,296	4.4%	2,293	4.5%	2,397	2,296	4.4%	2,293	4.5%
Retail Clinic Visits										
Retail Clinic	65	74	-12.2%	71	-8.5%	65	74	-12.2%	71	-8.5%

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
OCTOBER 2024

	CURRENT YEAR	PRIOR FISCAL YEAR END HOSPITAL UNAUDITED	PRO CARE UNAUDITED	TRAUMA CARE UNAUDITED	CURRENT YEAR CHANGE
ASSETS					
CURRENT ASSETS:					
Cash and Cash Equivalents	$ 30,478,188	$ 39,080,496	$ 4,500	$ -	$ (8,606,808)
Investments	51,674,114	51,625,680	-	-	48,434
Patient Accounts Receivable - Gross	239,395,293	214,878,735	20,514,645	2,184,343	1,817,571
Less: 3rd Party Allowances	(151,842,544)	(137,537,477)	(11,562,038)	(1,672,339)	(1,070,690)
Bad Debt Allowance	(46,283,284)	(38,524,192)	(5,030,483)	(410,000)	(2,318,609)
Net Patient Accounts Receivable	41,269,465	38,817,066	3,922,124	102,004	(1,571,728)
Taxes Receivable	11,233,291	11,080,895	-	-	152,396
Accounts Receivable - Other	9,035,196	4,024,723	84,681	-	4,925,792
Inventories	10,212,013	9,707,477	481,637	-	22,900
Prepaid Expenses	5,298,595	5,310,963	154,463	24,531	(191,363)
Total Current Assets	159,200,864	159,647,300	4,647,405	126,535	(5,220,376)
CAPITAL ASSETS:					
Property and Equipment	522,412,195	521,685,955	403,173	-	323,067
Construction in Progress	18,273,200	17,368,743	-	-	904,458
	540,685,395	539,054,698	403,173	-	1,227,524
Less: Accumulated Depreciation and Amortization	(379,201,850)	(377,031,484)	(338,723)	-	(1,831,644)
Total Capital Assets	161,483,545	162,023,214	64,449	-	(604,119)
LEASE ASSETS					
Leased Assets	4,190,843	4,190,843	-	-	0
Less Accrumulated Amortization Lease Assets	(2,023,773)	(1,956,677)	-		(67,097)
Total Lease Assets	2,167,069	2,234,166	-	-	(67,097)
SUBSCRIPTION ASSETS					
Subscription Assets	8,449,699	8,410,917	-	-	38,782
Less Accrumulated Amortization Subscription Assets	(2,893,443)	(2,749,774)	-	-	(143,670)
Total Subscription Assets	5,556,256	5,661,144	-	-	(104,888)
LT Lease Recieivable	6,106,346	6,227,920	-	-	(121,574)
RESTRICTED ASSETS:					
Restricted Assets Held by Trustee	4,896	4,896	-	-	-
Restricted Assets Held in Endowment	6,469,359	6,469,359	-	-	-
Restricted TPC, LLC	1,707,903	1,707,903	-	-	-
Investment in PBBHC	30,997,988	30,997,988	-	-	-
Restricted MCH West Texas Services	2,358,638	2,356,263	-	-	2,375
Pension, Deferred Outflows of Resources	10,795,764	10,795,764	-	-	-
Assets whose use is Limited	286,831	-	271,068	6,480	9,284
TOTAL ASSETS	$ 387,135,458	$ 388,125,916	$ 4,982,922	$ 133,015	$ (6,106,396)
LIABILITIES AND FUND BALANCE					
CURRENT LIABILITIES:					
Current Maturities of Long-Term Debt	$ 1,880,000	$ 1,880,000	$ -	$ -	$ -
Self-Insurance Liability - Current Portion	3,640,526	3,640,526	-	-	-
Current Portion of Lease Liabilities	662,583	627,362	-	-	35,221
Current Portion of Subscription Liabilities	1,300,649	1,325,425	-	-	(24,776)
Accounts Payable	31,061,604	35,655,859	(1,957,165)	(531,939)	(2,105,150)
A/R Credit Balances	3,320,332	2,596,359	-	-	723,973
Accrued Interest	310,163	214,256	-	-	95,907
Accrued Salaries and Wages	13,519,119	5,947,335	6,995,870	232,095	343,819
Accrued Compensated Absences	5,581,794	5,326,543	-	-	255,252
Due to Third Party Payors	8,683,192	8,683,192	-	-	-
Deferred Revenue	(1,288,492)	261,004	(22,952)	-	(1,526,543)
Total Current Liabilities	68,671,471	66,157,860	5,015,753	(299,844)	(2,502,141)
ACCRUED POST RETIREMENT BENEFITS	30,493,801	31,003,241	-	-	(509,441)
LESSOR DEFFERED INFLOWS OF RESOUCES	6,910,419	7,050,609			(140,190)
SELF-INSURANCE LIABILITIES - Less Current Portion	2,422,562	2,422,562	-	-	-
LEASE LIABILITIES	2,016,912	2,097,459			(80,547)
SUBSCRIPTION LIABILITIES	3,742,061	3,919,443			(177,383)
LONG-TERM DEBT - Less Current Maturities	28,309,359	28,360,398	-	-	(51,038)
					-
Total Liabilities	142,566,585	141,011,572	5,015,753	(299,844)	(3,160,896)
FUND BALANCE	244,568,872	247,114,344	(32,831)	432,859	244,601,703
TOTAL LIABILITIES AND FUND BALANCE	$ 387,135,458	$ 388,125,916	$ 4,982,922	$ 133,015	$ (6,106,396)

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Inpatient Revenue	$ 57,356,017	$ 61,890,018	-7.3%	$ 52,877,623	8.5%	$ 57,356,017	$ 61,890,018	-7.3%	$ 52,877,623	8.5%
Outpatient Revenue	71,125,704	69,158,324	2.8%	64,253,847	10.7%	71,125,704	69,158,324	2.8%	64,253,847	10.7%
TOTAL PATIENT REVENUE	$ 128,481,721	$ 131,048,342	-2.0%	$ 117,131,470	9.7%	$ 128,481,721	$ 131,048,342	-2.0%	$ 117,131,470	9.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 83,191,820	$ 85,583,698	-2.8%	$ 77,168,428	7.8%	$ 83,191,820	$ 85,583,698	-2.8%	$ 77,168,428	7.8%
Policy Adjustments	1,153,582	1,296,846	-11.0%	1,022,109	12.9%	1,153,582	1,296,846	-11.0%	1,022,109	12.9%
Uninsured Discount	8,849,700	7,571,028	16.9%	5,154,350	71.7%	8,849,700	7,571,028	16.9%	5,154,350	71.7%
Indigent	1,673,036	1,081,715	54.7%	884,129	89.2%	1,673,036	1,081,715	54.7%	884,129	89.2%
Provision for Bad Debts	6,958,779	8,057,537	-13.6%	8,260,146	-15.8%	6,958,779	8,057,537	-13.6%	8,260,146	-15.8%
TOTAL REVENUE DEDUCTIONS	$ 101,826,918	$ 103,590,824	-1.7%	$ 92,489,162	10.1%	$ 101,826,918	$ 103,590,824	-1.7%	$ 92,489,162	10.1%
	79.25%	79.05%		78.96%		79.25%	79.05%		78.96%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 1,810,333	$ 1,810,333	0.0%	$ 1,551,832	16.7%	$ 1,810,333	$ 1,810,333	0.0%	$ 1,551,832	16.7%
DSRIP/CHIRP	(594,038)	494,167	-220.2%	1,180,928	-150.3%	(594,038)	494,167	-220.2%	1,180,928	-150.3%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OTHER PATIENT REVENUE	$ 1,216,295	$ 2,304,500	-47.2%	$ 2,732,760	-55.5%	$ 1,216,295	$ 2,304,500	-47.2%	$ 2,732,760	-55.5%
NET PATIENT REVENUE	$ 27,871,098	$ 29,762,018	-6.4%	$ 27,375,068	1.8%	$ 27,871,098	$ 29,762,018	-6.4%	$ 27,375,068	1.8%
OTHER REVENUE										
Tax Revenue	$ 6,729,882	$ 6,693,589	0.5%	$ 6,790,731	-0.9%	$ 6,729,882	$ 6,693,589	0.5%	$ 6,790,731	-0.9%
Other Revenue	1,730,328	1,589,477	8.9%	1,258,444	37.5%	1,730,328	1,589,477	8.9%	1,258,444	37.5%
TOTAL OTHER REVENUE	$ 8,460,210	$ 8,283,066	2.1%	$ 8,049,175	5.1%	$ 8,460,210	$ 8,283,066	2.1%	$ 8,049,175	5.1%
NET OPERATING REVENUE	$ 36,331,308	$ 38,045,084	-4.5%	$ 35,424,243	2.6%	$ 36,331,308	$ 38,045,084	-4.5%	$ 35,424,243	2.6%
OPERATING EXPENSES										
Salaries and Wages	$ 16,732,482	$ 16,286,615	2.7%	$ 15,044,547	11.2%	$ 16,732,482	$ 16,286,615	2.7%	$ 15,044,547	11.2%
Benefits	2,294,843	2,047,182	12.1%	1,926,183	19.1%	2,294,843	2,047,182	12.1%	1,926,183	19.1%
Temporary Labor	1,487,421	1,513,799	-1.7%	1,913,070	-22.2%	1,487,421	1,513,799	-1.7%	1,913,070	-22.2%
Physician Fees	1,301,348	1,198,962	8.5%	1,124,377	15.7%	1,301,348	1,198,962	8.5%	1,124,377	15.7%
Texas Tech Support	992,714	1,002,447	-1.0%	968,868	2.5%	992,714	1,002,447	-1.0%	968,868	2.5%
Purchased Services	4,578,226	4,806,792	-4.8%	4,376,497	4.6%	4,578,226	4,806,792	-4.8%	4,376,497	4.6%
Supplies	8,088,550	7,083,909	14.2%	6,536,364	23.7%	8,088,550	7,083,909	14.2%	6,536,364	23.7%
Utilities	331,860	389,249	-14.7%	310,061	7.0%	331,860	389,249	-14.7%	310,061	7.0%
Repairs and Maintenance	761,978	1,040,196	-26.7%	843,552	-9.7%	761,978	1,040,196	-26.7%	843,552	-9.7%
Leases and Rent	163,914	107,447	52.6%	130,963	25.2%	163,914	107,447	52.6%	130,963	25.2%
Insurance	226,781	207,411	9.3%	191,228	18.6%	226,781	207,411	9.3%	191,228	18.6%
Interest Expense	89,056	117,840	-24.4%	100,479	-11.4%	89,056	117,840	-24.4%	100,479	-11.4%
ECHDA	86,221	283,446	-69.6%	162,020	-46.8%	86,221	283,446	-69.6%	162,020	-46.8%
Other Expense	239,599	274,100	-12.6%	147,995	61.9%	239,599	274,100	-12.6%	147,995	61.9%
TOTAL OPERATING EXPENSES	$ 37,374,991	$ 36,359,395	2.8%	$ 33,776,205	10.7%	$ 37,374,991	$ 36,359,395	2.8%	$ 33,776,205	10.7%
Depreciation/Amortization	$ 2,049,516	$ 2,009,687	2.0%	$ 1,976,423	3.7%	$ 2,049,516	$ 2,009,687	2.0%	$ 1,976,423	3.7%
(Gain) Loss on Sale of Assets	-	-	0.0%	(27,000)	-100.0%	-	-	0.0%	(27,000)	-100.0%
TOTAL OPERATING COSTS	$ 39,424,507	$ 38,369,082	2.8%	$ 35,725,627	10.4%	$ 39,424,507	$ 38,369,082	2.8%	$ 35,725,627	10.4%
NET GAIN (LOSS) FROM OPERATIONS	**$ (3,093,199)**	**$ (323,998)**	**-854.7%**	**$ (301,385)**	**-926.3%**	**$ (3,093,199)**	**$ (323,998)**	**854.7%**	**$ (301,385)**	**926.3%**
Operating Margin	-8.51%	-0.85%	899.7%	-0.85%	900.7%	-8.51%	-0.85%	899.7%	-0.85%	900.7%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 66,625	$ 137,303	-51.5%	$ 183,111	-63.6%	$ 66,625	$ 137,303	-51.5%	$ 183,111	-63.6%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	
Opiod Abatement Fund	-	-	0.0%	-	0.0%	-	-		-	
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	64,243	-		-		64,243	-		-	
COVID-19 Stimulus	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
						(954,627)	1,803,529		1,775,517	
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (2,962,331)	$ (186,695)	-1486.7%	$ (118,273)	-2404.6%	$ (2,962,331)	$ (186,695)	-1486.7%	$ (118,273)	-2404.6%
Unrealized Gain/(Loss) on Investments	$ 14,457	$ -	0.0%	$ 179,634	-92.0%	$ 14,457	$ -	0.0%	$ 179,634	-92.0%
Investment in Subsidiaries	2,375	96,879	-97.5%	19	12736.8%	2,375	96,879	-97.5%	19	12736.8%
CHANGE IN NET POSITION	**$ (2,945,500)**	**$ (89,816)**	**-3179.5%**	**$ 61,379**	**4898.8%**	**$ (2,945,500)**	**$ (89,816)**	**-3179.5%**	**$ 61,379**	**4898.8%**

ECTOR COUNTY HOSPITAL DISTRICT
HOSPITAL OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Inpatient Revenue	$ 57,356,017	$ 61,890,018	-7.3%	$ 52,877,623	8.5%	$ 57,356,017	$ 61,890,018	-7.3%	$ 52,877,623	8.5%
Outpatient Revenue	59,333,524	57,247,776	3.6%	53,084,615	11.8%	59,333,524	57,247,776	3.6%	53,084,615	11.8%
TOTAL PATIENT REVENUE	$ 116,689,540	$ 119,137,794	-2.1%	$ 105,962,238	10.1%	$ 116,689,540	$ 119,137,794	-2.1%	$ 105,962,238	10.1%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 77,215,544	$ 79,633,802	-3.0%	$ 71,591,764	7.9%	$ 77,215,544	$ 79,633,802	-3.0%	$ 71,591,764	7.9%
Policy Adjustments	28,463	81,360	-65.0%	40,958	-30.5%	28,463	81,360	-65.0%	40,958	-30.5%
Uninsured Discount	8,659,204	7,307,462	18.5%	4,714,640	83.7%	8,659,204	7,307,462	18.5%	4,714,640	83.7%
Indigent Care	1,662,656	1,070,589	55.3%	845,758	96.6%	1,662,656	1,070,589	55.3%	845,758	96.6%
Provision for Bad Debts	5,734,659	6,869,104	-16.5%	7,344,841	-21.9%	5,734,659	6,869,104	-16.5%	7,344,841	-21.9%
TOTAL REVENUE DEDUCTIONS	$ 93,300,526	$ 94,962,317	-1.7%	$ 84,537,960	10.4%	$ 93,300,526	$ 94,962,317	-1.7%	$ 84,537,960	10.4%
	79.96%	79.71%		79.78%		79.96%	79.71%		79.78%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 1,810,333	$ 1,810,333	0.0%	$ 1,551,832	16.7%	$ 1,810,333	$ 1,810,333	0.0%	$ 1,551,832	16.7%
DSRIP/CHIRP	(594,038)	494,167	-220.2%	1,180,928	-150.3%	(594,038)	494,167	-220.2%	1,180,928	-150.3%
TOTAL OTHER PATIENT REVENUE	$ 1,216,295	$ 2,304,500	-47.2%	$ 2,732,760	-55.5%	$ 1,216,295	$ 2,304,500	-47.2%	$ 2,732,760	-55.5%
NET PATIENT REVENUE	$ 24,605,309	$ 26,479,977	-7.1%	$ 24,157,038	1.9%	$ 24,605,309	$ 26,479,977	-7.1%	$ 24,157,038	1.9%
OTHER REVENUE										
Tax Revenue	$ 6,729,882	$ 6,693,589	0.5%	$ 6,790,731	-0.9%	$ 6,729,882	$ 6,693,589	0.5%	$ 6,790,731	-0.9%
Other Revenue	1,366,583	1,377,127	-0.8%	984,785	38.8%	1,366,583	1,377,127	-0.8%	984,785	38.8%
TOTAL OTHER REVENUE	$ 8,096,465	$ 8,070,716	0.3%	$ 7,775,516	4.1%	$ 8,096,465	$ 8,070,716	0.3%	$ 7,775,516	4.1%
NET OPERATING REVENUE	$ 32,701,774	$ 34,550,693	-5.4%	$ 31,932,554	2.4%	$ 32,701,774	$ 34,550,693	-5.4%	$ 31,932,554	2.4%
OPERATING EXPENSE										
Salaries and Wages	$ 11,860,095	$ 11,403,809	4.0%	$ 10,534,616	12.6%	$ 11,860,095	$ 11,403,809	4.0%	$ 10,534,616	12.6%
Benefits	1,943,965	1,677,886	15.9%	1,553,931	25.1%	1,943,965	1,677,886	15.9%	1,553,931	25.1%
Temporary Labor	768,354	905,407	-15.1%	815,991	-5.8%	768,354	905,407	-15.1%	815,991	-5.8%
Physician Fees	1,384,383	1,240,268	11.6%	1,167,843	18.5%	1,384,383	1,240,268	11.6%	1,167,843	18.5%
Texas Tech Support	992,714	1,002,447	-1.0%	968,868	2.5%	992,714	1,002,447	-1.0%	968,868	2.5%
Purchased Services	4,886,517	5,120,828	-4.6%	4,694,902	4.1%	4,886,517	5,120,828	-4.6%	4,694,902	4.1%
Supplies	8,002,292	7,009,661	14.2%	6,451,639	24.0%	8,002,292	7,009,661	14.2%	6,451,639	24.0%
Utilities	330,901	388,672	-14.9%	308,665	7.2%	330,901	388,672	-14.9%	308,665	7.2%
Repairs and Maintenance	761,978	1,038,904	-26.7%	840,141	-9.3%	761,978	1,038,904	-26.7%	840,141	-9.3%
Leases and Rentals	13,011	(38,486)	-133.8%	(8,541)	-252.3%	13,011	(38,486)	-133.8%	(8,541)	-252.3%
Insurance	165,003	145,158	13.7%	131,443	25.5%	165,003	145,158	13.7%	131,443	25.5%
Interest Expense	89,056	117,840	-24.4%	100,479	-11.4%	89,056	117,840	-24.4%	100,479	-11.4%
ECHDA	86,221	283,446	-69.6%	162,020	-46.8%	86,221	283,446	-69.6%	162,020	-46.8%
Other Expense	156,626	190,155	-17.6%	99,517	57.4%	156,626	190,155	-17.6%	99,517	57.4%
TOTAL OPERATING EXPENSES	$ 31,441,117	$ 30,485,995	3.1%	$ 27,821,513	13.0%	$ 31,441,117	$ 30,485,995	3.1%	$ 27,821,513	13.0%
Depreciation/Amortization	$ 2,037,585	$ 1,997,460	2.0%	$ 1,969,456	3.5%	$ 2,037,585	$ 1,997,460	2.0%	$ 1,969,456	3.5%
(Gain)/Loss on Disposal of Assets	-	-	0.0%	(27,000)	-100.0%	-	-	0.0%	(27,000)	-100.0%
TOTAL OPERATING COSTS	$ 33,478,702	$ 32,483,455	3.1%	$ 29,763,969	12.5%	$ 33,478,702	$ 32,483,455	3.1%	$ 29,763,969	12.5%
NET GAIN (LOSS) FROM OPERATIONS	**$ (776,928)**	**$ 2,067,238**	**-137.6%**	**$ 2,168,584**	**135.8%**	**$ (776,928)**	**$ 2,067,238**	**-137.6%**	**$ 2,168,585**	**135.8%**
Operating Margin	-2.38%	5.98%	-139.7%	6.79%	-135.0%	-2.38%	5.98%	-139.7%	6.79%	-135.0%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 66,625	$ 137,303	-51.5%	$ 183,111	-63.6%	$ 66,625	$ 137,303	-51.5%	$ 183,111	-63.6%
Tobacco Settlement	-	-	0.0%	-	0.0%	-	-		-	0.0%
Opiod Abatement Fund	-	-	0.0%	-	0.0%	-	-		-	0.0%
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	64,243	-	0.0%	-	0.0%	64,243	-		-	0.0%
COVID-19 Stimulus	-	-	0.0%	-	0.0%	-	-		-	0.0%
CHANGE IN NET POSITION BEFORE CAPITAL CONTRIBUTION	$ (646,060)	$ 2,204,541	-129.3%	$ 2,351,696	-127.5%	$ (646,060)	$ 2,204,541	-129.3%	$ 2,351,696	-127.5%
Procare Capital Contribution	(2,360,472)	(2,413,901)	-2.2%	(2,544,200)	-7.2%	(2,360,472)	(2,413,901)	-2.2%	(2,544,200)	-7.2%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (3,006,532)	$ (209,360)	-1336.1%	$ (192,504)	-1461.8%	$ (3,006,532)	$ (209,360)	-1336.1%	$ (192,503)	-1461.8%
Unrealized Gain/(Loss) on Investments	$ 14,457	$ -	0.0%	$ 179,634	-92.0%	$ 14,457	$ -	0.0%	$ 179,634	-92.0%
Investment in Subsidiaries	2,375	96,879	-97.5%	19	12736.8%	2,375	96,879	-97.5%	19	12736.8%
CHANGE IN NET POSITION	**$ (2,989,701)**	**$ (112,481)**	**-2558.0%**	**$ (12,851)**	**-23164.2%**	**$ (2,989,701)**	**$ (112,481)**	**-2558.0%**	**$ (12,851)**	**-23164.6%**

ECTOR COUNTY HOSPITAL DISTRICT
PROCARE OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 11,570,063	$ 11,712,673	-1.2%	$ 10,966,063	5.5%	$ 11,570,063	$ 11,712,673	-1.2%	$ 10,966,063	5.5%
TOTAL PATIENT REVENUE	$ 11,570,063	$ 11,712,673	-1.2%	$ 10,966,063	5.5%	$ 11,570,063	$ 11,712,673	-1.2%	$ 10,966,063	5.5%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 5,860,612	$ 5,854,875	0.1%	$ 5,511,205	6.3%	$ 5,860,612	$ 5,854,875	0.1%	$ 5,511,205	6.3%
Policy Adjustments	1,091,350	1,185,237	-7.9%	957,128	14.0%	1,091,350	1,185,237	-7.9%	957,128	14.0%
Uninsured Discount	190,496	263,566	-27.7%	439,710	-56.7%	190,496	263,566	-27.7%	439,710	-56.7%
Indigent	10,380	11,126	-6.7%	38,371	-72.9%	10,380	11,126	-6.7%	38,371	-72.9%
Provision for Bad Debts	1,193,781	1,158,056	3.1%	892,396	33.8%	1,193,781	1,158,056	3.1%	892,396	33.8%
TOTAL REVENUE DEDUCTIONS	$ 8,346,620	$ 8,472,860	-1.5%	$ 7,838,810	6.5%	$ 8,346,620	$ 8,472,860	-1.5%	$ 7,838,810	6.5%
	72.14%	72.34%		71.48%		72.14%	72.34%		71.48%	
NET PATIENT REVENUE	$ 3,223,443	$ 3,239,813	-0.5%	$ 3,127,253	3.1%	$ 3,223,443	$ 3,239,813	-0.5%	$ 3,127,253	3.1%
OTHER REVENUE										
Other Income	$ 360,203	$ 211,275	70.5%	$ 270,187	33.3%	$ 360,203	$ 211,275	70.5%	$ 270,187	33.3%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 3,583,646	$ 3,451,088	3.8%	$ 3,397,439	5.5%	$ 3,583,646	$ 3,451,088	3.8%	$ 3,397,439	5.5%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 4,635,258	$ 4,637,901	-0.1%	$ 4,255,405	8.9%	$ 4,635,258	$ 4,637,901	-0.1%	$ 4,255,405	8.9%
Benefits	341,597	346,679	-1.5%	359,707	-5.0%	341,597	346,679	-1.5%	359,707	-5.0%
Temporary Labor	719,066	608,392	18.2%	1,097,079	-34.5%	719,066	608,392	18.2%	1,097,079	-34.5%
Physician Fees	176,213	217,942	-19.1%	215,783	-18.3%	176,213	217,942	-19.1%	215,783	-18.3%
Purchased Services	(310,512)	(315,539)	-1.6%	(319,595)	-2.8%	(310,512)	(315,539)	-1.6%	(319,595)	-2.8%
Supplies	86,050	74,056	16.2%	84,285	2.1%	86,050	74,056	16.2%	84,285	2.1%
Utilities	959	577	66.1%	1,396	-31.3%	959	577	66.1%	1,396	-31.3%
Repairs and Maintenance	-	1,292	-100.0%	3,411.04	-100.0%	-	1,292	-100.0%	3,411	-100.0%
Leases and Rentals	148,910	143,940	3.5%	137,511	8.3%	148,910	143,940	3.5%	137,511	8.3%
Insurance	52,056	54,021	-3.6%	51,510	1.1%	52,056	54,021	-3.6%	51,510	1.1%
Other Expense	82,591	83,501	-1.1%	48,179	71.4%	82,591	83,501	-1.1%	48,179	71.4%
TOTAL OPERATING EXPENSES	$ 5,932,187	$ 5,852,762	1.4%	$ 5,934,672	0.0%	$ 5,932,187	$ 5,852,762	1.4%	$ 5,934,672	0.0%
Depreciation/Amortization	$ 11,930	$ 12,227	-2.4%	$ 6,967	71.2%	$ 11,930	$ 12,227	-2.4%	$ 6,967	71.2%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 5,944,118	$ 5,864,989	1.3%	$ 5,941,639	0.0%	$ 5,944,118	$ 5,864,989	1.3%	$ 5,941,639	0.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (2,360,472)**	**$ (2,413,901)**	**-2.2%**	**$ (2,544,200)**	**-7.2%**	**$ (2,360,472)**	**$ (2,413,901)**	**-2.2%**	**$ (2,544,200)**	**-7.2%**
Operating Margin	-65.87%	-69.95%	-5.8%	-74.89%	-12.0%	-65.87%	-69.95%	-5.8%	-74.89%	-12.0%
COVID-19 Stimulus	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
MCH Contribution	$ 2,360,472	$ 2,413,901	-2.2%	$ 2,544,200	-7.2%	$ 2,360,472	$ 2,413,901	-2.2%	$ 2,544,200	-7.2%
CAPITAL CONTRIBUTION	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Office Visits	8,595	8,133	5.68%	7,805	10.12%	8,595	8,133	5.68%	7,805	10.12%
Total Hospital Visits	6,815	6,837	-0.32%	6,297	8.23%	6,815	6,837	-0.32%	6,297	8.23%
Total Procedures	14,676	13,960	5.13%	12,970	13.15%	14,676	13,960	5.13%	12,970	13.15%
Total Surgeries	781	776	0.64%	775	0.77%	781	776	0.64%	775	0.77%
Total Provider FTE's	86.5	89.7	-3.49%	84.9	1.92%	86.5	89.7	-3.49%	84.9	1.92%
Total Staff FTE's	113.8	136.6	-16.74%	103.2	10.21%	113.8	136.6	-16.74%	103.2	10.21%
Total Administrative FTE's	7.8	11.5	-32.55%	11.7	-33.88%	7.8	11.5	-32.55%	11.7	-33.88%
Total FTE's	208.1	237.8	-12.51%	199.9	4.10%	208.1	237.8	-12.51%	199.9	4.10%

ECTOR COUNTY HOSPITAL DISTRICT
TRAUMACARE OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 222,117	$ 197,875	12.3%	$ 203,169	9.3%	$ 222,117	$ 197,875	12.3%	$ 203,169	9.3%
TOTAL PATIENT REVENUE	$ 222,117	$ 197,875	12.3%	$ 203,169	9.3%	$ 222,117	$ 197,875	12.3%	$ 203,169	9.3%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 115,664	$ 95,021	21.7%	$ 65,460	76.7%	$ 115,664	$ 95,021	21.7%	$ 65,460	76.7%
Policy Adjustments	33,769	30,249	11.6%	24,023	40.6%	33,769	30,249	11.6%	24,023	40.6%
Uninsured Discount	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Indigent	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Provision for Bad Debts	30,338	30,377	-0.1%	22,909	32.4%	30,338	30,377	-0.1%	22,909	32.4%
TOTAL REVENUE DEDUCTIONS	$ 179,771	$ 155,647	15.5%	$ 112,392	60.0%	$ 179,771	$ 155,647	15.5%	$ 112,392	60.0%
	80.94%	78.66%		55.32%		80.94%	78.66%		55.32%	
NET PATIENT REVENUE	$ 42,346	$ 42,228	0.3%	$ 90,777	-53.4%	$ 42,346	$ 42,228	0.3%	$ 90,777	-53.4%
						19.1%				
OTHER REVENUE										
Other Income	$ 3,542	$ 1,075	229.5%	$ 3,472	2.0%	$ 3,542	$ 1,075	229.5%	$ 3,472	2.0%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 45,888	$ 43,303	6.0%	$ 94,250	-51.3%	$ 45,888	$ 43,303	6.0%	$ 94,250	-51.3%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 237,129	$ 244,905	-3.2%	$ 254,525	-6.8%	$ 237,129	$ 244,905	-3.2%	$ 254,525	-6.8%
Benefits	9,281	22,617	-59.0%	12,545	-26.0%	9,281	22,617	-59.0%	12,545	-26.0%
Temporary Labor	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Physician Fees	(259,248)	(259,248)	0.0%	(259,248)	0.0%	(259,248)	(259,248)	0.0%	(259,248)	0.0%
Purchased Services	2,220	1,503	47.7%	1,190	86.6%	2,220	1,503	47.7%	1,190	86.6%
Supplies	208	192	8.3%	440	-52.7%	208	192	8.3%	440	-52.7%
Utilities	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Repairs and Maintenance	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Leases and Rentals	1,993	1,993	0.0%	1,993	0.0%	1,993	1,993	0.0%	1,993	0.0%
Insurance	9,722	8,232	18.1%	8,275	17.5%	9,722	8,232	18.1%	8,275	17.5%
Other Expense	382	444	-14.0%	299	27.6%	382	444	-14.0%	299	27.6%
TOTAL OPERATING EXPENSES	$ 1,687	$ 20,638	-91.8%	$ 20,019	-91.6%	$ 1,687	$ 20,638	-91.8%	$ 20,019	-91.6%
Depreciation/Amortization	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 1,687	$ 20,638	-91.8%	$ 20,019	-91.6%	$ 1,687	$ 20,638	-91.8%	$ 20,019	-91.6%
NET GAIN (LOSS) FROM OPERATIONS	**$ 44,201**	**$ 22,665**	**95.0%**	**$ 74,230**	**-40.5%**	**$ 44,201**	**$ 22,665**	**95.0%**	**$ 74,230**	**-40.5%**
Operating Margin	96.32%	52.34%	84.0%	78.76%	22.3%	96.32%	52.34%	84.0%	78.76%	22.3%
COVID-19 Stimulus	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
MCH Contribution	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
CAPITAL CONTRIBUTION	**$ 44,201**	**$ 22,665**	**95.0%**	**$ 74,230**	**-40.5%**	**$ 44,201**	**$ 22,665**	**95.0%**	**$ 74,230**	**-40.5%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Procedures	647	580	11.55%	623	3.85%	647	580	11.55%	623	3.85%
Total Provider FTE's	7.4	7.8	-5.79%	8.5	-12.99%	7.4	7.8	-5.79%	8.5	-12.99%
Total Staff FTE's	1.0	0.9	12.83%	1.0	0.00%	1.0	0.9	12.83%	1.0	0.00%
Total FTE's	8.4	8.7	-3.89%	9.5	-11.61%	8.4	8.7	-3.89%	9.5	-11.61%

ECTOR COUNTY HOSPITAL DISTRICT
DIABETES SCREENING CLINIC - SOUTH - OPERATIONS SUMMARY
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR	ACTUAL	BUDGET	BUDGET VAR	PRIOR YR	PRIOR YR VAR
PATIENT REVENUE										
Outpatient Revenue	$ 7,700	$ 4,078	88.8%	$ -	0.0%	$ 7,700	$ 4,078	88.8%	$ -	0.0%
TOTAL PATIENT REVENUE	$ 7,700	$ 4,078	88.8%	$ -	0.0%	$ 7,700	$ 4,078	88.8%	$ -	0.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
Self Pay Adjustments	7,560	2,439	209.9%	-	0.0%	7,560	2,439	209.9%	-	0.0%
Bad Debts	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL REVENUE DEDUCTIONS	$ 7,560	$ 2,439	209.9%	$ -	0.0%	$ 7,560	$ 2,439	209.9%	$ -	0.0%
	98.2%	59.8%		#DIV/0!		98.2%	59.8%		#DIV/0!	
NET PATIENT REVENUE	$ 140	$ 1,639	-91.4%	$ -	0.0%	$ 140	$ 1,639	-91.4%	$ -	0.0%
OTHER REVENUE										
Other Revenue	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
TOTAL OTHER REVENUE	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
NET OPERATING REVENUE	$ 140	$ 1,639	-91.4%	$ -	0.0%	$ 140	$ 1,639	-91.4%	$ -	0.0%
OPERATING EXPENSE										
Salaries and Wages	$ 852	$ 530	60.7%	$ -	0.0%	$ 852	$ 530	60.7%	$ -	0.0%
Benefits	140	78	79.5%	-	0.0%	140	78	79.5%	-	0.0%
Physician Services	2,000	937	113.4%	-	0.0%	2,000	937	113.4%	-	0.0%
Cost of Drugs Sold	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Supplies	60	722	-91.7%	-	0.0%	60	722	-91.7%	-	0.0%
Utilities	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Repairs and Maintenance	40	3,061	-98.7%	-	0.0%	40	3,061	-98.7%	-	0.0%
Leases and Rentals	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 3,092	$ 5,328	-42.0%	$ -	0.0%	$ 3,092	$ 5,328	-42.0%	$ -	0.0%
Depreciation/Amortization	$ 905	$ 2,137	-57.7%	$ 2,769	-67.3%	$ 905	$ 2,137	-57.7%	$ 2,769	-67.3%
TOTAL OPERATING COSTS	$ 3,996	$ 7,465	-46.5%	$ 2,769	44.3%	$ 3,996	$ 7,465	-46.5%	$ 2,769	44.3%
NET GAIN (LOSS) FROM OPERATIONS	**$ (3,856)**	**$ (5,826)**	**33.8%**	**$ (2,769)**	**-39.2%**	**$ (3,856)**	**$ (5,826)**	**33.8%**	**$ (2,769)**	**-39.2%**
Operating Margin	-2748.12%	-355.46%	673.1%	0.00%	0.0%	-2748.12%	-355.46%	673.1%	0.00%	0.0%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	25	14	78.6%	-	0.0%	25	14	78.6%	-	0.0%
Hospital FTE's (Salaries and Wages)	0.2	0.2	0.0%	-	0.0%	0.2	0.2	0.0%	-	0.0%

ECTOR COUNTY HOSPITAL DISTRICT
OCTOBER 2024

REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 45,913,071	39.3%	$ 41,786,999	39.5%	$ 45,913,071	39.3%	41,786,999	39.5%
Medicaid	12,640,449	10.8%	13,043,103	12.3%	12,640,449	10.8%	13,043,103	12.3%
Commercial	42,238,101	36.2%	36,698,348	34.6%	42,238,101	36.2%	36,698,348	34.6%
Self Pay	11,868,629	10.2%	10,631,423	10.0%	11,868,629	10.2%	10,631,423	10.0%
Other	4,029,291	3.5%	3,802,365	3.6%	4,029,291	3.5%	3,802,365	3.6%
TOTAL	**$ 116,689,540**	**100.0%**	**$ 105,962,238**	**100.0%**	**$ 116,689,540**	**100.0%**	**105,962,238**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 9,941,462	39.5%	$ 7,710,979	35.3%	$ 9,941,462	39.5%	7,710,979	35.3%
Medicaid	1,832,366	7.3%	2,634,695	12.1%	1,832,366	7.3%	2,634,695	12.1%
Commercial	10,539,842	41.9%	9,628,692	44.0%	10,539,842	41.9%	9,628,692	44.0%
Self Pay	1,451,968	5.8%	1,228,699	5.6%	1,451,968	5.8%	1,228,699	5.6%
Other	1,380,222	5.5%	651,534	3.0%	1,380,222	5.5%	651,534	3.0%
TOTAL	**$ 25,145,859**	**100.0%**	**$ 21,854,599**	**100.0%**	**$ 25,145,859**	**100.0%**	**21,854,599**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
STATEMENT OF CASH FLOW
OCTOBER 2024

	Hospital	ProCare	TraumaCare	Blended
Cash Flows from Operating Activities and Nonoperating Revenue:				
Excess of Revenue over Expenses	$ (2,989,701)	-	44,201	$ (2,945,500)
Noncash Expenses:				
Depreciation and Amortization	2,041,102	1,308	-	2,042,410
Unrealized Gain/Loss on Investments	14,457	-	-	14,457
Accretion (Bonds) & COVID Funding	(51,038)	-	-	(51,038)
Changes in Assets and Liabilities				
Patient Receivables, Net	1,401,821	177,372	(7,465)	1,571,729
Taxes Receivable/Deferred	(1,674,412)	(4,528)	-	(1,678,940)
Inventories, Prepaids and Other	(4,760,526)	2,213	984	(4,757,329)
LT Lease Rec	121,574			
Deferred Inflow of Resources	-			
Accounts Payable	(2,299,692)	959,754	(41,239)	(1,381,177)
Accrued Expenses	1,818,220	(1,136,044)	3,518	685,695
Due to Third Party Payors	-	-	-	-
Accrued Post Retirement Benefit Costs	(649,631)	-	-	(649,631)
Net Cash Provided by Operating Activities	$ (7,027,826)	75	-	$ (7,027,751)
Cash Flows from Investing Activities:				
Investments	$ (62,891)	-	-	$ (62,891)
Acquisition of Property and Equipment	(1,266,306)	-	-	(1,266,306)
Net Cash used by Investing Activities	$ (1,329,197)	-	-	$ (1,329,197)
Cash Flows from Financing Activities:				
Current Portion Debt	$ -	-	-	$ -
Principal Paid on Subscription Liabitlities	$ (24,776)			
Principal Paid on Lease Liabitlities	$ 35,221			
Intercompany Activities	-	-	-	-
LT Liab Subscriptions	(177,383)			
LT Liab Leases	(80,547)			
Net Repayment of Long-term Debt/Bond Issuance	-	-	-	-
Net Cash used by Financing Activities	(247,485)	-	-	(247,485)
Net Increase (Decrease) in Cash	(8,604,508)	75	-	(8,604,433)
Beginning Cash & Cash Equivalents @ 9/30/2024	49,618,916	4,500	-	49,623,416
Ending Cash & Cash Equivalents @ 10/31/2024	$ 41,014,409	$ 4,575	$ -	$ 41,018,984

ECTOR COUNTY HOSPITAL DISTRICT
MEDICAID SUPPLEMENTAL PAYMENTS
FISCAL YEAR 2025

CASH ACTIVITY	TAX (IGT) ASSESSED	GOVERNMENT PAYOUT	BURDEN ALLEVIATION	NET INFLOW
DSH				
1st Qtr	$ (3,159,960)	$ -		$ (3,159,960)
2nd Qtr	-	-		-
3rd Qtr	-	-		-
4th Qtr	-	-		-
DSH TOTAL	$ (3,159,960)	$ -		$ (3,159,960)
UC				
1st Qtr	$ -	$ -		-
2nd Qtr	-	-		-
3rd Qtr	-	-		-
4th Qtr	-	-		-
UC TOTAL	$ -	$ -		$ -
GME				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
GME TOTAL	$ -	$ -		$ -
CHIRP				
1st Qtr	$ -	$ 26,823		$ 26,823
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
CHIRP TOTAL	$ -	$ 26,823		$ 26,823
HARP				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
HARP TOTAL	$ -	$ -		$ -
TIPPS				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
TIPPS TOTAL	$ -	$ -		$ -
MCH Cash Activity	**$ (3,159,960)**	**$ 26,823**		**$ (3,133,137)**
ProCare Cash Activity	$ -	$ -	$ -	**$ -**
Blended Cash Activity	**$ (3,159,960)**	**$ 26,823**	**$ -**	**$ (3,133,137)**

INCOME STATEMENT ACTIVITY:	**BLENDED**
FY 2025 Accrued / (Deferred) Adjustments:	
DSH	$ 810,000
UC	710,000
GME	143,000
CHIRP	(594,038)
HARP	124,000
TIPPS	23,333
Regional UPL Benefit	-
Medicaid Supplemental Payments	1,216,295
DSRIP Accrual	-
Total Adjustments	**$ 1,216,295**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF HOSPITAL TEMPORARY LABOR FTE'S
OCTOBER 2024

	CURRENT MONTH					YEAR TO DATE				
TEMPORARY LABOR DEPARTMENT	**ACTUAL**	**BUDGET**	**BUDGET VAR**	**PRIOR YR**	**PRIOR YR VAR**	**ACTUAL**	**BUDGET**	**BUDGET VAR**	**PRIOR YR**	**PRIOR YR VAR**
Cardiopulmonary	12.9	11.9	8.6%	13.0	-0.5%	12.9	11.9	8.6%	13.0	-0.5%
Operating Room	10.6	12.4	-14.5%	10.4	1.9%	10.6	12.4	-14.5%	10.4	1.9%
Imaging - Diagnostics	4.6	3.4	35.7%	2.8	65.1%	4.6	3.4	35.7%	2.8	65.1%
Labor & Delivery	4.0	5.0	-19.4%	4.2	-4.5%	4.0	5.0	-19.4%	4.2	-4.5%
Laboratory - Chemistry	1.9	6.5	-70.6%	3.7	-47.9%	1.9	6.5	-70.6%	3.7	-47.9%
7 Central	1.6	1.0	59.6%	0.4	278.9%	1.6	1.0	59.6%	0.4	278.9%
4 East - Post Partum	1.3	1.5	-14.9%	1.1	15.1%	1.3	1.5	-14.9%	1.1	15.1%
Imaging - Ultrasound	1.0	1.0	2.5%	1.4	-28.7%	1.0	1.0	2.5%	1.4	-28.7%
Recovery Room	0.8	0.5	70.5%	1.6	-47.5%	0.8	0.5	70.5%	1.6	-47.5%
UTILIZATION REVIEW	0.8	0.6	39.7%	-	0.0%	0.8	0.6	39.7%	-	0.0%
Laboratory - Histology	0.7	0.9	-26.2%	1.1	-39.8%	0.7	0.9	-26.2%	1.1	-39.8%
6 Central	0.5	0.3	68.2%	0.2	129.2%	0.5	0.3	68.2%	0.2	129.2%
Imaging - Nuclear Medicine	0.4	-	0.0%	-	0.0%	0.4	-	0.0%	-	0.0%
Intensive Care Unit (ICU) 2	0.3	1.6	-79.6%	0.7	-53.7%	0.3	1.6	-79.6%	0.7	-53.7%
Intensive Care Unit (CCU) 4	0.3	1.2	-77.2%	0.2	21.7%	0.3	1.2	-77.2%	0.2	21.7%
3 West Observation	0.2	0.5	-57.5%	0.1	182.7%	0.2	0.5	-57.5%	0.1	182.7%
9 Central	0.2	0.2	-15.6%	0.3	-41.9%	0.2	0.2	-15.6%	0.3	-41.9%
Center for Health and Wellness - Sports Medici	0.1	1.7	-92.3%	0.6	-76.8%	0.1	1.7	-92.3%	0.6	-76.8%
Emergency Department	0.1	0.5	-73.4%	-	0.0%	0.1	0.5	-73.4%	-	0.0%
4 Central	0.1	0.5	-86.2%	-	0.0%	0.1	0.5	-86.2%	-	0.0%
5 West - Pediatrics	0.1	-	0.0%	-	0.0%	0.1	-	0.0%	-	0.0%
6 West	0.1	0.1	-2.7%	0.5	-87.3%	0.1	0.1	-2.7%	0.5	-87.3%
5 Central	0.1	0.3	-80.8%	0.1	-4.7%	0.1	0.3	-80.8%	0.1	-4.7%
PM&R - Occupational	-	1.0	-100.0%	1.7	-100.0%	-	1.0	-100.0%	1.7	-100.0%
Imaging - Cat Scan	-	-	0.0%	1.1	-100.0%	-	-	0.0%	1.1	-100.0%
Nursing Orientation	-	-	0.0%	0.2	-100.0%	-	-	0.0%	0.2	-100.0%
Neonatal Intensive Care	-	-	0.0%	0.6	-100.0%	-	-	0.0%	0.6	-100.0%
Care Management	-	-	0.0%	0.5	-100.0%	-	-	0.0%	0.5	-100.0%
Laboratory - Hematology	-	2.1	-100.0%	-	0.0%	-	2.1	-100.0%	-	0.0%
PM&R - Physical	-	0.5	-100.0%	-	0.0%	-	0.5	-100.0%	-	0.0%
Imaging - CVI	-	1.0	-100.0%	-	0.0%	-	1.0	-100.0%	-	0.0%
Cardiopulmonary - Neonatal Intensive Care Uni	-	0.7	-100.0%	-	0.0%	-	0.7	-100.0%	-	0.0%
SUBTOTAL	**42.7**	**56.8**	**-24.8%**	**46.6**	**-8.3%**	**42.7**	**56.8**	**-24.8%**	**46.6**	**-8.3%**
TRANSITION LABOR										
Laboratory - Chemistry	4.5	-	0.0%	3.1	42.3%	4.5	-	0.0%	3.1	42.3%
SUBTOTAL	**4.5**	**-**	**0.0%**	**3.1**	**42.3%**	**4.5**	**-**	**0.0%**	**3.1**	**42.3%**
GRAND TOTAL	**47.2**	**56.8**	**-17.0%**	**49.7**	**-5.1%**	**47.2**	**56.8**	**-17.0%**	**49.7**	**-5.1%**

Financial Presentation

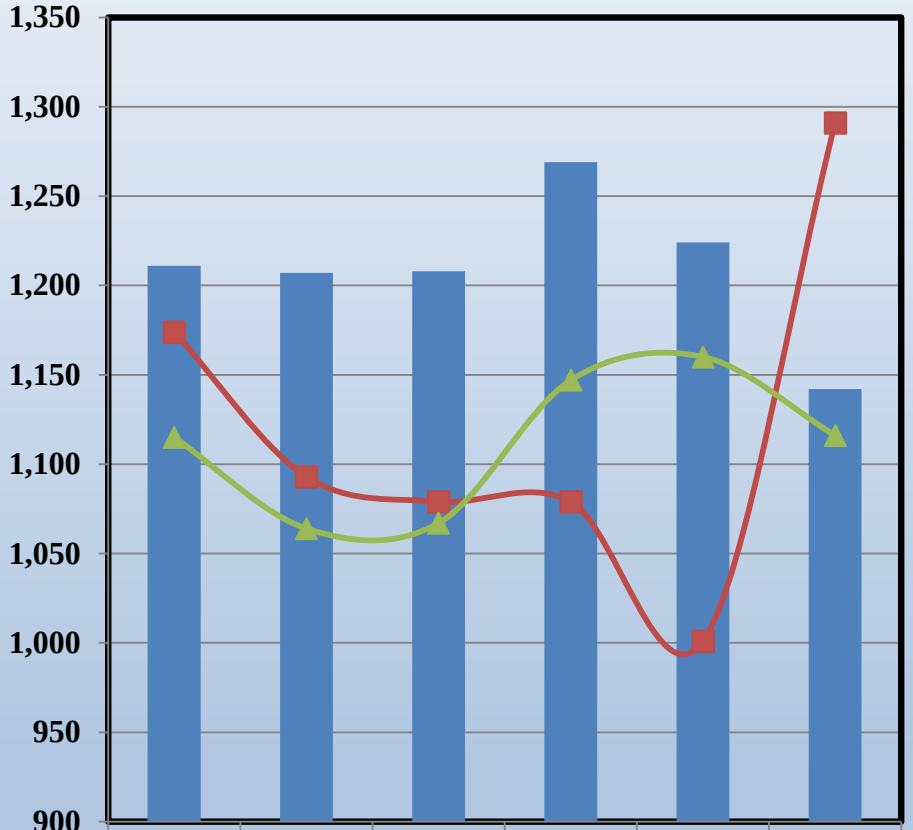
For the Month Ended

October 31, 2024

Volume

Admissions

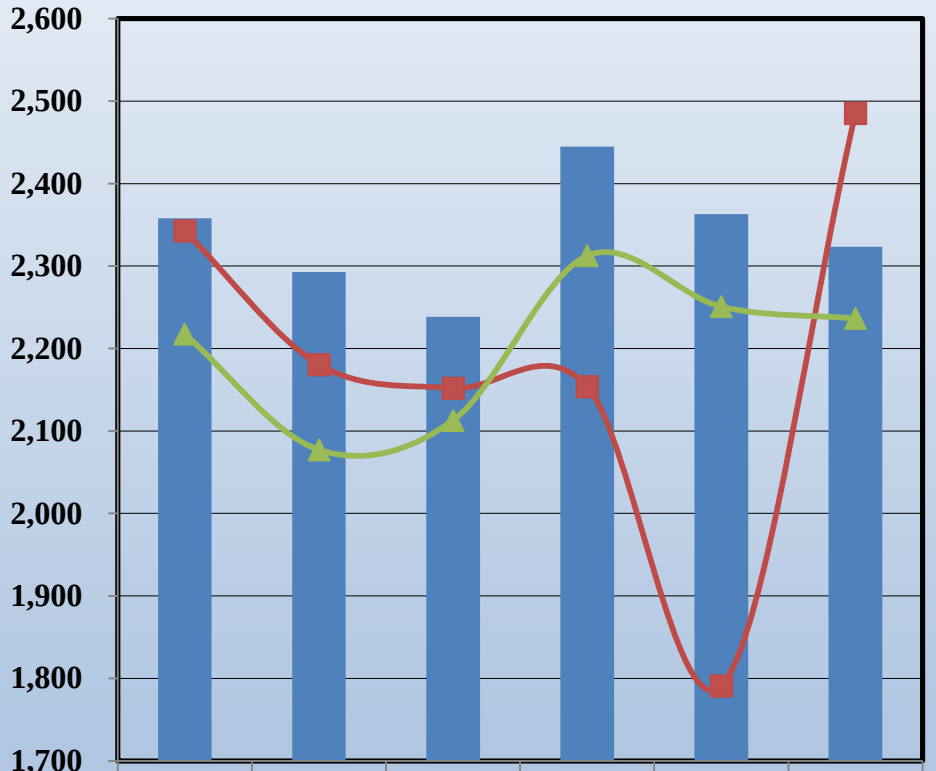
Total – Adults and NICU



	May	Jun	Jul	Aug	Sep	Oct
Act	1,211	1,207	1,208	1,269	1,224	1,142
Bud	1,174	1,093	1,079	1,079	1,001	1,291
Prior	1,115	1,064	1,067	1,147	1,160	1,116

	Actual	Budget	Prior Year
Month	1,142	1,291	1,116
Var %		-11.5%	2.3%
Year-To-Date	1,142	1,291	1,116
Var %		-11.5%	2.3%
Annualized	14,441	13,365	13,171
Var %		8.1%	9.6%

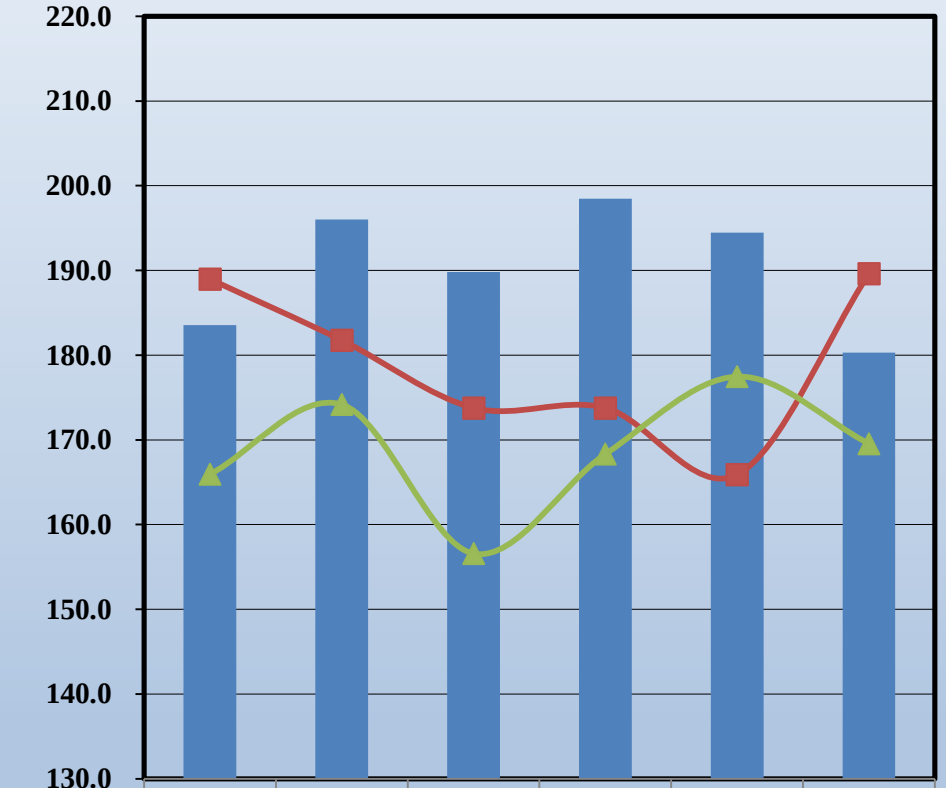
Adjusted Admissions



	May	Jun	Jul	Aug	Sep	Oct
Act	2,358	2,293	2,238	2,445	2,363	2,323
Bud	2,343	2,181	2,152	2,154	1,791	2,485
Prior	2,217	2,077	2,113	2,313	2,251	2,236

	Actual	Budget	Prior Year
Month	2,323	2,485	2,236
Var %		-6.5%	3.9%
Year-To-Date	2,323	2,485	2,236
Var %		-6.5%	3.9%
Annualized	27,687	26,355	25,535
Var %		5.1%	8.4%

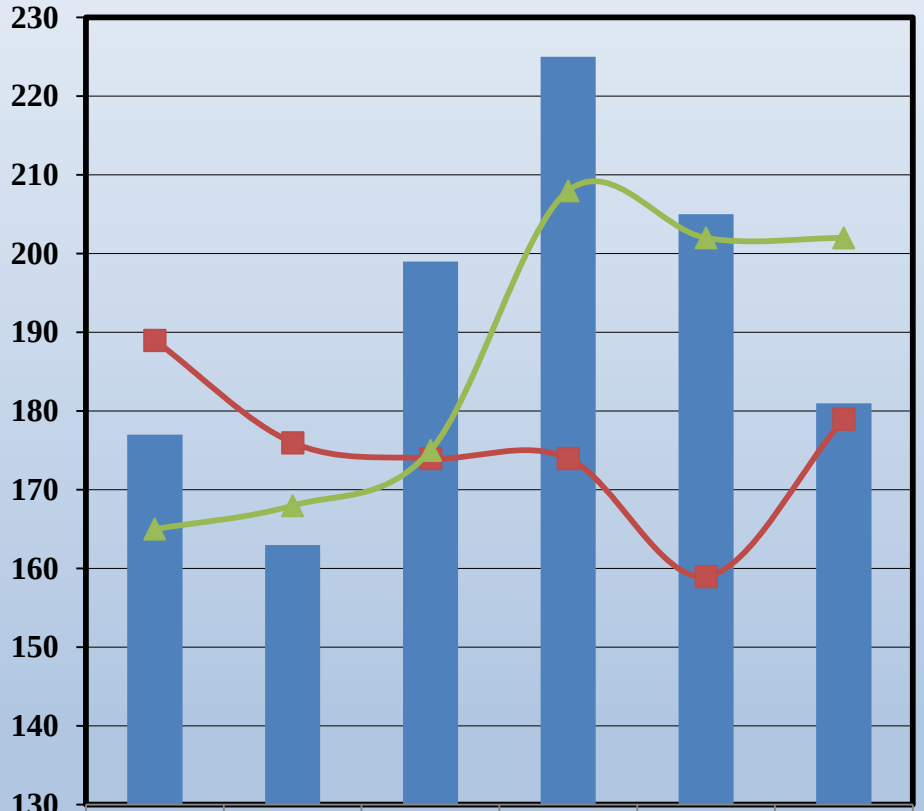
Average Daily Census



	May	Jun	Jul	Aug	Sep	Oct
Act	183.5	196.0	189.8	198.5	194.5	180.3
Bud	189.0	181.8	173.8	173.8	165.9	189.6
Prior	165.9	174.2	156.6	168.3	177.5	169.5

	Actual	Budget	Prior Year
Month	180.3	189.6	169.5
Var %		-4.9%	6.3%
Year-To-Date	180.3	189.6	169.5
Var %		-4.9%	6.3%
Annualized	189.4	180.7	175.5
Var %		4.8%	7.9%

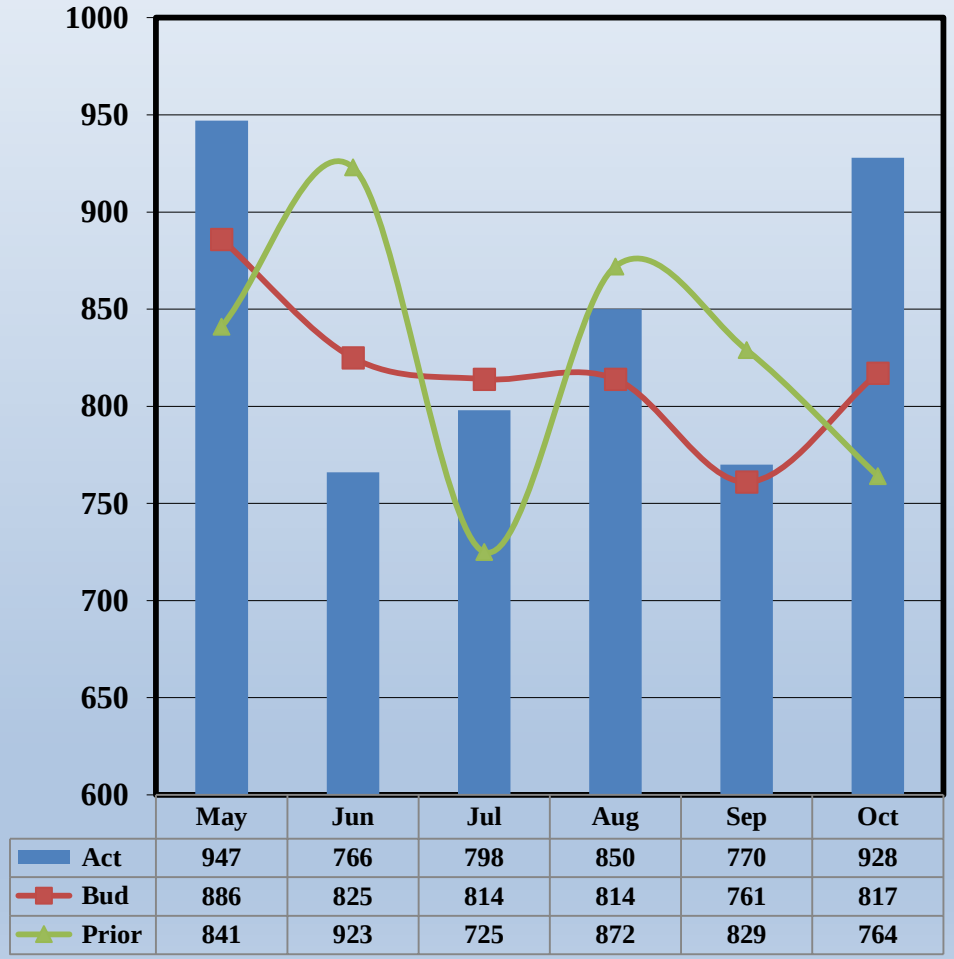
Deliveries



	May	Jun	Jul	Aug	Sep	Oct
Act	177	163	199	225	205	181
Bud	189	176	174	174	159	179
Prior	165	168	175	208	202	202

	Actual	Budget	Prior Year
Month	181	179	202
Var %		1.1%	-10.4%
Year-To-Date	181	179	202
Var %		1.1%	-10.4%
Annualized	2,201	2,122	2,201
Var %		3.7%	0.0%

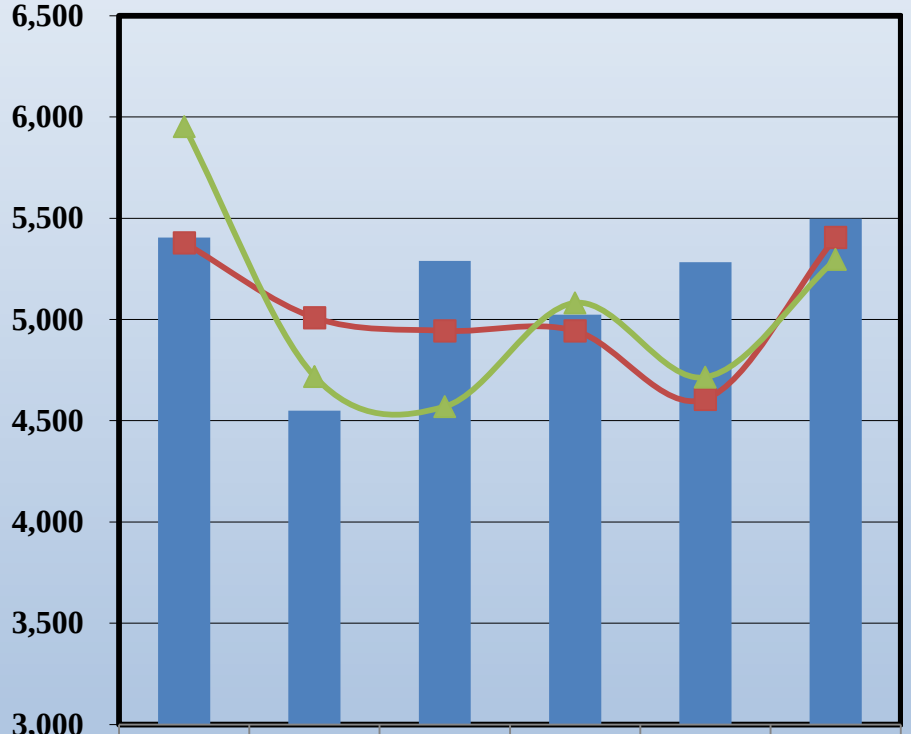
Total Surgical Cases



	May	Jun	Jul	Aug	Sep	Oct
Act	947	766	798	850	770	928
Bud	886	825	814	814	761	817
Prior	841	923	725	872	829	764

	Actual	Budget	Prior Year
Month	928	817	764
Var %		13.6%	21.5%
Year-To-Date	928	817	764
Var %		13.6%	21.5%
Annualized	9,434	9,934	9,508
Var %		-5.0%	-0.8%

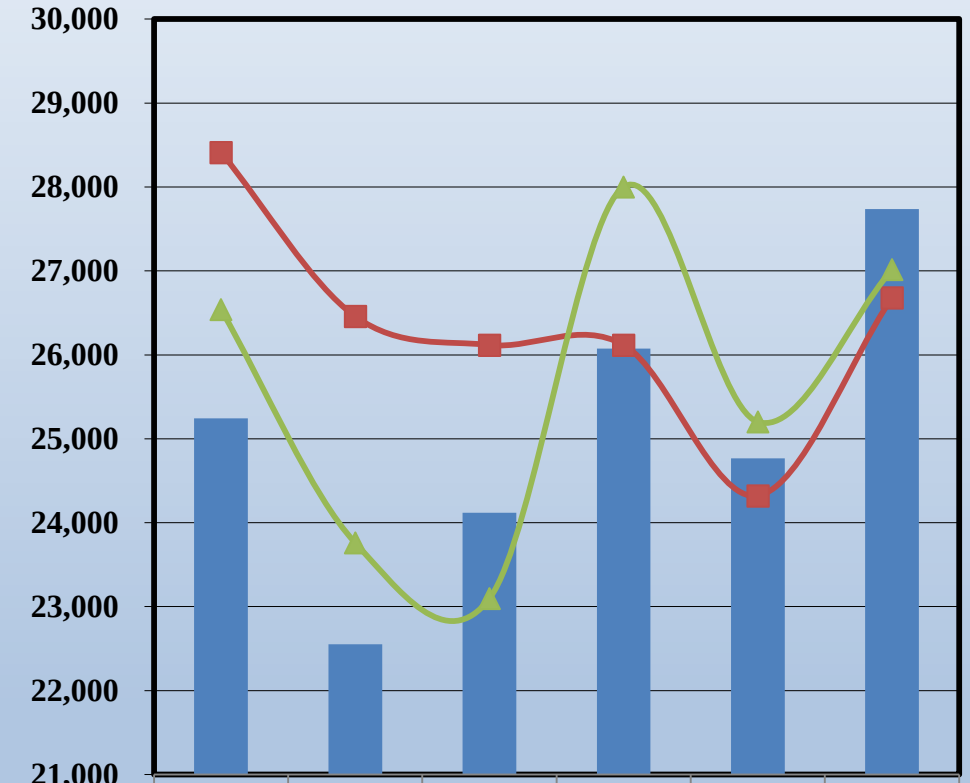
Emergency Room Visits



	May	Jun	Jul	Aug	Sep	Oct
Act	5,405	4,550	5,290	5,023	5,283	5,498
Bud	5,379	5,009	4,944	4,944	4,607	5,406
Prior	5,953	4,719	4,570	5,082	4,715	5,297

	Actual	Budget	Prior Year
Month	5,498	5,406	5,297
Var %		1.7%	3.8%
Year-To-Date	5,498	5,406	5,297
Var %		1.7%	3.8%
Annualized	63,687	60,753	61,123
Var %		4.8%	4.2%

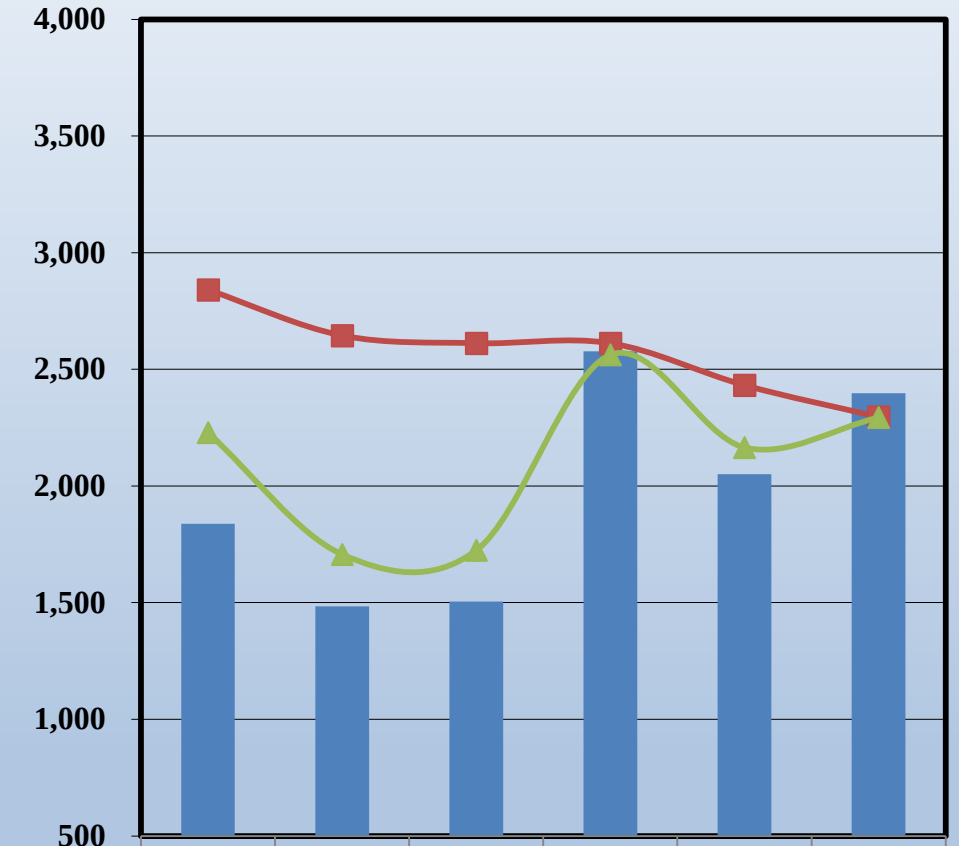
Total Outpatient Occasions of Service



	May	Jun	Jul	Aug	Sep	Oct
Act	25,243	22,553	24,118	26,074	24,766	27,736
Bud	28,413	26,458	26,118	26,118	24,322	26,682
Prior	26,540	23,760	23,097	28,001	25,201	27,016

	Actual	Budget	Prior Year
Month	27,736	26,682	27,016
Var %		4.0%	2.7%
Year-To-Date	27,736	26,682	27,016
Var %		4.0%	2.7%
Annualized	308,458	319,040	305,917
Var %		-3.3%	0.8%

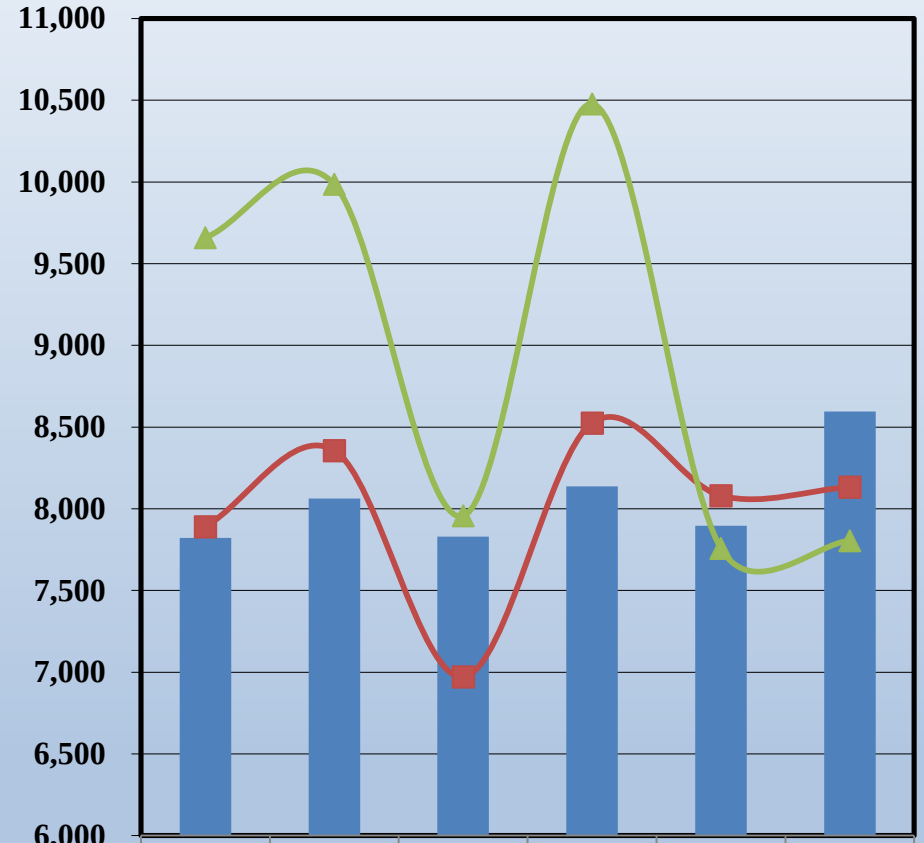
Urgent Care Visits



	May	Jun	Jul	Aug	Sep	Oct
Act	1,838	1,484	1,505	2,577	2,051	2,397
Bud	2,841	2,645	2,612	2,612	2,432	2,296
Prior	2,229	1,707	1,724	2,562	2,165	2,293

	Actual	Budget	Prior Year
Month	2,397	2,296	2,293
Var %		4.4%	4.5%
Year-To-Date	2,397	2,296	2,293
Var %		4.4%	4.5%
Annualized	27,012	31,529	28,396
Var %		-14.3%	-4.9%

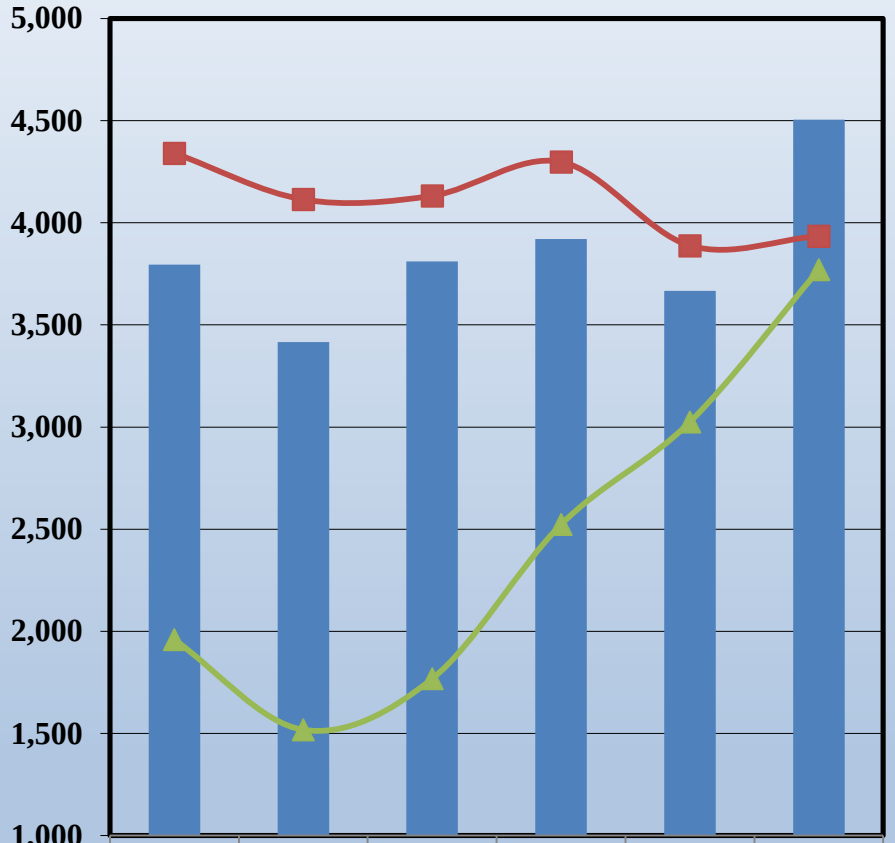
Total ProCare Office Visits



	May	Jun	Jul	Aug	Sep	Oct
Act	7,821	8,063	7,830	8,137	7,897	8,595
Bud	7,890	8,357	6,971	8,525	8,080	8,133
Prior	9,658	9,985	7,956	10,477	7,757	7,805

	Actual	Budget	Prior Year
Month	8,595	8,133	7,805
Var %		5.7%	10.1%
Year-To-Date	8,595	8,133	7,805
Var %		5.7%	10.1%
Annualized	94,749	93,651	107,734
Var %		1.2%	-12.1%

Total Family Health Clinic Visits



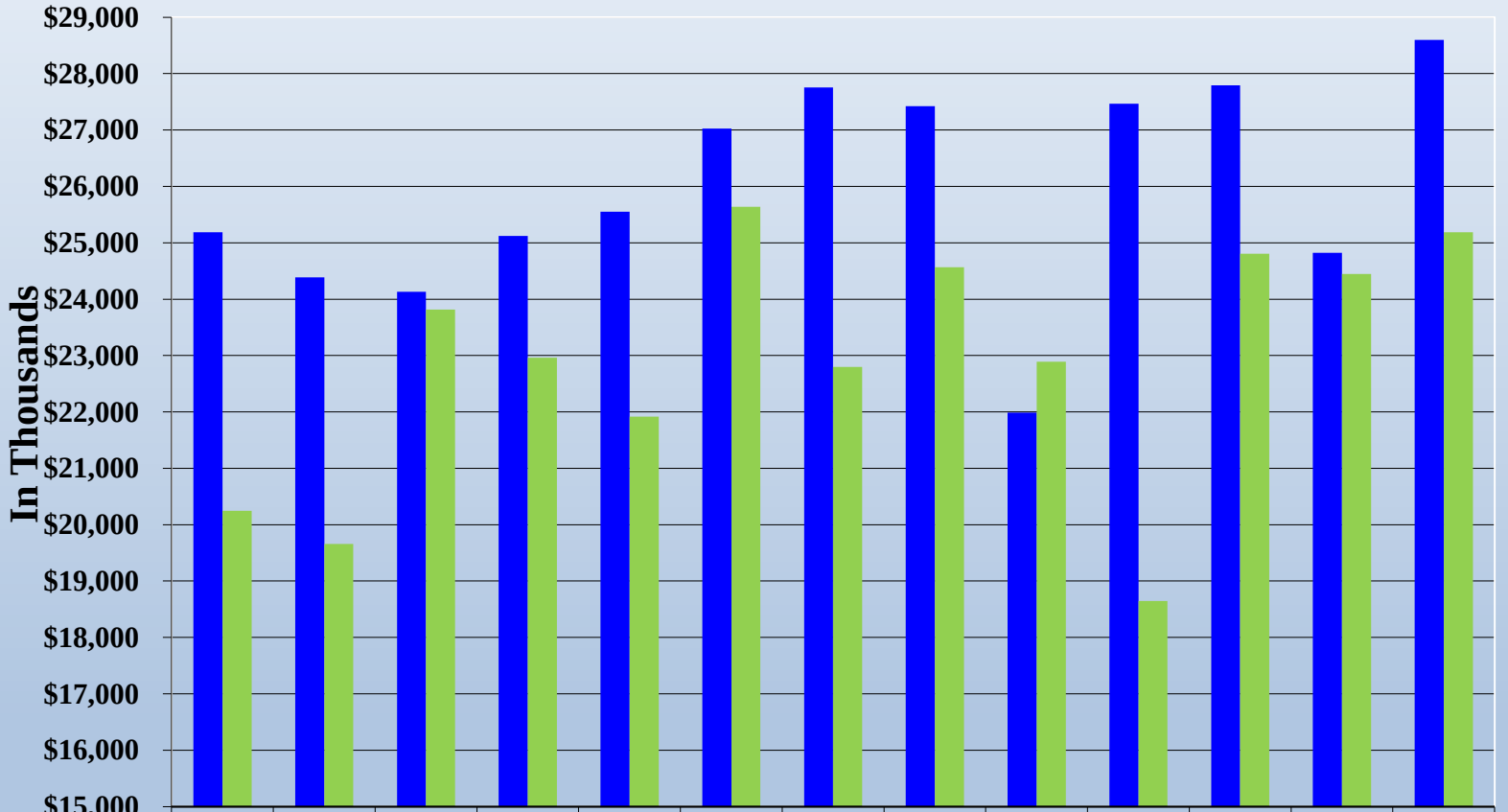
	May	Jun	Jul	Aug	Sep	Oct
Act	3,795	3,416	3,811	3,921	3,667	4,504
Bud	4,341	4,114	4,132	4,298	3,888	3,935
Prior	1,959	1,518	1,768	2,523	3,025	3,770

	Actual	Budget	Prior Year
Month	4,504	3,935	3,770
Var %		14.5%	19.5%
Year-To-Date	4,504	3,935	3,770
Var %		14.5%	19.5%
Annualized	45,476	48,590	26,708
Var %		-6.4%	70.3%

Accounts Receivable

Total AR Cash Receipts

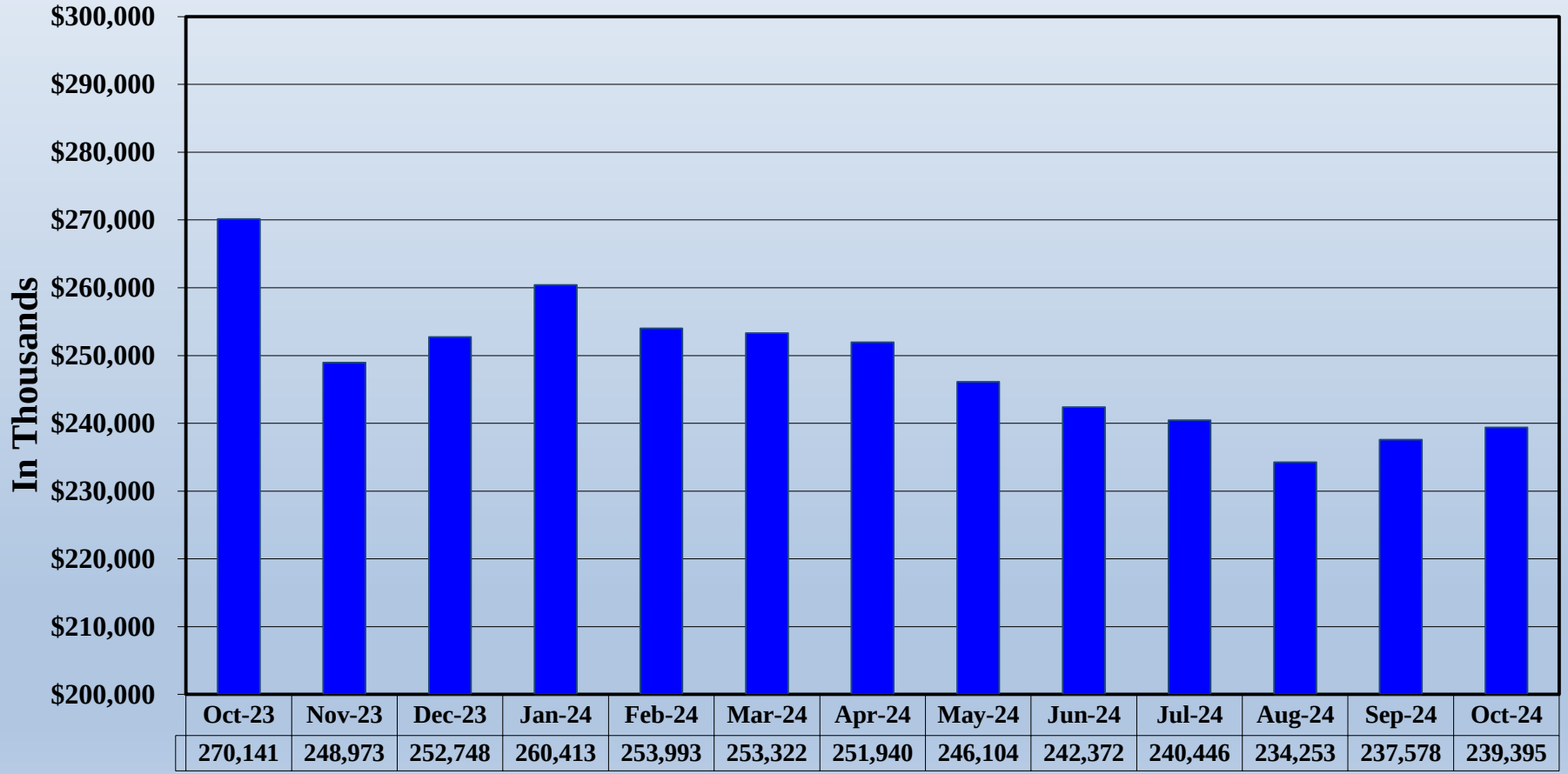
13 Month Trending



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
CY	25,185	24,385	24,130	25,123	25,550	27,025	27,756	27,425	21,985	27,465	27,795	24,820	28,600
PY	20,248	19,659	23,814	22,960	21,915	25,637	22,799	24,568	22,889	18,648	24,808	24,445	25,185

Total Accounts Receivable – Gross

Thirteen Month Trending

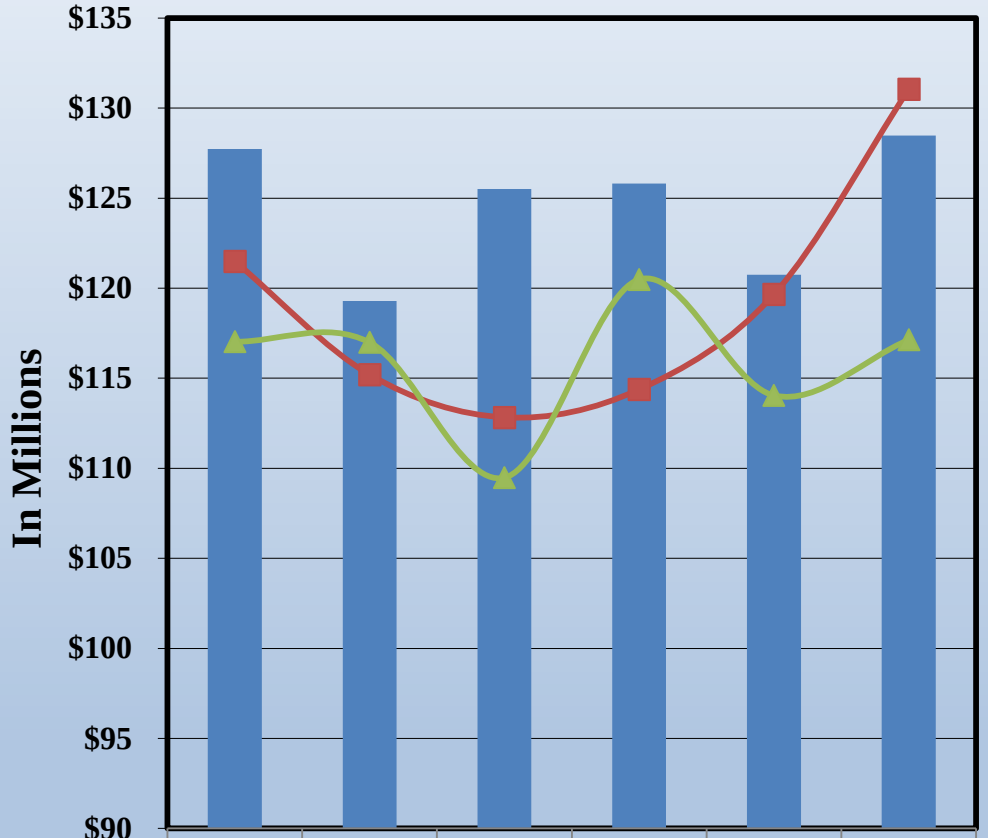


Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
270,141	248,973	252,748	260,413	253,993	253,322	251,940	246,104	242,372	240,446	234,253	237,578	239,395

Revenues & Revenue Deductions

Total Patient Revenues

(Ector County Hospital District)



	May	Jun	Jul	Aug	Sep	Oct
Act	$127.7	$119.3	$125.5	$125.8	$120.7	$128.5
Bud	$121.5	$115.2	$112.8	$114.4	$119.7	$131.0
Prior	$117.0	$117.0	$109.5	$120.5	$114.0	$117.1

	Actual	Budget	Prior Year
Month	$ 128.5	$ 131.0	$ 117.1
Var %		-2.0%	9.7%
Year-To-Date	$ 128.5	$ 131.0	$ 117.1
Var %		-2.0%	9.7%
Annualized	$ 1,463.1	$ 1,408.9	$ 1,367.4
Var %		3.8%	7.0%

Total Net Patient Revenues

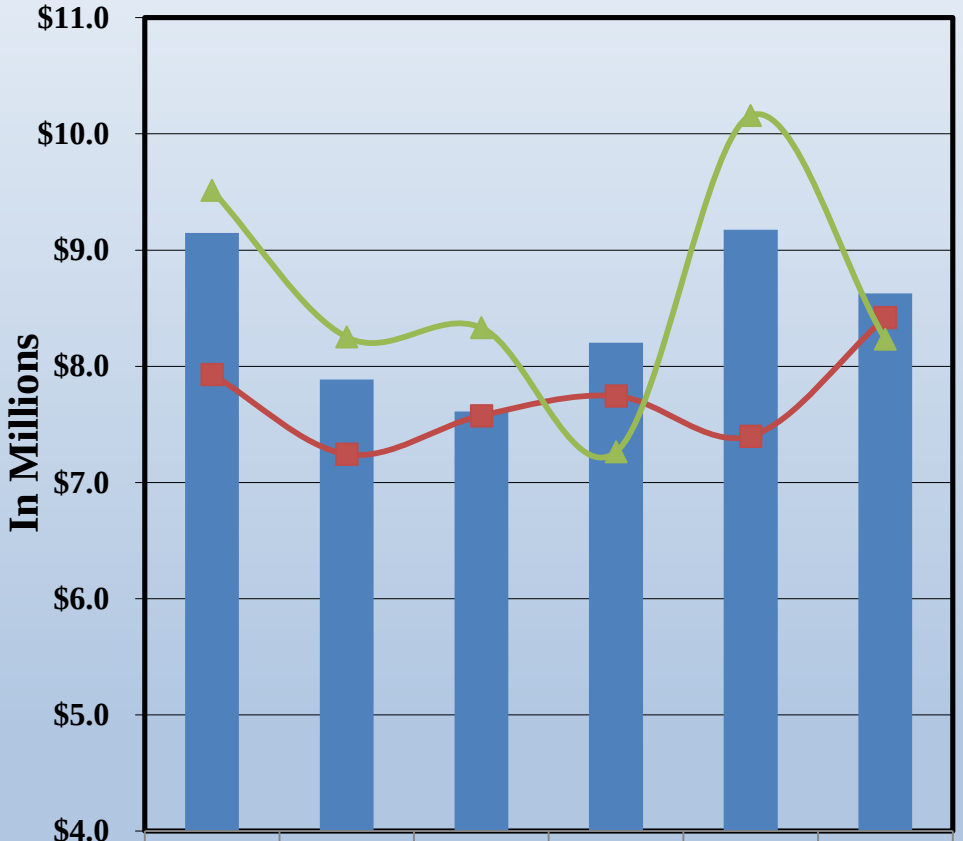
	May	Jun	Jul	Aug	Sep	Oct
Act	$28.5	$26.2	$28.5	$29.7	$45.5	$27.9
Bud	$29.3	$28.0	$27.5	$27.8	$26.3	$29.8
Prior	$26.0	$25.4	$27.2	$31.1	$28.5	$27.4

	Actual	Budget	Prior Year
Month	$ 27.9	$ 29.8	$ 27.4
Var %		-6.4%	1.8%
Year-To-Date	$ 27.9	$ 29.8	$ 27.4
Var %		-6.4%	1.8%
Annualized	$ 351.6	$ 336.6	$ 323.4
Var %		4.5%	8.7%

Other Revenue

(Ector County Hospital District)

Including Tax Receipts, Interest & Other Operating Income



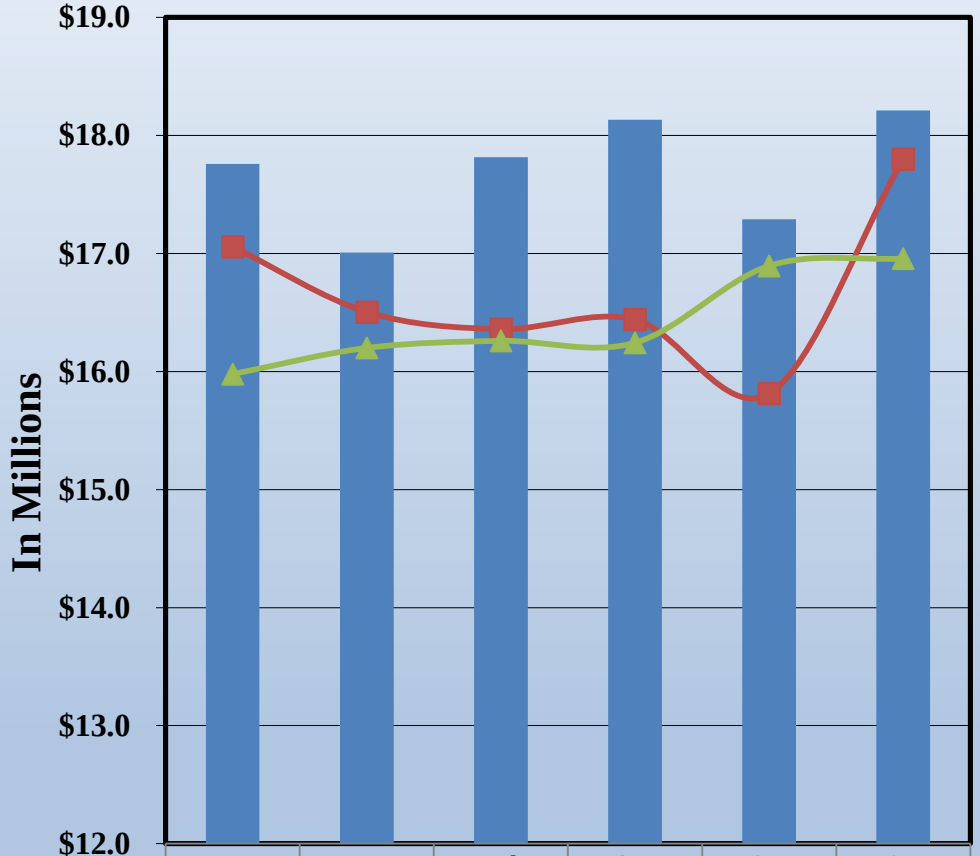
	May	Jun	Jul	Aug	Sep	Oct
Act	$9.1	$7.9	$7.6	$8.2	$9.2	$8.6
Bud	$7.9	$7.2	$7.6	$7.7	$7.4	$8.4
Prior	$9.5	$8.3	$8.3	$7.3	$10.2	$8.2

	Actual	Budget	Prior Year
Month	$ 8.6	$ 8.4	$ 8.2
Var %		2.0%	4.4%
Year-To-Date	$ 8.6	$ 8.4	$ 8.2
Var %		2.0%	4.4%
Annualized	$ 100.1	$ 91.8	$ 95.4
Var %		9.0%	4.9%

Operating Expenses

Salaries, Wages & Contract Labor

(Ector County Hospital District)

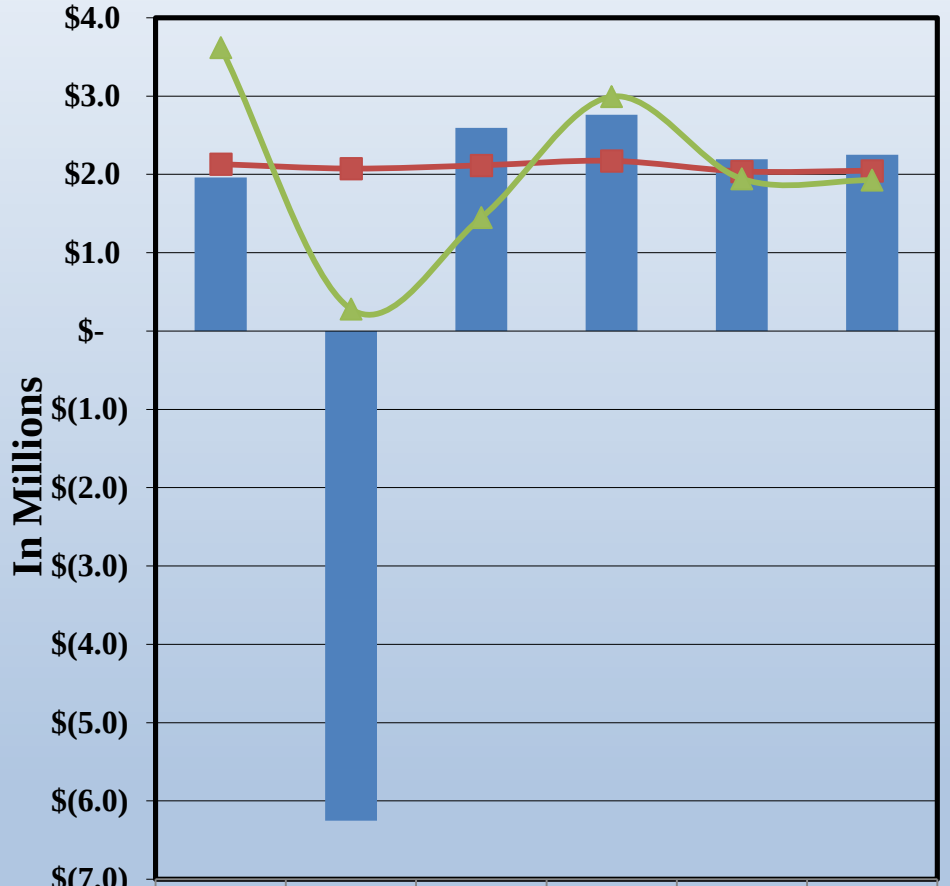


	May	Jun	Jul	Aug	Sep	Oct
Act	$17.8	$17.0	$17.8	$18.1	$17.3	$18.2
Bud	$17.1	$16.5	$16.4	$16.4	$15.8	$17.8
Prior	$16.0	$16.2	$16.3	$16.2	$16.9	$17.0

	Actual	Budget	Prior Year
Month	$ 18.2	$ 17.8	$ 17.0
Var %		2.2%	7.1%
Year-To-Date	$ 18.2	$ 17.8	$ 17.0
Var %		2.2%	7.1%
Annualized	$ 207.2	$ 198.2	$ 192.5
Var %		4.5%	7.6%

Employee Benefit Expense

(Ector County Hospital District)



	May	Jun	Jul	Aug	Sep	Oct
Act	$2.0	$(6.3)	$2.6	$2.8	$2.2	$2.3
Bud	$2.1	$2.1	$2.1	$2.2	$2.0	$2.0
Prior	$3.6	$0.3	$1.4	$3.0	$1.9	$1.9

	Actual	Budget	Prior Year
Month	$ 2.3	$ 2.0	$ 1.9
Var %		12.1%	19.1%
Year-To-Date	$ 2.3	$ 2.0	$ 1.9
Var %		12.1%	19.1%
Annualized	$ 24.0	$ 25.8	$ 31.6
Var %		-7.1%	-24.1%

Supply Expense

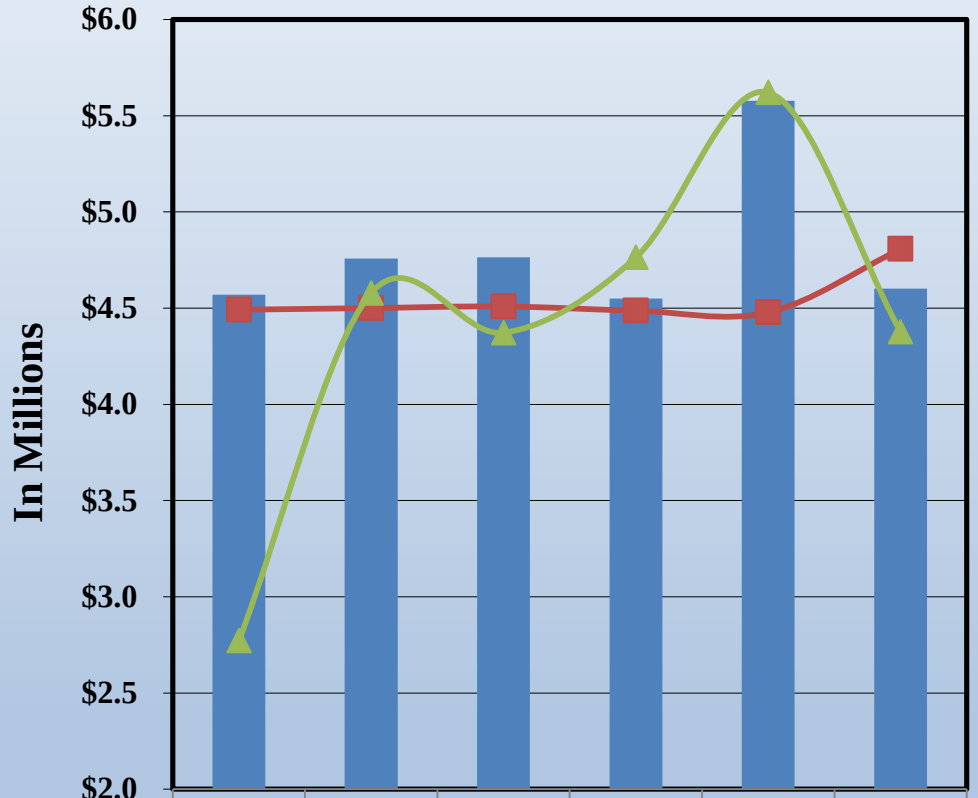
(Ector County Hospital District)

	May	Jun	Jul	Aug	Sep	Oct
Act	$6.9	$6.1	$7.0	$7.1	$6.3	$8.1
Bud	$6.4	$6.2	$6.1	$6.1	$5.8	$7.1
Prior	$6.1	$6.4	$5.4	$6.6	$5.0	$6.5

	Actual	Budget	Prior Year
Month	$ 8.1	$ 7.1	$ 6.5
Var %		14.2%	23.7%
Year-To-Date	$ 8.1	$ 7.1	$ 6.5
Var %		14.2%	23.7%
Annualized	$ 80.1	$ 74.9	$ 70.8
Var %		6.9%	13.1%

Purchased Services

(Ector County Hospital District)

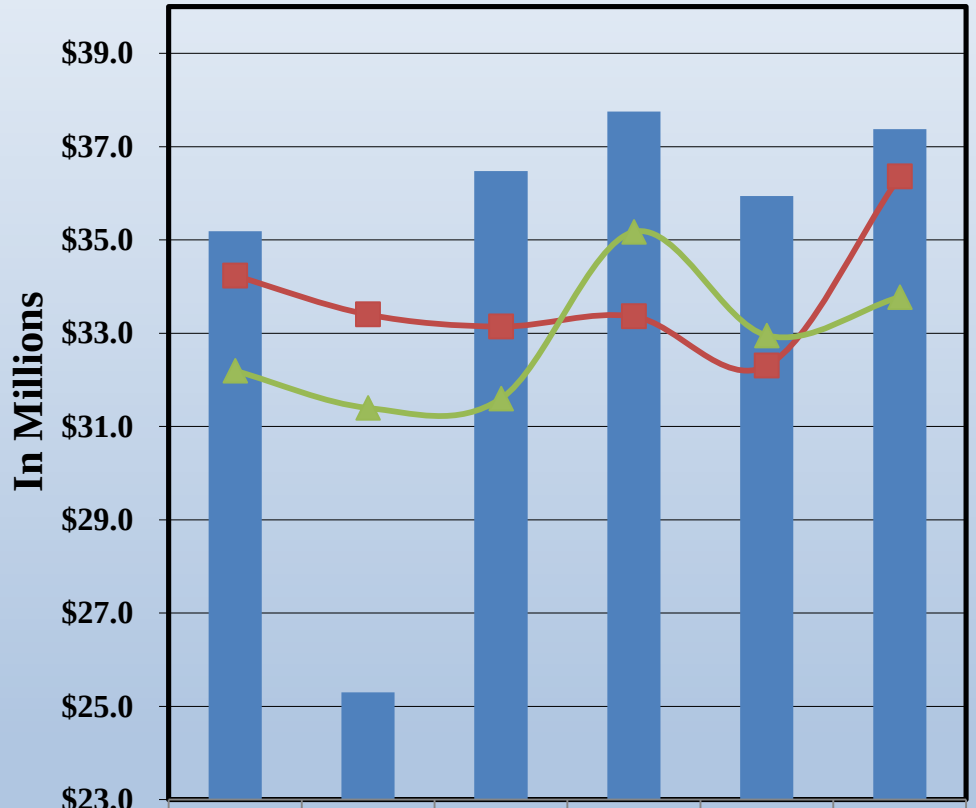


	May	Jun	Jul	Aug	Sep	Oct
Act	$4.6	$4.8	$4.8	$4.6	$5.6	$4.6
Bud	$4.5	$4.5	$4.5	$4.5	$4.5	$4.8
Prior	$2.8	$4.6	$4.4	$4.8	$5.6	$4.4

	Actual	Budget	Prior Year
Month	$ 4.6	$ 4.8	$ 4.4
Var %		-4.8%	4.6%
Year-To-Date	$ 4.6	$ 4.8	$ 4.4
Var %		-4.8%	4.6%
Annualized	$ 56.9	$ 54.7	$ 53.7
Var %		4.3%	5.5%

Total Operating Expense

(Ector County Hospital District)

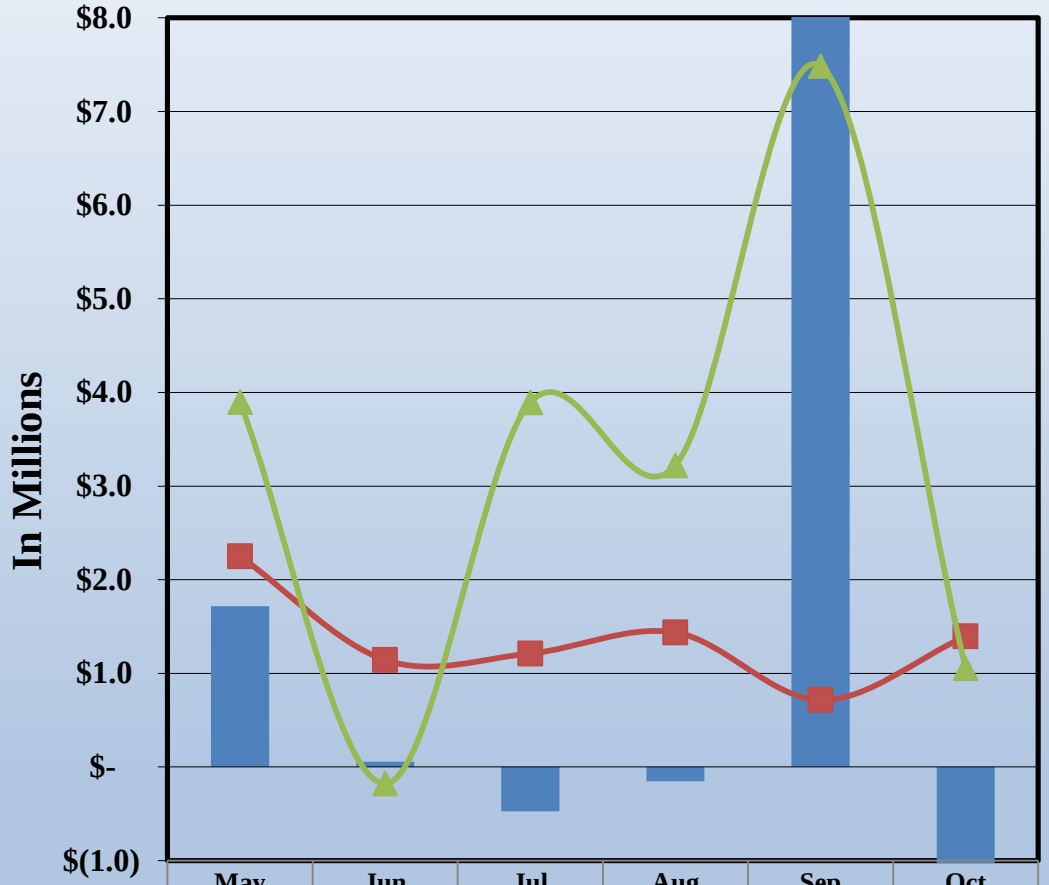


	May	Jun	Jul	Aug	Sep	Oct
Act	$35.2	$25.3	$36.5	$37.8	$35.9	$37.4
Bud	$34.2	$33.4	$33.1	$33.4	$32.3	$36.4
Prior	$32.2	$31.4	$31.6	$35.2	$33.0	$33.8

	Actual	Budget	Prior Year
Month	$ 37.4	$ 36.4	$ 33.8
Var %		2.8%	10.7%
Year-To-Date	$ 37.4	$ 36.4	$ 33.8
Var %		2.8%	10.7%
Annualized	$ 413.6	$ 404.2	$ 396.4
Var %		2.3%	4.3%

Adjusted Operating EBIDA

Ector County Hospital District Operations



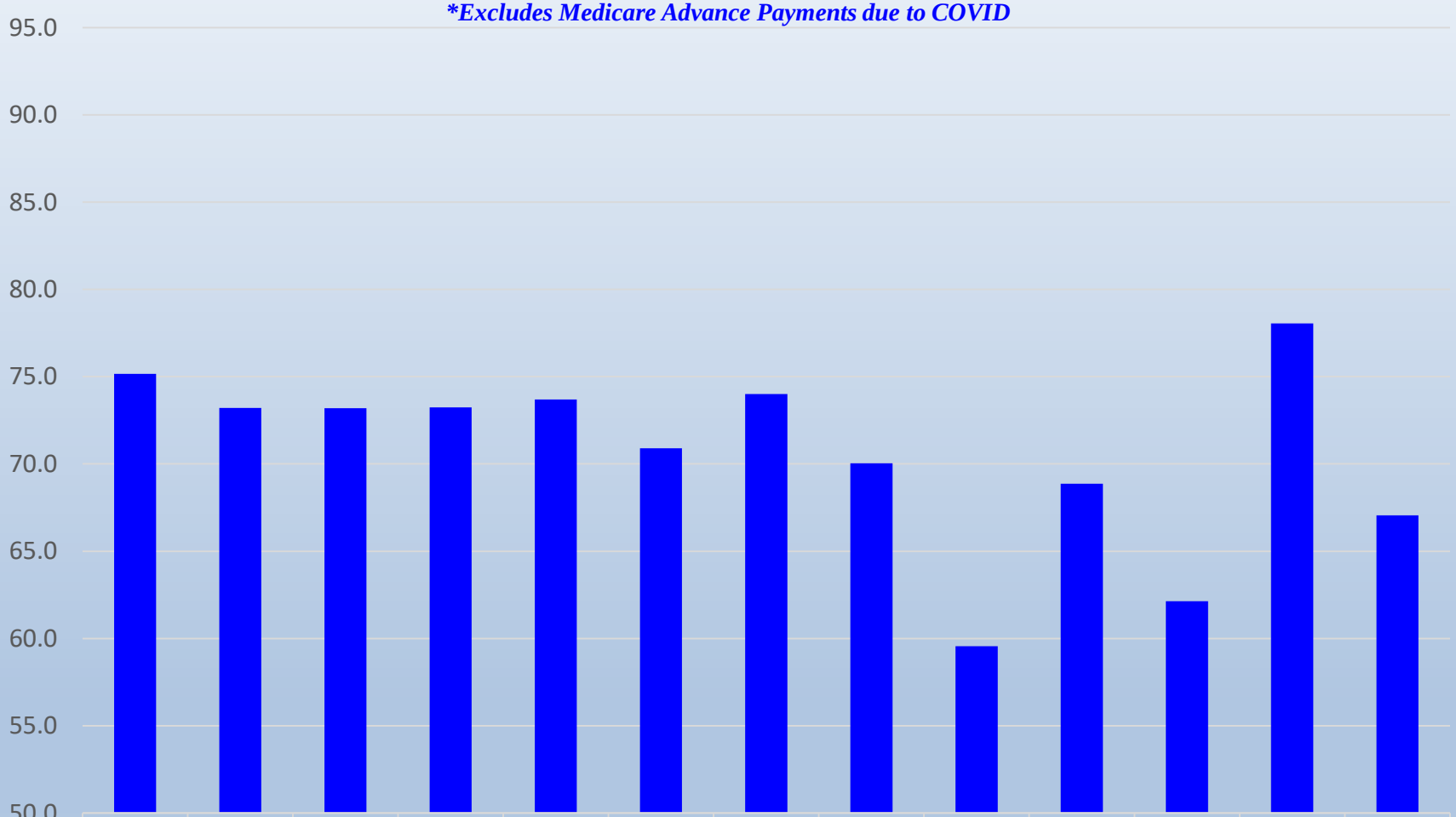
	May	Jun	Jul	Aug	Sep	Oct
Act	$1.7	$0.1	$(0.5)	$(0.2)	$18.2	$(1.4)
Bud	$2.3	$1.1	$1.2	$1.4	$0.7	$1.4
Prior	$3.9	$(0.2)	$3.9	$3.2	$7.5	$1.1

	Actual	Budget	Prior Year
Month	$ (1.4)	$ 1.4	$ 1.1
Var %		-200.0%	-227.3%
Year-To-Date	$ (1.4)	$ 1.4	$ 1.1
Var %		-200.0%	-227.3%
Annualized	$ 21.9	$ 14.8	$ 23.8
Var %		48.0%	-8.0%

Days Cash on Hand

Thirteen Month Trending

**Excludes Medicare Advance Payments due to COVID*



	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Days	75.2	73.2	73.2	73.2	73.7	70.9	74.0	70.0	59.6	68.9	62.1	78.1	67.0


mch
mch

Medical Center Health System
Your One Source for Health

MEMORANDUM

TO: ECHD Board of Directors

FROM: Linda Carpenter, Chief Information Officer

SUBJECT: Cisco SmartNet Hardware/Software Maintenance Support

DATE: December 1, 2024

Cost:

Cisco SmartNet Hardware/Software Maintenance Support *(1-Yr Renewal Support)*	$ 99,650.00

Budget Reference:

FY2025 Operational Funds	$ 99,650.00

Background:

Medical Center Health System (MCHS) uses Cisco devices for our data network. Network switches and routers serve as the central exchange point for network data flowing between computers, servers and medical equipment.

Cisco SmartNet service helps reduce downtime with fast, expert technical support and flexible hardware coverage provided by the Cisco Technical Assistance Center. It also provides OS software updates, including actionable security alerts required to secure our infrastructure network. Continued Hardware/License support for another year term will ensure the required management to further secure our network.

Funding:

Cisco SmartNet Hardware/Software 1YR Maintenance Support in the amount of $99,650.00 from Calian Corporation will come from FY2025 budgeted operational funds.

Medical Center Health System
Your One Source for Health

MEMORANDUM

TO: Russell Tippin

FROM: Tara Ward, Divisional Director of Laboratory Services
Through Matt Collins, Chief Operating Officer

SUBJECT: Roche Diagnostics Contract Extension for Liat PCR devices

DATE: November 22, 2024

Cost:

4 cobas Liat PCR devices (value)	($68,106.80)
Depot Service for all Liat PCR Devices (13 total devices—Value)	($43,166.67)
Annual Test Kit Commitment Spend (Respiratory and Strep kits)	$499,500.00
Test Kit Commitment Spend over 36-month term	**$1,498,500.00**
Actual Spend FY2024	$901,890.00
Expected Actual Spend over term	$2,759,783.40

Background:

MCH Emergency Department uses the Roche cobas Liat PCR device to perform point-of-care testing for COVID/Flu A&B and Strep A. Roche has recently been granted FDA approval for a new combo test cartridge that includes COVID/Flu A&B/RSV and is approved for all ages. The ED currently has 5 Liat Devices and uses a significant amount of test cartridges for both respiratory and strep, especially on FastTrack patients. They have requested more devices to help with wait times in the ED and increase their efficiency in moving patients through, especially as we have entered the respiratory disease season in the area and expect the volume of patients seen to increase.

This contract extension places 4 more devices in exchange for a 36-month commitment of 9000 respiratory tests and 5000 strep tests per year, for a total of 27,000 respiratory and 15,000 strep tests over term. The cost of the annual commitment is $499,500.00 and total cost over term is $1,498,500.00. MCH is spending well over that amount annually; in FY2024, the total spend was $901,890.00. Factoring in volume increases of 2% and 4% over the expected term, expected actual spend would be $2,759,783.40. The value received in this contract extension amounts to $111,273.47 plus the faster throughput in ED.

To:	ECHD Board of Directors
Through:	Russell Tippin, President & CEO
Through:	Matt Collins, COO
From:	Jerry Hild, Divisional Director of Radiology
Date:	11/13/24
RE:	NovaRad PACS

Operational Cost:	Initial Set-up Fee $165,965 Monthly License subscription fee $12,211
Term:	3 year initial term

REQUEST

The current PACS, Merge, will sunset its application December 31, 2025, and will no longer offer the current application. After careful consideration and review of comparison vendors we have selected NovaRad PACS for MCHS. Capital expenditure for NovaRad PACS System has been approved for 2025.

We are questing to begin the process of migrating images that equal over three terabytes of data. This can be the most laborious process in the switching of systems. The sooner we begin the migration the less issues we will encounter when we approach a go live date.

PURPOSE OF CONTRACT

PACS is a critical system and essential for the hospital as all radiology imaging acquisition and distribution throughout the main facility and clinics are managed by this system. The service contract provides 24/7 support for any system issues.

Medical Center Health System
Your One Source for Health

MEMORANDUM

TO: ECHD Board of Directors

FROM: Trevor Tankersley, Director of Public Relations
Through Alison Pradon, Vice President of Development

SUBJECT: WebMD Ignite Call Center – Renewal Contract

DATE: December 3, 2024

Cost:

Contact Center Calls (English and Spanish) *(Based off estimated 250 calls/month - $4,875/month)*	**$58,500.00**
Monthly Maintenance *(Additions/Changes to Database – $950/month for 12 months)*	**$11,400.00**
Contact Center Weblink License & Maintenance (*License & Maintenance Fee – $2,500/month for 12 months)*	**$30,000.00**
Contract Total	**$99,900.00**

Background:
This contract will be a one (1) year contract beginning on the service date (12/3/2024). WebMD Ignite will provide a point of contact for all calls coming into the 640-6000 number. This includes event registrations, maintenance of online "Find a Physician" database, and warm transfer when connecting patients with clinics. This is a budgeted item for FY2025 and is the same contract price and same services as FY2024. We had been paying approximately $13,075/month (or $156,900 annually) previous to FY2024.

Staffing:
No additional FTE's required.

Disposition of Existing Equipment:
N/A

Implementation Time Frame:
Immediately

Funding:
$99,900.00 ($8,325/month) budgeted for Fiscal Year 2025 for monthly services.

Medical Center Hospital
A Member of Medical Center Health System

Memorandum

Date: November 11, 2024

To: Ector County Hospital District Board of Directors

Through: Russell Tippin, President / CEO
Kim Leftwich, DNP, RN Vice-President / CNO

From: Michelle Sullivan MSN, RN, ACNO Surgical Services
Jade Barroquillo BSN, RN, Director of Surgical Operations

Re: Stryker Surgicount Tablets (Replacement)

Total Cost over 3 years-non-budgeted **$320,000 ($120,000/yr)**

OBJECTIVE

Join into subscription agreement to replace current Stryker 1st Generation Surgicount Tablets (PN:0694-001-010 Stryker SurgiCount Safety Sponge System) that were obsolescence in 2021. We currently have 26 tablets but will only be replacing these with 20 new tablets (17 for OR and 3 for L&D).
The tablets can no longer be protected with the Microsoft security patches. This makes our system vulnerable to attack. IT suggests replacement as well for our system's safety.

HISTORY

This system is adjunct technology paired with the traditional manual counting of sharps, sponges Raytec and towels to assist with prevention of retained surgical items, (RSI's) using Radiofrequency Identification (RFID) technology. Each sponge or towel has a RFID tag embedded in it that can be tracked /located. All sponges are scanned into the system before the surgical procedure and all sponges scan "out" before the closing of the procedure.

Our current Stryker SurgiCount Safety Sponge System has reached obsolescence, and notification was given by Stryker that Microsoft will no longer fully support the connection protocol with regular security patches. The system began being utilized in 2016 after 3 patients experienced retained surgical objects (1 in L&D and 2 in OR). The system received a software update in 2019 for compatibility with the new Windows 10. Now in 2024, the Surgicount tablets pose a vulnerability issue due to the absence of Microsoft security patches.

PURCHASE CONSIDERATIONS

Continue to use RFID technology to retard against retained surgical items.
Our policy and procedures states that this adjunct counting device will be utilized in all surgical procedures that require entrance into a bodily cavity or deep incision.
It is a recommended practice by the Association of Operating Room Nurses (AORN).
This technology/system is utilized as an adjunct counting method in Labor and Delivery and all Operating Rooms.
Updating this technology will assist with vulnerability of attack on our computer system's here at MCH. (which has been discussed with Brad Dummer and team).

INSTALLATION & TRAINING

Stryker to in-service our employees. Stryker and MCH IT to work together on instillation.
Should just be replacing old ones.

WARRANTY AND SERVICE CONTRACT

Contract is for 3 years. The new proposed system will go obsolete in 2027. The contract Stryker sets forth states that at the time of obsolescence in 2027 these devices (20 tablets) will be replaced/upgraded for free.

DISPOSITION OF EXISTING EQUIPMENT

Return tablets that are obsolescent back to Stryker.

LIFE EXPECTANCY OF EQUIPMENT

3 years

MD BUYLINE INFORMATION

Meets MD Buyline and Vizient pricing recommendations.

COMMITTEE APPROVAL

ECHD Board

MEDICAL CENTER HEALTH SYSTEM

Internal Audit Update to the Audit Committee

November 21, 2024

weaver
Assurance • Tax • Advisory

FY 2024 Internal Audit Status

Project	Project Summary	Status
FY2024 Internal Audit Plan		
Audit Pack Examination #1	A continuous program evaluating key accounting close and financial reporting activities supporting accurate and complete preparation of period-close activities. Procedures performed included assisting with drafting policies and procedures over account reconciliation activities and reviewing fixed asset management processes.	**Complete**
Basin Emergency Physicians	MCHS management requested this audit to assess a phishing incident involving the impersonation of an existing vendor. We evaluated the events that led to the fraudulent incident, resulting in monetary funds being routed to the adversary's fraudulent account. The results of this audit are outlined on slide 10.	**Complete**
Third Party Vendor Management	We identified key third-party vendor relationships and evaluate the current process of third-party vendor management to identify data analytics and associated controls included in the following activities: vendor management system access and restrictions, vendor relationship management, and contract management, utilization, and compliance.	**Complete**
Audit Pack Examination #2	A continuous program evaluating key accounting close and financial reporting activities supporting accurate and complete preparation of period-close activities. Coverage areas are to be determined.	**Reporting**
FY2024 Special Projects Completed		
Post Cybersecurity-Event Review	Weaver performed a post cybersecurity event review over the activities that were conducted in response to the Rich Cabinets payment fraud attempt (in June 2024) to assess the System's capabilities for responding to social engineering incidents.	**Complete**
Retail Pharmacy Special Project	We evaluated the core transactional cycles for the MCH Pharmacy, from initiation to recording and reporting. This included the Revenue and AR, Purchase to Pay, and Inventory cycles. We gained an understanding of data sources, systems, and revenue cycle to identify the root cause of discrepancies in reported revenue between the retail pharmacy and the accounting department.	**Complete**
Rescheduled to FY2025		
Payroll	We will evaluate the design of the payroll process and associated internal controls including the following sub-processes: payroll system access provisioning and segregation of duties, timekeeping and tracking, monthly processing, reporting and review, deductions and benefits processing, and disbursement.	**Rescheduled FY 2025**

FY2025 Internal Audit Plan Update

Project	Project Summary
FY2025 Internal Audit Plan	
Admissions	We will evaluate the design of the admissions process and identify associated internal controls within sub-processes such as: insurance pre-certification, coding and admission, and patient disclosures and consent.
Payroll	We will evaluate the design of the payroll process and associated internal controls including the following sub-processes: payroll system access provisioning and segregation of duties, timekeeping and tracking, monthly processing, reporting and review, deductions and benefits processing, and disbursement.
Recurring Internal Audit Projects	
Audit Pack Examination #1 & #2	A continuous program evaluating key accounting close and financial reporting activities supporting accurate and complete preparation of period-close activities. Coverage areas are to be determined.
Prior Engagement Follow-up	Follow up procedures on findings, observations, and recommendations resulting from prior internal audit projects, such as: charge capture, information security, and cash collections.
Project Management & AC Reporting	Procedures include tracking overall internal audit progress, coordinating audit activities, continuous reporting to management, preparation of Audit Committee materials and in-person presentation during scheduled meetings.
Reserved / Future Audits	
Facilities Management	We will evaluate the design of the facilities maintenance process and identify associated controls within sub-processes such as: property maintenance, leasing, handicap and ambulatory loading, and general custodial services.
Scheduling & Rostering	We will evaluate the design of procedures to facilitate the scheduling/rostering of staff resources and associated controls including the following: nurse scheduling, physician scheduling, nurse and physical workload monitoring and compliance, and medical equipment scheduling.

Audit Pack Examination #1

Objective: Evaluate monthly accounting and financial reporting activities, identify opportunities to improve these processes and enhance period-close and monthly internal financial reporting.

Procedures:

1. **Account Reconciliations:**
   - Evaluated existing governing materials to identify current practices.
   - Prepared a draft policy and procedures document for journal entry and reconciliations for management's consideration
   - Developed flowcharts to illustrate existing procedures.
2. **Fixed Asset Management Check Up #2**:
   - Conducted walkthroughs with key personnel to expand our understanding of month-end fixed asset procedures performed.
   - Compared expected controls to identified controls.

Results/Conclusion

This Audit Pack Examination (APE) **successfully validated** all scope areas. We identified Points for Consideration (PFC) that relate to preparation and documentation of materials supporting monthly Board Financial Packets.

- Highly collaborative, yet informal procedures exist to maintain and track fixed asset inventory.
- Formal process is not in place to facilitate effective and timely disposals.
- Cerner's Fixed Asset Management Module is not periodically reviewed for completeness and accuracy.

Recommendations

- Establish formal guidance to ensure consistent and effective month-end activities.
- Focus on defining roles and responsibilities, specific fixed assets to assess, and documentation requirements.
- Establish and implement a policy and procedure to ensure disposals are approved, documented, and accurately updated within Cerner.
- Develop accounting-specific instructions to update system records completely and accurately.
- Establish formal guidance, including defined responsibilities, established timeframes, and monitoring procedures.
- Leverage system reports available from service contractor, Trimedx, to accurately count and value diagnostic and therapeutic machinery.

Our evaluation procedures, listed above, over the fixed asset process **identified 14 controls** within the Capital Budgeting, Asset Disposal, and Fixed Asset Inventory sub-activities:

Fixed Asset Inventory Expected Controls		
Sub-Process	**Activity Points**	**Identified Controls**
Capital Budgeting	5	5
Asset Disposal	8	5
Fixed Asset Inventory	12	4
Total	**25**	**14**

Additionally, Weaver provided the Accounting Department with draft journal entry and reconciliation procedures.

Third Party Vendor Management

Objective: Evaluate and document the Third-Party Vendor Management process and activities.
Identify existing controls and gaps that provide opportunities to improve efficiency and consistency.

Procedures:
- Identified a representative sample of vendors[1] by analyzing total vendor spend from March 2023 through February 2024.
- Conducted interviews with key personnel to understand the overall vendor management process and activities and identify existing internal controls.
- Documented the process via **flowcharts** and provided to MCHS management.
- Developed vendor **dashboards** to document key relationships attributes, mitigating activities, and risk prioritization mapping.

Results/Conclusion

- We identified control activities in place for the five (5) vendors reviewed covering significant risks identified as part of this evaluation. Operational risks were determined to be the highest priority due to the nature of the services provided by the vendors reviewed.
- Dashboards were developed and provided to the System that outline the significant risk categories identified for each of the five (5) vendors reviewed, as well as internal controls in place to mitigate inherent risks.
- System limitations result in inefficiencies within Premier due to a lack of integration between the Accounts Payable and Contract Management modules.
- Over 900 contracts are managed by the System, largely by directors and c-suite personnel, and vendor tiering is not in place to ascertain criticality.

Recommendations

- Consult with Cerner to enhance system capabilities and interfacing with other modules to enhance monitoring activities.
- Establish and deploy vendor tiering to facilitate tailored, insightful contract evaluation procedures; designate contractual ownership based on criticality and delegate.
- Enhance contractual governance to ensure all required BAAs and third-party pricing evaluations, through MD Buyline, are include consistently obtained.
- Assess existing vendors during the vendor selection process to determine if they can fulfill the business need, including purchases processed through the check request procedure.
- Require COI declarations as part of the new vendor onboarding process.

[1]Evaluated vendors included: **McKesson, Cerner, Cardinal, Davin Healthcare Workforce Solutions, and Trimedx**

Retail Pharmacy Design Evaluation

Objective: We will evaluate the core transactional cycles for the MCH Pharmacy, from initiation to recording and reporting. This will include the Revenue and AR, Purchase to Pay, and Inventory cycles. We will gain an understanding of data sources, systems, and revenue cycle to identify the root cause of discrepancies in reported revenue between the retail pharmacy and the accounting department.

Procedures:
- Conducted interviews with Pharmacy and Accounting
- Recalculated Pharmacy and Accounting revenue for August 2024
- Analyzed FY2024 revenues and identified outliers
- Quantified value discrepancies in August 2024 for commercial RX, Script Care, and Medimpact.
- Reviewed Accounts Payable and Inventory processes, noting Accounting's reliance on standard flows without booking related journal entries.

Results/Conclusion

Variances in monthly revenues between Accounting and Pharmacy stem from two key issues:

1. *Data Sources*: Accounting and Pharmacy use difference source data and revenue calculation methods. A monthly reconciliation is not performed to identify discrepancies.

2. *Third Parties*: Two (2) events caused by third-parties resulted in three (3) significant impacts to pharmacy revenue reporting from October 2023 – August 2024. 1) WebTPA paid outstanding claims in November 2023, and 2) The Change Healthcare impacted provide pay in March 2024 which was later trued up in July 2024.

Recommendations

- Reconcile WinRX, ProviderPay, and Cash on a monthly basis.
- Facilitate monthly meetings with Accounting, Pharmacy, and Provider Pay to identify and resolve variances.
- Ensure the Accounting Department has access to source data.
- Identify the root cause of contractual issues with Script care, reasons for the Pharmacy Department adjusting Medimpact revenue to acquisition cost, timing issues, and coupons.
- Monthly, analyze AR balances within ProviderPay and reserve aging AR that is considered not collectible.

Data Sources		
Transaction	**Accounting**	**Pharmacy**
RX / Claim	Provider Pay	WinRX
MedImpact	Weekly	Monthly
Script Care	Provider Pay	SCL Statement
Cash/Co-pay	Cerner	WinScan POS
Accounts Receivable	Provider Pay	N/A

Post Cybersecurity-Event Review

Objective: Review the System's approach for responding to the June 2024 social engineering attack where Accounting received an emailed request to update ACH information from a vendor email account (i.e., Rich Cabinets), that later was found to be controlled by an adversary.

Procedures: Performed inquiry with key personnel involved with the event (i.e., Security Accounting) and reviewed supporting evidence (e.g., email correspondence, event timelines, alerting configurations, etc.) as well as relevant existing incident response policies, plans, and procedures in their current state.

Results/Conclusion

This review resulted in enhancement opportunities that will assist MCHS in improving capabilities of the incident response program as it relates to social engineering attacks and phishing emails. We identified Points for Consideration (PFC) related to event escalation, notification, documentation, ticket categorization, phishing KPI tracking, incident response playbooks, vendor management reporting, and post-mortem procedures.

Positive Highlights:

- Enhanced vendor verification procedures supported the MCHS Accounting team's capabilities for identifying the adversarial fraud attempt, ultimately preventing the situation from progressing to an incident and causing a negative financial impact.
- The Accounting personnel involved in the social engineering attack notified other members of their team to alert them to the situation with vendor to ensure they were extra vigilant in any further required communications. They also alerted Oracle (i.e., Brad D.) allowing him to perform the necessary investigation and analysis to determine the depth of the issue.

Recommendations

Incident Response Escalation and Notification: Procedures for analyzing security events, including criteria for determining when a detected and/or reported threat event requires notification to leadership (e.g., Information Security Officer, Chief Information Officer, and management) were not clearly defined to ensure understanding across incident responders at MCHS.

Reported Phishing Acknowledgment and Documentation: MCHS maintains multiple avenues for individuals to report suspicious activity and/or social engineering attempts, however all methods do not result in formally documenting events within a ticket. This may result in an unacknowledged/unaddressed issue and generally speaking, the lack of documentation limits the data available for monitoring trends over time as well as evidence should further investigation to respond to an incident be required.

Incident Response Social Engineering Playbooks: At the time of the review, incident response playbooks for social engineering events were not defined to ensure comprehensive investigation and consistency in response activities across all team members (i.e., Security leadership, Helpdsk, Oracle, etc.).

Discussion

John Wauson, CPA | Partner-in-Charge, Risk Advisory Services
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Memorandum

To: Steve Ewing *CFO Medical Center Heath System (MCHS)*
Grant Trollope *Assistant CFO Medical Center Heath System*
From: Weaver - Risk Advisory Services
Date: June 2024
Subject: 2024 Audit Pack Examination (APE) #1

This memo presents the summary procedures and results of our Audit Pack Examination (APE) performed for the period of October 1, 2023 - December 31, 2023 (Q1 2024).

Purpose and Background

Each APE iteration is designed to evaluate monthly accounting and financial reporting activities, identify opportunities to improve these processes and enhance period-close and monthly internal financial reporting. APE's are intended to focus on specific areas that change with each iteration, based on current trends and key accounting areas.

APE's include an evaluation of the efficiency and effectiveness of processes and associated control activities as well as the timeliness of activities reported results. Within this iteration, we will begin assisting the System, as necessary, in preparing formal policies and procedures for improvement opportunities identified within prior APE's.

This APE is not an audit of the financial statements and does not provide an opinion nor should be relied upon regarding the accuracy, completeness and presentation of interim financial statements and related disclosures.

Scoping and Procedures Performed

We conducted a scoping analysis to determine the areas for evaluation within this APE. The scoping analysis included the following considerations:

- Financial statement assessment, identifying significant line items for the period October through December 2023.
- Discussions with the Assistant CFO and Assistant Controller to identify reporting areas that have changed or experienced challenges during the examination period.
- Points for consideration issued during prior audit pack examinations, including formalization of processes and establishment of documented policies and procedural guidance.

Through these procedures and collaboration with management, we determined the following scope areas to perform our APE evaluation activities, summarized as:

1. ***Account Reconciliations,*** including drafting a formal policy and procedure to govern and facilitated consistent and timely periodic account reconciliation activities.
2. ***Fixed Asset (FA) Management Check Up #2,*** including a walkthrough of the Fixed Asset Inventory process to expand our foundational understanding of inventory valuation, documentation, and applicable disposals/impairments determinations.

We performed the following validation and evaluation procedures over the above in-scope areas*:

- Evaluation of applicable policies, procedures, and guidance materials to support users in effectively performing activities.
- Walkthroughs of procedures performed and relevant process documentation with responsible accounting personnel, as needed.
- Comparison of expected controls to identified controls within the Fixed Asset process.
- Policy and procedure drafting to facilitate common understanding among staff, and efficient and effective processes.

**Note*: Procedures listed above were applied to each review area based on the nature of the objective.

Account Reconciliation Policy

We have identified points for consideration related to the month-end account reconciliation process through evaluations performed during several prior-year iterations of audit pack examinations. Specifically, we have determined that a critical opportunity for improvement includes the implementation of formal policies and procedures to govern the month-end reconciliation activities performed and documented.

We have developed an account reconciliation policy and procedure and accompanying checklists/tracking templates for MCHS management to leverage in their efforts to remediate the previously identified points for consideration. Recommended remediation activities should include:

- Review the drafted policy for alignment with management's expectations and current practices.
- Formally adopt the policy and make available to all employees via the System's intranet or other centralized platform.
- Communicate implementation of the policy to all key stakeholders.
- Conduct training for all responsible personnel to facilitate understanding and awareness.
- Periodically evaluate the policy to maintain relevance and consistency with current practice.

Once adopted, we will validate the performance and alignment of updated procedures in future audit pack examinations with the governing policy, and that consistent and effective month-end reconciliation activities are performed.

Refer to Appendix D – Account Reconciliation Policy and Procedure

Conclusion & Summary of Results

This APE successfully validated all scope areas.

Our evaluation procedures, listed above, over the fixed asset process identified 15 controls within the Capital Budgeting, Asset Disposal, and Fixed Asset Inventory sub-activities:

Fixed Asset Inventory Expected Controls		
Sub-Process	**Activity Points**	**Identified Controls**
Capital Budgeting	5	5
Asset Disposal	8	5
Fixed Asset Inventory	12	4
Total	**25**	**14**

We identified three (3) Points for Consideration (PFCs) in the performance of our evaluation procedures. Identified PFCs relate to preparation and documentation of materials supporting monthly Board Financial Packets. A summary of these PFCs is presented in the table below, additional detail over procedures and results is available in *Appendix A* and *B*, respectively.

Ref	Status	Summary
PFC-01	New	Fixed Asset Inventory Valuation: - Identification of 11 control opportunities through comparison of expected controls and existing controls. - Establishment and implementation of annual fixed asset inventory analysis to reconcile items on hand and ensure accurate and appropriate valuations.
PFC-02	New	Asset Disposal Procedures: - Formalization of fixed asset disposal procedures to ensure timely recordkeeping and maximization of profits, when applicable.
PFC-03	New	Fixed Asset Management System Review: - Formalization of fixed asset rollforward procedures, with focus on the validation of the appropriateness and accuracy of fixed asset activity (i.e., additions and disposals).

Please find appendices on the following pages:

Appendix A – *Detailed Results of Procedures Performed.*

Appendix B – *Points for Consideration* for additional information regarding improvement opportunities and recommendations.

Appendix C – *Fixed Asset Inventory – Expected Control Matrix.*

Appendix D – *Account Reconciliation Policy and Procedures*

Appendix A: Detailed Results of Procedures Performed

Area	Description	Objective	Procedures Performed:	PFC Ref.
Account Reconciliation	Reconciliations performed by the Accounting Department to validate figures presented within the balance sheet.	Assist in documenting a formalized process to govern consistent and timely month-end account reconciliation and continuous monitoring activities.	1. Examined existing documentation over account reconciliations and identified areas where the current policy does not align with current practices or needs. 2. Drafted a policy and procedure to expand upon and reflect current practices, included the following: - *Technical expansions*, such as Balance Sheet account-specific and Income Statement account-specific reconciliation methodologies - *Instructional guidance* to facilitate effective execution, such as source input validations, formal signoffs, monitoring activities, etc.	**N/A**
Fixed Asset (FA) Management	The process of recording or tracking long-term assets over their entire lifecycle, from acquisition to disposal.	Walkthrough Fixed Asset Inventory process to expand our foundational understanding of inventory valuation, documentation, and applicable disposals/impairments determinations.	1. Performed a walkthrough with accounting staff to understand the procedures performed during the Fixed Asset Inventory, including assets examined, valuation methodology, and applicable disposals/impairments determinations. 2. Compared expected controls to identified controls to highlight control opportunities within the Fixed Asset Inventory process.	**PFC-01** **PFC-02** **PFC-03**

Appendix B: Points for Consideration

PFC	Issue Identified	Risk	Rating	Recommendation
01	**Fixed Asset Inventory and Tracking:** Our walkthrough of the fixed asset inventory process identified highly collaborative, however informal, communication between departments and accounting staff. Specifically, we did not identify a formal process in place over the fixed asset inventory to verify the existence of assets, their working condition, and recorded value.	Ineffectively governed or performed fixed asset inventory activities increases risk for over/ understatement of fixed assets and financial report inaccuracy.	**Moderate**	We recommend that MCHS establish and implement a formal policy and procedure to effectively analyze and monitor fixed assets and their respective value, including: <u>General Guidelines</u>: 1. Define specific fixed assets, or relative asset value thresholds, subject to inventory assessment and physical examination. 2. Establish roles and responsibilities between departments and accounting staff for required activities. 3. Require a periodic physical count of fixed assets, defined in Item 1, on hand and subsequent reconciliation against system records. 4. Establish guidelines and indicators to determine the remaining useful life of fixed asset classes based on the condition of the asset. 5. Require periodic review of BNA system to ensure applicable asset impairments are identified and monitored effectively. 6. Develop an Impairment Checklist to capture routine steps and facilitate formal documentation of the process. 7. Require ongoing communication between accounting and department staff to investigate and resolve identified variances. <u>Technical Instructions</u>**:** 1. Establish instructions to generate relevant system reports (i.e., active fixed asset listing, fully depreciated assets, etc.). 2. Develop procedures to validate the completeness and accuracy of all system generated reports. 3. Develop procedures to value and record impairments, if applicable, based on current fair value. *Note: The Expected Control Matrix at Appendix C may be leveraged in preparing the above materials.*

PFC	Issue Identified	Risk	Rating	Recommendation
02	**Asset Disposal:** Walkthrough procedures, including inquiry with key accounting personnel, did not identify a formal approval process in place to ensure effective and timely disposals. Our procedures identified: - Preparation of the *Fixed Asset Disposal Request (FADR) Form* is not enforced and may not be completed for all disposals. - Disposals may not be appropriately authorized as evidenced by FADR sign-off (observed within two (2) selected disposal instances). - Items valued under $2,000, which are not considered fixed assets, are often included in the FADRs.	Absence of formal guidance over the fixed asset disposal process increases risk of unapproved disposals, untimely system record maintenance, or over / understating asset balances.	**Low**	We recommend MCHS establish a system-wide policy and procedure to facilitate effective and consistent fixed asset disposals, including: <u>Policy</u>: - Mandatory preparation of the FADR form, including appropriate authorization by staff separate from the FADR preparer. - Define an asset value threshold (e.g., $2,000) requiring an FADR. - Require that all approved disposals be submitted to accounting staff prior to month-end. - Mandatory completion of training (including asset disposal processes) for responsible staff, at onboarding and annual intervals. <u>Procedures</u>: - Instructions for department leaders across the System to access and complete necessary fields within the Fixed Asset Disposal Request Form. - Accounting-specific instructions to update BNA records in accordance to approved disposals. *Management may also consider automating (via system workflow) any of the above components, where possible.*

PFC	Issue Identified	Risk	Rating	Recommendation
03	**Fixed Asset Management System Review:** Discussions over the fixed asset management process with key accounting personnel indicated that the appropriateness and accuracy of monthly fixed asset activity (i.e., additions and disposals) within the System's Fixed Asset Management module, BNA, is not formally reviewed. Our evaluations during the FY23 APE determined that the Fixed Asset Listing from BNA is utilized as source data to prepare the monthly fixed asset rollforward. Accuracy of system records is critical and must be validated as part of month-end procedures.	Inaccurate fixed asset system records may increase the risk of misclassifying or over / under stating fixed asset balances.	**Low**	We recommend that MCHS establish and implement formal procedures over the monthly fixed asset rollforward process, including: <u>General:</u> - Define personnel responsible for preparing and reviewing the fixed asset rollforward. - Define the established timeframe (monthly) in which fixed asset rollforwards should be performed. - Require utilization of exception reporting to identify anomalies or deviations. - Establish monitoring activities to ensure that all deviations are effectively tracked and remediated timely. <u>Data Validation:</u> For all major movable equipment, including **diagnostic and therapeutic machinery**, covered within the Trimedx service contract, consider leveraging the following information available for alignment with data captured in BNA: - Total additions/disposals during the period - Equipment nearing end of service or end or life and respective value For fixed assets not covered under the service contract, establish and implement formal procedures for the following: - Require a review over the fixed asset source reports generated from BNA to ensure that all monthly activity is appropriate and accurate. - Develop methodology to validate applicable changes for appropriateness and accuracy.

Risk Ratings

Residual risk is the risk derived from the environment after considering the mitigating effect of internal controls. The area under evaluation has been assessed from a residual risk level utilizing the following risk management classification system.

High

High risk findings have qualitative factors that include, but are not limited to:

- Significant potential for inaccuracy within financial reporting.
- Significantly inhibitive and/or inefficient process in the preparation of financial reports.
- Opportunities to significantly improve the effectiveness and efficiency of financial reporting processes, including opportunities for automation.
- Opportunities to significantly improve the oversight and monitoring of financial reporting processes.

Moderate

Moderate risk findings have qualitative factors that include, but are not limited to:

- Enhanced risk of non-compliance with Health and Human Services (HHS), or Centers for Medicare and Medicaid Services (CMS) requirements.
- Opportunities to define and communicate guidance and policies and procedures.
- Opportunities to improve oversight and monitoring of third-party risks that may have a material impact to MCHS.
- Opportunity to mitigate potential risks that may have an impact across more than one function.

Low

Low risk findings have qualitative factors that include, but are not limited to:

- Potential of events that do not directly threaten the organization's strategic priorities.
- Opportunities to enhance the formality, definition and communication of supporting guidance, policies and procedures.
- Opportunity to improve upon process efficiency, however is non-critical.
- Low potential of financial or operational impact to the organization.

Appendix C: Fixed Asset Inventory – Expected Control Matrix

Fixed Asset Inventory - Expected Control Matrix				
Risk	**EC Ref**	**Expected Control**	**IC Ref**	**Identified Control**
Capital Budget Meeting				
Capital budgets are not periodically reviewed and approved by appropriate personnel.	**EC-01**	A periodic review of fixed assets is performed, including the valuation and physical count of the inventory.	**FA-01**	Annually, MCHS management meets to review the list of active fixed assets based on acquisition price. All fixed assets are evaluated to determine if new additions are needed for the upcoming year. Budgets are approved prior to usage of funds.
Asset cost methodology is not appropriately or accurately valued.	**EC-02**	Regular audits or valuations are performed on fixed assets, including market fluctuations and depreciation.	**FA-02**	Consideration of Fixed asset valuation methodology is included within annual auditing provided by third party services (currently BKD). As of FY2024, the system utilizes net book value.
Approved budgets do not include necessary capacity for ad-hoc or unplanned purchases.	**EC-03**	A flexible budgeting approach is used to allow for adjustments based on changing circumstances and unforeseen expenses.	**FA-03**	Annually, the accounting team prepares a Capital Equipment Contingency Fund Schedule that includes all capital assets purchased during the fiscal year. The schedule identifies each assets' budgeted amount, purchase price, and resulting variance to be recorded in the contingency fund.
Asset listing utilized for capital budget planning is not validated for completeness and accuracy.	**EC-04**	Asset listing is reviewed for accuracy and completeness before being distributed for capital budget meeting,	**FA-04**	Prior to the capital budget meeting, the accounting team generates a listing of active fixed assets from the fixed asset management system (BNA) and provides the reports to respective department heads. Each department reviews the listing to ensure that all asset on hand agree to the system report. If discrepancies exist, the department head notes the changes and provides an updated listing to the accounting team.
A managerial review of fixed asset balances and trends is not performed for strategic purposes.	**EC-05**	Senior management meets annually to analyze fixed asset balances and related trends, including potential miscount of inventory or inaccurate year-end balances.	**FA-05**	Annually, the Board reviews and approves the capital listing to ensure that budget values appear reasonable and accurate, and the total budget aligns with organizational strategies.

Risk	EC Ref	Expected Control	IC Ref	Identified Control
Asset Disposal				
Documentation used in asset disposal transaction is inadequate, incorrect, incomplete, or not retained.	**EC-06**	Documentation is completed and maintained for tracking and detailing the disposal of all fixed assets.	**FA-06**	The Equipment Disposal Request Form is used by department personnel to document all assets that may be disposed or transferred to storage. Department personnel must include the date of request, department ID, asset tag numbers (if available), quantity, and disposition method. All forms must be signed by the Department Director/Manager/Supervisor prior to submission.
Asset disposals are not approved prior to disposal.	**EC-07**	The disposal request is reviewed and approved prior to action being taken to dispose of the item.	**CO-01**	***Control Opportunity***
Asset disposal activities are not effectively monitored.	**EC-08**	A periodic review of all fixed asset disposals is performed, including a review of all changes made in within the Asset Management System.	**FA-07**	Periodically, the accounting team will generate a list of active fixed assets from the fixed asset management system (BNA) and disseminate the listing to respective department heads. The department heads review the listing and reconcile the BNA records to items on hand. If discrepancies are identified, the department head notes the changes and provides an updated listing back to the accounting team.
Access to the fixed asset management system is not restricted to authorized personnel.	**EC-09**	Access to the fixed asset management system is restricted to appropriate personnel.	**FA-08**	Access to BNA is restricted to the Assistant CFO, Assistant Controller, and the two accountants responsible for asset-related accounting processes. An annual review of system access is performed by the Assistant Controller to ensure that system access and authorities are restricted to appropriate personnel.
Disposed assets are not appropriately or timely updated within the asset management system,	**EC-10**	The appropriate personnel is notified when fixed assets are disposed and need to be removed from the system.	**FA-09**	Asset Disposal Forms completed and submitted by department personnel are automatically routed to the accounting team for review. Updates are made within BNA once forms are received and reviewed.
The fixed asset listing is not periodically reviewed for changes, including disposals.	**EC-11**	An individual other than the preparer of the changes within the listing reviews and approves them in a timely manner.	**FA-06**	The Equipment Disposal Request Form is used by department personnel to document all assets that may be disposed or transferred to storage. Department personnel must include the date of request, department ID, asset tag numbers (if available), quantity, and disposition method. All forms must be signed by the Department Director/Manager/Supervisor prior to submission.
Assets that could have been reused or repurposed within the company are disposed of prematurely, leading to missed opportunities for cost savings.	**EC-12**	A thorough asset reuse evaluation process is in place that includes inspection of the asset, ensuring the product no longer holds enough value and cannot be repurposed.	**CO-02**	***Control Opportunity***
Assets are not properly valued during the disposal processes, resulting in financial losses for the company.	**EC-13**	Periodic valuation procedures are performed, and each asset's worth is assessed before approving the disposal, transfer, or auction of the item.	**CO-03**	***Control Opportunity***

Risk	EC Ref	Expected Control	IC Ref	Identified Control
Fixed Asset Inventory				
Fixed assets within the company are not properly labeled or tagged for effective identification, tracking, and management.	**EC-14**	All fixed assets are labeled or tagged, and accurate documentation exists to track and maintain them.	**FA-10**	All fixed assets must be tagged with a unique identification number to facilitate tracking and management of the asset.
Periodic physical inventory counts are not conducted to ensure that items on hand reflect items recorded in the system.	**EC-15**	A periodic physical inventory count is conducted and is reconciled with current records.	**CO-04**	***Control Opportunity***
Assets are not allocated to a specific department or allocated to the incorrect department	**EC-16**	A fixed asset clearing account is used when there is a delay in classification, and a form is consistently used to approve fixed asset transfers.	**FA-07**	Periodically, the accounting team will generate a list of active fixed assets from the fixed asset management system (BNA) and disseminate the listing to respective department heads. The department heads review the listing and reconcile the BNA records to items on hand. If discrepancies are identified, the department head notes the changes and provides an updated listing back to the accounting team.
			FA-11	When new additions to fixed assets occur, the item is entered into the system and must be designated to a cost center.
A periodic review of depreciating assets is not performed.	**EC-17**	Regular depreciation reports are ran and department heads are notified when asset is nearing or fully depreciated.	**CO-05**	***Control Opportunity***
Fixed asset documentation is not consistently maintained and accurate.	**EC-18**	Documentation is completed and maintained for the tracking and detailing history of all fixed assets.	**CO-06**	***Control Opportunity***
Fixed assets located in storage are not monitored or periodically reviewed for both inventory and condition.	**EC-19**	A regular inspection of fixed assets located in storage is performed to verify count, condition, and security	**CO-07**	***Control Opportunity***
An independent, secondary review is not performed on all changes to the fixed asset listing (transfers, additions, and disposals).	**EC-20**	A review is performed on all changes to the fixed asset listing (transfers, additions, and disposals). This review is performed by an individual different than the one making the changes.	**FA-12**	Monthly, the fixed asset rollforward is independently reviewed by the Assistant Controller to ensure that fixed asset account balances agree to BNA balances, assets are appropriately classified under the Fixed Asset or Construction in Progress accounts, and total depreciation is accurate.
Fixed asset book values are not periodically compared to current market prices.	**EC-21**	A periodic comparison of book values to current market prices to identify discrepancies or potential overvaluations.	**CO-08**	***Control Opportunity***

Risk	EC Ref	Expected Control	IC Ref	Identified Control
Fixed Asset Inventory				
Fixed assets are inappropriately classified based on current state and use.	**EC-22**	A periodic review of fixed assets is performed to ensure assets are appropriately classified within 'Construction in Progress' or 'Fixed Assets' accounts.	**FA-13**	Monthly, accounting staff prepares the fixed asset rollforward. All assets are analyzed to ensure that they are appropriately classified between the 'Fixed Asset' and 'Construction in Progress' accounts via discussions and validations with respective department heads. Any necessary transfers are executed as applicable.
A periodic evaluation is not performed to determine whether useful life extensions are feasible, valid and appropriate for fixed assets on hand.	**EC-23**	A periodic assessment is performed to determine if fixed assets on hand are subject to an extension of their useful life based on performance and condition.	**CO-09**	***Control Opportunity***
Useful life extensions on fixed assets are not reviewed for accuracy and appropriateness.	**EC-24**	Fixed assets with extended useful lives are reviewed for accuracy and appropriateness before final updates are made within BNA.	**CO-10**	***Control Opportunity***
Enhancements to fixed assets are not appropriate and are not accurately recorded to adjust the fixed asset balance.	**EC-25**	Recorded adjustments related to fixed assets enhancements (i.e., repairs, upgrades, or improvements) are reviewed for completeness, accuracy, and appropriateness)	**CO-11**	***Control Opportunity***

Appendix D: Account Reconciliation Policy

Overview and Purpose

The System is responsible for maintaining methodology for the reconciliation of all balance sheet accounts. Reconciliation activities are to be delegated to responsible accounting staff provided that a system for ongoing review and approval exists. Any material reconciling items or out of balance conditions must be adjusted and reported on a timely basis by the person responsible for the account.

Monthly reconciliation of general ledger balance sheet accounts represents a fundamental internal control practice. All balance sheet accounts must be formally reconciled monthly to substantiate and validate the completeness and accuracy of balances as reported in the financial records.

Frequency

Below is defined timeline for completing account reconciliation tasks:

Task	Timeline
Close Accounts	Within 7 business days of month-end
Reconciliation Preparation	Within 15 business days of month-end
Reconciliation Review & Approval	Within 26 business days of month-end
Resolve Discrepancies	Within 1 month of identification

Accounts to Reconcile

Each account's recorded balance must have a foundation based on the unique characteristics of that account. Regarding the reconciliation process, balance sheet accounts are considered based on the following categories: control accounts, clearing accounts, and posting accounts.

Control Account: Account supported by a subsidiary system or ledger to be reconciled against to ensure accuracy with the underlying supporting records for the balance. Control accounts may include the following:

- Accounts Receivable (substantiated by A/R sub-ledger)
- Accounts Payable (substantiated by A/P sub-ledger)
- Fixed Assets (substantiated by Fixed Asset sub-ledger)

Clearing Account: Account used for open item transactions that cannot be immediately resolved. This type of account allows for transactions that require temporary holding or reconciliation to be managed before they are properly categorized or recorded in the financial statement. Clearing accounts may include the following:

- Inventory Clearing Account (i.e., transactions related to movement of inventory between different departments before the inventory can be properly assigned to a specific inventory account)
- Tax Clearing Account (i.e., holding funds collected for taxes until they are remitted to the appropriate tax authorities)
- Accounts Payable Clearing Account (i.e., holding payments until they can be allocated to the appropriate vendor invoices

Posting Account: Account supported by third-party or internal documentation for reconciliation purposes. Posting Accounts may include the following:

- Cash (Supported by Bank Statement)
- Deferred Tax Balances (Supported by tax estimates and schedules)
- Accruals (Supported by estimation documentation or calculations)

All key accounts must be reconciled at the end of each accounting period. A key account is considered an account that holds significant financial importance or has a substantial impact on the overall financial statements of the organization. These are typically accounts with large (material) balances.

Key Accounts*:

- Cash and Cash Equivalents
- Accounts Receivable
- Inventory
- Fixed Assets
- Accounts Payable
- Payroll-Related Accounts
- Tax Accounts
- Intercompany Accounts
- Intangible Assets

*Key accounts listed may be the aggregate balance of several sub-ledger accounts and must be individually reconciled to ensure that final account balances are complete and accurate.

All sub-ledger accounts that may contribute to the aggregate balance presented on the month-end statements may be reconciled in a consolidated manner. The accounts eligible for consolidated reconciliation must have a balance below $1.5 million (i.e., Prepaid Insurance and Prepaid Other – Misc.). Proper documentation of the consolidated reconciliation must be maintained including a summary of accounts included and all supporting documentation.

Roles and Responsibilities

The accounting department is responsible for validating the completeness and accuracy of monthly balance sheet account activity and ending balances. Reconciliations should be completed to support the procedure performed. All accounting personnel who are responsible for reviewing completed reconciliations must be separate and at least one level senior to the individual who prepared them.

The following duties must be performed during the month-end balance sheet account reconciliations for each account:

Task	Preparer	Reviewer	Assistant Controller
Reconciliation Preparation			
Assign balance sheet accounts for month-end reconciliation preparation			X
Generate Premiere source reports	X		
Gather relevant supporting documentation/calculations/schedules	X		
Validate completeness and accuracy of Premiere source reports	X		
Agree GL account balances (beginning and ending) to Template inputs	X		
Agree monthly account activity to supporting documentation	X		
Ensure clerical accuracy of reconciliation	X		
Investigate and resolve identified variances	X		
Document completed preparation via Reconciliation Checklist sign-off	X		
Reconciliation Review			
Perform secondary review of reconciliation performed		X	
Verify source input validation procedures were appropriately performed		X	
Verify that account activity is sufficiently supported		X	
Verify that account activity is accurately recorded		X	
Verify that reconciliation is clerically accurate		X	
Ensure that all identified variances include an explanatory note or resolution		X	
Document completed review via Reconciliation Checklist sign-off		X	
Provide review comments as needed to reconciliation preparer		X	
Monitoring Procedures			
Ensure identified variances are resolved timely			X
Ensure reconciliations included dated signoffs by preparer/reviewer			X
Ensure all documentation is retained electronically or in physical form			X
Ensure timely completion and review of account reconciliations			X

Reconciliation Format and Documentation Standards

The following documents must be used for all reconciliations:

- Reconciliation Checklist
- Reconciliation Template
- Supporting systems reports, calculations, and other documentation
- Explanatory notes/details for identified variances
- Variance Tracking Sheet

A Reconciliation Checklist must be utilized to facilitate standard and consistent steps performed during the account reconciliation process. The designated preparer and reviewer must complete all steps listed and evidence as such through dated sign-off. Additionally, a summary sheet must be utilized and maintained to ensure that all key accounts were reconciled by the designated individual. Refer to ***Account Reconciliation Checklist*** for all detailed steps required.

All balance sheet reconciliations must be formally documented and retained for review and auditing purposes. The Reconciliation Template should be utilized to facilitate consistent and accurate documentation of account reconciliations.

- At a minimum, each account reconciliation documentation must include the following:
    - G/L Account Number (Premiere)
    - G/L Account Name
    - G/L Account Purpose
    - G/L Account Balance – Prior Month (i.e. beginning balance)
    - G/L Account Balance – Current Month (i.e. ending balance)
- All supporting documentation (i.e., invoices, calculations, schedules, reports, etc.) should be maintained and attached to substantiate monthly activity reported.
- Preparers and reviewers must include dated sign-offs for each account reconciliation on the day it is completed/reviewed.

A Variance Tracking Sheet must be used to monitor the progress of identified variances over $25 and ensure completion. Regular reviews of the tracking sheet will be conducted to identify any trends, address all discrepancies in a timely manner, and clarify the individual(s) responsible for resolving the issue.

Review and Approval

The approver must verify the following:

- Reconciliation agrees to the general ledger balance
- Reconciliation is reasonable, adequate, accurate, and complete
- Satisfactory corrective action of identified variances is established and executed, if applicable
- Reconciliation has been prepared timely, as specified in the "Frequency" section above

The approver must initial and date the reconciliation and forward it back to the preparer for filing or additional work as needed. A variance greater than $100 **or** 10% of the account balance defines the threshold requiring further investigation or adjustment. The approval is to be completed in accordance with the timeframes specified in the "Frequency" section above.

Monitoring Activities and Compliance

Variances above the designated threshold or unexplained differences require documentation of further investigation or corrective action. This includes the identification of current reconciling items and instances of imbalanced conditions. These must be identified with the following:

- Nature of Variance or Difference
- Date of Identification
- Amount
- Corrective Action Plan
- Employee Responsible for Resolving Issue
- Due Date for Completion
- Review/Approval of Resolution

All unresolved issues must be documented within the ***Variance Tracking Sheet*** to monitor progress, timeliness, and outline necessary actions.

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Account Reconciliation Checklist

Account Summary	
Account Number:	
Account Name:	
Period:	

Checklist Steps [Please include a checkmark next to each step once completed]	
Preparation	
	Download Premiere report
	Validate completeness and accuracy of Premiere balances
	Gather other supporting documentation/calculations/schedules
	Agree GL account balances to Premiere report
	Agree monthly activity to supporting documentation
	Include explanatory note for variances greater than $25
	Input unresolved variances within Variance Tracking Sheet
Review	
	Verify source input validation procedures were appropriately performed
	Verify that account activity is sufficiently supported
	Verify that account activity is accurately recorded
	Verify that reconciliation is clerically accurate
	Ensure that all variances greater than $25 include an explanatory note.
	Ensure that all unresolved variances are included in the Variance Tracking Sheet.
	Discuss applicable review comments with the responsible preparer.

Sign-Offs [Please include date of completion]	
Preparer:	
Reviewer:	

Account Reconciliations – Variance Tracking Template

Ref. No.	Date Variance Identified	Reconciliation Period	Responsible Preparer	Variance Amount ($)	Variance to Total Account Balance (%)	Explanatory/Investigative Comments	Action Plan	Resolution Date	Reviewer Sign-Off

MEDICAL CENTER HEALTH SYSTEM

Internal Audit Special Project Retail Pharmacy

October 2024

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Engagement Objectives & Procedures

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Engagement Objectives

- Understand and evaluate the transactional cycles for the Retail Pharmacy, from initiation to recording and reporting.

Engagement Procedures Performed

- Our procedures included conducting interviews with key process owners to gain an understanding of how systematic reporting is utilized by the Accounting and Pharmacy Department to calculate monthly revenue. We performed the following procedures:
  - ❑ Conducted in-person and virtual meetings with both the Pharmacy and Accounting Departments to gain an understanding of the transactional flow of prescription processing, pricing, inventory management, and accounting.
  - ❑ Interviewed the MCHS's Provider Pay liaison and gained an understanding of the system generated reporting used by Accounting to prepare monthly journal entries for Retail Pharmacy activity.
  - ❑ Recalculated revenue for both the Pharmacy and Accounting Department for August 2024 to identify the causes of ongoing variances in reported revenue.
  - ❑ Analyzed revenues for the fiscal year 2024 and determined the cause of significant outliers (*see graph on slide #4*), which resulted in fluctuations of revenue and provider pay.
  - ❑ Quantified the value discrepancies for commercial RX, Script Care and Medimpact for the month of August 2024 when comparing different methodologies used by Accounting and Pharmacy.
  - ❑ Gained an understanding of Accounts Payable and Inventory for the Retail Pharmacy; the Accounting Department relies upon the standard transaction flow and does not book journal entries for pharmacy payables or inventory.

Background

Provider Pay is the Retail Pharmacy's third-party service provider which performs intermediary functions to support the Retail Pharmacy's including:

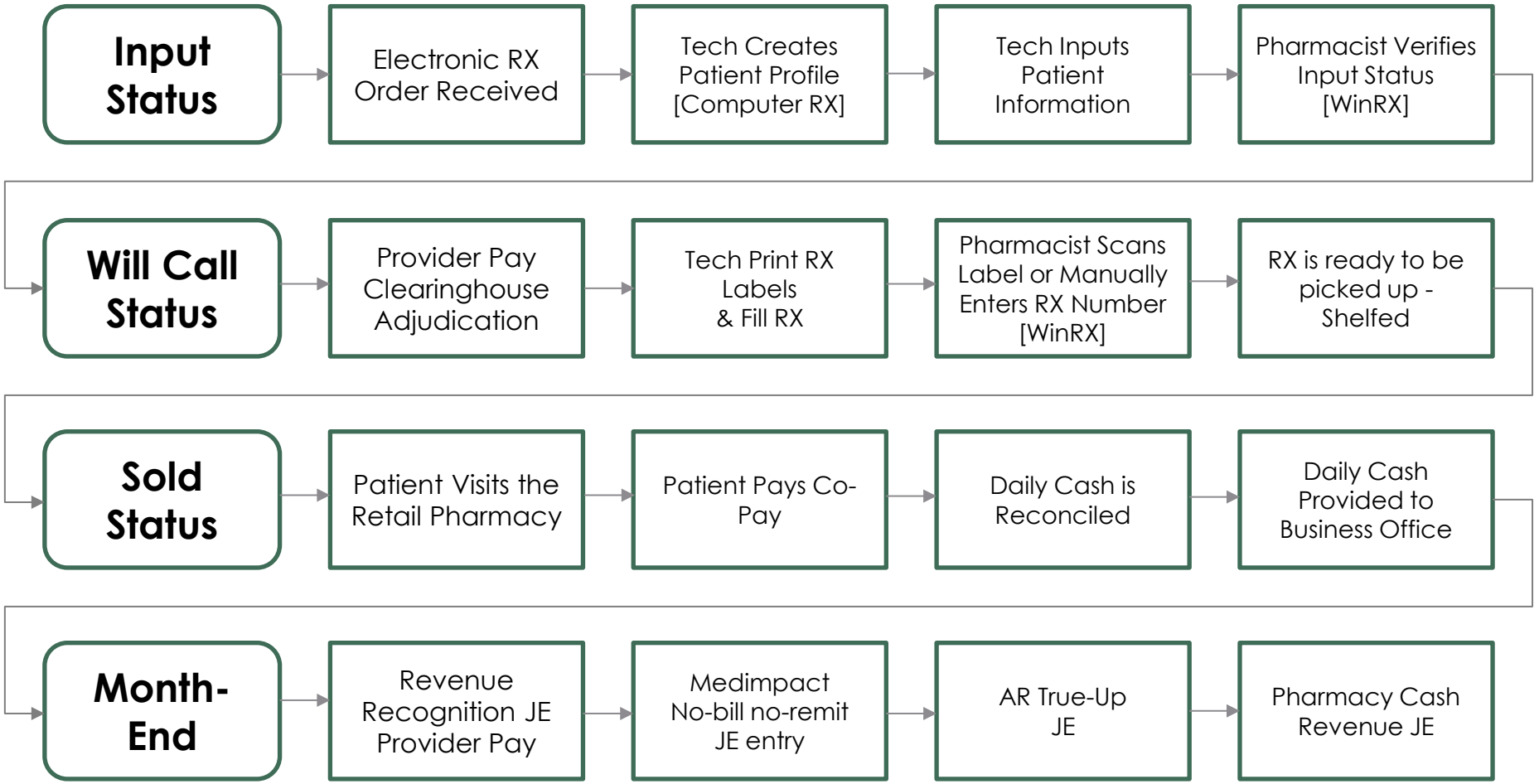
- claims processing
- payment processing
- reimbursement management
- revenue cycle management
- claims adjudication reconciliation
- communication and customer service

Inventory par levels are maintained for most frequent drugs, provided by McKesson (~95%). Inventory counts are performed periodically. Accounting expenses all inventory pharmacy costs as they are incurred and does not track pharmacy inventory perpetually.

RX transactions' flow through three (3) district phases – **Input, Will-Call, and Sold**

Note: We did not perform detailed testing over individual revenue transactions or the physical inventory counts.

RX Transaction Flowchart



Summary of Results

The results of our procedures identified **two key issues** which are contributing to variances between the Accounting and Pharmacy monthly revenues.

1. **Data Sources:** The Accounting and Pharmacy Department use different source data and methods to calculate revenue, which result in variances which are caused by multiple factors. A monthly reconciliation is not performed to identify discrepancies between the Pharmacy system (WinRX), Provider Pay, and Cerner (cash/co-pay), to identify and determine the root cause of discrepancies.

   We reviewed reported revenue figures produced by the Accounting and Pharmacy Departments for the month of August 2024 and identified a variance of $27,816, or 4%, in total. The following factors contribute to these variances on an ongoing basis:

   - WinRX and Provider Pay, for commercial insurance totaled $7,596.79.
   - Medimpact variances from methodology differences totaled $10,387.
   - Script Care variances totaled $1,531.
   - Cash / Copays variances totaled $1,684.
   - Timing and coupon transactions between the two systems also have known issues which likely resulted in the remaining, $6,617.

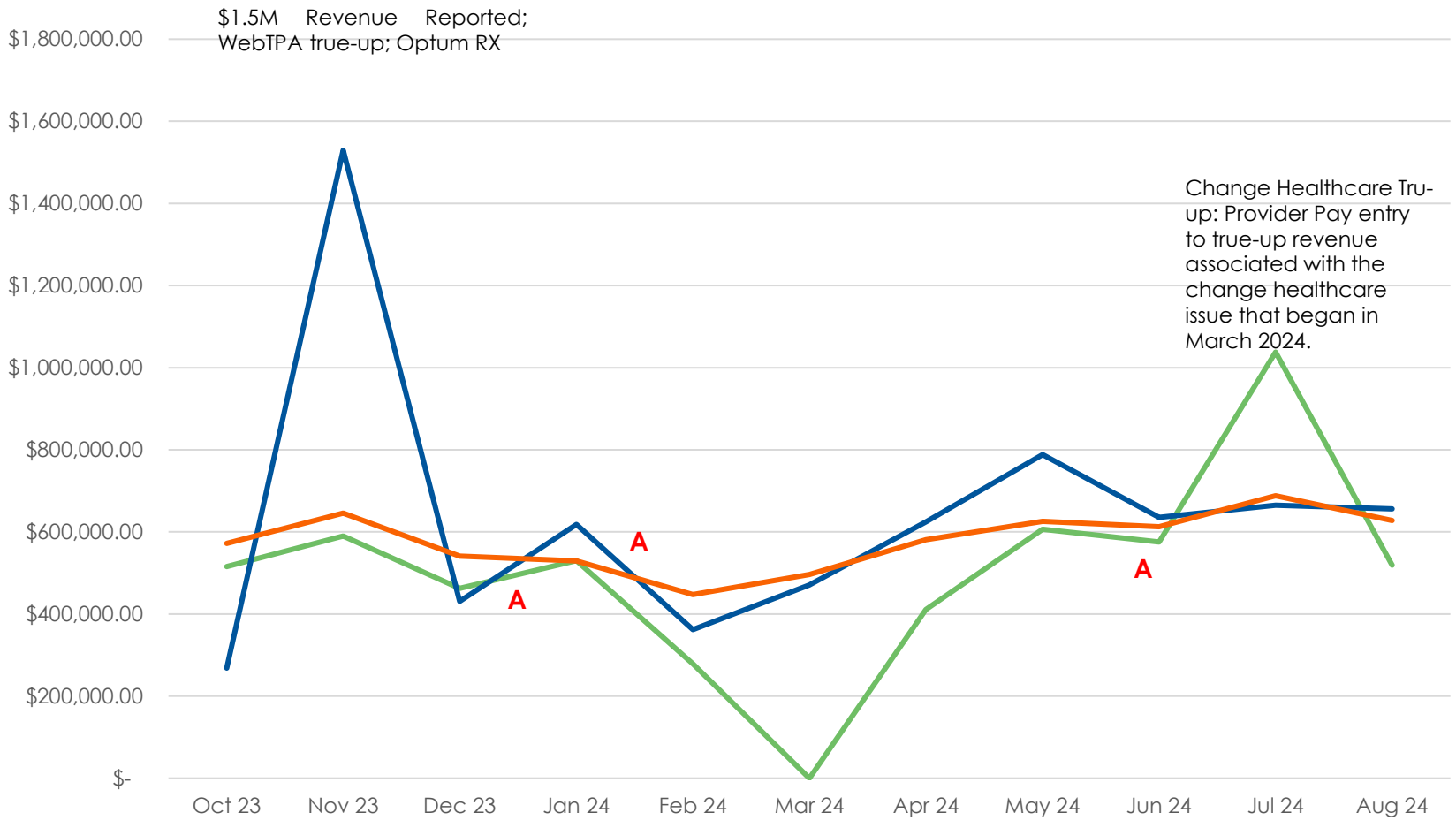
Data Sources – PFC 1			
Transaction	**Accounting**	**Pharmacy**	**PFC**
RX / Claim	Provider Pay	WinRX	*
MedImpact	Weekly	Monthly	*
Script Care	Provider Pay	SCL Statement	*
Cash/Co-pay	Cerner	WinScan POS	*
Accounts Receivable	Provider Pay	N/A	-

2. Third-Parties: We reviewed annual reported revenue from the Accounting and Pharmacy Department from October 2023 – August 2024 and identified two (2) events caused by third-parties which resulted in three (3) significant impacts to pharmacy revenue reporting, and ultimately contributed to variances between the reported revenue of the Accounting and Pharmacy Departments. These issues included the following:

- **November 2023**: WebTPA caught up on delinquent payments, which were booked as a lump-sum during the month, resulting in a spike in the Accounting Department's Revenue.
- **March & July 2024**: The Change Healthcare hack resulted in delinquent provider pay data; no data was received for March, and this was ultimately trued-up in July.

See the corresponding chart on the next slide for details

Retail Pharmacy Revenue



A Expected activity; Pharmacy, Accounting, and Provider Pay are trending similarly without large peaks.

Change Healthcare issue, MCHS was not receiving provider pay data. JE/Rev was calculated based on the % of co-pay to estimate revenue.

Fiscal Year 2024 Revenue Totals

We obtained source data for the fiscal year 2024 retail pharmacy revenue, including the following:

- Third-Party and Commercial
- Cash and Copays
- MedImpact
- Script Care
- Optum

These aggregate totals result in a total of **$7,024,412** for the year ended September 31, 2024.

In Nov. 2023, a catch-up entry was recorded to recognize revenue from prior year that was missed. This was identified and recorded by management and is additional to the WinRx processed revenues for the year ended 9/30/2024.

We recommend Accounting create journal entries in September to true up revenues and AR to the full activity for the year, as reported from the source information.

This will include recognizing bad debt for uncollectible AR.

WinRX	$	3,586,564.95
Medimpact	$	1,848,185.24
Scripcare	$	45,541.45
Optum	$	893,353.52
Winscan Cash	$	650,767.13
	$	7,024,412.29
+ November WebTPA	$	781,912.67
Net Revenue	**$**	**7,806,324.96**

Accounts Receivable:

Total AR	$838,913
Medimpact, Scriptcare, Optum	$(337,828)
Reserve Balances over 120 Days	$(173,269)
Year End AR Balance	**$327,814**

Year-End Retail Pharmacy Inventory:

Total Inventory	$798,373
MCSOP [McKesson / 340B]	$(347,190)
Year End Inventory	**$451,183**

Recommended Next Steps

Go-forward Recommendations:

- We recommend that the Accounting Department, Retail Pharmacy Department, and Provider Pay meet on a monthly basis and reconcile Cerner (cash), WinSCAN POS, WinRX, and Provider Pay. The Accounting Department should establish a threshold tolerance, i.e. 5-10%. Deviations beyond this tolerance should be investigated and resolved within 5-10 business days.

- We also suggest that in FY 25, management consider just recording the net revenue, rather than using the adjustment account as the adjudicated amount is known immediately upon completion of the transaction within WinRx.

- Additionally, the following steps should be taken to ensure revenue is booked completely and accurately:
  - Identify the root cause of the contractual issue with **Script care** and determine the best course of action to correct the issue within WinRX. This will remediate the issue associate with a discrepancy between Provider Pay's adjudicated amount and the billed amount within WinRX.
  - Review the adjustments that the Pharmacy Department is performing on **Medimpact** revenue to reduce revenue to the acquisition cost to determine the materiality, and if adjustments are necessary while booking monthly revenue journal entries.
  - Utilize WinRX as the source data when booking monthly entries to revenue within the Accounting Department to reduce **timing issues** and reconcile against Provider Pay on a monthly basis.
  - Analyze the known issues associated with RX **coupons** to determine the root cause of the issue and determine overall materiality.
  - Each month, AR balances from ProviderPay should be analyzed and a reserve should be incorporated for AR that is aged and not considered collectible.

Discussion

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Memorandum

To: Grant Trollope, Assistant CFO Medical Center Health System (MCHS)
From: Weaver – Governance, Risk, and Controls (GRC)
Date: September 2024
Subject: Third-Party Vendor Management Advisory Consultation

This memo presents the summary procedures and results of the Third-Party Vendor Management Process Review.

Background

MCHS leverages third-party vendors to optimize patient care, operational efficiency, and cost effectiveness. Third parties may be used to supplement internal resources and capabilities (i.e., billing, medical supplies, technology, prescriptions, etc.). It is critical to ensure that all vendors and respective agreements are effectively managed through the performance of the following sub-processes:

- Vendor selection, acceptance, setup, and maintenance
- Contract development, revisions, renewal, and maintenance
- Contractual key terms identification
- Vendor benefit maximization
- Third-party risk and compliance
- Vendor performance monitoring
- Third-party communication and reporting

Purpose and Objectives

The purpose of this advisory engagement was to assist the System in evaluating and documenting the Third-Party Vendor Management processes and activities (as currently performed), including the identification of existing controls and any gaps which may provide opportunities to improve efficiency and consistency. The objectives for this engagement included:

A. Identifying a representative sample of third-party vendor relationships significant to the System.
B. Develop an understanding of the sampled vendor relationships, including nature of significance and associated risks.
C. Developing an understanding of the System's overall third-party vendor acceptance and management processes, specifically identifying and evaluating internal controls that exist within the process today.
D. Documenting the flow of vendor acceptance and management procedures in flowcharts or manuals to articulate the overall third-party vendor management process and existing control activities.
E. Developing sample-specific vendor dashboards to document key relationship attributes, mitigating activities, and risk prioritization mapping.
F. Developing recommendations for existing third-party vendor acceptance and management processes to enhance timeliness, completeness, and accuracy of daily processes.

Procedures Performed

To achieve the objectives listed above, we identified key personnel over the System-wide vendor management process and performed the following:

- Conducted interviews to understand the overall vendor acceptance and management processes and System-wide procedures performed.
- Examined process documentation (i.e., policies, procedures, flowcharts, etc.) and observed system demonstrations to validate the procedures identified.
- Developed flowcharts to illustrate the sub-activities performed within the vendor acceptance and management processes (*refer Appendix C*).
- Developed recommendations for consideration and areas of improvement.

Additionally, we selected five (5) vendors to assess contract acceptance and management activities. Sampling procedures included:

- Analysis of highest total payments made from March 2023 through February 2024.
- The nature of the contractual relationship (i.e., staffing, goods distribution, etc.).
- Discussions with the Assistant CFO.

The following vendors were selected to facilitate our evaluation:

Sample	Vendor Name	Total Payment
1	McKesson Drug Company	$16,443,722.29
2	Cerner Corp	$11,634,644.73
3	Cardinal Non-Stock Products	$9,793,407.60
4	Davin Healthcare Workforce Solutions, Inc.	$8,854,165.84
5	Trimedx, Inc.	$4,788,190.60

We identified contract owners for the above selections and performed the following:

- Interviews to understand the nature of each contractual relationship and key contract terms.
- Determined relevant risks associated with each third-party relationship.
- Identified existing contract acceptance and management activities performed for each vendor contract.
- Obtained and examined documentation to validate the procedures identified.
- Developed vendor-specific dashboards displaying key attributes and relevant risk prioritization.

Results of the procedures listed above are captured in the following appendices:

Appendix A – Points for Consideration (PFC)
Appendix B – Vendor Dashboards
Appendix C – Vendor Management Process Flowcharts

Results of Procedures Performed

Vendor-Specific Procedures

Through interviews with key contract owners, we assessed the inherent risk for each contractual relationship and documented the control activities addressing these risks. Given the nature of the vendors assessed, Operational Risk was inherently the most critical, highest rated risk, followed by Safety and Financial. The table below depicts the inherent risk rating for each assessed risk.

Risk Category	Vendor				
	Davin	McKesson	Cardinal	Cerner	Trimedx
Operational	High	High	High	High	High
Safety	Moderate	High	High	Moderate	High
Financial	High	Moderate	Moderate	Moderate	Moderate
Compliance	Low	Moderate	Moderate	Moderate	Moderate
Information Security	Low	Low	Moderate	High	Moderate
Reputational	Moderate	Low	Low	Low	Low
Oversight	Moderate	Moderate	Low	Low	Low

While the Inherent risk associated with managing these vendors and they goods / services they provide to MCHS may vary, the overall response to these inherent risks by management is intentional and appropriate. **Our procedures confirmed that effective monitoring exists for the selected vendors to mitigate prevalent risks.**

Below is a summary of the top risk and its mitigating control for each of the five selected vendors:

Vendor Name	Highest Priority Risk	Control Activity
McKesson Drug Company	**Operational**: Disruption in operations and patient care schedules due to delay or error in timely delivery and inadequate pharmaceutical stock levels.	Quarterly meetings are facilitated between the Director of Pharmacy and McKesson to review the Partnership Alignment Report, which includes contractual agreements and purchasing metrics (i.e., spend to date, purchase by drug class, stockouts and proposed alternatives, etc.).
Cerner Corp	**Information Security:** Cyberattacks, system downtime, data corruption, or unauthorized access to patient data that significantly impact the System's daily operations and business continuity.	The CIO holds monthly meetings with Cerner representatives to discuss and review operational performance and Service Level Agreements/Objectives (SLA/SLO).
Cardinal Non-Stock Products	**Operational:** Delayed deliveries, stockouts, or incorrect orders leading to delay in staff operations and execution of scheduled procedures.	Weekly meetings are facilitated between the Director of Materials Management and Cardinal Account Managers to discuss potential product delays, alternatives to identified stockouts, overall supply chain health, etc.
Davin Healthcare Workforce Solutions	**Operational:** The integration of temporary staff to the hospital may be challenging and maintaining staffing needs may lead to operational risks.	MCHS engages with four additional staffing agencies, ensuring their staffing needs are consistently met across the different departments and increasing their pool of qualified individuals.
Trimedx, Inc.	**Operational:** Prolonged hospital equipment downtime and delay in patient service execution due to ineffective routine maintenance, inefficient service repairs, and inability to source and procure parts.	The COO reviews the Quarterly Orderly Value Report, which includes performance metrics including total value of replacements, total additions, and disposals, remaining useful life or service life, etc.

Refer to *Appendix B – Vendor Dashboards* for the full dashboards illustrating relevant risk prioritization and management activities for the five selected vendor relationships.

Centralized Vendor Selection Process

Additionally, our procedures identified the following strengths gained through the System's centralized purchasing process via Materials Management:

- ✓ Purchasing is system facilitated and work flowed via Premier's purchasing module.
- ✓ Vendor selection is limited to pre-approved and vetted parties, onboarded by AP and Legal.
- ✓ Primary vendors are determined by Materials Management based on competitive purchasing and value maximization (e.g., volume-based purchasing).
- ✓ Secondary vendors are selected by Procurement in instances where primary vendors are unable to fulfill the requisition.
- ✓ Purchase requisitioners are system-restricted from vendor selection or discretionary purchasing outside of the system facilitated order guides developed by Materials Management.

Contract Management System Capabilities

We interviewed key contract management personnel to assess the vendor setup process and identified two Premier applications used:

AP Module	**Contract Management Module**
• Restricted to Accounting team • Houses Vendor Master File • Generates vendor numbers • Stores payment history	• Restricted to Contract Management team • Contract owners have view-only privilege • Houses vendor contracts/documentation • Workflows contract execution process

Through interviews and system observations, we identified the following limitations inhibiting effective and efficient contract management activities:

1. AP setup must precede contract account setup, creating potential delays.
2. Vendor payment history is unavailable in the contract management module.
3. Contract renewals/amendments require separate, manually linked accounts to the initial contract account.
4. Required manual entry of new contracts raises clerical error risks.
5. Contract renewal notifications to owners do not contain hyperlinks for easy contract access.
6. Expired contracts require manual deactivation to minimize notifications for inactive contracts.

MCHS should collaborate with Premier to investigate opportunities for automation to minimize the manual efforts required and facilitate more insightful metrics for contract owners. Refer to *Appendix A (PFC #1)* for further detail related to the identified opportunity for improvement and Appendix D – Vendor Setup Checklist to guide vendor setup and verification procedures.

Vendor Performance Monitoring and Contract Ownership

We determined that the System is currently without formal processes to evaluate the volume and appropriateness of contract assignments, which inhibit contract owners in conducting effective and routine contract monitoring activities.

Of the 900 existing contracts documented within Premier, we determined that certain MCHS personnel are assigned over 30 active contracts at a time. Our observations are highlighted below:

Primary Responsible Party	Total Contract Assignments
President, ProCare	192*
Chief Information Officer	86
Chief Financial Officer	55
Chief Operations Officer	50
Division Director, Laboratory Services	43
Executive Director, Human Resources	34
Director of Pharmacy	32

*A large volume of the contracts identified include employment contracts.

Additionally, the existing Vendor Performance Tool does not contain the following:

- Open-ended responses, to support detailed feedback from contract owners.
- Guidelines for specific KPIs.
- Review performed by the contract management team over the results of each assessment.

Implementing vendor tiering is considered best practice for discerning the criticality of vendor relationships. This stratification indicates the significance of each vendor and enables the creation of tailored vendor evaluation procedures that align with the level of impact of each vendor. Refer to *Appendix A - PFC #2* for further detail related to the identified opportunity for improvement.

Conclusion

Our evaluation of the third-party vendor management process identified five (5) points for consideration (PFCs) summarized as follows:

Ref	Risk Rating	Summary
PFC #01	Low	Contract Management System Capabilities: - Six system limitations identified, hindering effective and efficient contract monitoring procedures. - Collaboration with Premier consultants to investigate and assess system functionality.
PFC #02	Low	Vendor Performance Evaluations and Contract Ownership: - Establishment and implementation of vendor tiering with tier-based performance evaluation criteria. - Implementation of formal process to assess contract owner assignments by appropriateness and volume.
PFC #03	Moderate	Contract Management Governing Materials: - Enhancement to Contract Administration and Process Policy to guide the identification of vendors requiring Business Association Agreements (BAA) and third-party review of contract terms/rates.
PFC #04	Low	Vendor Conflicts of Interest: – Incorporating a formal conflict of interest evaluation as standard with all new vendor setups, to promote objectivity, transparency, and competitive procurement.

Appendix A: Points for Consideration (PFC)

The Points for Consideration (PFC) have been identified through the performance of this advisory consultation including inquiry with MCHS stakeholders involved in respective processes. This list is presented for management's review and consideration to promote mitigation of risk identified within associated processes.

PFC	Observation	Risk	Rating	Recommendation
#01	**Contract Management System Capabilities** We identified several functional inefficiencies within Premier that inhibit efficient and effective contract monitoring procedures, including the following: 1. The contract management application does not have the capability of tracking key contractual terms that require performance monitoring, and performance monitoring mechanisms are not built into the system. 2. Premier requires manual entry of new contracts and renewals, increasing the likelihood of data entry errors and inconsistencies. 3. Contract owners cannot view payment history for their respective vendor within the contract management system, as it is not integrated with the AP system. 4. Vendor numbers must be established within the AP system prior to initiation of new contract setup within the contract management system. 5. Premier provides a workflow for vendor contract execution, however only one workflow can be enabled under each account. New accounts must be created for every amendment or renewal, and separate accounts must be manually link as one vendor. 6. Contracts owners are notified via email of impending expirations 120 days in advance. However, the email does not contain a link to the system to facilitate easy access to the contract requiring review. 7. Expired contract must be manually deactivated by the Contract Manager to ensure that contract owners only receive system notifications for active contracts.	Ineffective monitoring procedures may lead to untimely renewals and over/underpayments to vendors in accordance with executed agreements.	Low	We recommend that MCHS collaborate with Premier to determine if system capabilities can be modified to facilitate efficient and effective vendor contract monitoring procedures, including: • Automation of new contract setup to minimize the need for manual entry. • Enable multiple contract approval workflows within one vendor contract account so initial, renewed and amended contracts can be housed within one account. • Automation to deactivate expired contracts to ensure that contract owners are only monitoring active contracts. • Integration of the AP system and contract management system to facilitate automated data transfer for critical information such as vendor numbers, payment history, billing information and changes, etc. • Investigate ability to include a hyperlink to specific contracts when owners receive notifications of impending expirations that require review. Once system changes are implemented, we recommend that all key contract management personnel be trained to ensure consistent understanding of the updated features. Additionally, contract management personnel should establish and implement a procedural guide to provide to any new contract owners.

PFC	Observation	Risk	Rating	Recommendation
#02	**Third-Party Vendor Management Best Practices** We determined that the System's ability to delegate, structure, and assign third-party vendor management performance monitoring could be enhanced to align with industry best practices. Specifically, we identified the following issues: 1. Vendor Tiering: Vendors are not categorized into defined tiers based on total spend, volume of transactions, or criticality to the System, which inhibits a standardized approach in evaluations. Additionally, there is not criteria defined to evaluate vendors based on tier, including assessment frequency. As a result, we identified a large amount of contracts allocated to contract owners and we were unable to determine the criticality of third-party vendor management activities under their purview. 2. Performance Assessments: The current Vendor Performance Tool is broad in nature with limited opportunity for contract owners to provide detailed feedback. Only direct patient service contracts require KPI metrics, however there is no consistent understanding of the measurements to be included. Due to the nature of the Performance Tool, the Contract Manager can only monitor assessment for completeness rather than the underlying results. 3. Contract Assignments: There is not a formal procedure to assign contracts to appropriate MCHS personnel. Our analysis determined that several c-suite level employees were assigned 30 – 50 active contracts at a time, which are informally delegated to designees. However, assigned personnel must complete all actions within the contract management system, creating potential bottlenecks within various contract management activities.	Ineffective vendor performance monitoring activities may lead to untimely detection and resolution of unsatisfactory performance and operational disruptions.	Low	We recommend that MCHS establish and implement formal guidance to ensure effective and consistent vendor performance evaluations and monitoring. The following should be included: Vendor Tiering and Performance Assessment: • Define vendor tiers based on critical contract components such as total annual spend, complexity of contractual terms and relationship, overall risk exposure, reliance on goods/services provided, etc. • Establish performance assessment procedures that correspond with each defined vendor tier, including the assessment frequency, KPIs, compliance check requirements, etc. • Enhance the current Performance Tool to incorporate the tier-based assessment procedures. • Require a review over Performance Tool results and facilitate a discussion between the Contract Manager and contract owner for any assessments displaying unsatisfactory results. • Establish and implement a procedure to track and document action plans for vendors with unsatisfactory performance. Once vendor tiering has been established, we recommend the System revisit contract ownership delegation to ensure that contract owners are not overloaded with tier-1, or tier-2 contracts and have a sustainable workload that allows them to effectively monitor vendor performance. Contract Ownership: • Reallocate contract ownership to individuals who contain the necessary experience and authority to manage vendor contracts. • Collaborate with current contract owners to determine individuals within the System who have been informally assigned contract ownership responsibilities. • Update the Contract Administration and Process policy to require that MCHS personnel only own a defined quantity of active contracts at a time. • Require and facilitate periodic training for all new and existing contract owners to ensure common understanding of vendor monitoring procedures.

PFC	Observation	Risk	Rating	Recommendation
#03	**Contract Management Governance** Contract development processes can be enhanced to mitigate risks associated with executing agreements or activating vendors prematurely. Procedures are not in place to ensure governing documents, such as Business Association Agreements (BAA) and required third-party evaluations (performed by: EMTS and MD Buyline), are obtained prior to executing agreements with vendors. • We did not identify formal procedures used by the System to determine whether BAA's are required for vendors as part of the vendor acceptance process and BAA's for the vendors reviewed were not maintained in the contract management system. • The Contract Administration and Process policy requires all new, renewed and amended contracts be reviewed by a third-party to ensure that applicable rates are competitive and reasonable. However, documentation to evidence this process took place was unavailable.	Failure to enforce critical steps within the contract development process may lead to excessive liability and expenses for the System.	Moderate	We recommend that MCHS enhance the current vendor management policy to capture critical procedures within the vendor management process. The following should be included: • Require contract owners and legal team to evaluate BAA needs prior to the execution of all new and renewed contracts. • Establish criteria to determine and evaluate the need for vendors to execute a BAA, such as the nature of the services provided and degree in which a vendor has access to PHI (both direct and indirect). • Define a timeline in which contract owners should initiate rates validation with the third-party reviewer prior to contract execution. • Establish and implement detailed steps to guide contract owners over the necessary procedures to vet prices and costs with MD Buyline or EMTS, such as methods to submit rates, information to be submitted, etc. • Require annual training over the updated policy for contract owners to ensure consistent understanding of required steps within the process. • Establish a process to include notifications to contract owners for the renewal of BAA's and other supplemental contract agreements.
#04	**Vendor Conflicts of Interest** The System's new vendor request process does require conflicts of interest declarations from requisitioning departments or other involved parties.	Vendors may be selected inappropriately, and competitive procurement be inhibited.	Low	We recommend that MCHS management expand the new vendor request/onboarding process to require conflict of interest (COI) declarations from all involved stakeholders. COI declarations should be independently reviewed to ensure objectivity in vendor selection.

Appendix B: Vendor Dashboards

Medical Center Health System
Third-Party Vendor Management Dashboard
Cardinal Health
July 2024

Cardinal Health - Medical Product Distributor (Non-Stock)

Introduction

The purpose of this dashboard is to summarize the key attributes of the contractual association and to document the methods by which MCHS oversees the vendor services provided by Cardinal Health. Additionally, the risk prioritization section of this dashboard lists the relevant third-party risks, each ranked from highest to lowest. These third-party risks include the following:

- **Compliance Risk:** The risk that the vendor does not comply with relevant contractual requirements and expectations, including safety, clinical, and operational execution.
- **Information Security Risk**: The risk that the vendor has access to MCHS' systems, PHI data, or sensitive information that are not appropriately secured.
- **Oversight Risk:** The risk that the vendor's activities are not closely managed and in-line with management expectations and needs.
- **Financial Risk**: The risk of the vendor becoming financially insolvent or unable to perform or deliver according to services outlined in the contracts in place.
- **Reputational Risk:** The risk that working with a specific third-party may reflect poorly on the System, either by association or as a result of an incident.
- **Safety Risk:** The risk of safety incidents to personnel and patients when utilizing the vendor services.
- **Operational Risk:** Includes the risk of losses or disruptions related to the activities, processes, or performance of engaging with a third-party vendor.

Key Attributes

- Primary distributor of medical and surgical products and services to MCHS facilities.
- Source, package, and ship products included within the System's Core Product List.
- Adhere to agreed delivery schedules (four times a week).
- Ensure the timely delivery of medical and surgical supplies ordered by MCHS.
- Source and recommend alternative brands during product stock-outs or backorders.
- Maintain accurate product pricing within distributor system and facilitate accurate pricing reconciliations with MCHS.
- Collaborate with MCHS to resolve pricing discrepancies, discontinued products, and upcoming price changes.
- Provision of various reports to assess vendor performance, improvement opportunities, etc.

Year Relationship with MCHS Formed	Parent Company	Headquarters
2018	Cardinal Health	Dublin, OH

Relationship with MCHS

Nature of Relationship with MCHS	Medical and surgical supplies distributor
Vendor payments per current contract (Mar 2023-Feb 2024)	$9.8 MM
Key MCHS Contacts	Cheryl McQueen, Director of Materials Management
MCHS Offices	Medical Center Health Care System
Additional agreements	Medical-Surgical Distribution Agreement Amendment to Addendum

Contracts executed with MCHS

MCHS has a Letter of Commitment (LOC) with Cardinal Health as part of their involvement and partial ownership of TPC,LLC.

Agreement(s)	Executed by	Execution Date	Renewal Term
Letter of Commitment - Enhancement Addendum	Michael B. Moon, SVP, Sourcing	December 12, 2019	Nov 2023 - Nov 2024

Third-Party Management

How is performance of the third-party monitored and managed?

- **Weekly Supply Chain Calls:** Weekly, the MCHS Director of Materials Management and various senior leaders meet with the Cardinal account managers for each supply specialty (i.e., medical, surgical, laboratory, etc.). These meetings address issues related to the supply chain, shipping docks, product delays, and possible product alternatives. Additionally, Cardinal presents MCHS with outside vendor pricing discount opportunities that may be leveraged during specific time periods.

- Weekly Billing/Pricing Calls: Weekly, the Director of Materials Management facilitates a meeting with the designated Cardinal pricing advocates and the MCHS contracts coordination team to review and reconcile invoices at a line-item level and discuss pricing discrepancies identified in Cardinal's ordering system. Necessary changes are executed in real-time, or unresolved items are added and monitored within a running report for future investigation.

- Quarterly Business Reviews: Quarterly, MCHS leadership and the designated Cardinal account representatives for each supply specialty discuss the Business Review slides and identify various strategic priorities. These discussions cover business relationship touchpoints, departmental updates, service levels, distribution spending, and savings opportunities.

- Closed Receipt File Review: Cardinal provides the Texas Purchasing Coalition (TPC) with a file of closed receipts, which TPC then extracts and analyzes. TPC monitors the spending data to ensure that MCHS pays fair prices and remains in contractual compliance.

- **Performance Tool Report**: The Director of Materials management completes a Performance Tool report annually through the System's contract management system, Premiere, to evaluate vendor performance and identify any areas of dissatisfaction in accordance with DNV (Det Norske Veritas) requirements regarding contract reviews. Additionally, the Contract Manager ensures that performance evaluation forms are completed and reports on compliance with contract review monthly during the directors' meeting.

Risk Prioritization

Priority	Risk Category	Significant Risks
1	**Operational Risk**	Supply chain disruptions may inhibit clinical workflows, patient treatment schedules, and emergency responses. Significant operational risks include the following: ➢ Critical medical and surgical supplies are not received within the expected or agreed-upon timeframe. ➢ Supplies received are expired, damaged, or improperly handled/shipped. ➢ Shipments are incomplete or inaccurately reflect orders placed.
2	**Safety Risk**	Patient and staff safety may be compromised due to inadequate quality, availability, and handling of medical and surgical supplies by Cardinal. Significant safety risks include the following: ➢ Shortages or delays in essential supplies may delay patient care, potentially compromising patient health outcomes. ➢ The delivery of defective or contaminated supplies may be subsequently used by staff to treat patients. ➢ Medical supplies that are supposed to be sterile are contaminated and pose infection risks. ➢ Supplies may be mislabeled, resulting in the use of inappropriate instruments for treatment and surgeries.

Risk Prioritization		
Priority	**Risk Category**	**Significant Risks**
3	**Financial Risk**	Unexpected or uncommunicated price increases or decreases in the group purchasing benefits as part of the Cardinal agreement may lead to higher expenses and budgetary challenges. Significant financial risks include the following: ➢ Items recorded on invoices are incorrect or do not reflect good requested and/or received. ➢ Shortages of essential supplies may necessitate emergency purchases at higher costs. ➢ Failure to meet contractual purchase requirements may result in additional markup costs.
4	**Compliance Risk**	Cardinal may violate regulatory standards and risk the System's compliance by sourcing and distributing supplies without quality control. Significant compliance risks include the following: ➢ Lack of quality assurance processes may result in product recalls. ➢ Delivery of supplies that have not been validated for medical and clinical use by regulatory bodies such as the FDA.
5	**Information Security Risk**	Intercepting communications or transactions between MCHS and Cardinal can lead to data breaches or tampering, compromising the confidentiality and integrity of sensitive information. Significant informational security risks include the following: ➢ EFT or ACH payment transaction interceptions. ➢ Fictitious or fraudulent changes to vendor information.
6	**Oversight Risk**	Inadequate oversight over Cardinal's performance and distribution processes may lead to increased risk of operational inefficiencies and strain the relationships of the TPC group members. Significant oversight risks include the following: ➢ Lack of visibility into Cardinal's performance (i.e., percentage of on-time deliveries, inaccurate order rates, price changes, etc.) can affect TPC effectiveness and benefits.
7	**Reputational Risk**	Supply shortages or poor quality of supplies provided by Cardinal may harm the hospital's reputation, leading to decreased patient trust. Significant reputational risks include the following: ➢ Negative perceptions by the community due to supply shortages and delays in patient care. ➢ Poor or harmful patient services performed due to defective or expired supply utilization.

Medical Center Health System
Third-Party Vendor Management Dashboard
Cerner Corporation
July 2024

Cerner Corporation (now Oracle Corporation)- Electronic Health Record System

Introduction

The purpose of this dashboard is to summarize the key attributes of the contractual association and to document the methods by which MCHS oversees the vendor services provided by Cerner Corp. Additionally, the risk prioritization section of this dashboard lists the relevant third-party risks, each ranked from highest to lowest. These third-party risks include the following:
- **Compliance Risk**: The risk that the vendor does not comply with relevant contractual requirements and expectations, including safety, environmental, and operational execution.
- **Information Security Risk:** The risk that the vendor has access to MCHS' systems, PHI data, or sensitive information that are not appropriately secured.
- **Oversight Risk**: The risk that the vendor's activities are not closely managed and in-line with management expectations and needs.
- **Financial Risk:** The risk of the vendor becoming financially insolvent or unable to perform or deliver according to services outlined in the contracts in place.
- **Reputational Risk**: The risk that working with a specific third-party may reflect poorly on the System, either by association or as a result of an incident.
- **Safety Risk:** The risk of safety incidents to personnel and patients when utilizing the vendor services.
- **Operational Risk**: Includes the risk of losses or disruptions related to the activities, processes, or performance of engaging with a third-party vendor.

Note: Cerner Corporation was acquired by Oracle Corporation in June 2022 and is now part of the broader Oracle Brand. For the purposes of this dashboard and the related contract agreement, we will continue to reference the vendor as "Cerner Corp.".

Key Attributes

• Provision of various software solutions and services including:
  - Licensed Software, Subscriptions, Application Services, Shared Computing Services, Managed Services (RHO), Professional Services, Equipment, Sublicensed Software, and Equipment and Sublicensed Software Maintenance.
• Enablement and operations of Performance Improvement.
• Provision, installation, and support of data extraction and automation tools.
• Maintaining data privacy and security in compliance with healthcare regulations.
• Provision of comprehensive training to hospital staff on the use of software solutions.

Year Relationship with MCHS Formed	Parent Company	Headquarters
2015	Cerner Corporation	Kansas City, MO

Relationship with MCHS

Nature of Relationship with MCHS	Provides licensed software solutions and services
Vendor payments per current contract (Mar 2023-Feb 2024)	$11.6 MM
Key MCHS Contacts	Linda Carpenter, CIO
MCHS Offices	• Ector County Hospital District/Medical Center Hospital and various • Various MCH ProCare facilities • Various Urgent Care facilities
Additional agreements	Cerner ITWorks Services Agreement

Contracts executed with MCHS

MCHS has a Software License and Services Business Agreement with Cerner Corporation.

Agreement(s)	Executed by	Execution Date	Renewal Term
Business Agreement	William Webster, CEO	June 30, 2015	09/01/2023-10/01/2028

Third-Party Management

How is performance of the third-party monitored and managed?

- Monthly Operational Meetings: Monthly, the Chief Information Officer meets with the Cerner team to discuss system performance and review various operational performance assessment reports via a slide deck. Discussions include review of Service Level Objectives (SLOs), Service Level Agreements (SLAs), and various performance statistics, including the number of tickets processed, customer satisfaction, timeliness, and actions taken.

- Revenue Cycle Action Team (RCAT): RCAT typically meets monthly, though the frequency may change based on different implementations. RCAT was assembled as a conditional term of the agreement with Cerner and usually involves various department leaders, IT, application leads, and financial accounting members. The purpose of these meetings is to ensure that the revenue cycle and technical teams are in communication to discuss open issues, new Charge Description Master (CDM) build-outs, and revenue cycle components.

- Lights-On Dashboard Reporting: Access to the Lights-On Network allows the CIO daily visibility of system up-time, patch levels, and performance. Additionally, the CIO can access the monthly operational meeting reports presented by Cerner in the monthly operational meeting.

- Cerner Counterpart Meetings: The CIO facilitates informal monthly meetings with their Cerner counterpart to discuss and resolve high-priority escalations or issues requiring a resolution.

- Cerner Advocate Meetings: The CIO facilitates informal bi-weekly meetings with the Cerner customer advocate representative to address any open items and maintain the vendor relationship.

- **Performance Tool Report:** The CIO completes a Performance Tool report annually through the System's contract management system, Premier, to evaluate vendor performance and identify any areas of dissatisfaction in accordance with DNV (Det Norske Veritas) requirements regarding contract reviews. Additionally, the Contract Manager ensures that performance evaluation forms are completed and reports on compliance with contract review monthly during the directors' meeting.

Risk Prioritization

Priority	Risk Category	Significant Risks
1	**Information Security Risk**	Due to the nature of the hospital management software services provided by Cerner, there is an increased risk of information security issues that are inherent to the System. Significant Information Security risks include: ➢ Failure or inaccessibility of the Cerner systems due to technical issues, maintenance, or unplanned downtime. ➢ Unauthorized access to the Cerner systems resulting in compromised/fraudulent patient privacy or data corruption. ➢ Errors or malfunctions of the Cerner systems' functionality due to software bugs or glitches. ➢ Fictitious or fraudulent changes to vendor information. ➢ Delays in deploying critical software patches and updates can expose the system cyber attack vulnerabilities.

Priority	Risk Category	Significant Risks
2	**Operational Risk**	Cerner is the software provider for all MCHS facilities, covering various patient care activities and administrative functions. As such, system downtime poses a significant operational risks, including the following: ➢ Disruptions in system service may lead to delayed patient admissions, discharges, transfers, and scheduling issues. ➢ Operational inefficiencies to the hospital workflow may arise from delayed equipment deliveries or inadequate administrative support from Cerner. ➢ Prolonged system downtime may prevent healthcare providers from accessing patient histories, lab results and diagnostics, and medication records maintenance.
3	**Financial Risk**	Failure or disruption to the hospital's software system may lead to cost overruns or unanticipated expenses that strain the projected budget. Significant financial risks include the following: ➢ Invoices do not accurately reflect services or goods delivered. ➢ Services provided during system downtime may not be properly recorded, resulting in charge capture errors. ➢ System interruptions may delay or prevent processing of patient billing and insurance claims.
4	**Safety Risk**	Software issues that fail to deliver accurate and timely information may endanger patient safety, including: ➢ Staff may be unable to access patient medical histories, lab results, imaging studies, and other vital records, leading to delays in diagnosis and treatment. ➢ System failures may prevent the output of crucial medical alerts regarding important medical considerations. ➢ System disruptions may prevent access to accurate records and lead to the prescription of incorrect drug dosage or missed dosages.
5	**Compliance Risk**	Failure to implement robust data security measures and effective/timely updates based on regulatory changes may lead to contractual or regulatory non-compliance. Significant compliance risks include: ➢ Violations of the SLA's may impact compliance obligations. ➢ Delayed or inadequate HIPAA breach reporting by Cerner may lead to non-compliance with HIPAA breach notification requirements. ➢ Software failures that prevent timely submission of required reports to regulatory agencies can lead to non-compliance.
6	**Reputational Risk**	A breach in data security, operational failures, or patient safety issues may affect the System's public image and trust among patients and staff. Significant reputational risks include the following: ➢ Long wait times due to software issues can lead to patient dissatisfaction. ➢ Breaches of PHI may diminish patient trust and result in negative public perception.
7	**Oversight Risk**	Poor governance and management of the Cerner Software services relationship may increase the likelihood of other risks occurring. Significant oversight risks include: ➢ Undetected opportunities to receive full benefits stipulated in the executed agreement due to improper oversight of terms and SLAs. ➢ Failing to monitor Cerner's performance can result in unaddressed system issues.

Medical Center Health System
Third-Party Vendor Management Dashboard
Davin Healthcare Solutions
July 2024

Davin Healthcare Workforce Solutions (now StatStaff Professionals) - Staffing Agency

Introduction

The purpose of this dashboard is to summarize the key attributes of the contractual association and to document the methods by which MCHS oversees the vendor services provided by Davin Healthcare Workforce. Additionally, the risk prioritization section of this dashboard lists the relevant third-party risks, each ranked from highest to lowest. These third-party risks include the following:

- **Compliance Risk**: The risk that the vendor does not comply with relevant contractual requirements and expectations, including safety, environmental, and operational execution.
- **Information Security Risk**: The risk that the vendor has access to MCHS' systems, PHI data, or sensitive information that are not appropriately secured.
- **Oversight Risk**: The risk that the vendor's activities are not closely managed and in-line with management expectations and needs.
- **Financial Risk:** The risk of the vendor becoming financially insolvent or unable to perform or deliver according to services outlined in the contracts in place.
- **Reputational Risk:** The risk that working with a specific third-party may reflect poorly on the System, either by association or as a result of an incident.
- **Safety Risk:** The risk of safety incidents to personnel and patients when utilizing the vendor services.
- **Operational Risk:** Includes the risk of losses or disruptions related to the activities, processes, or performance of engaging with a third-party vendor.

Note: Davin Workforce Solutions is now StatStaff Professionals. For the purposes of this dashboard and the related contract agreement, we will continue to reference the vendor as "Davin Healthcare.".

Key Attributes

- Recruit, screen, interview, and assign employees to perform the work described for each role requested by MCHS.
- Conduct industry-specific license verifications in accordance with the System's needs.
- Advertise and market temporary and temporary permanent open positions at MCHS facilities.
- Pay, withhold, and transmit assigned employee payroll taxes.
- Provision of an account manager to process employee job requests.
- Provision of assigned employee reports as requested by MCHS
- Guarantees the bill rates for the duration of the agreement.
- Arrange assigned employee replacements as necessary.
- Oversee performance evaluation of all assigned employees with assistance from MCHS.

Year Relationship with MCHS Formed	Parent Company	Headquarters
2018	Davin Healthcare Workforce	Saratoga Springs, NY

Relationship with MCHS

Nature of Relationship with MCHS	Professional Services Agreement
Vendor payments per current contract (Nov 2023-Feb 2024)	$8.8 MM
Key MCHS Contacts	Natalie Sandell, Associate Chief Nursing Officer
MCHS Offices	Ector County Hospital District dba Medical Center Hospital System
Additional agreements	Amendment No.1 to Managed Service

Contracts executed with MCHS

MCHS has a Professional/Managed Services Agreement with Davin Healthcare Workforce

Agreement(s)	Executed by	Execution Date	Renewal Term
Professional/Managed Services Agreement	Rick Napper, CEO	December 10, 2018	Nov 2023 - Nov 2024

Third-Party Management

How is performance of the third-party monitored and managed?

- **Tracking of Temp Employee Timesheets/Hours**: The Chief Nursing Officer, along with various senior leaders, maintain and review the Contract Labor Projections spreadsheet prepared by the Fiscal Services Accountant on a bi-weekly basis to accurately track temporary employee contract dates and hours worked, preventing both under-recording and over-recording of hours.

- **Maintaining Operational Integrity:** The Chief Nursing Officer and various senior leaders maintain a zero-tolerance policy for issues related to temporary employees, such as patient care concerns or competency. These issues are reported to Davin via email or phone. The Davin account manager then takes appropriate action, which may include terminating the temporary employee's contract, thus ensuring a strict adherence to the established hospital standards of care.

- Consistency of HR Activities: MCHS follows the same onboarding and offboarding process for temporary employees as it does for permanent staff. This ensures consistency and facilitates the integration of temporary staff into the hospital's protocols and reduces the burden on permanent staff.

- **Performance Tool Report:** The Chief Nursing Officer completes a Performance Tool report annually through the System's contract management system, Premier, to evaluate vendor performance and identify any areas of dissatisfaction in accordance with DNV (Det Norske Veritas) requirements regarding contract reviews. Additionally, the Contract Manager ensures that performance evaluation forms are completed and reports on compliance with contract review monthly during the directors' meeting.

Risk Prioritization

Priority	Risk Category	Significant Risks
1	**Operational Risk**	The integration of temporary staff to the hospital may be challenging and maintaining staffing needs may lead to operational risks. ➢ Frequent staff changes may affect patient continuity of treatment and care quality. ➢ Staffing issues can lead to low morale among permanent staff, reducing productivity, and work. environment quality. ➢ Onboarding temporary staff can be time-consuming, leading to operational delays. ➢ Staffing shortages may lead to longer wait times and decreased patient satisfaction.
2	**Financial Risk**	Assigned staff provided by Davin may work longer hours than expected, leading to financial risks including higher costs and unbudgeted overtime pay. Significant financial risks include the following: ➢ Staffing shortages may require MCHS to offer premium rates to meet personnel requirements. ➢ Staff assigned by Davin may be paid for overtime hours that were not approved by MCHS and lead to unanticipated overtime pay costs. ➢ Staff assigned by Davin may be erroneously processed through both MCHS's payroll and Davin's payroll, resulting in duplicate wages paid to certain individuals. ➢ Davin may invoice MCHS for hours not worked by Assigned employees and/or excessive placement fees, resulting in financial stain to MCHS.

Priority	Risk Category	Significant Risks
3	**Safety Risk**	Staffing of employees that do not have the appropriate education and experience increases the likelihood of safety risks. Significant Safety risks include: ➢ Inadequately trained staff are more likely to make medication errors and incorrect diagnosis. ➢ Staff without the proper experience may not respond appropriately to medical emergencies. ➢ Improper handling of patients by inexperienced temporary staff can result in patient falls and injuries.
4	**Oversight Risk**	Assessing the performance of agency staff and providing feedback may be difficult if there are no established processes for evaluation and communication with Davin and the staff they assign. Significant oversight risks include: ➢ Review of the hours worked by Assigned staff may not be performed to ensure accurate timekeeping. ➢ Employees may not receive onboarding and training that outlines expectations to the same extent as permanent employees. ➢ Incidents and errors are not reported timely, in accordance with the contract. ➢ Lack of accountability may lead to low performance standards for temporary staff.
5	**Reputational Risk**	Low quality of care provided by employees staffed by Davin can reflect poorly on the System's reputation for patient care. Significant reputational risks include the following: ➢ Inadequate competency and experience by Davin staff may erode the System's reputation for high-quality healthcare services. ➢ Negative reviews and feedback by temporary staff may damage the System's reputation for potential future employees.
6	**Compliance Risk**	The miscommunication by assigned staff and Davin may lead to non-compliance risks related to employment laws and regulations. Significant compliance risks include: ➢ Davin and MCHS may not appropriately cooperate to ensure compliance with FMLA requirements for assigned employees. ➢ MCHS has not appropriately informed and onboarded Assigned staff on OSHA compliance requirements, leading to non-compliance. ➢ Davin may provide assignment to an unlicensed employee leading to regulatory violations by MCHS for improper vetting. ➢ Assigned employees may work more than the contractually and legally allowable hours.
7	**Information Security Risk**	Davin assigned staff may have access to sensitive patient information, increasing the risk of data breaches if proper security access is not followed. Significant Information Security risks include: ➢ Inadequate access controls may allow agency staff to access systems or information beyond their authorization. ➢ Staff assigned by Davin may cause data breaches by fall victim to phishing attacks.

Medical Center Health System
Third-Party Vendor Management Dashboard
McKesson Drug Company
July 2024

McKesson Drug Company - Pharmaceuticals

Introduction

The purpose of this dashboard is to summarize the key attributes of the contractual association and to document the methods by which MCHS oversees the vendor services provided by Cerner Corp. Additionally, the risk prioritization section of this dashboard lists the relevant third-party risks, each ranked from highest to lowest. These third-party risks include the following:
- **Compliance Risk**: The risk that the vendor does not comply with relevant contractual requirements and expectations, including safety, environmental, and operational execution.
- **Information Security Risk:** The risk that the vendor has access to MCHS' systems, PHI data, or sensitive information that are not appropriately secured.
- **Oversight Risk**: The risk that the vendor's activities are not closely managed and in-line with management expectations and needs.
- **Financial Risk:** The risk of the vendor becoming financially insolvent or unable to perform or deliver according to services outlined in the contracts in place.
- **Reputational Risk**: The risk that working with a specific third-party may reflect poorly on the System, either by association or as a result of an incident.
- **Safety Risk** - The risk of safety incidents to personnel and patients when utilizing the vendor services.
- **Operational Risk** - Includes the risk of losses or disruptions related to the activities, processes, or performance of engaging with a third-party vendor.

Key Attributes

- Primary pharmaceutical wholesaler for three of the four departments that order medications.
- Sourcing and distribution of a wide array of pharmaceuticals to MCHS.
- The System's Affiliated Agreement with McKesson as a participant of the TPC, LLC (group of independent healthcare systems).
- Various reporting and communications to the System regarding total monthly sales volume and dollars spent.
- Collaboration with the System over potential cost savings, various brand offerings, etc.

Year Relationship with MCHS Formed	Parent Company	Headquarters
2019	McKesson Drug Company	Irving, TX

Relationship with MCHS

Nature of Relationship with MCHS	Provides pharmaceuticals and on a smaller scale pharmacy PAP and Revenue Recovery Services
Vendor payments last 12 months (Mar 2023 - Feb 2024)	$16.4MM
Key MCHS Contacts	Erica Wilson, Director of Pharmacy
MCHS Offices	Ector County Hospital District dba Medical Center Hospital
Additional agreements	• Pharmacy Optimization Agreement (PAP & Revenue Recovery) • Pharmacy Distribution Credit Addendum

Contracts executed with MCHS

MCHS executed an Agreement Joinder as part of the executed supply agreement between McKesson Corp., TTPC, LLC., and Vizient Supply, LLC.

Agreement(s)	Executed by	Execution Date	Renewal Term
Affiliation Agreement	Robert Abernathy, Interim CEO	August 29,2019	Oct 2023 - Oct 2024

Third-Party Management

How is performance of the third-party monitored and managed?

- Partnership Alignment Report: McKesson and MCHS hold quarterly meetings to review the Partnership Alignment Report, which details the System's net purchasing volume and drug brand metrics, including:
- Top Brands purchased by MCHS for the quarter
- Contract compliance purchasing ratios
- Total quarterly spending

Under the partnership with the Texas Purchasing Coalition (TPC), MCHS must meet a prime vendor purchasing commitment for pharmaceuticals to maintain contract discount benefits.

- Contract Renewal Notifications: The Director of Pharmacy receives notifications from the contract management system, Premier, regarding contracts nearing their expiration or renewal dates.

- Budget and Contract Spreadsheet Tracking: The Director of Pharmacy maintains a spreadsheet to monitor budgetary activities under the McKesson agreement, including purchases to date, minimum commitment spend, and related general ledger activity.

- **Performance Tool Report:** The Director of Pharmacy completes a Performance Tool report annually through the System's contract management system, Premier, to evaluate vendor performance and identify any areas of dissatisfaction in accordance with DNV (Det Norske Veritas) requirements regarding contract reviews. Additionally, the Contract Manager ensures that performance evaluation forms are completed and reports on compliance with contract review monthly during the directors' meeting.

Risk Prioritization

Priority	Risk Category	Significant Risks
1	**Operational Risk**	Disruptions in the supply chain by McKesson or related manufacturers may lead to shortages of essential medications, affecting patient care and staff productivity. Significant operational risks include the following: ➢ Hospital staff time and resources diverted to managing and resolving drug supply shortages. ➢ Inconsistent supply deliveries may lead to inventory stockouts or excessive inventory levels of low-demand products. ➢ Delivery of expired/defective medications may result in operational delays. ➢ Incomplete or inaccurate delivery of medications may lead to delay in or inability to execute patient care.
2	**Safety Risk**	Failure to maintain consistent pharmaceutical supply levels or issues with drug quality may jeopardize patient safety. Significant Safety risks include: ➢Low quality medications are delivered, leading to potential adverse patient drug effects. ➢ Patients may experience treatment interruptions due to supply shortages or delivery delays. ➢ Untimely reporting of recalls, drug formulation changes, or adverse side effects may lead to negative patient outcomes. ➢ Improper storage and transportation of medications can lead to the administration of ineffective drugs to patients.

Risk Prioritization		
Priority	**Risk Category**	**Significant Risks**
3	**Compliance Risk**	McKesson may fail to report critical information related to the medication it distributes, resulting in fines and sanctions. Significant compliance risks include: ➢ Liquidated damages are not redeemed for deviations to the adjusted fill rate threshold (95% or higher). ➢ Delivery of medications with inadequate or insufficient product information, which may lead to improper handling and storage, and ultimately regulatory violations. ➢ Failure to communicate noncompliance with Controlled Substance laws, rules, and regulations. ➢ Failure to provide MCHS with notice of their obligations to report and disclose on discounts, rebates, and other price reductions on cost reports submitted to federal or state healthcare programs.
4	**Financial Risk**	Unexpected and improperly assessed price changes and billing inaccuracies may place a strain in the hospital's budget and financial resources. Significant financial risks include the following: ➢ McKesson may unknowingly assess or increase fuel surcharges due to rising gas prices or courier fees without communicating the changes to MCHS. ➢ Quantity of goods invoiced do not accurately reflect units ordered and/or delivered. ➢ Failure to meet purchasing commitments may lead to the loss of contract discounts and negotiated pricing, increasing overall expenses. ➢ Supply disruptions can lead to legal disputes with the vendor or affected patients, incurring legal fees and potential settlement costs. ➢ McKesson's vendor pricing changes are not periodically assessed to ensure pricing remains fair and within expected budgetary limits.
5	**Oversight Risk**	Failure of McKesson to communicate accurate total spend or net volume of purchases on a periodic basis may not provide MCHS with visibility of achieving necessary purchasing commitments and failure to fully maximize the benefits of the agreement. Significant oversight risks include: ➢ Lack of transparency into McKesson's performance may hinder decision-making. ➢ Lack of accountability by McKesson may prevent effective planning and scheduling of deliveries. ➢ McKesson vendor agreement is not appropriately understood and managed to ensure compliance with the executed ➢ Failure to communicate transparently about supply chain issues or contract modifications may inhibit the System's ability to effectively manage the vendor relationship.
6	**Reputational Risk**	Unethical business practices or pharmaceutical company scandals can reflect poorly on the System's reputation and patient trust. Significant reputational risks include the following: ➢ Erosion of trust by patients and staff due to McKesson drug recalls or public controversy. ➢ Negative patient outcomes and community perception due to use of defective or expired pharmaceuticals. ➢ Breaches of contractual agreement may tarnish MCHS reputation for integrity.
7	**Information Security Risk**	McKesson may be subject to phishing or social engineering attacks which may compromise the System's internal data and information. Significant Information Security risks include: ➢ Inadequate control over who within the McKesson organization has access to the hospital's sensitive information can lead to unauthorized data access. ➢ Fictitious or invalid changes to vendor information within the System's Masterfile may result in fraudulent payments. ➢ Interception of payment information during electronic transactions can lead to broader data breaches.

Medical Center Health Systems
Third-Party Vendor Management Dashboard
Trimedx, Inc.
July 2024

TriMedX - Equipment Maintenance and Repair Services

Introduction

The purpose of this dashboard is to summarize the key attributes of the selected contractual relationship and to document the methods by which MCHS oversees the vendor services. Additionally, the risk prioritization section of this dashboard lists the relevant third-party risks, each ranked from highest to lowest. These third-party risks include the following:
- **Compliance Risk:** The risk that the vendor does not comply with relevant contractual requirements and expectations, including safety, environmental, and operational execution.
- **Information Security Risk**: The risk that the vendor has access to MCHS' systems, PHI data, or sensitive information that are not appropriately secured.
- **Oversight Risk:** The risk that the vendor's activities are not closely managed and in-line with management expectations and needs.
- **Financial Risk:** Includes the risk of the vendor becoming financially insolvent or unable to perform or deliver according to services outlined in the contracts in place.
- **Reputational Risk**: The risk that working with a specific third-party may reflect poorly on the System, either by association or as a result of an incident.
- **Safety Risk:** The risk of safety incidents to personnel and patients when utilizing the vendor services.
- **Operational Risk:** Includes the risk of losses or disruptions related to the activities, processes, or performance of engaging with a third-party vendor.

Key Attributes

- Provision of service and management for equipment listed in the 'Covered Equipment' provision within the executed agreement.
- Repair, inspection, preventative maintenance, and maintenance of all Covered Equipment.
- Procurement and payments of covered parts.
- Managing the System's covered equipment service contracts and entering new contracts.
- Providing standard reports and performance indicators to support regulatory reporting requirements.
- Maintaining a database for tracking all service events.

Year Relationship with MCHS Formed	Parent Company	Headquarters
2018	TriMedX	Indianapolis, IN

Relationship with MCHS

Nature of Relationship with MCHS	Provides maintenance and repair of the System's hospital equipment
Vendor payments per current contract (Mar 2023-Feb 2024)	$4.1MM
Key MCHS Contacts	Matt Collins, COO
Additional agreements	MEMP: Medical Equipment Management Plan

Contracts executed with MCHS

MCHS has a Purchased Service Agreement (PSA) with TriMedx Inc.

Agreement(s)	Executed by	Execution Date	Current Renewal Term
Purchase Service Agreement	Rick D. Napper, CEO	November 8, 2018	11/07/2023 -11/07/2024

Third-Party Management

How is performance of the third-party monitored and managed?

- Asset Addition/Disposal True-Up: Quarterly, a full equipment inventory is performed and equipment is retired or added. An adjustment to the price per unit that is built into the contract is evaluated based on the retirement or additions of equipment. TriMedx provides MCHS with a data analytics dashboard to monitor asset lifecycles.

- Safety Committee Reporting: Each month, the Safety Committee is presented with the percentage of service completion, up/downtime, work order turnaround time, response time, and customer satisfaction metrics.

- Orderly Value Review Reporting: Quarterly, TriMedx provides the MCHS COO with an Orderly Value Review Report detailing high level action items and performance metrics similar to what is reported to the Safety Committee. The System leverages this report to monitor vendor performance against agreed-upon services.

- Operations Review Meetings: Weekly meetings are held by the MCHS team and the TriMedx team for an operations review where they discuss identified issues, critical topics, and daily operations.

- Customer Satisfaction Surveys: Quality Value Reviews are disseminated to MCHS staff, such as clinicians and nurses, to gauge service satisfaction. Surveys are distributed via online forms to users that submit equipment service requests, or in-person interviews. Results/metrics are visible to MCHS management, including call time and work order type.

- Third-Party Regulatory Services: The System engages with DNV, an accreditation organization, to conduct an annual audit of the hospital equipment to ensure compliance with healthcare regulations. Minor enhancements are communicated to MCHS management during the onsite visit, and significant findings are issued through formal reports.

Risk Prioritization

Priority	Risk Category	Significant Risks
1	Operational Risk	The risk of disruptions to essential equipment may lead to downtime in critical healthcare operations and impact patient treatment schedules. Significant operational risks include the following: ➢ Inadequate staffing capacity by TriMedx may lead to extended service interruption which may impact patient care delivery. ➢ Delayed response time by TriMedx may cause prolonged equipment downtime. ➢ Parts procured by TriMedx that may be delayed, defective, or inadequate ➢ Hospital facility operations halt due to vendor service inconsistency and reliability.
2	Safety Risk	Failure to ensure adequate repairs and equipment maintenance by qualified Trimedx staff can increase the risk of accidents and the spread of infection among hospital personnel and patients. Significant Safety risks include: ➢ Failure to adhere to equipment manufacture guidelines may lead to false readings and incorrect patient diagnosis, therefore delaying appropriate treatment. ➢ Poorly maintained equipment may result in the injury of staff responsible for operating them daily due to leaks, loose pieces, or electrical issues. ➢ Patients are at risk of health threats and negative outcomes due to improper equipment repair and maintenance.
3	Information Security Risk	Trimedx manages equipment that runs diagnostics and processes patient information, increasing the sensitivity of PHI protection. Significant Information Security risks include: ➢ Trimedx may misuse or abuse their access privileges. ➢ Trimedx may experience data breaches within their proprietary software. ➢ Fictitious or fraudulent changes to vendor information. ➢ Trimedx may obtain unauthorized access to data during maintenance and repair activities.

Risk Prioritization		
Priority	**Risk Category**	**Significant Risks**
4	**Compliance Risk**	TriMedx may not adhere to executed contract terms or relevant laws and regulations, resulting in deviations between expected and delivered services. Significant compliance risks include: ➢ Inadequate, incomplete, or untimely documentation provided to support compliance. ➢ Provision of service is unsatisfactory, untimely, or incomplete. ➢ Services may deviated from manufacturer guidelines, which may compromise equipment performance and lead to regulatory non-compliance.
5	**Financial Risk**	TriMedx is a significant vendor for MCHS and is used extensively for the maintenance and repair of sophisticated medical equipment across multiple MCHS locations. Increase in rates may lead to a strain in the hospital's budget and financial resources, impacting patient service delivery. Significant financial risks include the following: ➢ Billing practices may not align with contractual agreements, resulting in overbilling for services. ➢ TriMedx may escalate prices during contract renewal if contract is not properly vetted. ➢ Invoices include additional services that were not actually provided.
6	**Oversight Risk**	Inadequate monitoring or supervision over Trimedx activities may lead to lack of accountability and limited transparency over the outsourced activities. Significant oversight risks include: ➢ Lack of transparency into Trimedx performance can hinder decision-making. ➢ Lack of accountability can cause inadequate service delivery. ➢ Lack of oversight may lead to untimely detection of performance deviations.
7	**Reputational Risk**	Unethical business practices or use of recalled parts by Trimedx can reflect poorly on the System's reputation and patient satisfaction. Significant reputational risks include the following: ➢ Erosion of trust by patients and staff due to Trimedx service outcomes or public controversy. ➢ Breaches of contractual agreement may tarnish the System's repudiation for integrity. ➢ Trimedx may obtain unauthorized access to PHI, leading to legal liability.

Appendix C: Vendor Management Process Flowcharts

Source: Information regarding the Third-Party Vendor Management process and sub-process flows were obtained via interviews with key contract owners for the selected vendors at the Medical Center Health System.

Purpose: To document the System's Third-party Vendor Management sub-processes and identify the existing controls and any gaps which may provide opportunities to improve efficiency and consistency.

Procedure: The following flowcharts are used to document the flow processes and activities related to Vendor Management within the MCHS system. Each sub-process or activity is presented separately.

The following provides a summary of each sub-process within the vendor management process:

- **Vendor Selection, acceptance, setup, and maintenance:** Involves identifying and selecting appropriate vendors, evaluating and accepting their suitability based on the System's requirements, setting up their profiles within Premier, and maintaining accurate and updated vendor information.

- **Contract development, revisions, renewal, and maintenance:** Includes the creation and drafting of vendor contracts, execution of necessary revisions, managing contract renewals, and ensuring all contracts are current.

- **Contractual key terms identification:** Identifying important terms and conditions within vendor contracts/agreements to ensure understanding and compliance to the terms.

- **Vendor benefit maximization:** Optimizing the benefits and value that can be obtained from the vendor agreements by negotiating favorable terms and ensuring reasonable costs.

- **Third-party risk and compliance:** Involves managing risks associated with engaging with third-party vendors, ensuring they comply with MCHS policies and industry regulations.

- **Vendor performance monitoring:** Regularly evaluating vendor performance against established and contractual benchmark to ensure vendors meet the System's standards and expectations to maintain effective and reliable operations.

- **Third-party communication and reporting:** Involves maintaining consistent communication with third-party vendors, and ensuring timely and accurate reporting on their activities, performance, and compliance to maintain transparency and effective collaboration.

Legend

Legend

- Company Process
- On Page Reference
- Decision
- Document
- Off Page Reference
- Database
- Consolidating Documents
- Process Terminator

Activity Supplemental References

- # — Control Point
- # — Point for Consideration (PFC) Reference

Control #1: As needed, changes to vendor payments or new vendor setups are requested by department leads and sent to the Sr. Accountant to apply the changes to the vendor profile in the AP system. The Assistant Controller reviews new vendor setups or existing vendor changes to ensure that the information in the system has been validated and agrees to supporting documents. If any variances are identified between the information in the system and supporting documentation, the Assistant Controller will notify the Fiscal Services team to resolve or action prior to final processing of the change. Approval is evidenced via workflow approval within the AP system.

Control #2: As needed, vendor contracts are entered in the contract management system to initiate the contract approval process. The Contact Manager receives and reviews the vendor signed documents (i.e., W-9, NPCRS, Vendor Information form, vendor signed contract, and BAA) and creates a new or renewal contract number in the system. Once, the contract has been setup and approved by the contract manger, it is sent for electronic approval to several designated approvers as per policy MCH-1059. Contracts exceeding the 50K threshold are sent for additional approval by the Ector County Hospital District (ECHD) Board. Rejection by any one designee prevents the contract from being finalized in the system.

Control #3: Upon vendor acceptance, the Department Director/Contract Owner submits the drafted contract to the legal department for review to ensure the contract includes appropriate terms and conditions that are in alignment with the System's strategic objectives. The legal department sends the reviewed contract back to the contract owner via email correspondence. Additionally, the legal department will send the contract owner a BAA agreement if needed, given the nature of the contract.

Control #4: Annually, contract owners receive email notification to complete a performance assessment over existing vendors. Contract owners prepare and sign the standard Performance Tool template to document whether vendors have been in compliance with relevant laws, regulations, and accreditation requirements, and if overall performance has been satisfactory. The Contract Management reviews all completed Performance Tools for completeness and ensures that a performance assessment was performed for all existing vendors.

Control #5: As needed, documents for new vendor setups or existing vendor modifications are reviewed by the Sr. Accountant using the Vendor Setup/Change Checklist to ensure that the request is valid, and the information provided is accurate. If any discrepancies or red flags are identified, the Sr. Accountant stops the vendor update process and alerts management. Completion and approval of the due diligence review is evidenced via sign-off on the Checklist. Approval of changes within the AP System is evidenced through the performance of **Control #1**.

Control #6: The Materials Management team maintains Order Guides within Premier's Materials Management Information System (MMIS) of items available for sale by existing, pre-approved vendors. Order guides are organized by user group or department, and the Department Directors are responsible for performing periodic review of the Order Guides to ensure that all items are relevant to the respective user group's / department's scope of work. Ad-hoc review/approval of additions or modifications to the Guides are performed as applicable.

Control #7: PR requestors do not have access to select a vendor when placing Order Guide Requisitions. The Materials Management Information System (MMIS) defaults the resulting PO to the primary vendor. Buyers must manually select a secondary, pre-approved vendor, if necessary, prior to approving and submitting the PO.

Control #8: As needed, Purchase orders are reviewed and approved within Premier based on tiered dollar amounts of the non-file PO. The designated approver for the associated purchase order type will review and approve the purchase order to ensure that the purchase is accurate and appropriate against the vendor contract and internal approval tiering. Higher-dollar purchases require additional approval by an individual of higher authority. The approved purchase order is then sent to a separate member of the materials management department to be finalized.

PFC #1: We identified several functional inefficiencies within Premier that inhibit efficient and effective contract monitoring procedures. Including:

1) The contract management application does not have the capability of tracking performance monitoring and key contractual terms.
2) Manual entry of contracts in Premier increases the risk of errors and inconsistencies.
3) Contract owners cannot view vendor payment history within the contract management system.
4) Vendor numbers must be established in the AP system before setting up new contracts.
5) Premier's workflow only allows for one contract execution per account.
6) Contract owners receive email notifications of expirations, but without a direct system link for easy access.
7) Expired contracts must be manually deactivated by the Contract Manager.

Note: The seven issues identified within PFC #1 are indicated by their corresponding suffix within the flowcharts, (i.e. PFC #1.1 refers to number 1 within this PFC).

PFC #2. The System's ability to delegate, structure, and assign third-party vendor management performance monitoring could be enhanced to align with industry best practices. The issues identified include:

1) Vendor Tiering is not established.
2) The current Vendor Performance Tool is broad in nature.
3) Formal procedure to assign contracts no established.

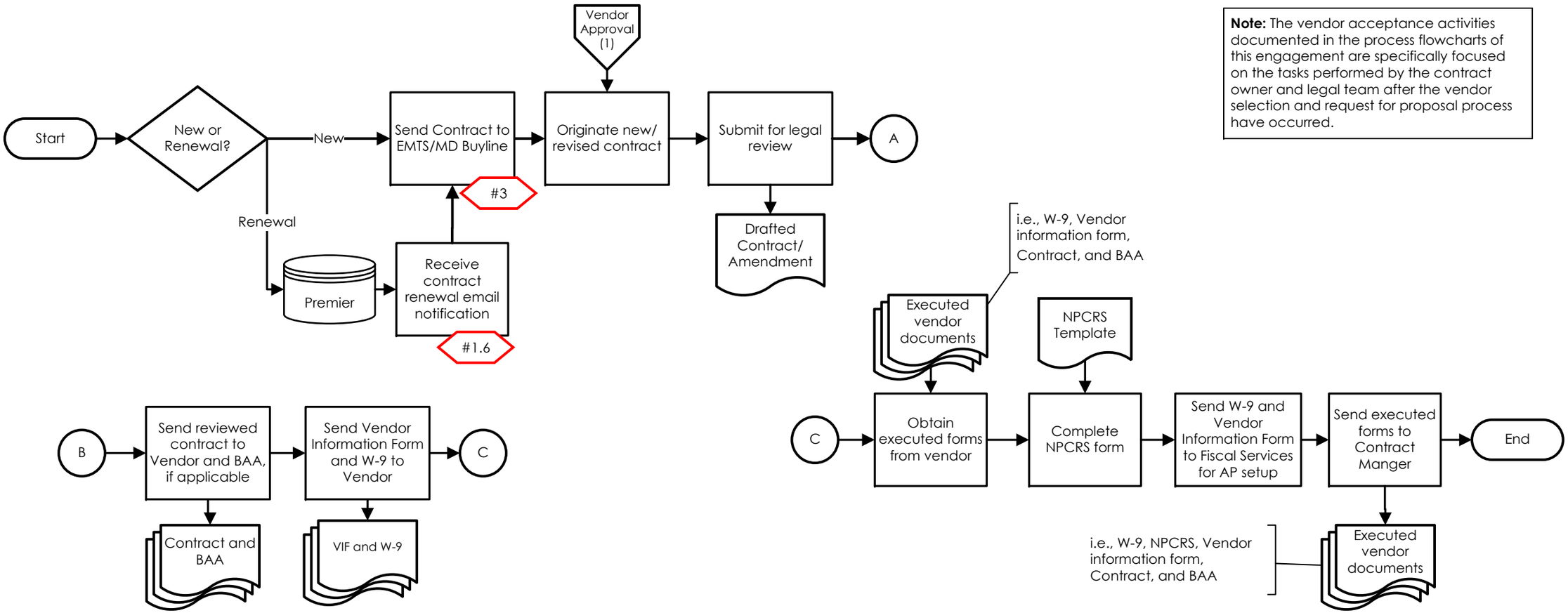
PFC #3. Procedures are not in place to ensure governing documents, such as Business Association Agreements (BAA) and required third-party evaluations (EMTS and MD Buyline), are obtained prior to executing agreements with vendors.

PFC #4. The System's new vendor request process does not require conflicts of interest declarations from requisitioning departments or other involved parties.

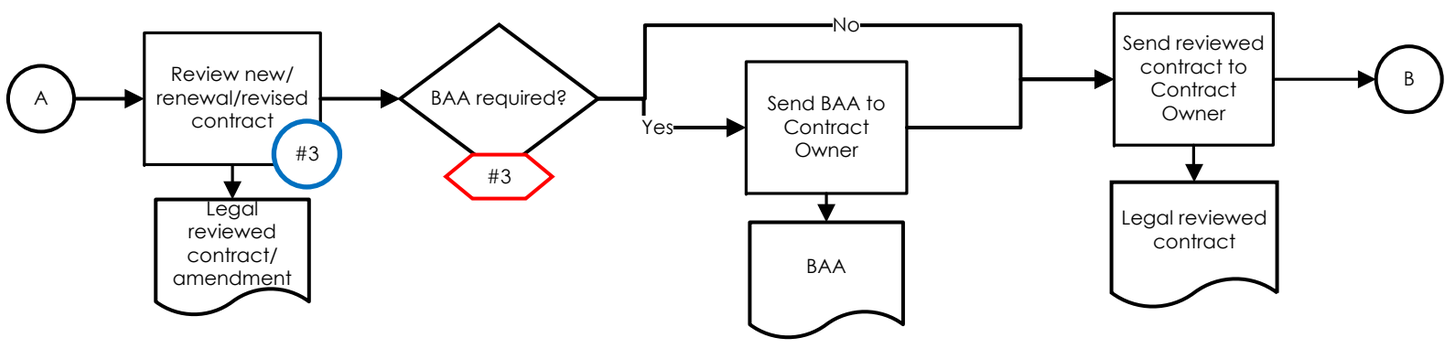
MEDICAL CENTER HEALTH SYSTEM

As Needed

MCHS Contract Owner



Legal Department



As Needed

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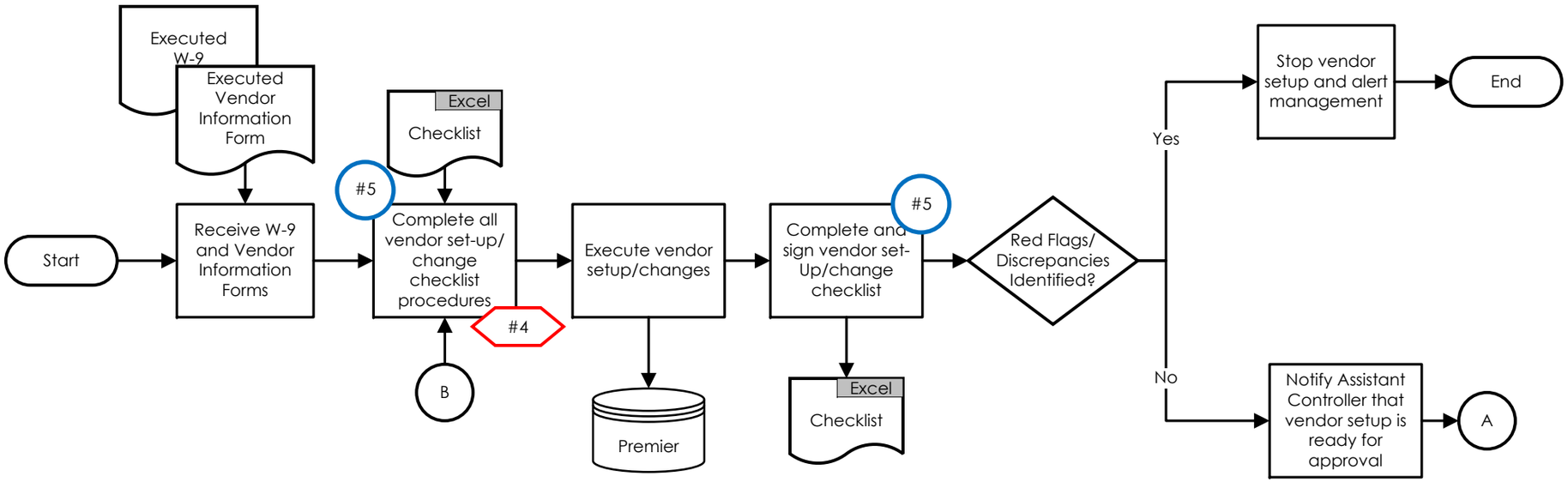

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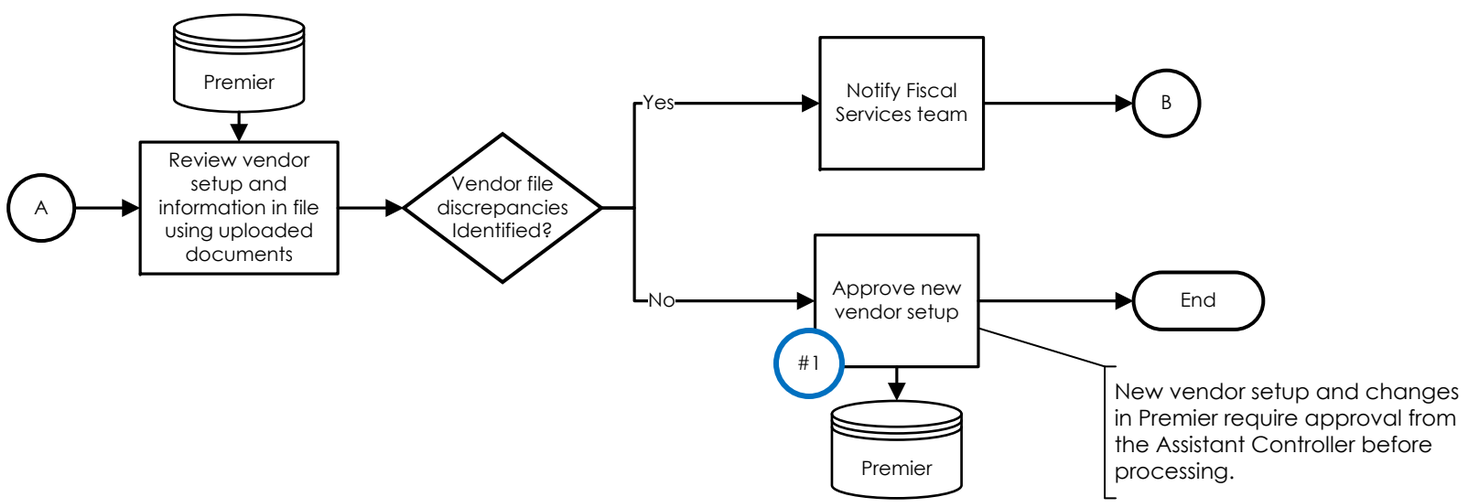

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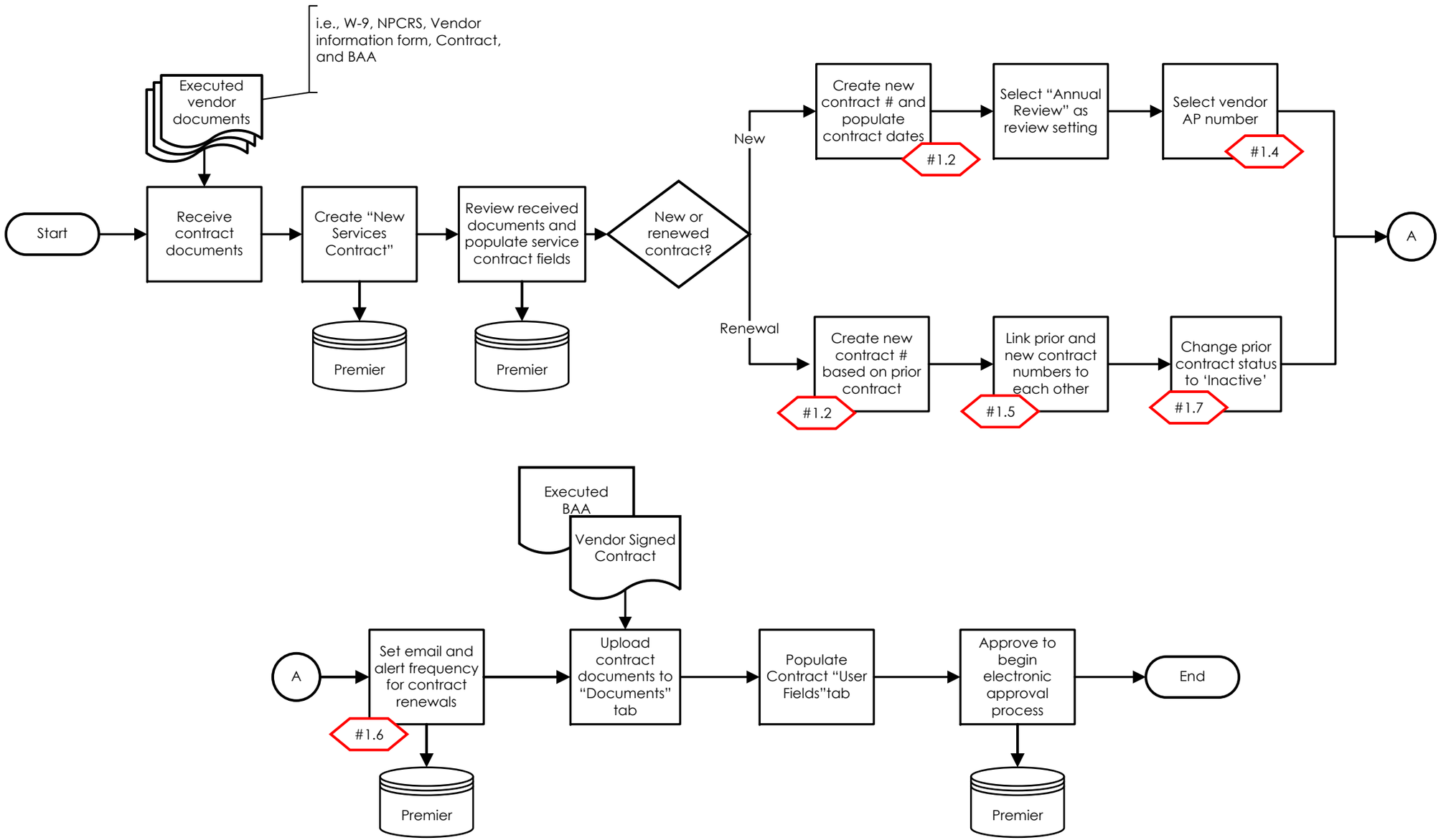
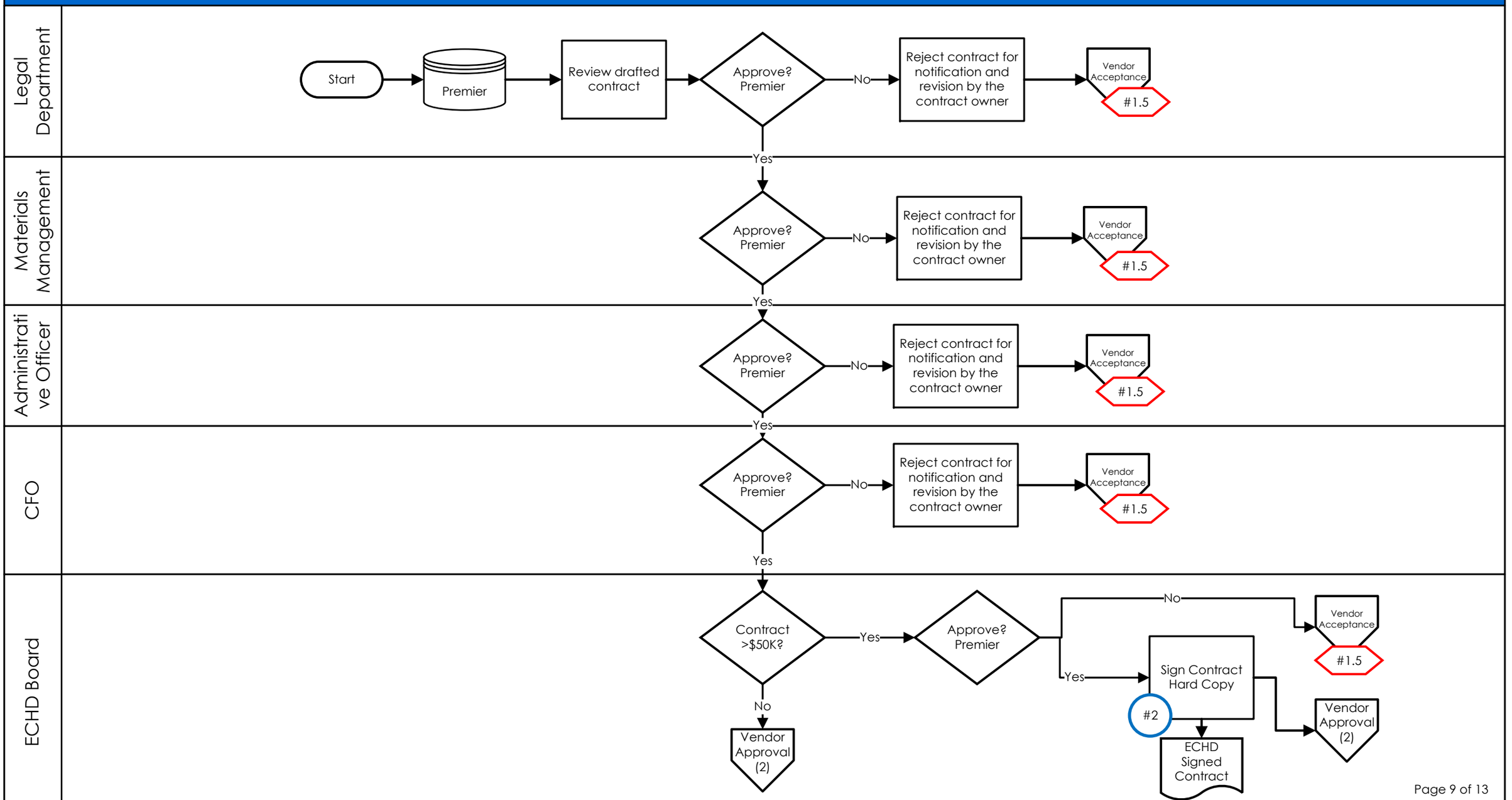


Vendor Approval (1)

MEDICAL CENTER HEALTH SYSTEM

As Needed



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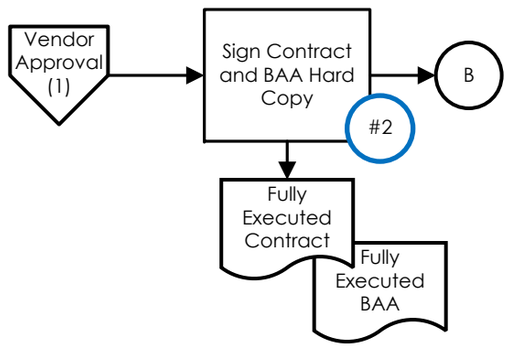
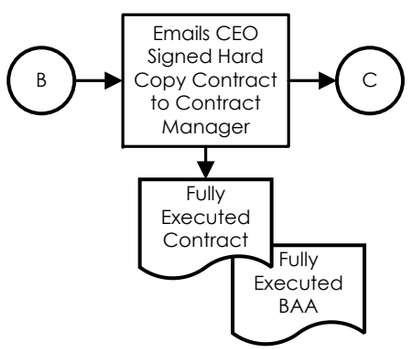
President/CEO



President/CEO Assistant



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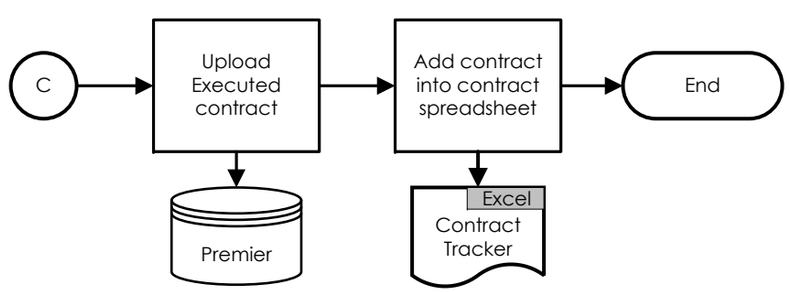

As Needed

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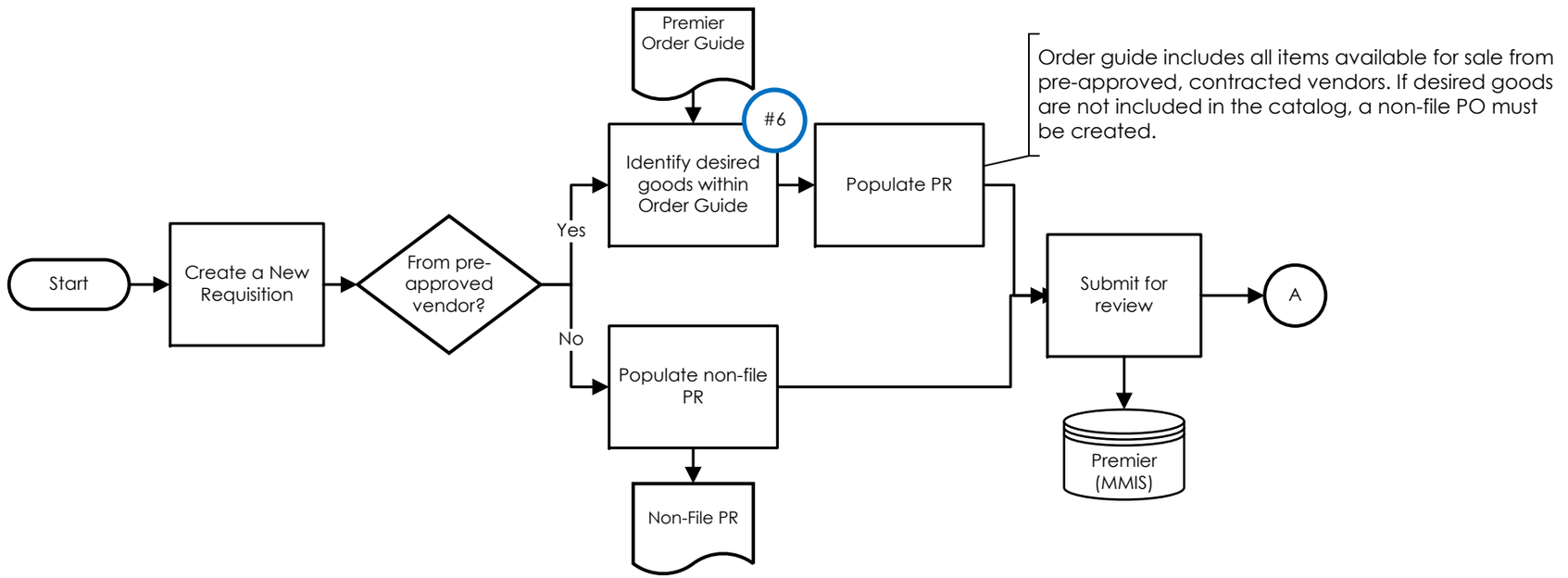
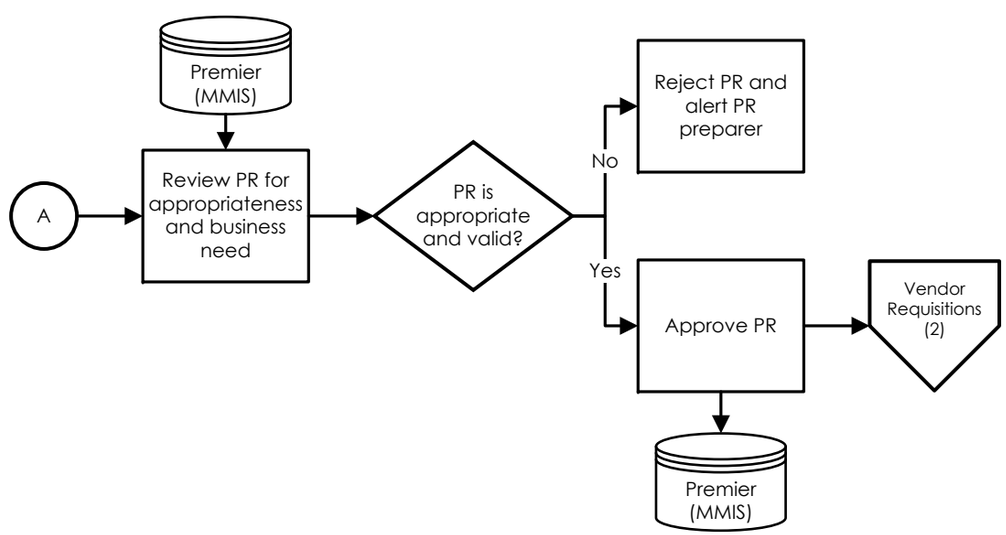


User Department Director (Requisition Approver)



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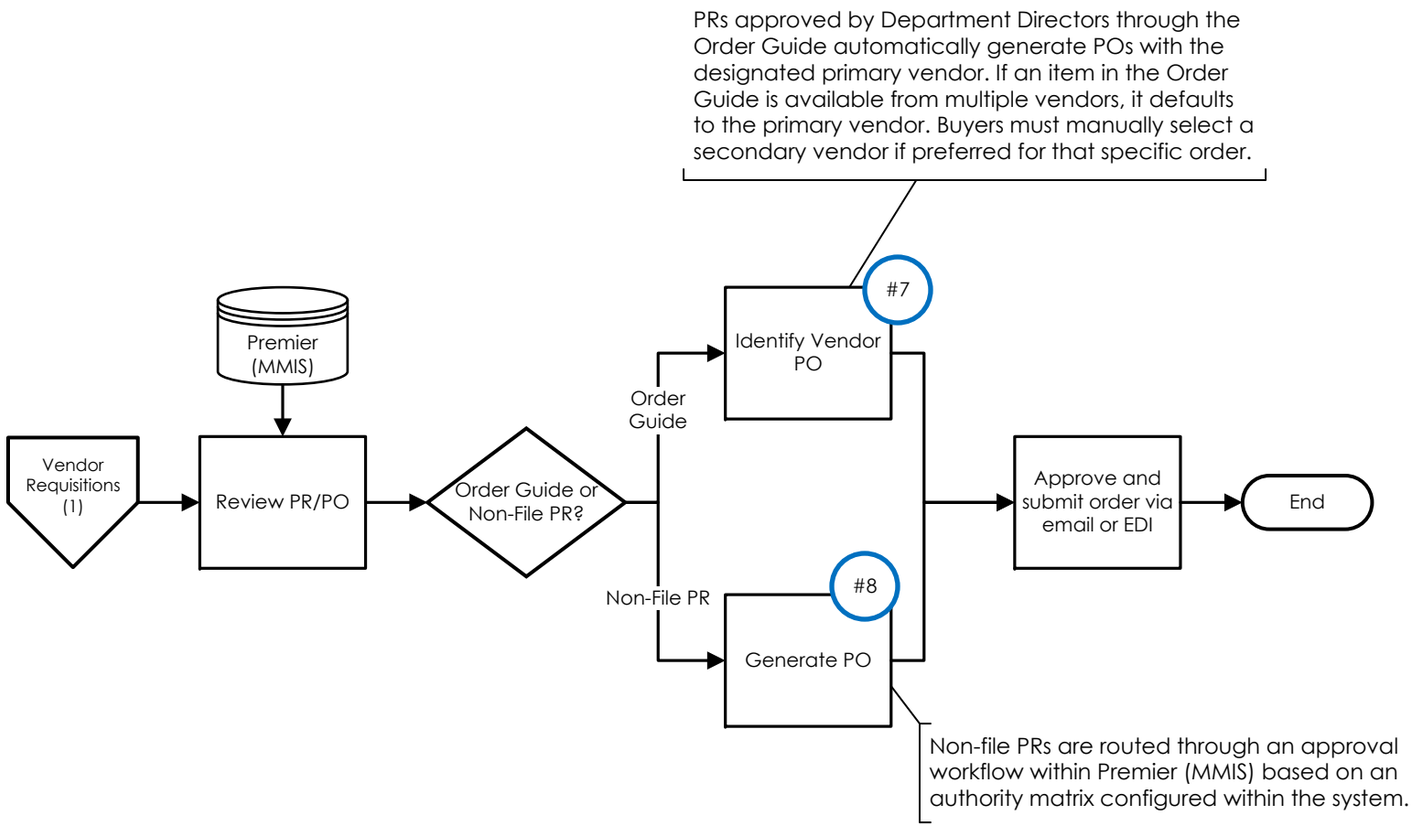
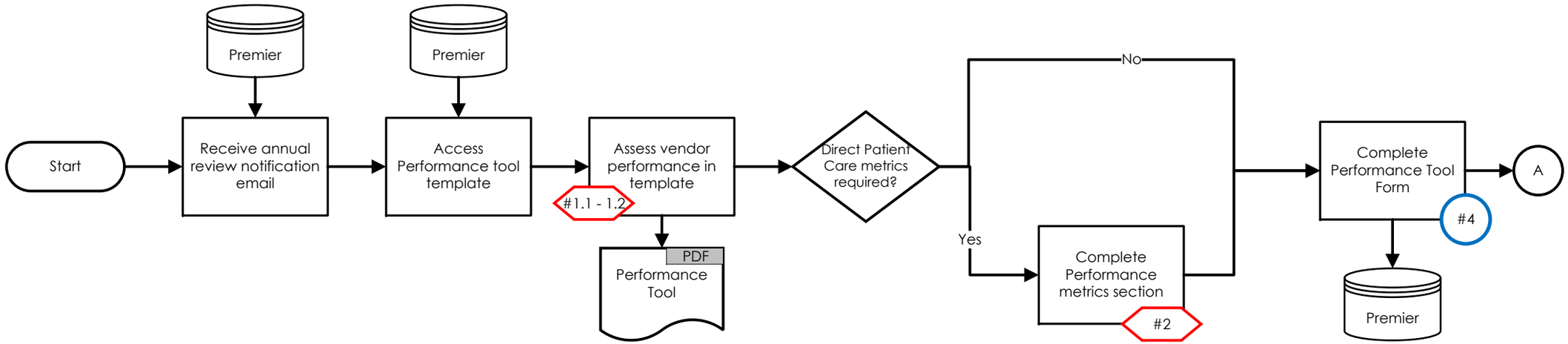
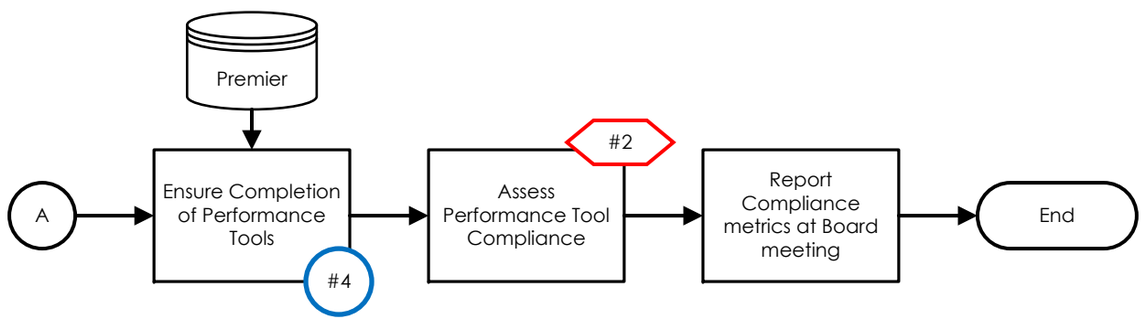


Annually

Contract Owner



Contract Manager- Marsha



Post Cybersecurity Event Review

Prepared for
Medical Center Health System

Review Date:
July 1, 2024 – July 26, 2024

Report Date:
August 27, 2024

CONFIDENTIAL INFORMATION:
This document is intended for the sole use of Medical Center Health System and contains confidential information.

weaver
Assurance · Tax · Advisory

TABLE OF CONTENTS

August 23, 2024

J. Grant Trollope
Assistant Chief Financial Officer
Medical Center Health System
500 W. 4th Street
Odessa, TX 79761

Weaver and Tidwell, L.L.P. (Weaver) was engaged by the Medical Center Health System ("the System", "MCHS") to perform a review over the System's approach and documented efforts for responding to the recent cybersecurity event involving the Rich Cabinets vendor in June 2024. The consulting review focused on key incident response activities conducted and associated artifacts, under the Statement of Work executed July 3, 2024.

The accompanying report details the scope, objectives, approach, and recommendations relating to the review. Our procedures were performed in accordance with the Statement on Standards for Consulting Services issued by the AICPA Management Consulting Services Executive Committee.

To accomplish our engagement objectives, we conducted inquiry with the System's key security and incident response stakeholders as well as accounting personnel that were targeted during the cybersecurity event. The review also assessed existing documentation, incident reports, procedures, phishing email statistics, and configurations related to activities performed during the incident response process at the time of the attempted social engineering event at MCHS.

This letter and the accompanying report is intended solely for the information and use by Management and the Audit Committee and is not intended to be used, and should not be used, by anyone other than the specified parties.

Please contact Trip Hillman, Trip.Hillman@weaver.com, if you have any questions or comments. We appreciate the opportunity to be of service to you and this letter and associated attachments conclude the engagement.

Weaver and Tidwell, L.L.P.

WEAVER AND TIDWELL, L.L.P.

Dallas, Texas

Assessment Overview

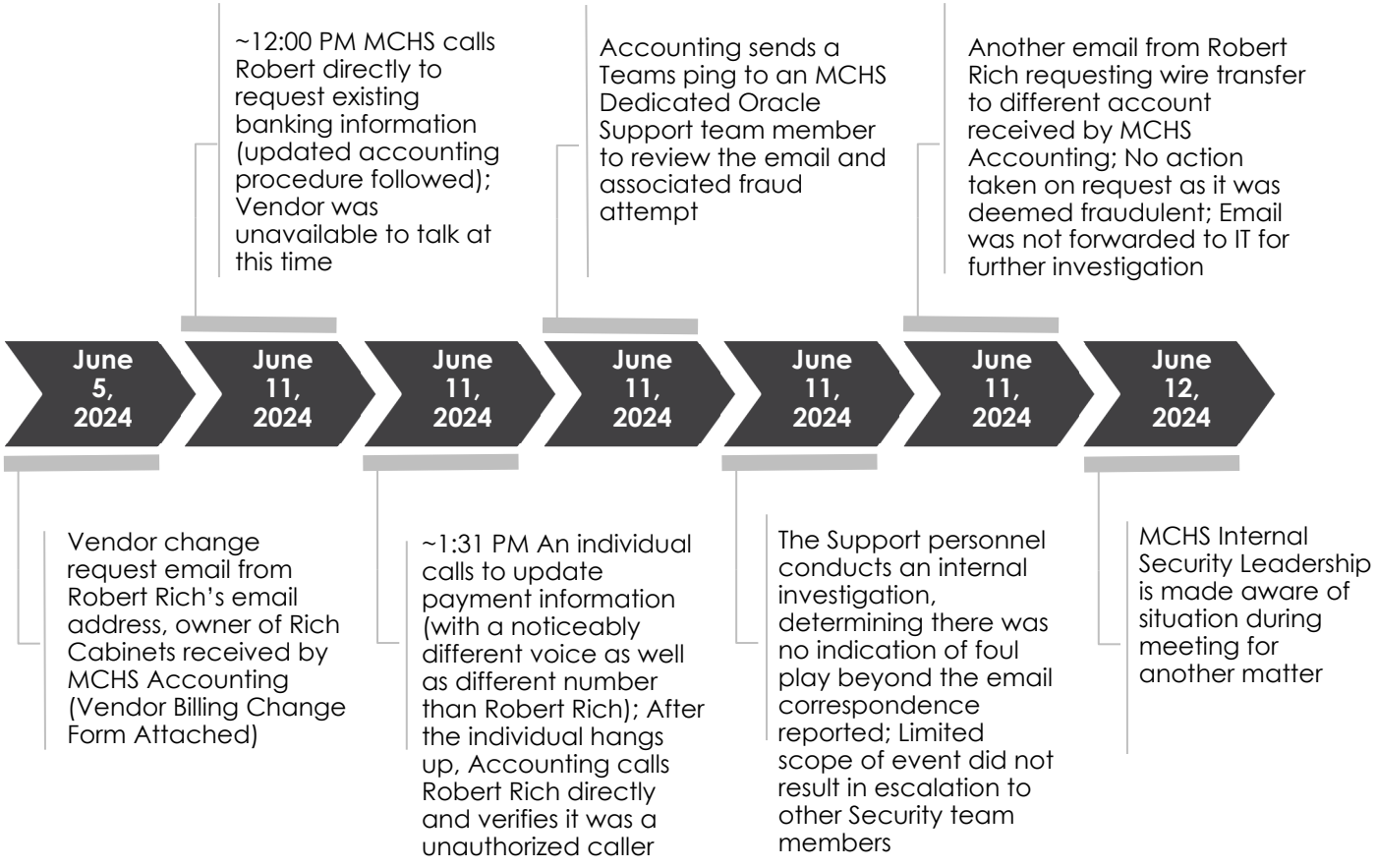
Project Background

Social Engineering Event

Medical Center Health System ("the System", "MCHS") experienced a social engineering attack resulting in attempted payment fraud during the month of June 2024 that originated from a vendor email account. The vendor involved, Rich Cabinets, was onboarded in February 2024 and was setup to receive paper checks for payment of services. During the month of June, an email from the CEO of Rich Cabinets was sent to request an update to payment information on file, inquire about an open invoice, and would later send a separate email to request a wire transfer. Upon further review as the event developed, MCHS would learn that while the email address was legitimate, the requests appeared to have been made from a malicious third-party. The event was positively identified as a social engineering attack, and no payments were made to the adversary's account.

Summary Timeline

The following graphic summarizes the key events that occurred throughout the social engineering attack. Please refer to Appendix B for further details around the event timeline and communications between involved personnel as well as the vendor.



Project Scope

Purpose

Employees are a critical line of defense for any entity's security plan. Employees are also the most vulnerable attack vector for malicious actors, which is why social engineering continues to be a key technique used by adversaries to compromise systems and data. For example, in the case of phishing, a malicious actor uses email in attempt to trick a user into performing an action or revealing sensitive information, in some cases, by posing as someone legitimate.

While the attempted payment fraud scheme was successfully identified by the accounting team and did not result in financial loss at the System, the System has experienced similar attempts within this past year, via email and in some cases phone call. The increased frequency of these types of events highlights the importance of periodically reviewing and adapting incident response procedures for responding to social engineering attacks.

The incident response function is foundational to any cybersecurity program and requires continuous testing and maturing to ensure teams have the necessary capabilities in place to effectively respond and recover from cybersecurity incidents while minimizing impact. The purpose of this project was to understand the scope of the Rich Cabinets potential incident and review the actions taken by key personnel to assess relevant incident response capabilities at the System.

Approach

During the month of July 2024, Weaver performed a security review over the response activities conducted for the Rich Cabinets payment fraud attempt. The engagement was coordinated by MCHS's Grant Trollope, Assistant Chief Financial Officer, and focused on assessing the System's capabilities for incident reporting and related analysis efforts for the potential incident.

We performed inquiry with key personnel in Security and Accounting and examined supporting artifacts related to the social engineering attack (e.g., email correspondence, event timelines, alerting configurations, etc.) as well as relevant existing policies, plans, and procedures in their current state. Please refer to Appendix C for further details of documentation reviewed as part of our engagement.

Key Objectives

- Review the System's approach for responding to the June 2024 social engineering attack (i.e., Rich Cabinets payment fraud attempts).
- Review related documented security incident report(s), tickets, and associated artifacts to understand the steps taken to verify the scope of the potential incident and document response efforts.
- Evaluate any indicators of compromise (IoC) that were used for comparison and investigation across devices, if applicable.
- Review available incident response plan(s), playbooks, and procedures utilized during response efforts.
- Understand logging and monitoring capabilities and detection strategy relative to impacted users, systems, network segments, etc.
- Understand where actions taken in response to the incident may have deviated from planned procedures.
- Identify potential gaps between the response plan used during the incident, triage steps, existing documentation, and industry standards.
- Enumerate opportunities of improvement for the incident response process.

Clarifying Remarks

- The assessment did not represent a holistic incident response or third-party risk management program review, rather, the engagement focused on reviewing response and risk management actions relating to the Rich Cabinets event in June 2024 to assess relevant incident response capabilities.

Project Results Summary

Conditions Present During Event

The following summarizes conditions Weaver observed to be present at the time of the review per walkthrough sessions with key stakeholders, including MCHS Security, Oracle, Accounting and Finance, and Vendor Management.

- **Accounting Positively Identified the Fraud Attempts:** Procedures for verifying vendor change requests have been enhanced this year to require multiple individuals to review, approve, and verify banking information with the vendor prior to applying any updates to vendor records. The Rich Cabinets change request form was reviewed by both Gabi Kent and Lorie Hyde, and the call placed to Robert Rich to verify banking information helped identify that the change request had a fraudulent bank account recorded.
- **Red Flags Present During Event:** The key red flags that presented themself during the attempted payment fraud via email from the vendor and phone call impersonation attempt included:
    - The original email was constructed with an urgent tone, requesting an update on an invoice
    - The phone number used to call MCHS Accounting to verify vendor information was a different phone number than the one that had been used to contact Robert Rich earlier in the day
    - The individual that called MCHS Accounting had a noticeably different voice than who they claimed to be (Robert Rich)
    - The bank accounts included within the Vendor Change Request form as well as the wire transfer request (via email) were unrecognized by the vendor
- **IT Security Event Analysis:** Response activities were conducted by Brad Dummer including a review of the email itself (e.g., sender, domain, header information, etc.) as well as login activity associated with the recipient, Lorie's, email account (e.g., MFA prompts, unusual/impossible logins, external login attempts, failed attempts, etc.). These activities resulted in no indication that there was foul play beyond the email itself. The reported social engineering attempt was not declared an incident and an incident response plan was not referenced during the analysis and/or handling of the event.
- **Event Report:** The attempted fraud event did not result in a documented ticket or incident report, per IT, based on the assessed limited scope of the event.
- **Phishing Reporting Channels:** MCHS employees can report potential phishing email attempts and social engineering attacks to IT personnel through four separate methods, two of which result in the creation of an IT ticket to document and track the reported email.
    - **Approved Reporting Channels**
        - **KnowBe4 Phish Alert Button**: Employees can report a suspicious email via the "Phish Alert Button" integrated within email. This function deletes the email from the user's inbox and forwards it to a shared inbox where MCHS and a limited number of Oracle Infrastructure and Security team members have access to perform further analysis. This method of reporting does not guarantee the creation of an IT ticket.
        - **Calling Helpdesk:** Employees can contact the Oracle Helpdesk (x1385) if they suspect a social engineering attempt or potential issue, and by utilizing this method, a ticket will automatically be created for the report to document and track the progress. Pending the severity of a reported incident, an IRC (Immediate Response Center via Incident Management Software xMatters) can be triggered that requires necessary parties (determined based on the scenario) to remain in contact until the issue is resolved.
        - **Submitting a Helpdesk Ticket Online:** Employees can report suspicious emails through the ticketing web-based portal available on the internal network at MCHS. As the reference implies, this method guarantees the creation of a ticket.

    - **Unofficial Reporting Channels**
        - **Direct Contact with IT/Security:** Employees can report suspicious emails by directly contacting Brad Dummer or Clinton Keene via phone call, email, or instant messaging (e.g., Microsoft Teams). This method does not guarantee the creation or documentation of an IT ticket.

- **Phishing Response Capabilities:** Clinton, Brad, and a limited number of Infrastructure personnel have access to search emails across the organization, and access to user inboxes to delete and/or forward messages if required. The current strategy for addressing reported phishing incidents includes identifying all users impacted by a particular phishing email, and utilizing these elevated permissions to remove the malicious email from user inboxes across the organization.
- **Phishing Alerting:** While alerts were not triggered related to this particular vendor email event, MCHS Security continues to configure additional rules within Microsoft 365 to block and alert on emails received from suspicious domains or emails that include suspicious content (based on a manual list of domains and verbiage maintained by MCHS Security).
- **Approximate Volume of Suspicious Emails Reported:** Approximately 5-10 potential phishing emails are reported directly to Brad Dummer on a weekly basis and approximately 1-2 potential phishing emails are reported via the Helpdesk monthly.
- **Phishing Analysis Documentation and Ticket Population:** At the time of the review, there was not a defined field within helpdesk tickets to allow for consistent flagging/labeling for reported phishing emails. A population of past phishing emails reported and associated documentation of analysis conducted for each was not available through the ticketing system.
- **Ticket Severity Levels:** The ticketing system deployed at MCHS through Oracle allows individuals to prioritize tickets into "High", "Medium", or "Low" criticality. The assigned criticality provides a level of precedence to be taken by IT when resolving reported issues.
- **Incident Response Plan and Playbooks**: At the time of the review, per MCHS security, the incident response plan was undergoing a rewrite and individual social engineering response playbooks had not yet been defined. Based on the limited scope of the attempted fraud event analyzed by Oracle, the incident response plan was not enacted, and ad-hoc analysis procedures were followed to close out the reported event.

Observation Summary

The review resulted in a number of enhancement opportunities that will assist MCHS in improving capabilities of the incident response program as it relates to social engineering attacks and phishing emails. The five points for consideration identified were classified according to the severity of a given risk exposure and resulted in the following breakdown. A detailed schedule of all recommendations are included in **Appendix A** of this report.

- One (1) point for consideration was considered **High** risk
- Three (3) points for consideration were considered **Medium** risk
- One (1) point for consideration was considered **Low** risk

Positive Highlights

- **Positive Identification of Fraud Attempt:** Enhanced vendor verification procedures supported the MCHS Accounting team's capabilities for identifying the adversarial fraud attempt, ultimately preventing the situation from progressing to an incident and causing a negative financial impact.
- **Sharing Awareness of Social Engineering:** The Accounting personnel involved in the social engineering attack notified other members of their team to alert them to the situation with vendor to ensure they were extra vigilant in any further required communications. They also alerted Oracle (i.e., Brad D.) allowing him to perform the necessary investigation and analysis to determine the depth of the issue.

Key Enhancement Considerations

- **Incident Response Escalation and Notification:** Procedures for analyzing security events, including criteria for determining when a detected and/or reported threat event requires notification to leadership (e.g., Information Security Officer, Chief Information Officer, and management) were not clearly defined to ensure understanding across incident responders at MCHS.
- **Reported Phishing Acknowledgment and Documentation:** MCHS maintains multiple avenues for individuals to report suspicious activity and/or social engineering attempts, however all methods do not result in formally documenting events within a ticket. This may result in an unacknowledged/unaddressed issue and generally speaking, the lack of documentation limits the data available for monitoring trends over time as well as evidence should further investigation to respond to an incident be required.
- **Incident Response Social Engineering Playbooks:** At the time of the review, incident response playbooks for social engineering events were not defined to ensure comprehensive investigation and consistency in response activities across all team members (i.e., Security leadership, Helpdesk, Oracle, etc.).

Given our understanding of the current state of response capabilities as it related to the June 11th social engineering event, we have provided a series of recommendations and points for consideration for management's review on the following pages.

Appendices

Appendix A - Detailed Points for Consideration

PFC Description and Recommendations

The following Points for Consideration (PFC) have been identified through the performance of review procedures including inquiry with MCHS stakeholders involved in the event. This list is presented for management's review and consideration to enhance existing practices.

Index #	PFC Title	Risk
1	**Security Event Escalation and Notification Procedures**	**HIGH**
Description	***Observation:*** Procedures for analyzing security events, including criteria for determining when a detected and/or reported threat event requires notification to the Information Security Officer, Chief Information Officer, and management, were not clearly defined. After identifying the Rich Cabinets payment fraud attempt on June 11, individuals of the Accounting team reached out to Brad Dummer directly via Teams ping to notify him of the event. Brad performed analysis (e.g., manual review of email attributes and sender domain), determined there were no indicators of compromise within the MCHS environment, and declared the event closed. MCHS security leadership (i.e., Clinton Keene, Linda Carpenter) were not notified of the event. *Note: The Accounting individual that was targeted notified the broader Accounting team to be vigilant when dealing in matters with this particular vendor.* ***Potential Impact:*** Without clear criteria defined, there may be uncertainty and inconsistent understanding among team members for when to notify leadership of a suspected security event or incident leading to a lack of transparency and awareness among key response personnel. This may hinder the ability to effectively analyze the risk associated with the event potentially delaying required response efforts. ***Recommendation:*** Management should formally document procedures and related criteria for assessing reported security threats and events, to clearly capture requirements for acknowledgement, analysis, and notification to the correct personnel on the status of a given event. This will help ensure that the necessary team members are involved to appropriately mitigate a threat event and/or formally declare an event as an incident, triggering the formal incident response process. Criteria considered may include various attributes of a reported event (e.g., how many users and/or endpoints impacted, sensitivity of data impacted, privileges of users impacted, etc.).	

Index #	PFC Title	Risk
2	**Phishing Event Acknowledgment and Documentation**	MEDIUM

Description

Observation: Formal acknowledgment of reported social engineering attempts (e.g., phishing emails) is not consistently documented or tracked (e.g., within a service ticket) to ensure each reported event is looked at, required stakeholders are notified, necessary actions are taken, potential risk is fully mitigated, and data for future analysis (e.g., trend reporting, further investigation, root cause analysis, etc.) is available.

MCHS has multiple methods for reporting suspected phishing emails, however only a subset of reporting channels results in the creation of a ticket to document analysis performed, actions taken, remediation required, and personnel involved.

- Methods that automatically result in a ticket:
  - Calling helpdesk (x1385)
  - Submitting a ticket via the internal web portal
- Methods that do not automatically result in a ticket:
  - Phish Alert Button email plugin (via KnowBe4 integration)

Further, Brad Dummer and Clinton Keene, are regularly contacted directly via email or Teams message. This effectively notifies key personnel, however, it often leads to a lack of documentation to capture the outcomes of the analysis performed by IT in response to the user reported security event, as tickets are not consistently created retroactively.

Potential Impact: Inconsistent documentation of reported security events may lead to incomplete or insufficient response and investigations, gaps in understanding of potential risk, limited visibility by all necessary stakeholders, and/or insufficient data to detect root cause of reported issues and further areas of concern. Missing documentation may also hinder the ability for the System to learn from past incidents for future reference and limit capabilities for measuring health of the cyber awareness program overtime.

Recommendation: Management should ensure that all reported social engineering events (e.g., suspected phishing emails), regardless of reported method, are formally acknowledged, analyzed, and documented. Conclusions based on preliminary response efforts should be captured within a ticket (or equivalent) to ensure that all required actions have taken place and there is documentation to assist necessary personnel in the event the potential security concern is escalated and/or requires further investigation. Requirements for what information is to be included within each ticket should be clearly defined, captured within policy, and shared with personnel responsible for responding to reported events so it is understood that tickets are required, even in a retroactive manner if necessary.

Additionally, Management should continue to train users on the methods for reporting potential social engineering attempts to ensure that approved channels are understood and utilized consistently. In addition to existing security awareness training reminders, management should consider periodic newsletters and/or emails to highlight information for contacting IT support, tips for what to include when submitting tickets, service desk hours, etc.

Lastly, Management should research the impact of integrating the "Phish Alert Button" with the IT service management system to automatically create tickets whenever users submit a suspicious email through this method. This will create a formal report that requires acknowledgment and response from responsible personnel and help contribute to creating

	historical data sets for additional analysis and tracking over time. *Note: Phishing simulations should be categorized in a manner that does not impede the response team's efforts to action real reported threats.*

Index #	PFC Title	Risk
3	**Ticket Categorization and Phishing KPI Tracking**	MEDIUM

Description

Observation: During the review, a population of reported phishing emails over a historical period could not be produced (e.g., via the ticketing system), primarily due to the inconsistency at which reported social engineering events are formally tracked. Additionally, if a ticket is created, there was not a defined classification scheme to help distinguish between the types of security events and/or service tickets reported (i.e., Social Engineering, Potential Phishing Email, Password Change Request, Software Request, etc.).

Per inquiry, there was no category description that was consistently used to clearly denote reported social engineering events (e.g., phishing emails) limiting capabilities to formally track phishing trends overtime. The lack of data hinders management's ability to effectively communicate with leadership the status of the security awareness training program and Key Points of Interest (KPI) surrounding the social engineering threat vector that is prevalent in targeting the MCHS environment.

Potential Impact: Absent clear categorization of tickets to support trend analysis over time may result in missing valuable insights (e.g., patterns common characteristics of phishing emails) that can be used to help improve security awareness training and email security controls. Further, the lack of categorized data points may hinder management's ability to effectively communicate the status of existing programs and the current threat landscape resulting in decisions and prioritizations based off limited data.

Recommendation: Management should review the ticketing system to understand capabilities for implementing a standard set of labels/tags to properly categorize tickets associated with social engineering and reported phishing emails. This will create a consistent schema that contributes to necessary reporting over time (filtering) and enhances capabilities for reviewing social engineering metrics. Where possible, automation associated with tagging and categorizing tickets should be prioritized based upon the best use of existing resources (e.g., tools and personnel). Examples may include:

- Relying on native features within the ticketing system (e.g., utilizing suggested categorization based on key words within the ticket).
- Automatically labeling tickets submitted via the Phish Alert Button with the 'Phishing' category.

Management should also clearly define KPIs (e.g., number of phishing emails received, time to respond to reported social engineering events, number of phishing tickets resolved, phishing simulation click rates, etc.) related to the security awareness and incident response programs at MCHS to incorporate consistent measurement of control/safeguard capabilities, identify opportunities for enhancement, and facilitate effective communication with leadership.

Index #	PFC Title	Risk
4	**Incident Response Playbooks for Social Engineering**	MEDIUM

Description

Observation: At the time of the review, MCHS or dedicated Oracle support personnel did not have incident response playbooks defined to help enumerate the steps and considerations for efficiently analyzing and responding to reported social engineering events and suspected phishing emails.

Potential Impact: Without defined procedures and guidelines, individuals tasked with investigating social engineering events may lack the necessary structure and guidance to ensure a thorough and comprehensive investigation.

Additionally, the absence of defined steps increases the risk of inconsistent performance across team members potentially resulting in crucial components being overlooked and/or bypassed, inconclusive analysis, incomplete investigations, gaps in leadership's visibility, and an overall increase of potential impact for a phishing event.

Recommendation: MCHS Management should ensure social engineering incident response playbooks (e.g., Wiki, Checklist, Automated workflows, etc.) are maintained to define procedures to be followed by response personnel (inclusive of MCHS, Oracle, Helpdesk, etc.) in the case of a suspected social engineering attack (e.g., phishing email campaign).

Incident response playbooks should not conflict with the defined Incident Response Plan, rather, they should provide further detail for analyzing, containing, remediating, documenting, and preserving evidence for a specific type of probable incident, in this case, a social engineering or phishing email attack. Playbooks should be maintained and published/made available for necessary personnel to reference.

The playbook may consider portions of the response function that are highly repeatable as well as who to contact if nuances and/or special circumstances are experienced. For the example of phishing, a playbook should clearly define roles and responsibilities and consider all steps for responding to a phishing attack, including:

- Identifying the scope of the campaign
- Criteria for determining severity
- Analyzing the message securely (e.g., how to analyze links and attachments without exposing the network to further potential compromise)
- Investigating sender, domains, header information
- Scanning impacted systems
- Documenting analysis, conclusions, and remediation actions
- Preserving evidence for forensics
- Containing the attack (e.g., changing login credentials, blocking further emails and domains, sink-holing domains, removing delivered emails from inboxes, enhancing detection capabilities, etc.)
- Communicating status with necessary stakeholders based on severity

Further, as playbooks are a dependency of the Incident Response Plan, any use of the playbook in a response effort should trigger a 'lessons learned' activity which may link to the System's Incident Response Plan's required post-incident actions. This may include, documenting formal incident reports where necessary as well as capturing any lessons learned

	that can enhance the overall security posture at the System.

Index #	PFC Title	Risk
5	**Vendor Management Reporting and Post-Mortem Procedures**	LOW

Description	***Observation:*** MCHS did not have a defined process in place for performing a follow-up review with the vendor (Rich Cabinets), post-event, to positively confirm security of future communications, interactions, invoice payments, etc. At the time of the review, MCHS had not followed up with the vendor to understand how the adversary was able to leverage the vendor's email account to send the invoice and wire transfer requests to attempt to route payment to the attacker-controlled accounts. ***Potential Impact:*** Necessary enhancements related to the vendor management program may not be addressed if a post-mortem exercise, inclusive of the vendor's active participation, is not conducted. Further, root cause issues associated with the vendor originated attack may not be understood and applied across the program to uphold the minimum level of security expected for third-parties that interact with the System. ***Recommendation:*** Management should review existing vendor management policies to define requirements for performing post-mortem reviews with any vendors that the System suspects has experienced a security event and/or incident that may cause harm to MCHS (e.g., financial impact). This may also be achieved through requesting and reviewing affected vendors' post-incident analysis (write-up) to understand potential impact to the existing vendor management program at the System. More specifically, for the June 11th event, management should perform a follow-up review with the Rich Cabinets vendor, to understand the root cause and any remediation activities required to ensure secure practices are in place moving forward. Additionally, MCHS Management (Security, Accounting, and Legal) should review vendor contracts to consider clauses requiring notifications to necessary personnel at MCHS in the event a vendor experiences a security incident that could impact the System.

Appendix B – Incident Timeline (Detailed Occurrences)

Detailed Timeline	
Date/Time (All Times CT)	**Event Summary**
Date: February 2024	**Initial Vendor Setup** • The vendor, Rich Cabinets is onboarded and initially setup within MCHS systems • Paper checks is elected as the vendor payment method (i.e., no banking account information is put on file)
Date: May 7, 2024 **Time:** 4:17 PM	• Robert Rich 'robert@richcabinets.com' emails Carlos Aguilar at MCHS with attached Shop Drawings for the 3 West Millwork Project; Email Subject: Millwork Drawings 3 West • Robert requests a signed approval of the drawings
Date: June 5, 2024	**Vendor Information Update Requested** • Vendor Robert Rich ('robert@richcabinets.com'), sends a vendor change request form requesting an update to billing account information and a completed W9 to Gabi Kent, AP Clerk at 'gkent@echd.org' • The request being sent by 'Robert Rich' was typical form of communication from this specific vendor • Gabi forwards the completed forms to Lorie Hyde who is required to review vendor change forms prior to processing (i.e., change requests require multiple personnel to review prior to approving) • The form submitted by Rich Cabinets was inspected upon delivery and did have a signature present by Robert Rich
Date: June 10, 2024 **Time**: 4:59 PM	• Robert Rich 'robert@richcabinets.com' emails Carlos Aguilar reminding Carlos about co-signing the payment of the invoice (related to Millwork Drawings 3 West) • Robert requests confirmation of payment • Robert's email presents urgent tones
Date: June 11, 2024 **Time**: 6:27 AM	• Carlos Aguilar notifies Robert Rich ('robert@richcabinets.com' via email that he would provide a status after looking into it with accounting
Date: June 11, 2024 **Time**: 7:36 AM	• Robert Rich 'robert@richcabinets.com' responds via email to Carlos notifying him that he awaits a "quick response" and is currently online to confirm from his bank; the signature within email includes Robert Rich's phone number on file
Date: June 11, 2024 **Time:** 11:21 AM	• Lorie calls Robert Rich to perform verification of the banking information to switch from paper check to ACH (previous form send on June 5); Vendor verification requires confirmation of banking information with the requester • Robert Rich was away from his desk and did not have the banking information handy to perform verification • Per Robert's request, Lorie sends an email to Robert Rich 'robert@richcabinets.com' that includes her direct line so that Robert can call her back when he is ready with the information
Date: June 11, 2024 **Time:** ~12:00 PM	• Robert calls Lorie, but she was unable to answer the call and discuss the vendor request at the time • Lorie calls Robert Rich, asking to reconvene (via call) around 1:30 PM to complete the vendor request form

Detailed Timeline	
Date/Time (All Times CT)	**Event Summary**
Date: June 11, 2024 **Time:** 1:31 PM	• Lorie receives a call (from a phone number different than the one Robert called with earlier in the day); The individual on the call claimed that they were from Rich Cabinets and wanted to follow-up on a payment ○ Note: This individual was asking about a separate matter from the previous vendor change request form that Lorie was attempting to get in touch with Robert Rich to verify earlier this day. • Lorie states that they must first validate the vendor information with the owner, Robert Rich, and complete the vendor verification process before any payments are made • The individual then claims that they are Robert Rich and can complete the verification process • Lorie does not recognize the individuals voice (as she spoke with Robert earlier in the day) and the unknown individual hangs up; The individual had a different accent than Robert and appeared to be younger
Date: June 11, 2024 **Time:** 1:32 PM	• Lorie calls Robert Rich directly to inquire whether another employee was instructed to reach out; Robert appears confused and confirms he was unaware of another individual that would be calling on his behalf (alerting Lorie of the possibility of a further issue) • Lorie asks Robert to verify the vendor information included on the vendor change request form sent on June 5 • Lorie and Robert do not refer to a particular invoice that may have been inquired about during the fraud attempt phone call • The phone number (ending in 1294) and the banking information within the vendor form sent to MCHS on June 5th were unrecognized by Robert • Robert confirms again that he did not instruct any employees to reach out on his behalf • No payment is made to the fraudulent bank account

Date: June 11, 2024
Time: ~4:00 PM
	• Lorie and Christine reach out to Brad Dummer, via Teams ping to notify of situation; Brad calls Lorie to discuss; The initial email to Gabi on June 5th (with the vendor change request form attached) was forwarded to Brad for review
	• To determine the potential scope and impact of the event, Brad primarily reviewed the following:
	  ○ The forwarded email itself (DNS, Email Headers, Sender, etc.)
	  ○ Login activity associated with Lorie's email account (e.g., MFA prompts, unusual/impossible logins, external login attempts, failed attempts, etc.)
	  ○ No indication of foul play beyond the vendor sent email or further access attempts on the internal network identified
	• Due to the initial analysis determining the limited scope of the fraud attempt, correspondence is not further escalated to Security leadership (i.e., Clinton, Linda)
	• Helpdesk was not contacted to create a ticket for the event

Date: June 11, 2024 **Time:** ~3:30 PM	• Robert Rich calls Lorie to notify her that the original vendor information provided in February did not contain banking information because he wanted the payment method to be a paper check • Lorie and Robert discuss the possibility that a bad actor could be at play • Lorie shares information the rest of the Accounting team and the engineering team to be cautious of any further interactions with Rich Cabinets
Date: June 11, 2024 **Time**: 6:21 PM	• Carlos Aguilar notifies 'robert@richcabinets.com' via email that they will be cutting a check tomorrow (June 12, 2024) and will keep Robert updated

Detailed Timeline	
Date/Time (All Times CT)	**Event Summary**
Date: June 12, 2024 **Time:** 9:01 AM	• Carlos and Lorie receive an email from Robert Rich 'robert@richcabinets.com' requesting that the payment be provided via wire transfer due to accounting issues on their end; The new account information is different from what was previously sent in the vendor change request form • The email subject was "Millwork Drawings 3 West Payment Update" and was signed 'Thank you, Rich' versus "Robert" • No actions to process the wire transfer were taken by MCHS accounting
Date: June 12, 2024 **Time:** 2:07 PM	• Carlos carbon copied the fraudulent wire fraud email to Lorie who then forwarded it to Christine; This email was not forwarded to MCHS IT/Security • Rich Cabinets was notified of this additional email requesting wire transfer by phone call from Accounting
Date: June 12, 2024	• Grant notifies Linda of the situation during a meeting for another matter
Post-Event	• Since the event, there has been no coordination with Rich Cabinets to clarify what took place and if the issue has been internally resolved. • There are no parameters within the existing vendor contract requiring Rich Cabinets to notify MCHS of a suspected cybersecurity incident. • Payment methods have not been updated for this vendor.

Appendix C – Sources Utilized

Interview Summary

The following table documents the meetings that occurred with members of the MCHS team and a summarized list of items discussed.

Date	MCHS Stakeholders	Discussion Items
July 10, 2024	• Grant Trollope, Assistant Chief Financial Officer • Christine Stucks, Assistant Controller • Linda Carpenter, Vice President/CIO • Clinton Keene, Information Security Officer • Cuca Franco, Senior Accountant • Lorena Hyde, Accountant	• Event Timeline Overview • Phishing Reporting Channels • Monitoring and Alerting Technologies (Associated with Suspicious Email) • Incident Response Communication Procedures and Escalation • Incident Response Plan, Playbooks, Scripts
July 18, 2024	• Brad Dummer, IT Security Engineer • Clinton Keene, Information Security Officer	• Event Analysis and Associated Documentation • Follow-up Response Activities • Confirmation of How Event was Reported • Incident Response Plan, Playbooks, Scripts • Ticket System Overview (Categorization, Documentation, etc.) • Recent Phishing Attempts and Associated Analysis Activities

Documentation Reviewed Summary

The following table summarizes the provided documentation that was reviewed throughout the assessment.

Description	Reference
Email Blocking Statistics – A line graph demonstrating the number of blocked emails and the criteria in which they are blocked by (i.e., phishing email, spam, edge protection, rule messages, and malware)	"Email Blocked from MCH Environment.docx"
Fraud Attempt Description – Emails sent and received internally recounting the attempted fraud incident as well as providing the email evidence associated with the fraudulent vendor information change request and attempted wire fraud.	"FW Rich Cabinets' - Attempted fraud incident.msg"
Email Blocking Rules – Example rulesets configured by the System within MS365 to block emails based on suspicious domains, key words, and attachment types.	"M365 Rules that Block Email.docx"
Phishing Ticket Example – Example ticket within the Oracle Ticketing System for a social engineering attempt reported by an employee through the helpdesk.	"Oracle Phishing Ticket.docx"
IRC Group Members – Screenshot from the Xmatters portal demonstrating the four individuals that are members of the MCH_TX_OnSite_Ldrshp_ITWx support team, the first individuals contacted in the case of an incident and responsible for contacting other relevant personnel.	"Xmatters Leadership Group Call Out.docx"
Timeline Questionnaire – MCHS completed questionnaire provided by Weaver about the attempted fraud security event.	"MCHS_Post-Incident Assessment_Follow-Up Questions_07232024 (2).xlsx"

Appendix D – Risk Scoring Methodology

Individual observations are classified and prioritized according to the severity of a given risk exposure. The severity is a function of the impact of a risk event (i.e., considering financial, operational, legal, regulatory and reputational exposure) and its occurrence frequency or probability.

Risk Rating	Definition of Risk Rating
Low	A control deficiency represents a low degree of exposure due to weaknesses in control environment and / or instances of non-compliance with internal control. Compensating controls exist; however, implementation of a corrective action will facilitate the performance of the control. Issue may relate to improvements in existing controls and suggestions for alternative or additional control procedures. **Urgency of Corrective Action by Management**: Without regard for other dependencies, agreed upon action plans to address this issue will be executed at the discretion of the process owner(s). If resolution of the matter is a dependency for correcting other higher risk issues, then that may modify the urgency.
Medium	A control deficiency exists that represents a moderate degree of exposure due to weakness in the control environment and / or instances of non-compliance with internal control. When isolated, this issue may hinder, but not prevent Management from achieving assessed business objective. **Urgency of Corrective Action by Management**: Agreed upon action plans to address this issue will be executed within an agreed upon period.
High	A critical control deficiency exists that represents a significant exposure due to weaknesses in the control environment and / or instances of non-compliance with internal control. A minimum standard of internal control has not been met for this control. Compensating or mitigating controls could not be identified. **Urgency of Corrective Action by Management**: An immediate, comprehensive corrective action plan should be a high priority with progress being monitored by an appropriate level of management.