ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING
FEBRUARY 11, 2025 – 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 Richard Herrera (p.3)

VI. AWARDS AND RECOGNITION

A. February 2025 Associates of the Month ..... Russell Tippin
- Nurse - Pete Carrasco Flores Jr.
- Clinical – Pamela R. Randall
- Non-Clinical - Jazmin S. Rosas

B. Net Promoter Score Recognition ..... Russell Tippin
- Angela Green, NP
- Stephanie Kubacak, M.D.

VII. CHECK PRESENTATION FROM HUMAN BEAN ..... Alison Pradon

VIII. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

IX. PUBLIC COMMENTS ON AGENDA ITEMS

X. CONSENT AGENDA ..... Wallace Dunn (p.4-90)
(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, January 14, 2025
B. Consider Approval of Joint Conference Committee, January 28, 2025
C. Consider Approval of Federally Qualified Health Center Monthly Report, December 2024

XI. COMMITTEE REPORTS

A. Finance Committee ..... Don Hallmark (p.91-155)
1. Quarterly Investment Report – Quarter 1, FY 2025

2. Quarterly Investment Officer's Certification
3. Financial Report for Month Ended December 31, 2024
4. Consent Agenda
   a. Consider Approval of TD Industries Contract Renewal
   b. Consider Approval of the Service Agreement for Velys Robot for Total Knee
   c. Consider Approval of Additional Funds for IsoRX
   d. Consider Approval of Purchase of Skytron Surgical Tables & Accessories – MCH Foundation Funding Approved
5. Consider Approval of Strata Software Use Agreement
6. Consider Approval of Baxter Healthcare Agreement
7. Consider Approval of Junum Agreement
8. Consider Approval of Siemens Negative Pressure Monitors Purchase

B. Executive Policy Committee ..... Bryn Dodd (p.156-157)

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

XIII. 2025 EOC MANAGEMENT PLANS ..... Amanda Everett (p.158-182)

XIV. CONTRACT FOR ELECTION SERVICES ..... Steve Steen

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

A. Project Oasis
B. Ad hoc Report(s)

XVI. 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; (2) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code; (3) Deliberation regarding Real Property pursuant to Section 551.072 of the Texas Government Code; and (4) to receive the Compliance Report from the Chief Compliance Officer pursuant to Section 161.032 of the Texas Health and Safety Code.

XVII. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreements

XVIII. 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
JANUARY 14, 2025 – 5:30 p.m.

MINUTES OF THE MEETING

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

MEMBERS ABSENT: Richard Herrera

OTHERS PRESENT: Russell Tippin, Chief Executive Officer
Matt Collins, Chief Operating Officer
Steve Steen, Chief Legal Counsel
Kim Leftwich, Chief Nursing Officer
Dr. Nimat Alam, Vice 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 5:30 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 Richard Herrera was absent. His absence was excused.

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

Will Kappauf presented the Mission, Vision and Values of Medical Center Health System.

VI. AWARDS AND RECOGNITION

A. January 2025 Associates of the Month

Russell Tippin, Chief Executive Officer, introduced the January 2025 Associates of the Month as follows:

- Clinical – Jeremy Wayne Hild
- Non-Clinical – Daniela Torres
- Nurse – Agnes A. Villarojo

B. Net Promoter Score Recognition

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

- ProCare Family Medicine – Golder

C. 2024 Associates of the Year

- Dr. H.E. Hestand Humanitarian Award: Meagan Parker, RN
- Florence Nightingale Award: Lakesha Caufield, RN
- Chaplain Jimmy Wilson Service Excellence Award: John Arredondo
- Ted Crowe People's Choice Award: Audra Cullison

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, December 3, 2024
B. Consider Approval of Federally Qualified Health Center Monthly Report, November 2024
C. Consider Approval of Investment Policy Annual Review

Don Hallmark moved, and Will Kappauf 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. Financial Report for Month Ended November 30, 2024
2. Consent Agenda
   a. Consider Approval of Additional Funds for Airgas.
   b. Consider Approval of VMware Software License Support Renewal.
   c. Consider Approval of Additional Funds for Sophie PET Radiopharmaceuticals.
   d. Consider Approval of Additional Funds for Pylarify PET Radiopharmaceuticals.
   e. Consider Approval of Neonatal Transporter – CMN Funding Approved.

3. Consider Approval of Cyber Vault Backup Solution Purchase.

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

B. Executive Policy Committee

The Executive Policy Committee met on December 19, 2024 to review and approve sixteen (16) MCH policies meeting the committee guidelines. The committee recommends approval of the submitted policies as presented.

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

XI. TTUHSC AT THE PERMIAN BASIN REPORT

No report was provided.

XII. QAPI PLAN ANNUAL REVIEW

Courtney Look-Davis, Chief Experience Officer, presented the Annual Review of QAPI Plan for 2025 to the Board for approval.

Kathy Rhodes moved, and Bryn Dodd seconded the motion to approve the QAPI Plan for 2025 as presented. The motion carried.

XIII. INFECTION PREVENTION PLAN ANNUAL REVIEW

Courtney Look-Davis, Chief Experience Officer, presented the Annual Review of the Infection Prevention Plan for 2025 to the Board for approval.

Kathy Rhodes moved, and Bryn Dodd seconded the motion to approve the Infection Prevention Plan for 2025 as presented. The motion carried.

XIV. PATIENT SAFETY PLAN ANNUAL REVIEW

Courtney Look-Davis, Chief Experience Officer, presented the Annual Review of the Patient Safety Plan for 2025 to the Board for approval.

Kathy Rhodes moved, and Bryn Dodd seconded the motion to approve the Patient Safety Plan for 2025 as presented. The motion carried.

XV. PATIENT SAFETY SURVEY RESULTS FOR REVIEW

Courtney Look-Davis, Chief Experience Officer, presented the Patient Safety Survey results for the Board to review.

This information was informational only. No action was taken.

XVI. DESIGNEE FOR INFECTION PREVENTION PRACTICES – BRENDA DALRYMPLE

Courtney Look-Davis, Chief Experience Officer, requested the board appoint Brenda Dalrymple as the Infection Prevention Practices designee for Medical Center Hospital.

Kathy Rhodes moved, and Will Kappauf seconded the motion to appoint Brenda Dalrymple as the Infection Prevention Practices designee. The motion carried.

XVII. DESIGNEE TO LEAD HOSPITAL WIDE QAPI PROGRAM – KYLE VAUGHT

Courtney Look-Davis, Chief Experience Officer, requested the board appoint Kyle Vaught as the Hospital Wide QAPI Program Lead for Medical Center Hospital.

Kathy Rhodes moved, and Will Kappauf seconded the motion to appoint Kyle Vaught as the Hospital Wide QAPI Program Lead. The motion carried.

XVIII. ORDER OF ELECTION OF DIRECTORS OF THE ECTOR COUNTY HOSPITAL DISTRICT

Steve Steen, Chief Legal Counsel, presented the Order of Election for ECHD District 1, 3, 5 and 7.

David Dunn moved, and Don Hallmark seconded the motion to approve the Order of Election as presented. The motion carried.

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

A. Tax Election / ESD Discussion

No report was given.

B. Humana Advantage Update

Russell Tippin, President/CEO, reported that the Humana Contract expired as of December 31, 2024, so MCH is now out-of-network, as are the other TPC hospitals.

This report was informational only. No action was taken.

C. Ad hoc Reports

A Newsweek article was provided to the Board Members, showing Ector County is 5th in the Nation for residents not having insurance coverage.

An update on the Diabetes Clinic was provided by Grant Trollope.

The Regional Services Update and the Communications & Marketing Update were provided in the board packet.

These reports were informational only. No action was taken.

XX. 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 negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code; (3) Deliberation regarding Real Property pursuant to Section 551.072 of the Texas Government Code; and (4) to receive the Compliance Report from the Chief Compliance Officer pursuant to Section 161.032 of the Texas Health and Safety Code.

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

Adiel Alvarado, President 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 Property Lease agreements to the ECHD Board of Directors during Executive Session,

Steve Steen, Chief Legal Counsel, reported to the ECHD Board about the sealed bids received for the 42nd Street Clinic sale.

Wallace Dunn, ECHD Board President led the board in discussion about surgery block time.

Russell Tippin, CEO, and Wallace Dunn, ECHD Board President, led the Board in discussions about establishing a PAC.

Steve Steen, Chief Legal Counsel, led the ECHD Board in discussion about FOIA requests.

Matt Collins, Chief Operating Officer and Kerstin Connolly, Paralegal, were excused from the remainder of Executive Session.

The ECHD Board members engaged in discussions about legal matters with Chief Legal Counsel.

Executive Session began at 6:12 p.m.
Executive Session ended at 8:10 p.m.

No action was taken during Executive Session.

XXI. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreements.

Wallace Dunn presented the following amendments:

- Eduardo Salcedo, M.D. – This is an amendment to a Wound Care Contract.
- Eduardo Morfa Romero, M.D. – This is an amendment to an Infectious Disease Contract.

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

B. Consider Approval of MCHS Lease Agreements.

Wallace Dunn presented the following MCHS Lease Agreements:

- MCH ProCare – WSMP Suite 300 – This is a three (3) year property lease agreement.
- Dr. Carl Brown – This is a one (1) year property lease agreement.

David Dunn moved, and Don Hallmark seconded the motion to approve the MCHS Lease Agreements as presented. The motion carried.

C. Consider the Sale of the 42nd Street Property.

No action was taken.

XXII. ADJOURNMENT

There being no further business to come before the Board, Wallace Dunn adjourned the meeting at 8:12 p.m.

Respectfully submitted,

David Dunn

David Dunn, Secretary
Ector County Hospital District Board of Directors

Medical Center Hospital
A Member of Medical Center Health System

February 11, 2025

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:
Medical Staff and Allied Health Professional 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
Patrick Craddock, MD	Emergency Medicine	Emergency Medicine	BEPO	02/11/2024-02/10/2025
**Alaa Eldemerdash, MD	Pediatrics	NICU	TTUHSC	02/11/2024-02/10/2025
Rickey Hamby, MD	Family Medicine	Family Medicine		02/11/2024-02/10/2025
**Kenneth Heym, MD	Pediatrics	Telemedicine Hematology/Oncology	Cook Children's	02/11/2024-02/10/2026
**Michelle Iverson, MD	Pathology	Pathology		02/11/2024-02/10/2025
**Clarissa Johnson, DM	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
**Cynthia Keator, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
**Adrian Lacy, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
** Jaehyung Lim, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
** Saleem Malik, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
Kristen Miller, MD	Radiology	Telemedicine	VRAD	02/11/2024-02/10/2026
**Jeffrey Murray, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
Obosa Osawe, MD	OB/GYN	OB/GYN		02/11/2024-02/10/2025
**Holly Pacenta, MD	Pediatrics	Telemedicine Hematology/Oncology	Cook Children's	02/11/2024-02/10/2026
Claude Perkins, MD	OB/GYN	OB/GYN		02/11/2024-02/10/2025
**Dave Shahani, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
**Marcela Torres, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
Christine Tracy, DO	Emergency Medicine	Emergency Medicine	BEPO	02/11/2024-02/10/2025
**Linh Tran, DO	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026
**Kelly Vallance, MD	Pediatrics	Telemedicine Hematology/Oncology	Cook Children's	02/11/2024-02/10/2026
Steven Wegert, MD	Radiology	Telemedicine	VRAD	02/11/2024-02/10/2026
**Sibo Zhao, MD	Pediatrics	Telemedicine Neurology	Cook Children's	02/11/2024-02/10/2026

Medical Center Hospital
A Member of Medical Center Health System

Allied Health:

Applicant	Department	AHP Category	Specialty/Privileges	Group	Sponsoring Physician(s)	Dates
Jennifer Navarez, NP	Medicine	AHP	Nurse Practitioner	Permian Nephrology	Dr. Okwuwa, Dr. Bashir and Dr. Thokala	02/11/2024-02/10/2026
DeVontee Rayford, 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	02/11/2024-02/10/2026

*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

February 11, 2025

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
Tarek Anderson, MD	Pediatrics	Yes	Associate to Active	NICU		None	03/01/2025-02/28/2027
Thomas Cook, MD	Surgery	Yes	Active	Plastic Surgery		None	03/01/2025-02/28/2027
Saima Mahmood, MD	Medicine	Yes	Associate	Internal Medicine	ProCare	None	03/01/2025-02/28/2026
Armugam Mekala, MD	Hospitalist	Yes	Associate to	Hospitalist	ProCare	None	03/01/2025-02/28/2027
Brian Monks, MD	OB/GYN	Yes	Associate	OB/GYN		None	03/01/2025-02/28/2026
Mehul Shah, DO	Medicine	Yes	Associate	Gastroenterologist	Curative	None	03/01/2025-02/28/2026
Neel Srikishen, MD	Surgery	Yes	Associate	Urology	ProCare	None	03/01/2025-02/28/2026
Joseph Ifokwe, MD	Radiology	Yes	Telemedicine	Telemedicine	VRAD	None	04/01/2025-03/31/2027
Juliet Lwanga, MD	Medicine	Yes	Associate	Hospitalist	Jackson & Coker	None	04/01/2025-03/31/2026

Allied Health Professionals:

Applicant	Department	AHP Category	Specialty / Privileges	Group	Sponsoring Physician(s)	Changes to Privileges	Dates
Francisco Baeza, FNP	Cardiology	AHP	Nurse Practitioner	ProCare	Deephak Swaminath, MD	None	03/01/2025-02/28/2027
Veronica Garcia, NP	Surgery	AHP	Nurse Practitioner		Dr. Raphael Nwojo	Yes	03/01/2025-02/28/2027
Amy Langston, 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	03/01/2025-02/28/2027
Elias Marquez, NP	Family Medicine	AHP	Nurse Practitioner	ProCare	Dr. Eduardo Salcedo	None	03/01/2025-02/28/2027
Jonathan Trollinger, 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	03/01/2025-02/28/2027

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

February 11, 2025

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
Veronica Garcia, NP	Surgery	**REMOVE: ACLS**

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

February 11, 2025

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
Carol Holden, CRNA	AHP	Anesthesia	12/31/2024	Resignation
Steven Irving, MD	Active	Emergency Medicine	09/30/2024	Lapse in Privileges
Amelia Josserand, PA	AHP	Emergency Medicine	12/19/2024	Resignation
Genaro Marquez, CRNA	AHP	Anesthesia	12/05/2024	Lapse in Privileges
James Moody, MD	Associate	Family Medicine	01/31/2025	Lapse in Privileges
Michael Perry, MD	Telemedicine	Pediatric	12/31/2024	Resignation
Katherine Powers, NP	AHP	Surgery	02/28/2025	Lapse in Privileges
Sandhya Puri, NP	AHP	Family Medicine	10/18/2024	Resignation
Cheryl Walter, CRNA	AHP	Anesthesia	12/31/2024	Resignation
Mabel Zevallos, MD	Associate	Medicine	11/06/2024	Lapse in Privileges

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

February 11, 2025

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
Tarek Anderson, MD	Pediatrics	Associate to Active
Armugam Mekala, MD	Hospitalist	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
Harshad Shah, MD	Courtesy	Surgery	11/22/24	LOA until March

February 11, 2025

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Removal of I-FPPE

Staff Member	Department	Removal/Extension
Tarek Anderson, MD	OB/GYN	**I-FPPE Removal**
Saima Mahmood, MD	Medicine	**I-FPPE Removal**
Brian Monks, MD	OB/GYN	**I-FPPE Removal**
Sudip Sheth, MD	Pediatrics	**I-FPPE Removal**
Regina Sledge, NP	Surgery	**I-FPPE Removal**
Neel Srikishen, MD	Surgery	**I-FPPE Removal**
Ryan Tubre, MD	Surgery	**I-FPPE Removal**
Dwan Turner, MD	OB/GYN	**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

February 11, 2025

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:

- Utilization Review Plan

Advice, Opinions, Recommendations and Motion:

- Utilization Review 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 Utilization Review Plan forms and forward this recommendation to the Ector County Hospital District Board of Directors.

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

February 11, 2025

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

Statement of Pertinent Facts:

The Medical Executive Committee recommends approval of the following:

- Department OPPE Plans

Advice, Opinions, Recommendations and Motion:

- Department OPPE Plans

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 Department OPPE Plans. 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

Utilization Review Plan

I. Definitions:

Utilization Review Plan – the hospital-wide plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the hospital and medical staff.

Physician Advisor or "PA" – a physician working under contract with Medical Center Hospital or in a medical staff position with the authority delegated by the Utilization Review Committee for the review of cases for clinical appropriateness and medical necessity of admissions, continued stays and services provided by the hospital.

Secondary Physician Review – a clinical review performed by a physician on the Utilization Review Committee other than the ordering physician when Cortex or other Medical Center Hospital approved clinical screening criteria guidelines suggest a different Patient Status of Level of Care than that ordered.

Cortex – clinical decision support guidelines that use an evidence-based clinical decision support tool approved for use by the Medical Executive Committee, to assist in clinically appropriate medical utilization decisions regarding patient status and level of care determinations. This decision support tool serves as guideline to prompt feedback and discussion. The physician order determines Patient Status and Level of Care determinations.

II. Purpose (42 CFR § 456.105)

The general aim of this plan is to codify the obligations of the utilization review (UR) committee, the hospital, its medical staff, and its associates to advance evidence-based, high-quality, cost effective, and safe care to our patients and our community.
The Utilization Review Plan is reviewed annually and revised as appropriate.

III. Scope

Utilization management is realized through the use of processes and procedures that assess, analyze, and evaluate medical necessity and appropriateness of the services provided. Recognized clinically applicable review criteria, trended patient population clinical care data, patterns of hospital resource utilization and clinical areas of the plan's scope include, but are not limited to:

- Delineation of the responsibilities and authority of personnel for conducting internal utilization review, conducting delegated review under managed care contracts, and facilitating external review under managed care and other payer contracts
- Establishes the protocols for the review of medical necessity of admissions, extended stays, professional services, and appropriateness of setting
- Outlines processes to review outlier cases based on extended length of stay and/or extraordinarily high costs
- Defines processes to review potential over-utilization, under-utilization, and inefficient utilization of resources
- Defines processes for coverage determination(s) denials, appeals and peer review within the organization
- Identifies the framework for reporting corrective action and documentation requirements for the utilization management process
- Establishes processes to identify patients with discharge planning needs or requests for discharge planning with timely evaluation of post-acute care services and availability of services to allow appropriate arrangements to be completed
- Optimizing efficient resource utilization through integration and coordination within the multi-interdisciplinary health care teams while maintaining optimal patient outcomes
- Reporting the results of resource management opportunities and efficiencies, patient clinical outcome data collection and reporting to the Utilization Review Committee, Medical Executive Committee, Quality Monitoring Committee, and Quality Assurance Performance Improvement Committee.

Objectives

- Review hospital inpatient admissions, observation stays, direct admissions and post-operative ambulatory procedure patients with a request for inpatient admission or observation, regardless of payer source.
- Conduct initial and concurrent medical record reviews to determine the medical necessity of the hospital stay and ensure the appropriate level of care is provided.
- Conduct individualized discharge planning screens to ensure early and timely identification of post-acute services required.
- Initiate and monitor any revisions in policies and procedures based on the Utilization Review's Plan scope, objectives and recommendations of the Utilization Review Committee.
- Professional and therapeutic services reviews are carried out to ensure availability, timeliness of delivery and medical necessity.

IV. Authority, Leadership and Accountability (42 CFR § 456.106 and 482.30(b))

The Utilization Review Committee
The Board of Directors of Medical Center Hospital recognizes its authority and responsibility for the delivery of effective and efficient medical care in keeping with professionally recognized standards and available resources. The Board has delegated the responsibility for monitoring the appropriate use of hospital resources to the Utilization Review Committee.

The UR committee has the authority to perform prospective, concurrent, or retrospective review of the medical record of any patient admitted to the hospital or treated on an outpatient basis; to review documents certifying medical necessity for acute care admission; to review resource utilization data to evaluate service line and/or physician performance; and to discuss findings with the physician or physicians concerned but does not have the authority to take disciplinary action.

Findings and recommendations of the UR committee are reported to the president of the medical staff, board of directors, and chief executive officer, who have the authority and responsibility for considering and acting on them.

- The Utilization Review Committee is a standing committee of the Medical Center Hospital Medical Staff (Medical Staff Bylaws, Article 3.R. Utilization Review Committee, 1 and 2) and must comprise three or more active physician (MD/DO) members of the medical staff, and other practitioners to perform the utilization management function as well as administrative and departmental representatives of the hospital.
- The Medical Director of Utilization and Outcomes Management will serve as chairperson of the committee (Medical Staff Bylaws, Article 3.R.(c))
- A copy of the Conflict-of-Interest Statement is to be completed by Utilization Review committee members. A conflict of interest (aside from ownership in the hospital) does not automatically disqualify a member from participating in any given review. Rather, the conflict is a factor for the UR Committee Chairperson to evaluate when weighing decisions about specific member recusals.
- No person on the committee (or on a committee performing functions delegated by the UR committee) may have a financial interest in the hospital
- No person may participate in the case review of any care in which he or she was professionally involved in providing care. (42 CFR § 456.106 (d)(2) and 42 CFR § 482.30 (b)(3))
- Conflict of Interest Statements are completed annually.

Utilization Review Committee Functions

- Advance the practice of evidence-based care. Promote cost-effective utilization of hospital resources and services in accordance with the patient's acute medical needs and preferences
- Provide educational opportunities to engage the medical staff and hospital associates
- Identify and correct patterns of care and situational factors that may contribute to under-, over-, and/or inappropriate utilization of hospital resources and services

- Use objective data to assess physician practice trends and patterns regarding length of stay and resource utilization for the purpose of improving quality of care and service delivery
- Recommend and/or take corrective actions to improve resource utilization and the quality of care
- Performs focused reviews with accompanying action plan and reports results.
- Monitors the implementation of corrective action to achieve improvement
- Establishes procedures for external utilization management representatives who perform on site reviews.
- Reports at least semi-annually to the Medical Executive Committee, Quality Assurance Performance Improvement Committee, Quality Monitoring Committee and the Governing Board.
- Reports findings from the QIO to the Medical Staff.
- Delegates to case management staff, any UM subcommittee(s), a physician member of the Utilization Review Committee, and/or the Physician Advisor the authority to act on a day-to-day utilization management matters including, but not limited to, using screening criteria to evaluate the appropriateness of stay and level of care, making determinations regarding the medical necessity / appropriateness of an admission/continued stay, and issuing notices of non-coverage or causing the admission category to be revised in accordance with CMS guidelines.

Committee Membership

- At least two physicians who broadly represent the composition of the medical staff.
- Three physicians of the committee will be appointed by the Utilization Review Director, Inpatient Operations Medical Director, in consultation with the Vice Chief of Staff and the Chief Medical Officer.
- Administrative and clinical members of the committee are appointed by the Chief Executive Officer, and service as ex officio, without vote. (Article 3.R.(b))
    - Additional members may include the following: Physician Advisor, medical department chairpersons, the Chief Operating Officer, and Chief Nursing Officer.
    - Representatives of the following departments: Quality Improvement, Patient Care Services/Nursing, Emergency Department, Health Information Management Services, Case Management Services, Compliance, Utilization Review, Denial Management, pharmacy, laboratory, diagnostic imaging, respiratory, behavioral health, revenue integrity.

Utilization Review Committee Meeting

- The committee will meet four times per year.
- Changes to the meeting schedule are made at the discretion of the chairperson.
- Additional meetings may be prompted as needed, at the call of its chair to manage the utilization management process.

- Review of individual cases may occur between the regular meeting with findings presented to the full committee.

Informational Requirements (42 CFR § 456.111)
Any information required for review by the Utilization Review Committee will be maintained in the patient's medical record. Information may include:

- Patient identification, physician name and date of admission
- Dates of application for and authorization of Medicaid benefits if application is made after admission
- The plan of care, initial and subsequent continued stay review dates
- Date of surgical and/or diagnostic procedures
- Justification of the ED admission, if applicable
- Reasons and plan for continued stay if the attending believes continued stay is necessary
- Other supporting material that the committee believes appropriate to be included in the record.

Records and Reports (42 CFR § 456.112)

- The Utilization Review Committee will submit a written report after each meeting to the Medical Executive Committee and the Governing Board by chair/member of the UR Committee.
- Standard reports presented at Committee meetings may include the following information:
  - Avoidable days, trending, and analysis
  - Length of Stay (LOS) – Medical, Surgical, Observation
  - Excess days by payer
  - Disputes
  - Appeal Outcomes
  - Condition Code 44
  - Inpatient only procedure performed as outpatient
  - Medicare Spend Per Beneficiary (MSPB), reported annually
  - Cortex - Medical Center Hospital approved clinical screening criteria or other preadmission review results (cases or number of days that do not satisfy criteria for admission, continued stay and /or level of care and secondary review(s) results)
  - Number of Admission Hospital Issued Notice of Non-coverage (HINN) letters issued
  - Number of Hospital Requested Reviews (HRR or HINN-10) for admission medical necessity
  - Observation information, including LOS in hours (observation unit and dispersed patients), number of observation stays converted to inpatient, the number of observation stays exceeding 24 and 48 hours
  - Summary report of the result of all cases reviewed by the Physician Advisor, including the number of cases converted from inpatient to outpatient observation or outpatient in

accordance with CMS guidelines (Condition Code 44) for Medicare and non-contracted MA plans
    - Percentage of medical necessity screening performed within 24 hours of admission
    - Readmission Review of cases readmitted within 30 days of pervious inpatient admission
    - Discharge Disposition reporting
    - Cortex report data
    - Reports of denials from KEPRO-Quality Improvement Organization (QIO) reviews (Medicare)
    - Reports of denials from commercial insurance companies, Medicare Recovery Audit, Medicare Claims Processor Administrator
    - Review of medical services by the appropriate peer review committee member as identified by the Utilization Review Committee
    - High Length of Stay (LOS) of 10 days or greater that is reviewed weekly
    - Provider Liable
- The Utilization Review Committee will formulate a written utilization review plan for the Hospital, to be approved by the Medical Executive Committee, the Chief Executive Officer, and the Board. (Medical Staff Bylaws, Article 3.R.2. (b))

V. Confidentiality (42 CFR § 456.113)

The proceedings of the UR committee, any sub committees, and all derivative documents and minutes are confidential and protected from discoverability under section 160.007 of the Texas Occupations Code § 160.007 (a) and the Peer Review Statute § 161.032 of the Texas Health and Safety Code.
During the utilization review process, the identities of individuals in all utilization records are kept confidential. Provides for confidentiality of the peer review process and findings.

VI. Types of Reviews

Prospective Pre-admission Reviews (42 CFR § 482.30 (c) (2), § 456.121 - § 456.123 n(a) - (g)

Transfers
- Agreement to accept a patient transfer from another facility requires the approval of a hospital physician in advance of the transfer.
- Following transferring hospital physician to accepting hospital physician communication regarding patient status and medical necessity, the accepting physician will confirm that the patient requires care that is not available at the transferring facility, and that the accepting hospital has the capability and capacity to provide necessary care.

Precertification for Elective Services
- Precertification completed by the physician office.

Medicare Inpatient-Only List

- Inpatient only procedures are verified at time of admission.

Admission Review Requirements (42 CFR § 456.121, § 456.122) – UR.2

- An admission review is completed on all patient admissions, observation, and post-operative ambulatory surgery patients with request for bed placement. Reviews are completed on all patients regardless of payer source.
- Admission reviews are completed using the clinical decision support tool or other Medical Center Hospital approved clinical screening criteria as soon as possible after admission or after the hospital is notified of the application for Medicaid.
- For payers with no authorization process: (sub-categorized the following)
    - If Cortex guidelines criteria are met on the initial review, the admission will be deemed appropriate.
    - If admission criteria are not satisfied, the reviewer must contact the attending physician for additional information. If additional information satisfies the admission criteria, the admission will be deemed appropriate.
    - If additional information is not provided or provided and still fails to satisfy admission criteria, the case must be referred for Secondary Review.

Concurrent/Continued Stay Review (42 CFR § 456.128, § 456.129, § 456.131 and § 456.132)

- Continued Stay Review (CSR) for medical necessity, must be performed for payers with no authorization process.
- Initial CSR date is determined at the time of the admission review by criteria, diagnosis, and any other pertinent factors for each patient.
- CSR for medical necessity are conducted as feasible based on prior Cortex screening results and anticipated date of discharge. The reviews are dependent upon available staff and census. All Medicare and Medicaid concurrent stays that may be reasonably assumed to qualify for an outlier payment are reviewed in the weekly outlier meeting with a member of the Utilization Committee or designee. (The weekly outlier meeting may be canceled due to certain circumstances such as holidays or throughput).,
- For payers with an authorization process, Medical Center Hospital will follow the specified language in the contract.
- The practitioner(s) responsible for a patient's care is/are consulted and afforded the opportunity to present his/her view before a determination is made that a hospitalization is not medically necessary.
- If the committee determines that an admission or continued stay is not medically necessary, written notification is given within two days to the hospital, the patient and the practitioner(s) responsible for the patient's care. (All federal guidelines will be strictly followed).

Continued Stay Review and Outlier Certification (42 CFR § 424.13)

- Inpatient continued-stay certification is required for patients who remain in the hospital more than 20 days.
- Prior to the 20th day and no later than the 20th day, the physician documents in the medical record justification of why the patient continues to require care in the hospital
- Documentation includes:
    - The reason for either:
        - Continued hospitalization of the patient for medical treatment of medically required diagnostic study
        - Special or unusual services for cost outlier cases such as participation in clinical trials or testing of new technologies
        - If the patient still requires care that could be provided in a sub-acute facility, such as a SNF, but there is not accepting facility in the area, the continuing stay can be certified but the physician note should indicate that a search for and accepting SNF is ongoing
    - Documentation includes the estimated time that the patient will need to spend in the hospital, such as an estimated LOS
    - The plans for post-hospital care, if appropriate.

Discharge Review (42 CFR § 482.43)

- Discharge review(s) (Named "Final Status" reviews in Cortex) must be performed when criteria for continued stay is not satisfied, or when help is needed in determining the next appropriate level of care within the facility or the appropriateness of discharge from the facility.
- If the case does not meet continued stay criteria, but the case is falling outside of the clinical stability parameters, the case manager must send the next review date and remove the barriers to discharge.
- If discharge indicators are met, the case manager will contact the physician to facilitate discharge or transfer to the next appropriate level of care.
- If the discharge indicators are met and the physician disagrees with the discharge, the case must be referred for secondary review.

Secondary Review Process

- When an admission or continued stay case is referred by the case manager/utilization review manager to the Physician Advisor or member of the UR Committee for secondary review, the secondary reviewer must review the case based on documentation in the medical record and discussions with the attending medical practitioner and make a determination using his/her medical judgment.
- Secondary review determination must be documented and supported with clinical rationale.
- Before determining that an admission or continued stay is not medically necessary, the Physician Advisor (PA) or physician member of the UR committee must consult with the

attending physician or the practitioner(s) responsible for the care of the patient and afford the attending and/or practitioner(s) the opportunity to present their views.

Adverse Decisions (42 CFR §456.124, 42 CFR § 456.126)

- If the Physician Advisor or member of the UR Committee determines that an admission or continued stay is not medically necessary and the attending physician or practitioner(s) responsible for the care of the patient agrees or fails(s) to present views regarding the case when afforded the opportunity, the case manager must facilitate discharge, transfer, or referral to the appropriate level of care.
- If the attending physician or practitioner(s) responsible for the care of the patient does not agree with the PA's determination, another physician member of the Utilization Review Committee must be consulted, and a further determination made.
- If the Utilization Review Committee or two physician members decide that the admission to, or continued stay in the hospital is not medically necessary, the Utilization Review Committee or designee must give written notification to:
    - the hospital
    - the patient
    - the Medicaid Intermediary (if Medicaid is the payer)
    - the attending physician or practitioner(s) responsible for the care of the patient.
- Notice is provided no later than (2) days after the determination
- In the case of Managed Care patients, the case manager must notify the Managed Care case manager regarding the medical necessity determination, pursuant to the Managed Care contract.

VII. Case Management Relationship with Third Party Payer Organizations

- The Director of Utilization Review must work to establish and maintain an effective and professional working relationship with third party payers, including managed care and external review organizations.
- Hospital policies regarding information privacy and security govern the processes for disclosure of protected health information.
- The case manager must provide clinical information as required by third-party payer contracts.
- The case manager must facilitate physician-to-physician communication when appropriate regarding adverse determinations by third party payers or external utilization review organization.
- Access to medical record and supervision of medical record review at the hospital by third party payer(s) and external review organization must be facilitated by the Director of HIM to

assure compliance with third party contracts and with procedures established by the Utilization Review Committee.

VIII. Medical Care Evaluation Studies (42 CFR § 456.141- 42 CFR § 456.145)

- Medical Care Evaluation Studies (MCES) are designed to promote both effective and efficient use of the facility that are consistent with patient needs and professionally recognized standards of care. MCES provide:
    - Emphasis on identification and analysis of patterns of patient care
    - Suggestions of appropriate changes needed to maintain high quality patient care
    - Suggestions for effective and efficient use of resources
- The Utilization Review Committee will select and conduct medical care evaluation studies.
    - The Utilization Review committee will determine study(s) utilizing the following methods: peer referral, review of records and reports, or in response to regulatory findings, external review bodies, or at the request of MEC and/or governing body.
    - MCES documentation will detail study findings, analysis, corrective action if indicated and specify how results are used to improve quality of care, efficiency, or improved resource utilization.
- The Utilization Review Committee will select appropriate subjects for study by identifying and analyzing factors related to patient care delivery where opportunities for improvement exist.
- Studies will include analysis of admissions, duration of stay, use of ancillary services and review of professional services.
- Findings will include any recommendations for change to improve quality of care, efficiency, or resource utilization.
- Appropriate data sources for MCES include, but is not limited to, medical records, statistics or profiles from external sources, information from the QIO, regulatory agencies, and fiscal agencies as appropriate.
- The Utilization Review Committee must, at least, have one study in progress at any time and complete one study per each calendar year.

IX. Information Management/Data

- Utilization management data is collected, analyzed and maintained to address issues of over-utilization, appropriateness of resource use, medical necessity of services and appropriate level of care assignment, and compliance with applicable federal and state regulations.
- Relevant utilization management data is collected and aggregated for tracking and trending reports using automated information systems wherever possible to optimize efficiency.
- Utilization management files must be maintained separate from individual patient medical records.

Medical Center Health System
Your One Source for Health

X. Utilization Review Plan, Evaluation Amendment and Revisions

- The UR Plan is reviewed and updated or modified as necessary based on the ongoing annual evaluation of utilization review activities.
- The reviewed and/or revised plan should be submitted for review annually.
- An evaluation of the entire utilization review program and its effectiveness in allocating resources must be documented and reported to the board of directors annually.

Approval	Date
Approved by UR Committee	
Approved by Medical Quality Committee	
Approved by Medical Executive Committee	
Approved by Board of Directors	

Medical Center Health System
Your One Source for Health

CONFLICT OF INTEREST STATEMENT

Effective UR is dependent upon a multidisciplinary team working together to ensure appropriate utilization of resources, while providing quality care to patients. To that end, and in order to avoid the appearance of any conflicts of interest between [hospital] and any member of Medical Center Hospital UR Committee and in accordance with Medicare Conditions of Participation set forth at 42 CFR § 482.30, no UM Committee member ("Member") may have a direct financial interest in Medical Center Hospital. Direct financial interest is defined as an ownership interest in the hospital through stock or otherwise. In addition, no Member may participate in the review and/or authorization of clinical cases in which he or she is the primary care giver, is a participant in a specific situation under review, or has any involvement either in the case or with the practitioner that impact him or her personally, professionally, or financially.
By signing below, Member acknowledges that no current conflict of interest or potential conflict of interest exists and agrees to notify the Chairperson of the UR Committee of any actual or potential conflict shall arise and agrees to abide by the decision of the Chairperson, including a request that the Member recuse himself or herself from the review of the clinical case in question.

Name

Signature

Date

Examples of potential conflicts of interest that should be reported to the UR Committee Chairperson:
· Member is related to the treating or consulting practitioner on the clinical case
· Member is in a group practice with the treating or consulting practitioner on the clinical case
· Member is related to the patient who is the subject of the clinical case
· Member is a competitor of the treating or consulting practitioner on the clinical case
This list is not exhaustive, nor does the inclusion of any relationship listed below necessarily constitute a conflict. The idea is to disclose matter which may raise a conflict so that they may be evaluated.

References

Medical Staff Bylaws: 3.A. Medical Staff Committees and Functions

Medical Staff Bylaws: 3.R. Utilization Review Committee

Title 42 Chapter IV-Centers for Medicare and Medicaid Services, Department of Health and Human Services, Subchapter G – Standards and Certification Part 482 – Conditions of Participation for Hospitals Subpart C – Basic Hospital Functions Section 482.30 – Condition of Participation: Utilization Review

Title 42 Chapter IV. Centers for Medicare and Medicaid Services, Department of Health and Human Services Sub Chapter C. Medical Assistance Programs, Part 456. Utilization Review

NIAHO Accreditation Standard Utilization Review (UR) UR.1 Documented Plan, UR.2 Sampling, UR.3 Medical Necessity Determination, UR.4 Extended Stay Review

Call for a Vote

- Utilization Review Plan
  - "The **hospital** must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs." - 42 Code of Federal Regulations 482.30.
  - The plan requires an annual review.
  - For this year, there have been no changes made.

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

2025

DEPARTMENT/SERVICE: Anesthesia Department

RESPONSIBILITY: The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.

SCOPE OF CARE: The Scope of Service for the Anesthesia Department shall encompass all functions performed by the Certified Registered Nurse Anesthetist (CRNA) and Anesthesiologists credentialed at this facility. Members of the Anesthesia staff function as preceptors in teaching anesthesiology to rotating OB/GYN and Family Practice residents.

DATA SOURCES: The patient's health care record.

SAMPLE: A representative sample of the patients receiving anesthesia 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 Anesthesia 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 Anesthesia 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.

ANESTHESIA DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns, trends, and errors for Drug Use Evaluation	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend.
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss), C section, Hysterectomy	**Adverse outcomes / Triggers:** • Mortality within 30 days • SSI • Unexpected disposition to ICU from OR/PACU • CODE Blue in OR/PACU or 24 hours after procedure. • Rapid Response in OR/PACU or 24 hours after procedure Goal 0/ provider Chair to review charts of adverse outcomes
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 10 cases. • Mortality within 6 hours of procedure all cases • Mortality in OR all cases • Mortality within *48 hours of procedure if they are elective, emergent (non-trauma) & all Pediatrics • Mortality within 24hrs of transfusion
SR.5 Anesthesia/Moderate Sedation Adverse Events;	**Adverse Events:** • Broken teeth • Failure to return to baseline consciousness • Bradycardia / Tachycardia due to sedation • Airway compromise needing airway rescue • Unplanned admission related to moderate sedation • Review of Post-Dural puncture headaches requiring blood patches (OB only) • Conversion to general anesthesia (OB only) • Mortality within 24 hrs • Code Blue within 24hrs of a procedure

SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • N/A **Unplanned returns to surgery:** • N/A
SR.7 Appropriateness of care for non-invasive procedures/interventions;	• N/A
SR.8 Utilization Data;	**Length of stay:** • N/A
SR.9 Significant deviations from established standards of practice;	• **N/A**
SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • Pre-op and post-op notes for timeliness and completion within 24 hours of procedure. 5 cases per provider reviewed on an annual basis. • Suspensions- 3 or more suspensions in a consecutive 6 months period will receive an automatic referral to PPEC.
SR.11 Any variant that should be analyzed for statistical significance.	• Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting. • Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

MEDICAL STAFF ASSESSMENT

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) PLAN

2025

DEPARTMENT/SERVICE: Cardiology Department

RESPONSIBILITY: The Department Chairman shall be Responsible for the implementation of the assessment process and use in OPPE/FPPE.

SCOPE OF CARE: Medical management of all inpatients admitted for cardiovascular diagnostic and therapeutic modalities.

DATA SOURCES: The patient's health care record.

SAMPLE: A representative sample of the patients receiving cardiovascular services will be screened, as indicated.

METHODOLOGY: Data is collected by appropriate personnel through established screening criteria. The data collected will correspond to identified performance standards. When indicated, the department member assigned that responsibility evaluates care. The chairperson and the clinical staff of the Cardiology Department review findings. The chairperson authorizes actions for cases in which opportunities to improve care are present.

REPORTING: The results of all assessment activities will be reported to the Cardiovascular 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.

CARDIOLOGY DEPARTMENT
MEASUREMENT AND ASSESSMENT

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) PLAN

2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns trends and errors for Drug Use Evaluation	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend.
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss), C section, Hysterectomy	**Measure appropriateness:** • **N/A** **Adverse outcomes / Triggers:** • N/A
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. • FPPE • Number of patients admitted with STEMI and discharged with no Beta-blocker prescribed on patients with no documented contraindications. • Number of patients admitted with STEMI and LVEF <40% discharged with no ACE/ARB/ARNI prescribed and no documented contraindications. • Number of patients admitted with STEMI and discharged with no High intensity statin prescribed and no documented contraindications. • Interventional procedures with complications resulting in emergent transfers to surgery.

	• PCI's with significant complications to include abrupt closure following PCI. • EP/Implant post-procedure complications including emergent transfers to surgery. • Mortality in the Cath Lab • Post-PCI mortality/**Rapid Response/ Code** Blue within 24 hours excluding patients with mortality as a complication of subsequent procedures (i.e. CABG) • Mortality within 24 hours of a blood transfusion.
SR.5 Anesthesia/Moderate Sedation Adverse Events;	**Adverse Events:** • **Rapid Response/ Code Blue Cath lab** • Failure to return to baseline consciousness. • Bradycardia / Tachycardia due to sedation • Airway compromise needing airway rescue • Unplanned admission related to moderate sedation • ORTS reported events
SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • Calculated expected readmission rate per provider versus true readmission rate. • Review of repeat CHF and AMI readmissions. Patients who have a CHF or AMI diagnosis and have 3 admissions that would fall into the 30-day readmissions criteria (regardless of payor) will be reviewed by department chair. **Unplanned returns to surgery:** • N/A
SR.7 Appropriateness of care for non-invasive procedures/interventions;	**Non-Invasive Procedures/Interventions:** • ECHO- random sampling reviews. One case per Cardiologist every 6 months. Reviewed for appropriateness and indication. • Nuclear Medicine Studies- Fives cases per each Cardiologist per year. Reviewed for appropriateness and indication.
SR.8 Utilization Data;	**Length of stay**: Observed / expected percentage by group and individual per quarter. Benchmark <= 1.2 per provider
SR.9 Significant deviations from established standards of practice;	**Cases with identified system failures in which recommendations can be made for performance improvement/patient safety.** • Door to balloon time for patients taken to Cath Lab. Review of patients that did not meet goal of < 90 minutes door to balloon time. Per AHA, ACC guidelines

SR.10 Timely and legible completion of patients' medical records	**Review of documentation:** • H&P complete within 24 hours • Consultation first note within 24 hours • Full operative report must be completed within 1 hour 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 procedure note must be entered prior to patient being transferred to the next level of care. • Suspensions- 3 or more suspensions in a consecutive 6 months period will receive an automatic referral to PPEC.
SR.11 Any variant that should be analyzed for statistical significance	• SSI- Number of SSI per surgeon per half year compared to average number of department surgeons per half year for Colon, Hysterectomy, C-section, CAB, Hip/Knee, AAA, CEA and PVBY's). Surgeons with > 100 cases per year- If average is > 1% those charts are reviewed by chair to identify practice errors; referral to PPEC if applicable. Surgeons with < 100 cases per year- If average is > 2% those charts reviewed by to identify practice errors; referral to PPEC if applicable. • Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting. • Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

- If a physician requests that another member of the committee be excluded from peer reviewing his/her case the case will be forwarded to external peer review.

- If a physician misses their designated OPPE/FPPE meeting, the physician may submit a valid excuse to the Chair for approval from the Cardiology Committee. If the physician is unable to attend the first requested meeting and has a valid excuse, the physician will have two more times to attend to review the case. If the physician fails to review the case after the third meeting or fails to review the case after two meetings and does not have an approved excuse, the case will automatically be referred to QMC for review.

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

2025

DEPARTMENT/SERVICE:	Emergency Department
RESPONSIBILITY:	The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.
SCOPE OF CARE:	Medical management of all inpatients admitted to the Emergency Department service utilizing diagnostic and therapeutic modalities.
DATA SOURCES:	The patient's health care record.
SAMPLE:	A representative sample of the patients receiving surgical 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 Emergency 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 Emergency 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.

EMERGENCY DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns, trends, and errors for Drug Use Evaluation	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend.
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss) C section, Hysterectomy	**Measure appropriateness / Indications per provider:** • **N/A** **Adverse outcomes / Triggers:** • N/A
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. • Mortality review of all patients who expire in ED • FPPE • Review of patients in full arrest who achieved ROSC in ED. 5 charts per month if available. • Review of procedural sedation, moderate sedation in ED with Propofol and Etomidate (this does not include intubation). (OPPE) • Mortality within 24hrs of blood transfusion
SR.5 Anesthesia/Moderate Sedation Adverse Events;	**Adverse Events:** • Failure to return to baseline consciousness • Bradycardia / Tachycardia due to sedation • Airway compromise needing airway rescue • Unplanned admission related to moderate sedation • Mortality

SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • N/A **Unplanned returns to surgery:** • N/A
SR.7 Appropriateness of care for non-invasive procedures/interventions;	• Review of patients undergoing closed reduction involving sedation. • Review of patients undergoing cardioversion involving sedation.
SR.8 Utilization Data;	**Length of stay:** • N/A
SR.9 Significant deviations from established standards of practice;	• Door to needle times within 45 minutes in 50% or more of acute ischemic stroke patients treated with IV thrombolytics. Per DNV Primary stroke center certification guidelines. • Door to balloon time for patients taken to Cath Lab. Review of patients that did not meet goal of < 90 minutes door to balloon time. Per ACC, AHA guidelines
SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • N/A • Suspensions- 3 or more suspensions in a consecutive 6 months period will receive an automatic referral to PPEC.
SR.11 Any variant that should be analyzed for statistical significance.	• Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed. • Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

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

2025

DEPARTMENT/SERVICE: Family Medicine Department

RESPONSIBILITY: The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.

SCOPE OF CARE: Medical management of all inpatients admitted to the Family Medicine Department service utilizing diagnostic and therapeutic modalities.

DATA SOURCES: The patient's health care record.

SAMPLE: A representative sample of the patients receiving surgical 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 Family Medicine 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 Family Medicine 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.

FAMILY MEDICINE DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns, trends, and errors for Drug Use Evaluation.	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend. • Review of CHF and AMI medication misses.
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss), Hysterectomy, C section	**Measure appropriateness / Indications per provider:** • **N/A** **Adverse outcomes / Triggers:** • N/A
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. • Mortality within 24 hours for non-ICU/CCU admissions. • FPPE • Mortality within 24 hours of a blood transfusion
SR.5 Anesthesia/Moderate Sedation Adverse Events;	**Adverse Events:** • N/A
SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • Calculated expected readmission rate per provider versus true readmission rate. Every provider from original admission will be compared to their department average. Chair or medical may refer to PPEC as trends are identified.

	Unplanned returns to surgery: • N/A
SR.7 Appropriateness of care for non-invasive procedures/interventions;	• Review of appropriateness and care of HBO cases. Minimum of 5 per year.
SR.8 Utilization Data;	**Length of stay:** • Observed / expected percentage by group and individual per quarter. Benchmark <= 1.2 per provider
SR.9 Significant deviations from established standards of practice;	• **N/A**
SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • H&P complete within 24 hours • Full procedure note must be completed within 1 hour after an operative procedure and entered into the record before the patient is transferred to the next level of care. • If a full operative note cannot be entered into to record within a reasonable amount of time after the operation or procedure, a 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 months period will receive an automatic referral to PPEC.
SR.11 Any variant that should be analyzed for statistical significance.	• Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting. • Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

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

2025

DEPARTMENT/SERVICE:	Hospitalist Department
RESPONSIBILITY:	The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.
SCOPE OF CARE:	Medical management of all inpatients admitted to the Hospitalist Department service utilizing diagnostic and therapeutic modalities.
DATA SOURCES:	The patient's health care record.
SAMPLE:	A representative sample of the patients receiving surgical 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 Hospitalist 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 Hospitalist 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.

HOSPITALIST DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns, trends, and errors for Drug Use Evaluation	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend. • Review of CHF and AMI medication misses.
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss) C -section, Hysterectomy.	**Measure appropriateness / Indications per provider:** • **N/A** **Adverse outcomes / Triggers:** • N/A
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. • Mortality within 24 hours for non-ICU/CCU admissions. • FPPE • Mortality within 24 hours of a blood transfusion.
SR.5 Anesthesia/Moderate Sedation Adverse Events;	**Adverse Events:** • N/A
SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • Calculated expected readmission rate per provider versus true readmission rate. Every provider from original admission will be compared to their department average. Chair or medical may refer to PPEC as trends are

	identified. **Unplanned returns to surgery: N/A**
SR.7 Appropriateness of care for non-invasive procedures/interventions;	• **N/A**
SR.8 Utilization Data;	**Length of stay**: • Observed / expected percentage by group and individual per quarter. Benchmark <= 1.2 per provider
SR.9 Significant deviations from established standards of practice;	• **N/A**
SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • H&P complete within 24 hours • Suspensions- 3 or more suspensions in a consecutive 6 months period will receive an automatic referral to PPEC.
SR.11 Any variant that should be analyzed for statistical significance.	• Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting. • Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

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

2025

DEPARTMENT/SERVICE:	OBGYN Department
RESPONSIBILITY:	The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.
SCOPE OF CARE:	Obstetrical/Gynecological management of all patients admitted to the OB/GYN service utilizing diagnostic and therapeutic modalities.
DATA SOURCES:	The patient's health care record.
SAMPLE:	A representative sample of the patients receiving OB/GYN 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 OB/GYN 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 OB/GYN 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.

OBGYN DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns, trends, and errors, for Drug Use Evaluation	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend.
SR.3 Surgical Case Review: C-section, Hysterectomy.	**Measure appropriateness / Indications per provider:** • **N/A** **Adverse outcomes / Triggers:** • Mortality within 30 days • SSI • Unexpected disposition to ICU from OR/PACU • CODE Blue in OR/PACU or 24 hours after procedure. • Rapid Response in OR/PACU or 24 hours after procedure Goal 0/ provider Chair to review charts of adverse outcomes.
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. • FPPE • Mortality • APGAR scores of < 7 at 5 minutes reviewed. • Mortality within 24 hours of a blood transfusion.
SR.5 Anesthesia/Moderate Sedation Adverse Events;	**Adverse Events:** • Broken teeth • Failure to return to baseline consciousness. • Bradycardia / Tachycardia due to sedation • Airway compromise needing airway rescue. • Unplanned admission related to moderate sedation. • Review of Post-Dural puncture headaches requiring blood patches (OB only)

	• Conversion to general anesthesia • Mortality within 24 hours of procedure
SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • Calculated expected readmission rate per provider versus true readmission rate. Every provider from original admission will be compared to their department average. Chair or medical staff may refer to PPEC as trends are identified. **Unplanned returns to surgery:** • OB/GYN inpatients and outpatients which require an unplanned return to surgery within 30 days for complication will be reviewed. Surgeons with > 100 cases per year- If average is > 1% those charts are reviewed by chair to identify practice errors; referral to PPEC if applicable. Surgeons with < 100 cases per year- If average is > 2% those charts reviewed by to identify practice errors; referral to PPEC if applicable.
SR.7 Appropriateness of care for non-invasive procedures/interventions;	**N/A**
SR.8 Utilization Data;	**Length of stay**: • Observed / expected percentage by group and individual per quarter. Benchmark <= 1.2 per provider
SR.9 Significant deviations from established standards of practice;	• Review of all < 39 weeks elective OB inductions • Review of all nulliparous cesarean sections per ACOG guidelines
SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • H&P complete within 24 hours • Consultation first notes within 24 hours • Full operative / procedure report must be completed within 1 hour 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 procedure note must be entered prior to patient being transferred to the next level of care. • Suspensions- 3 or more suspensions in a

SR.11 Any variant that should be analyzed for statistical significance.	consecutive 6-month period will receive an automatic referral to PPEC. • SSI- Number of SSI per surgeon per half year compared to average number of department surgeons per half year for Colon, Hysterectomy, C-section, CAB, Hip/Knee, AAA, CEA and PVBY's) Surgeons with > 100 cases per year- If average is > 1% those charts are reviewed by chair to identify practice errors; referral to PPEC if applicable. Surgeons with < 100 cases per year- If average is > 2% those charts reviewed by to identify practice errors; referral to PPEC if applicable. • Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting. • Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

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

2025

DEPARTMENT/SERVICE:	Pediatrics Department
RESPONSIBILITY:	The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.
SCOPE OF CARE:	Medical management of all inpatients admitted to the Pediatric Department service utilizing diagnostic and therapeutic modalities
DATA SOURCES:	The patient's health care record.
SAMPLE:	A representative sample of the patients receiving Pediatric 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 Pediatric 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 Pediatric 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.

PEDIATRIC DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns, trends, and errors for Drug Use Evaluation	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend.
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss), C-section, Hysterectomy.	**Measure appropriateness / Indications per provider: N/A** **Adverse outcomes / Triggers: N/A** • Mortality • SSI • Unexpected disposition to ICU from OR/PACU • CODE Blue in OR/PACU or 24 hours after procedure. • Rapid Response in OR/PACU or 24 hours after procedure Goal 0/ provider Chair to review charts of adverse outcomes
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 • FPPE • Mortality within 24hrs of a Blood Transfusion • Mortality if pediatric patient > 350 grams or signs of life

SR.5 Anesthesia/Moderate Sedation Adverse Events; *Only MD not AHP*	**Adverse Events:** • Broken teeth • Failure to return to baseline consciousness • Bradycardia / Tachycardia due to sedation • Airway compromise needing airway rescue • Unplanned admission related to moderate sedation • Review of Post-Dural puncture headaches requiring blood patches (OB only) • Conversion to general anesthesia • Mortality
SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • Calculated expected readmission rate per provider versus true readmission rate. Every provider from original admission will be compared to their department average. Chair or medical may refer to PPEC as trends are identified. **Unplanned returns to surgery: N/A**
SR.7 Appropriateness of care for non-invasive procedures/interventions;	**N/A**
SR.8 Utilization Data;	**Length of stay:** • Observed / expected percentage by group and individual per quarter. Benchmark <= 1.2 per provider
SR.9 Significant deviations from established standards of practice;	**N/A**
SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • H&P complete within 24 hours. • Consultation first note within 24 hours • Full operative report must be completed within 1 hour 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 procedure note must be entered prior to the patient being

SR.11 Any variant that should be analyzed for statistical significance.	transferred to the next level of care. • Suspensions- 3 or more suspensions in a consecutive 6 months period will receive an automatic referral to PPEC. • Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting. • Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

MEDICAL STAFF ASSESSMENT
MCH PATHOLOGY DEPARTMENT

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) PLAN

2025

DEPARTMENT/SERVICE:	Pathology Department
RESPONSIBILITY:	The Department Chairman shall be responsible for giving direction for the implementation of the assessment process and use in OPPE/FPPE for the Department of Pathology. The Department of Pathology's OPPE/FPPE will be implemented and reviewed by the Department Medical Director or Department Chairman, with a formal report prepared quarterly and sent to the Medical Staff Department for review and reporting to QMC and MEC on a quarterly basis.
SCOPE OF CARE:	The Pathology Department quality assurance program has been established with the laboratory pertaining to clinical and anatomic pathology, surgical pathology, cytopathology, and bone marrows, NOTE: Autopsies are no longer performed in-house by the Pathology Department. They are performed by an outside facility as necessary.
DATA SOURCES:	The patient's health care record and appropriate specimens.
SAMPLE:	A representative sample of the patients receiving anatomic pathology services will be examined, as indicated.
METHODOLOGY:	Data is collected by appropriate personnel through established screening criteria. The data collected will correspond to identified performance standards. The data is to be reviewed by the Medical Director or Medical Director designee in an objective manner. After the data has been reviewed with the Medical Staff Department, if actions for improvement in patient care are deemed necessary, recommendations will be made by the Medical Staff Department in coordination with the Pathology Department.

REPORTING:

The Pathology Department will report their individual results of all assessment activities at the next Pathology Department Meeting. Medical Staff will forward the reports to the Quality Monitoring Committee and then to MEC with recommendations in regard to actions necessary for improvement in patient care, if any. Appropriate reports will also be submitted to the Medical Staff Office and Quality Analytics Department for inclusion in the reappointment file and designated reports as deemed necessary.

References:
Pathology Department Policy and Procedure Manual.
College of American Pathologists Anatomic Pathology, Cytopathology and Autopsy Guidelines and Checklists.

MCH PATHOLOGY DEPARTMENT

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) PLAN

2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	• Pathologists do not order blood. However, pathologists actively participate in applying blood product utilization parameters for provider orders. Pathologists participate in monitoring and quality improvement in CAP/CLIA metrics for providers to include wastage, C:T ratio, and trauma product utilization.
SR. 2 Prescribing of medications: Prescribing patterns, trends, errors, and appropriateness of prescribing for Drug Use Evaluation	• N/A
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss), C -section, Hysterectomy.	• N/A
SR.4 Specific department indicators that have been identified by the medical staff;	• **Intramural / Intradepartmental Retrospective quality assurance:** Target: Minimum average of 10% over one quarter of cases (i.e. minimum of 10% of all surgical cases, minimum of 10% of all cytology cases, and a minimum of 10% of all bone marrow cases) for each pathologist. Threshold: 90% accuracy of final diagnosis following review of a minimum of 10% of cases by a second pathologist for intramural review. For the first major discrepancy discovered, an additional 5% of that pathologist's cases will be reviewed for that quarter. This additional 5% will be completed within 90 days after the quarter is complete. If more than one major discrepancy is discovered during a quarter, an additional 15% (Total of 20%)

	of that pathologist's cases will be reviewed for that quarter and will be completed within 90 days after the quarter is complete. • **Extramural Review/consultation** is performed when necessary Target < or = 0.7% of cases. The outside pathologist's report will be reviewed with the initial report by the pathologist responsible for the case and correlation will be reviewed and documented. Major discrepancies will be addressed as above for intramural OPPE/FPPE. • **Correlation of the Frozen section / Intraoperative Consultation with the Final Diagnosis for Concordance:** Target Rates: Correlation >96%; Deferral <5%. A statement should be placed in the final report as follows: "Permanent Sections are confirmatory" OR "Permanent Sections are not confirmatory because.....". • **Cases with previous MCH Histology material/reports:** The CoPath and PathNet (Cerner) system in the Histology Department stores previous case reports and these are to be reviewed before cases are signed out. This information is printed out along with the gross description with each case by transcription, or it is available for review in the Histology Department computer system. If the previous material or report is pertinent to the current case, then comparison of previous findings/reports should be made in the "Comment" section of the report with case number included. • **Cases with previous procedures/reports from other institutions:** If pertinent patient clinical history is not submitted with the specimen, it should be sought on the Powerchart (Cerner), and any pertinent outside case reports should be requested and reviewed for correlation with the current case. Documentation if a review was done, or if reports or slides were requested, but not received for review, should be made in the "Comment" section of the current report by the responsible pathologist for the current case. • **Random case review (OPPE*),** as necessary • **Focused reviews (FPPE*),** as necessary
SR.5 Anesthesia/Moderate Sedation Adverse Events;	• N/A

SR.6 Readmissions/unplanned return to surgery;	• Pathologist diagnosis discrepancies and their clinical impact are monitored through OPPE and prospective quality assurance to include repeat surgery and readmission.
SR.7 Appropriateness of care for non-invasive procedures/interventions;	• N/A
SR.8 Utilization Data; **SR.9 Significant deviations from established standards of practice;**	• **Frozen Section / Intraoperative Consultation turnaround time (TAT)** is documented and monitored. TAT Target Range < or = 20 minutes for all single uncomplicated frozen section diagnoses, and < or = 20 minutes on average, for 90% of all cases. This HIS computer time on monitors and terminals will be used to obtain IN and OUT times. The "In" time is when the frozen section specimen is received in pathology and the "Out" time is the time the pathologist calls the submitting physician or the OR with the results. The "In" and "Out" times are to be documented on the ancillary form and TAT is reported in the frozen section report. Per CAP • **Specimen TAT** is documented and monitored Target Rate: 90% or more of all cases should have either a final report or a preliminary report within 3 working days (72 hours) or less, not including weekend days. If a case is to be sent out for consultation or special studies are pending, a preliminary report should be issued before the case is sent out, and a preliminary report for cases with special studies should be issued within 3 working days. Per CAP
SR.10 Timely and legible completion of patients' medical records.	• TAT for pathology reporting
SR.11 Any variant that should be analyzed for statistical significance.	• Trends in knowledge deficiencies for pathology group and pathologists individually as identified in OPPE metrics. Chair and / or medical director will address trend or concern and take action to correct deficiency as appropriate.

*FPPE (Focused Professional Practice Evaluation)
*OPPE (Ongoing Professional Practice Evaluation)

MEDICAL STAFF ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

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)
2025

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.*

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

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

2025

DEPARTMENT/SERVICE:	Surgery Department
RESPONSIBILITY:	The Department Chairman shall be responsible for the implementation of the assessment process and use in OPPE/FPPE.
SCOPE OF CARE:	Medical and Surgical management of all patients Admitted to the surgical service utilizing diagnostic and therapeutic modalities.
DATA SOURCES:	The patient's health care record.
SAMPLE:	A representative sample of the patients receiving surgical 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 Surgical 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 Surgical 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.

SURGERY DEPARTMENT
MEASUREMENT AND ASSESSMENT
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)
2025

PERFORMANCE MEASURE	PERFORMANCE STANDARD/INDICATOR
SR.1 Blood Use (may include AABB transfusion criteria)	**Goal C:T ratio < 2.0 per month** • 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. 2 Prescribing of medications: Prescribing patterns, trends, and errors for Drug Use Evaluation	**Error:** • Goal 0 MORTS due to prescriber error per quarter; MORTS > 2 per quarter addressed by chair or risk management and referred to PPEC if trend.
SR.3 Surgical Case Review: appropriateness and outcomes for selected high- risk procedures; (Carotid endarterectomy, CABG, MV repair and replacement, Open aortic procedures, Colo/Rectal cancer surgery, Total knee, Total hip, bariatric surgery for weight loss.	**Measure appropriateness / Indications per provider:** • **TBD plan in progress** **Adverse outcomes / Triggers:** • Mortality **within 30 days** • SSI • Unexpected disposition to ICU from OR/PACU • CODE Blue in OR/PACU or 24 hours after procedure. • Rapid Response in OR/PACU or 24 hours after procedure Goal 0/ provider Chair to review charts of adverse outcomes.
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. * If 2 or more cases reviewed are a Level 1 or more, the provider will automatically have 5 more cases reviewed. • Mortality after elective surgery within 30 days • Mortality intraoperative • FPPE • Mortality within 24 hours of a blood transfusion
SR.5 Anesthesia/Moderate Sedation Adverse Events;	**Adverse Events:** • Broken teeth • Failure to return to baseline consciousness. • Bradycardia / Tachycardia due to sedation

	• Airway compromise needing airway rescue • Unplanned admission related to moderate sedation • Review of Post-Dural puncture headaches requiring blood patches (OB only) • Conversion to general anesthesia • Mortality
SR.6 Readmissions/unplanned return to surgery;	**Readmissions:** • Calculated expected readmission rate per provider versus true readmission rate. Every provider from original admission will be compared to their department average. Chair or medical may refer to PPEC as trends are identified. **Unplanned returns to surgery: within 30 days** • Surgery inpatients and outpatients which require an unplanned return to surgery within 30 days for complication will be reviewed. Surgeons with > 100 cases per year- If average is > 1% those charts are reviewed by chair to identify practice errors; referral to PPEC if applicable. Surgeons with < 100 cases per year- If average is > 2% those charts reviewed by to identify practice errors; referral to PPEC if applicable.
SR.7 Appropriateness of care for non-invasive procedures/interventions;	**N/A**
SR.8 Utilization Data;	**Length of stay**: • Observed / expected percentage by group and individual per quarter. Benchmark <= 1.2 per provider
SR.9 Significant deviations from established standards of practice;	• Neurosurgeon case review of at least 10 of their clipping cases annually. (If fewer than 10 cases for each practitioner, data from other hospitals where practitioner has performed more clippings can be accepted). If no clippings available from other hospitals, then other types of cases could include CEAs, craniotomies, & EVD placement for review. Per DNV Primary Stroke center certification guidelines.
SR.10 Timely and legible completion of patients' medical records.	**Review of documentation:** • H&P complete within 24 hours • Consultation first note within 24 hours

SR.11 Any variant that should be analyzed for statistical significance.	• Full operative report must be completed within 1 hour 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 procedure note must be entered prior to 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. • SSI- Number of SSI per surgeon per half year compared to average number of department surgeons per half year for Colon, Hysterectomy, C-section, CAB, Hip/Knee, AAA, CEA and PVBY's). Surgeons with > 100 cases per year- If average is > 1% those charts are reviewed by chair to identify practice errors; referral to PPEC if applicable. Surgeons with < 100 cases per year- If average is > 2% those charts reviewed by to identify practice errors; referral to PPEC if applicable. • Chart Review marked a level 2 or higher will be reviewed in executive session at the department meeting. • Patient Grievances/ORTS/Risk Management cases that have negative impact on patient will be reviewed by med staff and referred to PPEC as needed.

FPPE (Focused Professional Practice Evaluation)
OPPE (Ongoing Professional Practice Evaluation)

Family Health Clinic
February 2025
ECHD Board Update

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CENTERS COMBINED - OPERATIONS SUMMARY
DECEMBER 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	$ 1,535,450	$ 1,587,103	-3.3%	$ 1,366,711	12.3%	$ 5,282,404	$ 4,990,526	5.8%	$ 4,461,088	18.4%
TOTAL PATIENT REVENUE	$ 1,535,450	$ 1,587,103	-3.3%	$ 1,366,711	12.3%	$ 5,282,404	$ 4,990,526	5.8%	$ 4,461,088	18.4%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 769,630	$ 742,468	3.7%	$ 580,688	32.5%	$ 2,605,812	$ 2,328,853	11.9%	$ 1,985,365	31.3%
Self Pay Adjustments	164,913	74,712	120.7%	48,656	238.9%	391,723	230,712	69.8%	129,844	201.7%
Bad Debts	(11,680)	55,518	-121.0%	43,191	-127.0%	18,566	174,292	-89.3%	108,263	-82.9%
TOTAL REVENUE DEDUCTIONS	$ 922,863	$ 872,698	5.7%	$ 672,534	37.2%	$ 3,016,101	$ 2,733,857	10.3%	$ 2,223,472	35.6%
	60.10%	54.99%		49.21%		57.10%	54.78%		49.84%	
NET PATIENT REVENUE	$ 612,587	$ 714,405	-14.3%	$ 694,177	-11.8%	$ 2,266,304	$ 2,256,669	0.4%	$ 2,237,615	1.3%
OTHER REVENUE										
FHC Other Revenue	$ 41,038	$ 39,174	4.8%	$ 33,454	22.7%	$ 93,993	$ 117,522	-20.0%	$ 119,670	-21.5%
TOTAL OTHER REVENUE	$ 41,038	$ 39,174	4.8%	$ 33,454	22.7%	$ 93,993	$ 117,522	-20.0%	$ 119,670	-21.5%
NET OPERATING REVENUE	$ 653,625	$ 753,579	-13.3%	$ 727,631	-10.2%	$ 2,360,296	$ 2,374,191	-0.6%	$ 2,357,285	0.1%
OPERATING EXPENSE										
Salaries and Wages	$ 203,820	$ 173,694	17.3%	$ 190,532	7.0%	$ 597,867	$ 549,309	8.8%	$ 599,448	-0.3%
Benefits	42,389	26,939	57.4%	32,310	31.2%	104,357	83,311	25.3%	99,917	4.4%
Physician Services	516,614	498,196	3.7%	369,871	39.7%	1,568,006	1,494,588	4.9%	1,163,706	34.7%
Cost of Drugs Sold	82,915	55,341	49.8%	20,606	302.4%	295,341	177,181	66.7%	135,672	117.7%
Supplies	17,285	18,834	-8.2%	27,056	-36.1%	56,625	58,358	-3.0%	49,368	14.7%
Utilities	4,332	6,468	-33.0%	6,262	-30.8%	15,442	16,448	-6.1%	16,870	-8.5%
Repairs and Maintenance	1,382	2,099	-34.2%	1,146	20.6%	4,236	6,297	-32.7%	2,451	72.8%
Leases and Rentals	1,922	1,212	58.6%	2,449	-21.5%	3,602	3,636	-0.9%	6,245	-42.3%
Other Expense	1,000	1,427	-29.9%	1,000	0.0%	4,219	4,281	-1.5%	3,000	40.6%
TOTAL OPERATING EXPENSES	$ 871,659	$ 784,210	11.2%	$ 651,233	33.8%	$ 2,649,695	$ 2,393,409	10.7%	$ 2,076,678	27.6%
Depreciation/Amortization	$ 21,510	$ 25,319	-15.0%	$ 24,948	-13.8%	$ 64,890	$ 75,332	-13.9%	$ 74,889	-13.4%
TOTAL OPERATING COSTS	$ 893,170	$ 809,529	10.3%	$ 676,180	32.1%	$ 2,714,585	$ 2,468,741	10.0%	$ 2,151,566	26.2%
NET GAIN (LOSS) FROM OPERATIONS	**$ (239,545)**	**$ (55,950)**	**328.1%**	**$ 51,451**	**-565.6%**	**$ (354,289)**	**$ (94,550)**	**274.7%**	**$ 205,719**	**-272.2%**
Operating Margin	-36.65%	-7.42%	393.6%	7.07%	-618.3%	-15.01%	-3.98%	276.9%	8.73%	-272.0%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	3,576	3,597	-0.6%	3,203	11.6%	11,897	11,336	4.9%	10,535	12.9%
Average Revenue per Office Visit	429.38	441.23	-2.7%	426.70	0.6%	444.01	440.24	0.9%	423.45	4.9%
Hospital FTE's (Salaries and Wages)	46.2	39.5	16.9%	44.1	4.7%	46.2	42.1	9.7%	46.8	-1.2%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - SOUTH - OPERATIONS SUMMARY
DECEMBER 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	$ 148,517	$ 140,961	5.4%	$ 100,984	47.1%	$ 516,985	$ 458,333	12.8%	$ 437,637	18.1%
TOTAL PATIENT REVENUE	$ 148,517	$ 140,961	5.4%	$ 100,984	47.1%	$ 516,985	$ 458,333	12.8%	$ 437,637	18.1%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 52,991	$ 49,083	8.0%	$ 47,759	11.0%	$ 172,963	$ 159,595	8.4%	$ 213,833	-19.1%
Self Pay Adjustments	50,241	13,783	264.5%	11,904	322.1%	172,965	44,814	286.0%	45,870	277.1%
Bad Debts	3,470	7,883	-56.0%	3,267	6.2%	4,597	25,631	-82.1%	16,798	-72.6%
TOTAL REVENUE DEDUCTIONS	$ 106,702	$ 70,749	50.8%	$ 62,929	69.6%	$ 350,525	$ 230,040	52.4%	$ 276,501	26.8%
	71.8%	50.2%		62.3%		67.8%	50.2%		63.2%	
NET PATIENT REVENUE	$ 41,814	$ 70,212	-40.4%	$ 38,054	9.9%	$ 166,460	$ 228,293	-27.1%	$ 161,136	3.3%
OTHER REVENUE										
FHC Other Revenue	$ 41,038	$ 39,174	0.0%	$ 33,454	22.7%	$ 93,993	$ 117,522	0.0%	$ 119,670	-21.5%
TOTAL OTHER REVENUE	$ 41,038	$ 39,174	4.8%	$ 33,454	22.7%	$ 93,993	$ 117,522	-20.0%	$ 119,670	-21.5%
NET OPERATING REVENUE	$ 82,852	$ 109,386	-24.3%	$ 71,508	15.9%	$ 260,453	$ 345,815	-24.7%	$ 280,805	-7.2%
OPERATING EXPENSE										
Salaries and Wages	$ 58,715	$ 45,458	29.2%	$ 63,393	-7.4%	$ 175,672	$ 147,805	18.9%	$ 190,190	-7.6%
Benefits	12,211	7,050	73.2%	10,750	13.6%	30,663	22,417	36.8%	31,701	-3.3%
Physician Services	74,340	69,696	6.7%	51,936	43.1%	238,760	209,088	14.2%	169,758	40.6%
Cost of Drugs Sold	31,431	8,055	290.2%	-	0.0%	109,376	26,192	317.6%	13,754	695.2%
Supplies	3,217	6,088	-47.2%	1,880	71.1%	8,437	18,598	-54.6%	5,115	64.9%
Utilities	1,883	3,126	-39.8%	2,937	-35.9%	6,682	8,141	-17.9%	7,744	-13.7%
Repairs and Maintenance	531	1,278	-58.5%	527	0.8%	1,653	3,834	-56.9%	1,321	25.1%
Leases and Rentals	775	606	27.9%	488	58.9%	2,371	1,818	30.4%	1,641	44.5%
Other Expense	1,000	1,427	-29.9%	1,000	0.0%	4,219	4,281	-1.5%	3,000	40.6%
TOTAL OPERATING EXPENSES	$ 184,103	$ 142,784	28.9%	$ 132,912	38.5%	$ 577,831	$ 442,174	30.7%	$ 424,224	36.2%
Depreciation/Amortization	$ 4,048	$ 4,083	-0.8%	$ 4,048	0.0%	$ 12,145	$ 12,200	-0.5%	$ 12,191	-0.4%
TOTAL OPERATING COSTS	$ 188,151	$ 146,867	28.1%	$ 136,960	37.4%	$ 589,976	$ 454,374	29.8%	$ 436,415	35.2%
NET GAIN (LOSS) FROM OPERATIONS	**$ (105,299)**	**$ (37,481)**	**-180.9%**	**$ (65,452)**	**-60.9%**	**$ (329,523)**	**$ (108,559)**	**-203.5%**	**$ (155,610)**	**-111.8%**
Operating Margin	-127.09%	-34.26%	270.9%	-91.53%	38.9%	-126.52%	-31.39%	303.0%	-55.42%	128.3%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	540	505	6.9%	359	50.4%	1,915	1,642	16.6%	1,574	21.7%
Average Revenue per Office Visit	275.03	279.13	-1.5%	281.29	-2.2%	269.97	279.13	-3.3%	278.04	-2.9%
Hospital FTE's (Salaries and Wages)	9.9	8.6	16.1%	11.5	-13.4%	10.2	9.4	8.7%	11.9	-14.0%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WEST UNIVERSITY - OPERATIONS SUMMARY
DECEMBER 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	$ 201,135	$ 194,333	3.5%	$ 183,039	9.9%	$ 648,495	$ 575,724	12.6%	$ 563,825	15.0%
TOTAL PATIENT REVENUE	$ 201,135	$ 194,333	3.5%	$ 183,039	9.9%	$ 648,495	$ 575,724	12.6%	$ 563,825	15.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 81,874	$ 144,575	-43.4%	$ 77,690	5.4%	$ 262,404	$ 428,314	-38.7%	$ 272,427	-3.7%
Self Pay Adjustments	46,373	34,270	35.3%	24,942	85.9%	138,799	101,526	36.7%	52,694	163.4%
Bad Debts	3,257	10,433	-68.8%	13,368	-75.6%	9,443	30,908	-69.4%	24,421	-61.3%
TOTAL REVENUE DEDUCTIONS	$ 131,504	$ 189,278	-30.5%	$ 116,000	13.4%	$ 410,646	$ 560,748	-26.8%	$ 349,542	17.5%
	65.38%	97.40%		63.37%		63.32%	97.40%		61.99%	
NET PATIENT REVENUE	$ 69,631	$ 5,055	1277.5%	$ 67,040	3.9%	$ 237,848	$ 14,976	1488.2%	$ 214,283	11.0%
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	$ 69,631	$ 5,055	1277.5%	$ 67,040	3.9%	$ 237,848	$ 14,976	1488.2%	$ 214,283	11.0%
OPERATING EXPENSE										
Salaries and Wages	$ 26,884	$ 31,484	-14.6%	$ 18,492	45.4%	$ 74,790	$ 93,272	-19.8%	$ 62,029	20.6%
Benefits	5,591	4,883	14.5%	3,136	78.3%	13,054	14,146	-7.7%	10,339	26.3%
Physician Services	52,901	57,658	-8.2%	42,966	23.1%	169,033	172,974	-2.3%	134,283	25.9%
Cost of Drugs Sold	407	3,715	-89.0%	3,631	-88.8%	14,554	11,006	32.2%	5,714	154.7%
Supplies	2,669	1,755	52.1%	2,942	-9.3%	4,198	5,213	-19.5%	5,381	-22.0%
Utilities	2,450	3,342	-26.7%	3,325	-26.3%	8,761	8,307	5.5%	9,126	-4.0%
Repairs and Maintenance	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Leases and Rentals	71	40	77.2%	40	77.2%	154	120	28.7%	120	28.7%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 90,974	$ 102,877	-11.6%	$ 74,533	22.1%	$ 284,544	$ 305,038	-6.7%	$ 226,992	25.4%
Depreciation/Amortization	$ 17,387	$ 21,161	-17.8%	$ 20,824	-16.5%	$ 52,521	$ 62,907	-16.5%	$ 62,473	-15.9%
TOTAL OPERATING COSTS	$ 108,361	$ 124,038	-12.6%	$ 95,358	13.6%	$ 337,065	$ 367,945	-8.4%	$ 289,465	16.4%
NET GAIN (LOSS) FROM OPERATIONS	**$ (38,730)**	**$ (118,983)**	**-67.4%**	**$ (28,318)**	**36.8%**	**$ (99,216)**	**$ (352,969)**	**-71.9%**	**$ (75,182)**	**32.0%**
Operating Margin	-55.62%	-2353.77%	-97.6%	-42.24%	31.7%	-41.71%	-2356.90%	-98.2%	-35.09%	18.9%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	675	641	5.3%	606	11.4%	2,221	1,899	17.0%	1,884	17.9%
Average Revenue per Office Visit	297.98	303.17	-1.7%	302.05	-1.3%	291.98	303.17	-3.7%	299.27	-2.4%
Hospital FTE's (Salaries and Wages)	9.0	7.8	15.8%	6.7	34.9%	8.7	7.8	12.1%	7.0	23.8%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - JBS - OPERATIONS SUMMARY
DECEMBER 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	$ 377,444	$ 305,921	23.4%	$ 334,256	12.9%	$ 1,220,310	$ 1,043,558	16.9%	$ 1,000,251	22.0%
TOTAL PATIENT REVENUE	$ 377,444	$ 305,921	23.4%	$ 334,256	12.9%	$ 1,220,310	$ 1,043,558	16.9%	$ 1,000,251	22.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 193,850	$ 153,343	26.4%	$ 166,975	16.1%	$ 597,995	$ 523,083	14.3%	$ 500,200	19.6%
Self Pay Adjustments	18,168	6,853	165.1%	9,464	92.0%	40,074	23,378	71.4%	15,574	157.3%
Bad Debts	(8,970)	9,618	-193.3%	13,331	-167.3%	7,456	32,808	-77.3%	31,472	-76.3%
TOTAL REVENUE DEDUCTIONS	$ 203,048	$ 169,814	19.6%	$ 189,769	7.0%	$ 645,526	$ 579,269	11.4%	$ 547,245	18.0%
	53.80%	55.51%		56.77%		52.90%	55.51%		54.71%	
NET PATIENT REVENUE	$ 174,396	$ 136,107	28.1%	$ 144,486	20.7%	$ 574,784	$ 464,289	23.8%	$ 453,006	26.9%
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	$ 174,396	$ 136,107	28.1%	$ 144,486	20.7%	$ 574,784	$ 464,289	23.8%	$ 453,006	26.9%
OPERATING EXPENSE										
Salaries and Wages	$ 26,565	$ 30,489	-12.9%	$ 32,002	-17.0%	$ 79,622	$ 104,006	-23.4%	$ 96,176	-17.2%
Benefits	5,525	4,729	16.8%	5,427	1.8%	13,898	15,774	-11.9%	16,031	-13.3%
Physician Services	58,989	63,193	-6.7%	55,323	6.6%	194,295	189,579	2.5%	161,331	20.4%
Cost of Drugs Sold	23,492	17,298	35.8%	6,831	243.9%	76,519	59,008	29.7%	63,867	19.8%
Supplies	5,969	2,883	107.0%	10,667	-44.0%	20,148	9,644	108.9%	14,983	34.5%
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	$ 120,539	$ 118,592	1.6%	$ 110,250	9.3%	$ 384,482	$ 378,011	1.7%	$ 352,388	9.1%
Depreciation/Amortization	$ 75	$ 75	-0.2%	$ 75	0.0%	$ 225	$ 225	-0.2%	$ 225	0.0%
TOTAL OPERATING COSTS	$ 120,614	$ 118,667	1.6%	$ 110,325	9.3%	$ 384,706	$ 378,236	1.7%	$ 352,613	9.1%
NET GAIN (LOSS) FROM OPERATIONS	**$ 53,782**	**$ 17,440**	**208.4%**	**$ 34,161**	**57.4%**	**$ 190,078**	**$ 86,053**	**120.9%**	**$ 100,393**	**89.3%**
Operating Margin	30.84%	12.81%	140.7%	23.64%	30.4%	33.07%	18.53%	78.4%	22.16%	49.2%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	916	732	25.1%	864	6.0%	3,019	2,497	20.9%		0.0%
Average Revenue per Office Visit	412.06	417.92	-1.4%	386.87	6.5%	404.21	417.92	-3.3%	402.84	0.3%
Hospital FTE's (Salaries and Wages)	7.8	8.3	-5.8%	9.1	-13.6%	7.8	9.6	-18.8%	9.2	-15.5%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WOMENS CLINIC- OPERATIONS SUMMARY
DECEMBER 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	$ 808,354	$ 945,888	-14.5%	$ 748,433	8.0%	$ 2,896,615	$ 2,912,911	-0.6%	$ 2,459,374	17.8%
TOTAL PATIENT REVENUE	$ 808,354	$ 945,888	-14.5%	$ 748,433	8.0%	$ 2,896,615	$ 2,912,911	-0.6%	$ 2,459,374	17.8%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 440,916	$ 395,467	11.5%	$ 288,264	53.0%	$ 1,572,450	$ 1,217,861	29.1%	$ 998,906	57.4%
Self Pay Adjustments	50,130	19,806	153.1%	2,346	2037.2%	39,885	60,994	-34.6%	15,707	153.9%
Bad Debts	(9,437)	27,584	-134.2%	13,226	-171.4%	(2,931)	84,945	-103.5%	35,572	-108.2%
TOTAL REVENUE DEDUCTIONS	$ 481,608	$ 442,857	8.8%	$ 303,836	58.5%	$ 1,609,403	$ 1,363,800	18.0%	$ 1,050,184	53.2%
	59.58%	46.82%		40.60%		55.56%	46.82%		42.70%	
NET PATIENT REVENUE	$ 326,746	$ 503,031	-35.0%	$ 444,597	-26.5%	$ 1,287,211	$ 1,549,111	-16.9%	$ 1,409,190	-8.7%
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	$ 326,746	$ 503,031	-35.0%	$ 444,597	-26.5%	$ 1,287,211	$ 1,549,111	-16.9%	$ 1,409,190	-8.7%
OPERATING EXPENSE										
Salaries and Wages	$ 91,657	$ 66,263	38.3%	$ 76,645	19.6%	$ 267,784	$ 204,226	31.1%	$ 251,053	6.7%
Benefits	19,062	10,277	85.5%	12,997	46.7%	46,742	30,974	50.9%	41,846	11.7%
Physician Services	330,384	307,649	7.4%	219,645	50.4%	965,919	922,947	4.7%	698,334	38.3%
Cost of Drugs Sold	27,584	26,273	5.0%	10,144	171.9%	94,892	80,975	17.2%	52,337	81.3%
Supplies	5,430	8,108	-33.0%	11,566	-53.1%	23,843	24,903	-4.3%	23,889	-0.2%
Utilities	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Repairs and Maintenance	851	821	3.7%	619	37.5%	2,583	2,463	4.9%	1,130	128.6%
Leases and Rentals	1,076	566	90.1%	1,921	-44.0%	1,076	1,698	-36.6%	4,484	-76.0%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 476,043	$ 419,957	13.4%	$ 333,537	42.7%	$ 1,402,839	$ 1,268,186	10.6%	$ 1,073,073	30.7%
Depreciation/Amortization	$ -	$ -	0.0%	$ -	100.0%	$ -	$ -	0.0%	$ -	100.0%
TOTAL OPERATING COSTS	$ 476,043	$ 419,957	13.4%	$ 333,537	42.7%	$ 1,402,839	$ 1,268,186	10.6%	$ 1,073,073	30.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (149,298)**	**$ 83,074**	**-279.7%**	**$ 111,060**	**-234.4%**	**$ (115,628)**	**$ 280,925**	**-141.2%**	**$ 336,117**	**-134.4%**
Operating Margin	-45.69%	16.51%	-376.7%	24.98%	-282.9%	-8.98%	18.13%	-149.5%	23.85%	-137.7%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	1,445	1,719	-15.9%	1,374	5.2%	4,742	5,298	-10.5%	4,594	3.2%
Average Revenue per Office Visit	559.41	550.25	1.7%	544.71	2.7%	610.84	549.81	11.1%	535.34	14.1%
Hospital FTE's (Salaries and Wages)	19.4	14.8	30.5%	16.9	14.8%	19.5	15.4	26.7%	18.7	4.5%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC COMBINED
DECEMBER 2024

MONTHLY REVENUE

	Clements	West	JBS	Womens	Total	%
Medicare	$ 46,631	$ 41,419	$ -	$ 25,015	$ 113,065	8.3%
Medicaid	24,794	33,668	279,282	215,569	553,313	40.8%
FAP	-	-	-	-	-	0.0%
Commercial	23,727	60,365	82,245	392,026	558,362	41.2%
Self Pay	51,931	51,259	15,710	(11,516)	107,384	7.9%
Other	1,435	14,424	207	6,510	22,576	1.7%
Total	**$ 148,517**	**$ 201,135**	**$ 377,444**	**$ 627,604**	**$ 1,354,700**	**100.0%**

YTD REVENUE

	Clements	West	JBS	Womens	Total	%
Medicare	$ 171,063	$ 141,373	$ -	$ 95,917	$ 408,353	8.9%
Medicaid	78,923	97,805	828,210	724,484	1,729,421	37.5%
FAP	-	-	-	-	-	0.0%
Commercial	79,551	208,755	332,834	1,335,233	1,956,373	42.5%
Self Pay	183,692	167,386	54,792	33,724	439,594	9.5%
Other	3,757	33,176	4,474	31,752	73,158	1.6%
Total	**$ 516,985**	**$ 648,495**	**$ 1,220,310**	**$ 2,221,111**	**$ 4,606,900**	**100.0%**

MONTHLY PAYMENTS

	Clements	West	JBS	Womens	Total	%
Medicare	$ 23,556	$ 18,970	$ -	$ 12,835	$ 55,361	9.5%
Medicaid	11,436	19,031	133,226	$ 88,340	252,033	43.1%
FAP	-	-	-	$ -	-	0.0%
Commercial	7,982	30,442	48,513	$ 130,882	217,818	37.2%
Self Pay	8,427	11,226	10,212	$ 21,828	51,693	8.8%
Other	225	3,688	1,382	$ 2,843	8,137	1.4%
Total	**$ 51,626**	**$ 83,357**	**$ 193,332**	**$ 256,728**	**$ 585,042**	**100.0%**

YEAR TO DATE PAYMENTS

	Clements	West	JBS	Womens	Total	%
Medicare	$ 75,966	$ 56,459	$ -	$ 46,572	$ 178,996	10.0%
Medicaid	21,041	46,795	398,135	266,223	732,193	40.8%
FAP	-	-	-	-	-	0.0%
Commercial	25,155	85,914	152,045	395,246	658,359	36.7%
Self Pay	28,046	35,930	30,699	108,118	202,793	11.3%
Other	860	7,088	3,553	10,253	21,754	1.2%
Total	**$ 151,067**	**$ 232,186**	**$ 584,432**	**$ 826,411**	**$ 1,794,096**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
DECEMBER 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	$ 46,631	31.4%	$ 34,389	34.1%	$ 171,063	33.1%	139,459	31.9%
Medicaid	24,794	16.7%	15,675	15.5%	78,923	15.3%	79,184	18.1%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	23,727	16.0%	19,761	19.6%	79,551	15.4%	77,104	17.6%
Self Pay	51,931	34.9%	30,758	30.4%	183,692	35.5%	141,883	32.4%
Other	1,435	1.0%	400	0.4%	3,757	0.7%	8	0.0%
TOTAL	**$ 148,517**	**100.0%**	**$ 100,984**	**100.0%**	**$ 516,985**	**100.0%**	**437,637**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	23,556	45.6%	$ 24,111	46.2%	$ 75,966	50.2%	60,949	41.2%
Medicaid	11,436	22.2%	14,559	27.9%	21,041	13.9%	39,707	26.8%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	7,982	15.5%	9,587	18.3%	25,155	16.7%	29,141	19.7%
Self Pay	8,427	16.3%	3,777	7.2%	28,046	18.6%	17,704	12.0%
Other	225	0.4%	211	0.4%	860	0.6%	403	0.3%
TOTAL	**$ 51,626**	**100.0%**	**$ 52,245**	**100.0%**	**$ 151,067**	**100.0%**	**147,905**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
DECEMBER 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	$ 41,419	20.6%	$ 42,196	23.1%	$ 141,373	21.8%	$ 142,652	25.3%
Medicaid	33,668	16.7%	$ 31,738	17.3%	97,805	15.1%	95,435	16.9%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	60,365	30.0%	$ 51,616	28.2%	208,755	32.2%	161,832	28.7%
Self Pay	51,259	25.5%	$ 50,453	27.6%	167,386	25.8%	139,585	24.8%
Other	14,424	7.2%	$ 7,036	3.8%	33,176	5.1%	24,321	4.3%
TOTAL	**$ 201,135**	**100.0%**	**$ 183,039**	**100.0%**	**$ 648,495**	**100.0%**	**$ 563,825**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 18,970	22.8%	$ 19,094	36.2%	$ 56,459	24.3%	$ 56,597	30.9%
Medicaid	19,031	22.8%	9,722	18.4%	$ 46,795	20.2%	38,789	21.2%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	30,442	36.5%	19,221	36.4%	85,914	36.9%	62,251	34.0%
Self Pay	11,226	13.5%	4,090	7.7%	35,930	15.5%	19,995	10.9%
Other	3,688	4.4%	672	1.3%	7,088	3.1%	5,616	3.1%
TOTAL	**$ 83,357**	**100.0%**	**$ 52,799**	**100.0%**	**$ 232,186**	**100.0%**	**$ 183,249**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC JBS
DECEMBER 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%	$ (895)	-0.3%	$ -	0.0%	$ 68	0.0%
Medicaid	279,282	73.9%	$ 229,791	68.7%	828,210	67.8%	693,021	69.3%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	82,245	21.8%	$ 84,772	25.4%	332,834	27.3%	258,817	25.9%
Self Pay	15,710	4.2%	$ 18,134	5.4%	54,792	4.5%	39,770	4.0%
Other	207	0.1%	$ 2,454	0.7%	4,474	0.4%	8,576	0.9%
TOTAL	**$ 377,444**	**100.0%**	**$ 334,256**	**100.0%**	**$ 1,220,310**	**100.0%**	**$ 1,000,251**	**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	133,226	68.9%	80,612	68.1%	398,135	68.1%	253,231	68.4%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	48,513	25.1%	34,038	28.8%	152,045	26.0%	100,229	27.1%
Self Pay	10,212	5.3%	3,311	2.8%	30,699	5.3%	14,889	4.0%
Other	1,382	0.7%	332	0.3%	3,553	0.6%	1,995	0.5%
TOTAL	**$ 193,332**	**100.0%**	**$ 118,292**	**100.0%**	**$ 584,432**	**100.0%**	**$ 370,344**	**100.0%**

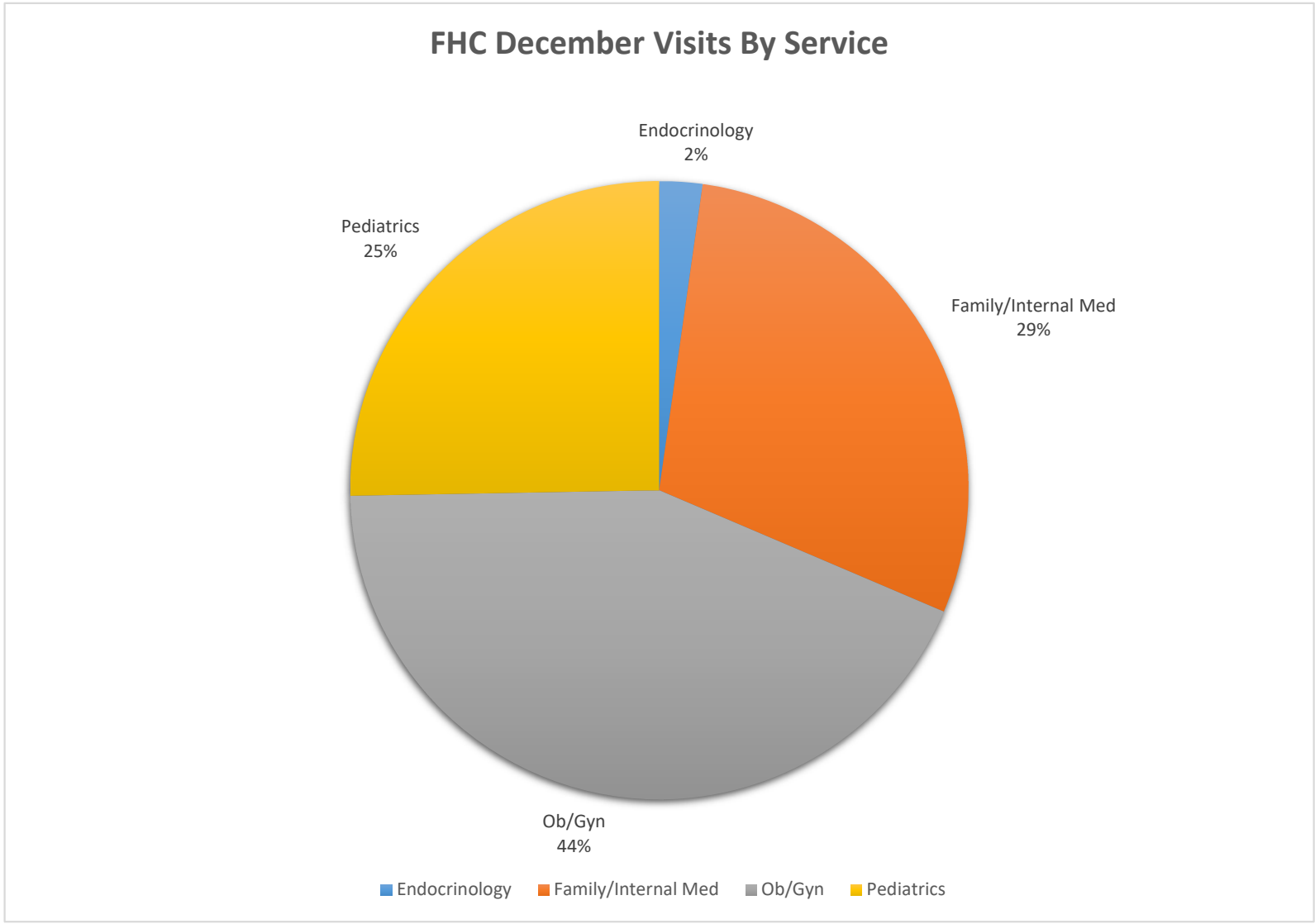
ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WOMENS CLINIC
DECEMBER 2024

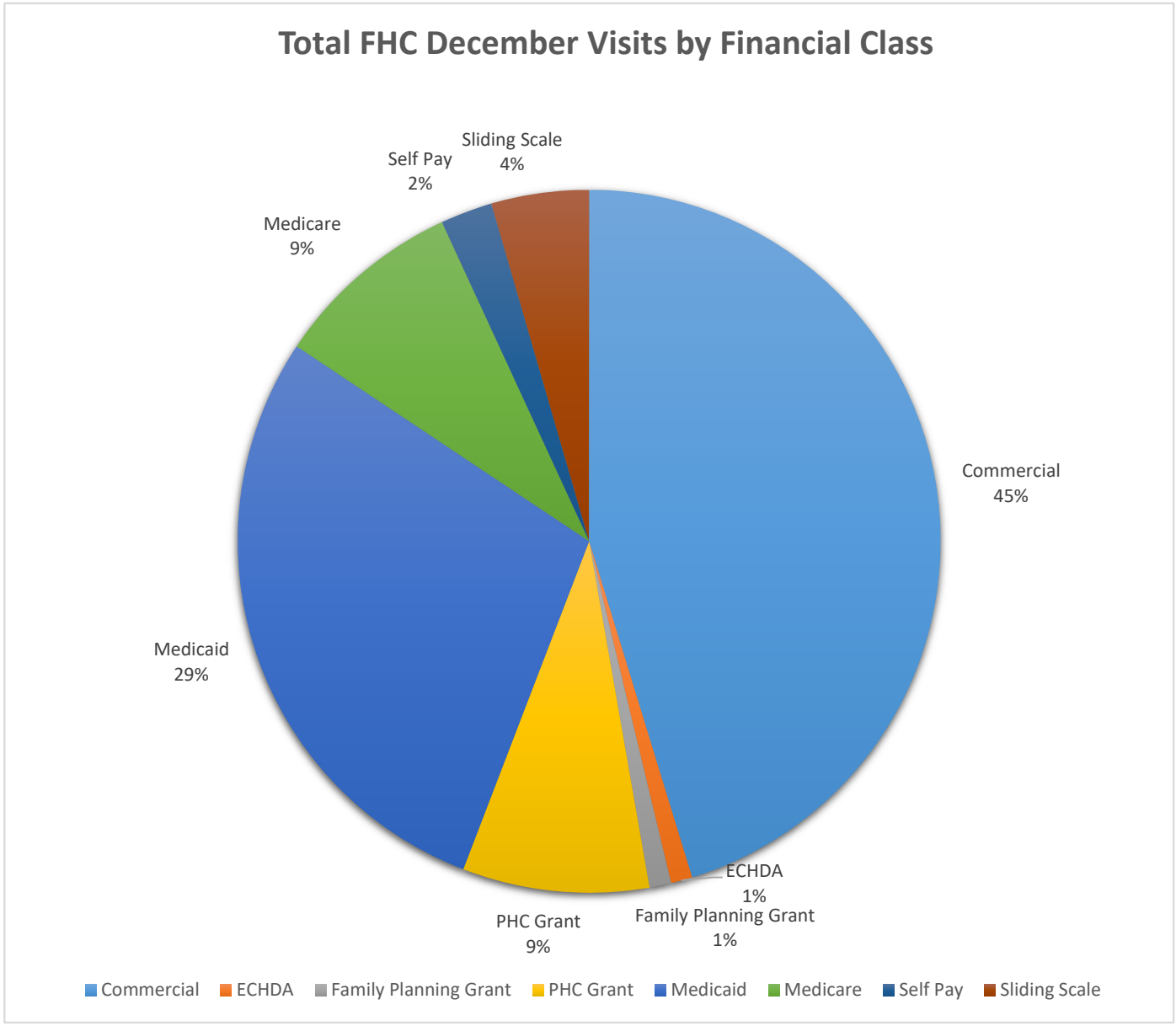
REVENUE BY PAYOR

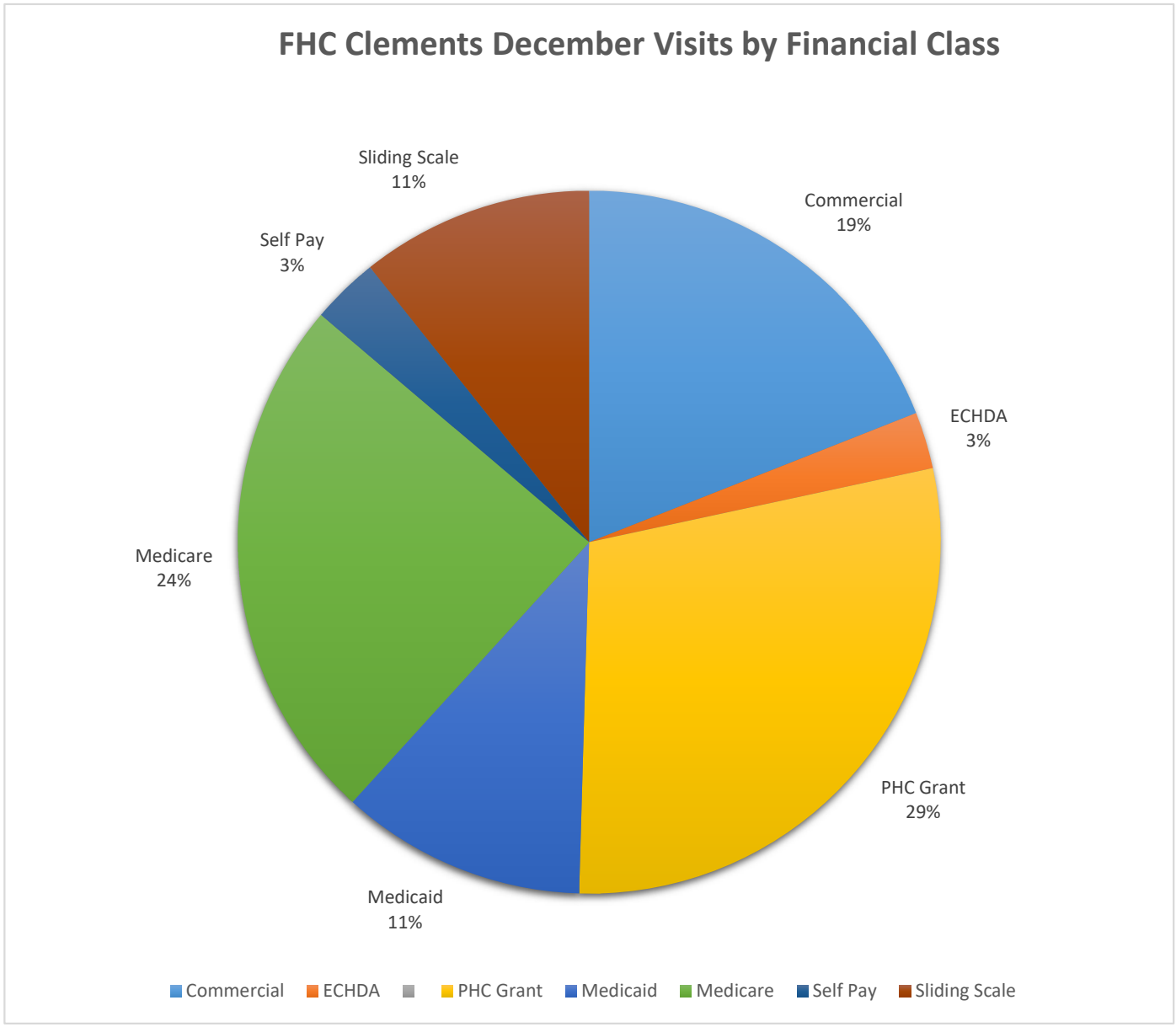
	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ 25,015	4.0%	$ 30,689	4.1%	$ 95,917	4.3%	$ 106,916	4.3%
Medicaid	215,569	34.3%	$ 261,220	34.9%	724,484	32.6%	820,042	33.3%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	392,026	62.5%	$ 434,709	58.1%	1,335,233	60.2%	1,433,614	58.3%
Self Pay	(11,516)	-1.8%	$ 16,328	2.2%	33,724	1.5%	65,379	2.7%
Other	6,510	1.0%	$ 5,487	0.7%	31,752	1.4%	33,423	1.4%
TOTAL	**$ 627,604**	**100.0%**	**$ 748,433**	**100.0%**	**$ 2,221,111**	**100.0%**	**$ 2,459,374**	**100.0%**

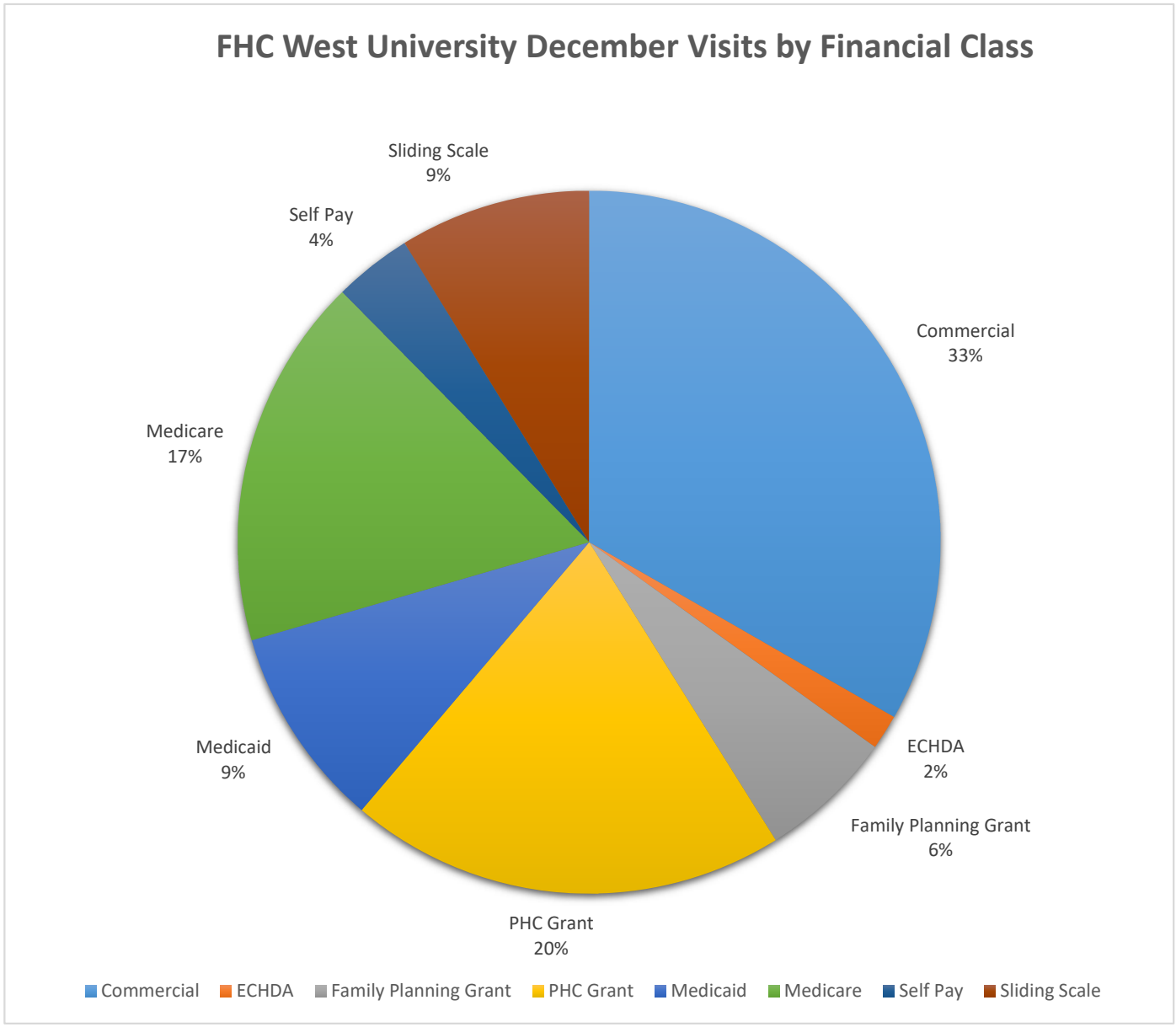
PAYMENTS BY PAYOR

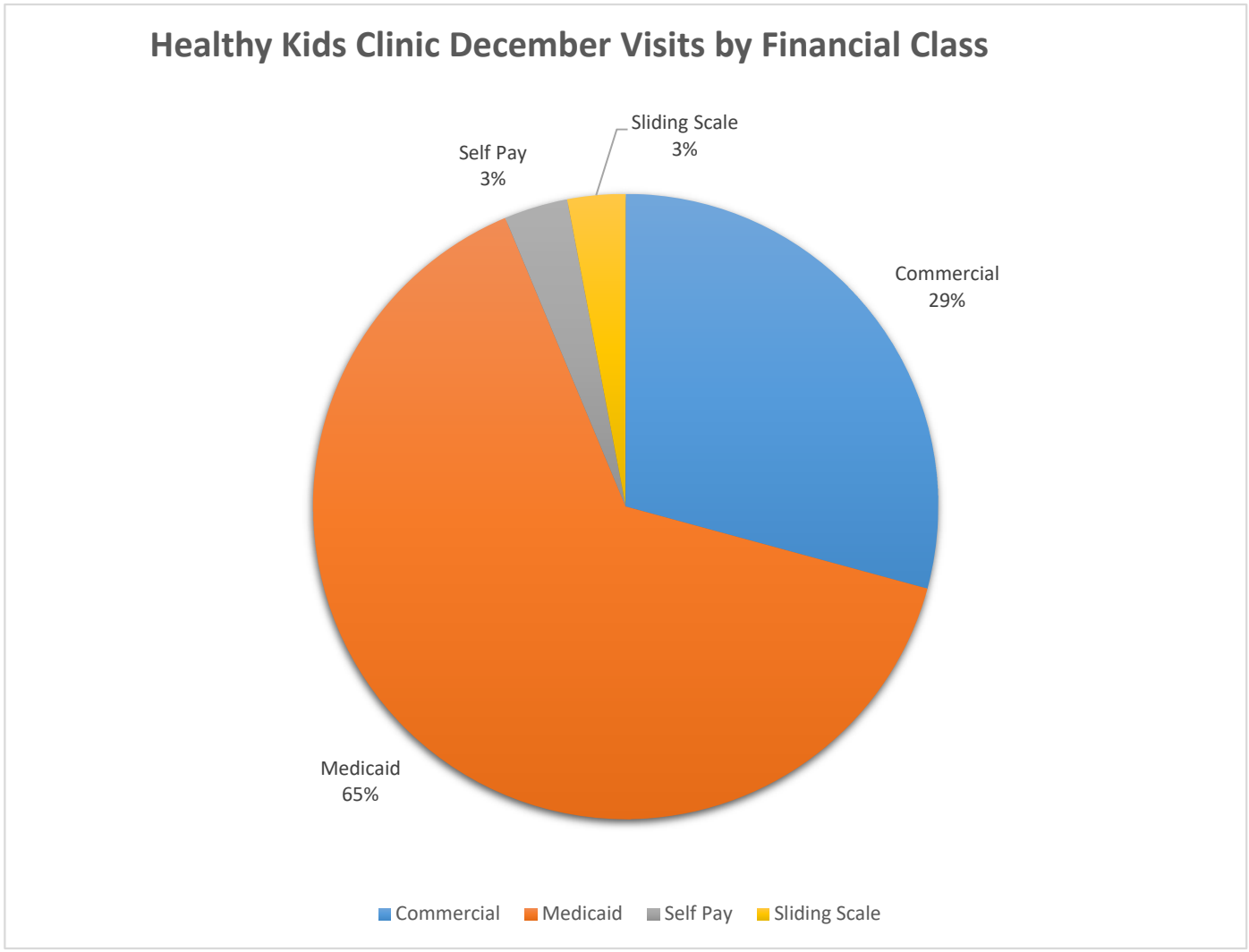
	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 12,835	5.0%	$ 6,141	4.3%	$ 46,572	5.6%	$ 17,838	3.6%
Medicaid	88,340	34.4%	22,330	15.5%	266,223	32.2%	76,256	15.5%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	130,882	51.0%	87,574	61.0%	395,246	47.9%	256,607	52.2%
Self Pay	21,828	8.5%	27,227	19.0%	108,118	13.1%	136,741	27.8%
Other	2,843	1.1%	379	0.3%	10,253	1.2%	4,566	0.9%
TOTAL	**$ 256,728**	**100.0%**	**$ 143,651**	**100.0%**	**$ 826,411**	**100.0%**	**$ 492,008**	**100.0%**

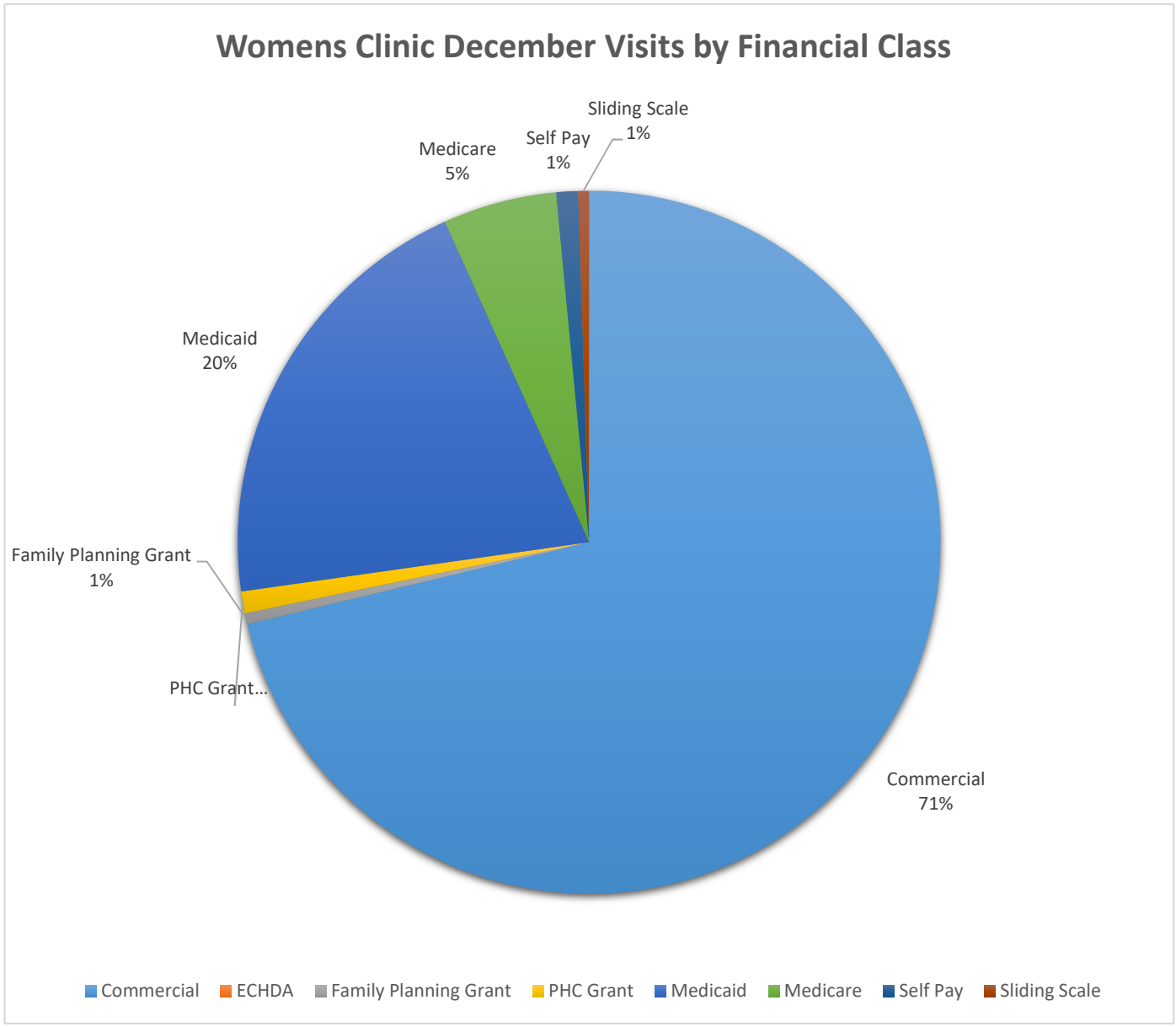

FHC December Visits By Service
Endocrinology
2%
Family/Internal Med
29%
Ob/Gyn
44%
Pediatrics
25%
Endocrinology
Family/Internal Med
Ob/Gyn
Pediatrics


Total FHC December Visits by Financial Class
Sliding Scale 4%
Self Pay 2%
Medicare 9%
Commercial 45%
Medicaid 29%
ECHDA 1%
Family Planning Grant 1%
PHC Grant 9%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC Clements December Visits by Financial Class
Sliding Scale
11%
Commercial
19%
Self Pay
3%
ECHDA
3%
Medicare
24%
PHC Grant
29%
Medicaid
11%
Commercial
ECHDA
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC West University December Visits by Financial Class
Sliding Scale 9%
Self Pay 4%
Commercial 33%
Medicare 17%
Medicaid 9%
ECHDA 2%
Family Planning Grant 6%
PHC Grant 20%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


Healthy Kids Clinic December Visits by Financial Class
Sliding Scale
3%
Self Pay
3%
Commercial
29%
Medicaid
65%
Commercial
Medicaid
Self Pay
Sliding Scale


Womens Clinic December Visits by Financial Class
Sliding Scale 1%
Self Pay 1%
Medicare 5%
Medicaid 20%
Family Planning Grant 1%
PHC Grant...
Commercial 71%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale

FHC Executive Director's Report-February 2025

- **Staffing Update**:
  - **Women's Clinic**: The Women's Clinic is currently in search of an Ultrasound Tech and LVN.
  - **Healthy Kids Clinic**: The Healthy Kids Clinic is currently in search of a LVN, Medical Assistant, and front desk position.

- **Provider Update:**
  - **West University**: We are currently searching for an additional Family Medicine physician and Nurse Practitioner for our West University location.
  - **Women's Clinic**: The Women's Clinic is currently searching for two OB/Gyns. Both Merritt Hawkins and Curative are assisting with the search.

Momentum Independent Network

Investor Statement

September 30, 2024- December 31, 2024

Prepared for

ECTOR COUNTY HOSPITAL DISTRICT

ECTOR COUNTY HOSPITAL DISTRICT
PO BOX 7239
Odessa, TX 79761

Advisor

Charles Brown & Jarrod Patterson
Momentum Independent Network Inc.

Momentum Independent Network

ECTOR COUNTY HOSPITAL DISTRICT
December 31, 2024

Yield Summary

Sector	Cost Basis	Weighted Avg Yield	Market Value	Unrealized Gain/Loss
Treasuries/Agencies/CDs	$ 53,123,775	2.80%	$ 53,064,436	$ -59,340
Money Market/Cash	$ 17,845,555	4.02%	$ 17,845,555	$ 0
Total	**$ 70,969,330**	**3.11%**	**$ 70,909,991**	**$ -59,340**

	12/31/2024	12/31/2023
3 MONTH TREASURY BILL	4.37%	5.40%
5 YEAR TREASURY BILL	4.38%	3.84%
10 YEAR TREASURY NOTE	4.58%	3.88%
30 YEAR TREASURY NOTE	4.78%	4.03%

The information is based on data received. Information supporting the recommendation is enclosed.
Mutual funds, ETFs and variable products are sold by prospectus. Please consider the investment objectives, risks, charges, and expenses of the investment company carefully before investing. The prospectus contains this and other information about the investment company. Prospectuses may be obtained from the investment company or from your registered representative. Please read the prospectus carefully before investing. Investors should consider their individual investment time horizon and income tax brackets, both current and anticipated, when making an investment decision. ETFs trade like a stock and may trade for less than their net asset value. Asset allocation and Diversification does not ensure a profit and may not protect against loss in declining markets. None of the named entities, herein, are affiliated.

ECTOR COUNTY HOSPITAL DISTRICT Reports: Rollup of All Accounts

Holdings Detail As of Dec 31, 2024

Momentum Independent Network

Holdings	Units	Cost [1]	Portfolio Value	Gain/Loss [2]	Gain/Loss %	% of Portfolio	Dur	Mat. Date	Price	YTM
26761549		$ 1,571,599	$ 1,532,399	$ -39,200	-2.52 %	2.16 %				
FHLBanks 0.860 10/27/25 '24 | 3130APGW9	1,500,000	1,497,680	1,458,480	-39,200	-2.62	2.06	0.78	Oct 27, 2025	$ 97.23	0.90 %
Dreyfus Government Cash Mgmt Inv | DGVXX	58,233.47	58,233	58,233	0	0.00	0.08			1.00	—
Cash		15,686	15,686			0.02				—
38285456		13,526,159	13,624,285	98,126	0.73	19.21				
US Treasury 2.000 02/15/25 | 912828J27	5,180,000	5,054,031	5,165,237	111,206	2.20	7.28	0.10	Feb 15, 2025	99.72	4.42
FHLBanks 0.860 10/27/25 '24 | 3130APGW9	500,000	499,240	486,160	-13,080	-2.62	0.69	0.78	Oct 27, 2025	97.23	0.90
Dreyfus Government Cash Mgmt Inv | DGVXX	7,858,815.02	7,858,815	7,858,815	0	0.00	11.08			1.00	—
Cash		114,073	114,073			0.16				—
26761610		733,372	717,681	-15,692	-2.16	1.01				
FHLBanks 0.860 10/27/25 '24 | 3130APGW9	600,000	599,084	583,392	-15,692	-2.62	0.82	0.78	Oct 27, 2025	97.23	0.90
Dreyfus Government Cash Mgmt Inv | DGVXX	126,512.2	126,512	126,512	0	0.00	0.18			1.00	—
Cash		7,776	7,776			0.01				—
26761530		5,593,338	5,451,147	-142,192	-2.57	7.69				
Freddie Mac 0.600 10/15/25 '25 MTN | 3134GWYS9	750,000	740,772	728,760	-12,012	-1.62	1.03	0.75	Oct 15, 2025	97.17	0.92
Fed Farm Cr Bnks 1.300 12/01/25 '24 | 3133ENGA2	4,600,000	4,605,703	4,475,524	-130,179	-2.83	6.31	0.87	Dec 1, 2025	97.29	1.03
Dreyfus Government Cash Mgmt Inv | DGVXX	182,253.67	182,254	182,254	0	0.00	0.26			1.00	—
Cash		64,609	64,609			0.09				—
26761506		48,583,786	48,646,932	63,146	0.13	68.60				
US Treasury Bill 01/23/25 | 912797JR9	3,020,000	2,954,267	3,012,541	58,273	1.97	4.25	0.04	Jan 23, 2025	99.75	4.62
Fed Farm Cr Bnks 1.300 12/01/25 '24 | 3133ENGA2	3,000,000	3,003,721	2,918,820	-84,901	-2.83	4.12	0.87	Dec 1, 2025	97.29	1.03
US Treasury Bill 04/17/25 | 912797KS5	3,738,000	3,573,771	3,692,621	118,850	3.33	5.21	0.27	Apr 17, 2025	98.79	4.56
US Treasury Bill 03/27/25 | 912797MU8	10,096,000	9,999,283	9,997,261	-2,022	-0.02	14.10	0.21	Mar 27, 2025	99.02	3.64
Freddie Mac 0.600 10/15/25 '25 MTN | 3134GWYS9	2,700,000	2,666,729	2,623,536	-43,193	-1.62	3.70	0.75	Oct 15, 2025	97.17	0.92
US Treasury 0.250 07/31/25 | 91282CAB7	7,180,000	6,898,195	7,016,727	118,532	1.72	9.90	0.55	Jul 31, 2025	97.73	4.30
FHLBanks 0.860 10/27/25 '24 | 3130APGW9	2,300,000	2,296,432	2,236,336	-60,096	-2.62	3.15	0.78	Oct 27, 2025	97.23	0.90
US Treasury 1.750 03/15/25 | 91282CED9	6,859,000	6,845,054	6,824,431	-20,623	-0.30	9.62	0.18	Mar 15, 2025	99.50	1.82
Dreyfus Government Cash Mgmt Inv | DGVXX	9,330,459.9	9,330,460	9,330,460	0	0.00	13.16			1.00	—
Morgan Stanley Bk N A Cd 1.10000% 11/19/202 | 61765Q6N4	250,000	241,192	236,835	-4,358	-1.81	0.33		Nov 19, 2026	94.73	1.89
Goldman Bank USA 1.800 03/09/26 | 38149M2P7	250,000	250,002	243,380	-6,622	-2.65	0.34	1.13	Mar 9, 2026	97.35	1.80
MIDWEST INDPT BANKERSBANK JEFFERSON CITY MO CTF DEP 1.800% 03/16/26 DTD 03/16/22 CLB | 59833LAY8	250,000	250,002	243,215	-6,787	-2.71	0.34			97.29	1.80

	Live Oak Banking 1.900 09/15/25 | 538036VN1	250,000	250,001	246,092	-3,909	-1.56	0.35	0.67	Sep 15, 2025	98.44	4.12
	Cash		24,678	24,678			0.03				1.90
38285461			961,075	937,547	-23,528	-2.48	1.32				
	FHLBanks 0.860 10/27/25 '24 | 3130APGW9	900,000	898,616	875,088	-23,528	-2.62	1.23	0.78	Oct 27, 2025	97.23	0.90
	Dreyfus Government Cash Mgmt Inv | DGVXX	51,137.78	51,138	51,138	0	0.00	0.07			1.00	—
	Cash		11,321	11,321			0.02				—
Total			**70,969,330**	**70,909,991**	**-59,340**	**-0.08**					

1 Cost basis values are not provided by the custodian in all cases, and should be independently verified from your original purchase records.

2 Capital gain/loss data presented here is a general guide and should not be relied upon in the preparation of your tax returns.

3 Sector information is provided by Morningstar.

4 An indication of the current dividends and interest vs. the current market value of the holdings. The yield represents the current amount of income that is being generated from the portfolio without liquidating the principal or capital gains on the portfolio. However, the yield will fluctuate daily and current or past performance is not a guarantee of future results.

5 Net and Gross expense ratio data is obtained from a third party data provider and is believed to be accurate, but has not been verified by Envestnet.

For Canadian mutual funds and ETFs, management expense ratio (MER) will be used as a net expense ratio equivalent. MER differs from Net Expense Ratio in that MER takes into consideration investment management fees, operating expenses and taxes while Net Expense Ratio reflects the amount paid for investment management fees after accounting for discounts and temporary fee waivers, distribution fees, 12(b)-1 fees and other operating expenses.

These reports are not to be construed as an offer or the solicitation of an offer to buy or sell securities mentioned herein. Information contained in these reports is based on sources and data believed reliable. The information used to construct these reports was received via a variety of sources. These reports are for informational purposes only. These reports do not take the place of any brokerage statements, any fund company statements, or any tax forms. You are urged to compare this report with the statement you receive from your custodian covering the same period. Differences in positions may occur due to reporting dates used and whether certain assets are not maintained by your custodian. There may also be differences in the investment values shown due to the use of differing valuation sources and methods.

Note regarding loan balance: Your group annuity contract loan balance (if applicable) is not itemized in this report although it is reflected in your Contract Value. For more details regarding your loan balance please review your most recent group annuity statement or contact your Advisor who can assist you in obtaining this information.

ECTOR COUNTY HOSPITAL DISTRICT Reports: Rollup of All Accounts

Bond Analysis As of Dec 31, 2024

Momentum Independent Network

Overview [1] [2]

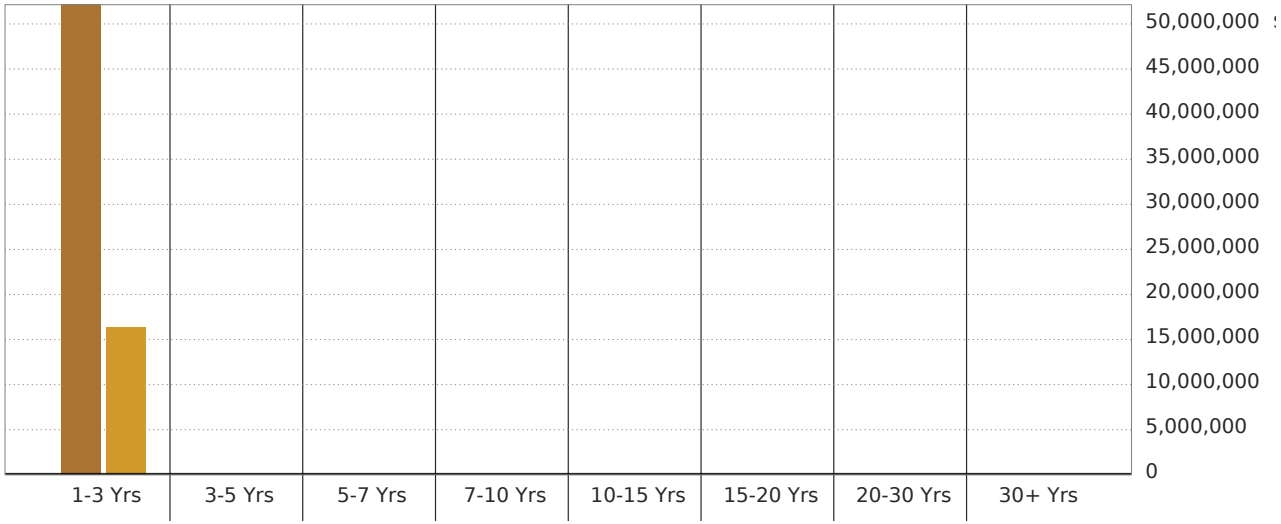
Total Number of Issues	15
Face Value	52,923,000
Market Value	$ 52,132,110
Long/Intermediate Term Average S&P Rating [3]	—
Long/Intermediate Term Average Moody's Rating [3]	#Aaa

Statistics [1] [2]

Average Bond Yield [4]	0.79 %
Average Yield to Maturity [5]	4.36 %
Average Yield to Worst [6]	4.36 %
Average Coupon	0.78 %
Average Modified Duration (Years) [7]	0.43
Average Effective Duration (Years) [8]	0.43
Average Duration to Worst [9]	0.43
Average Convexity (par) [10]	0.00

Bond Maturity vs. Call Date Distribution

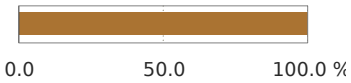
Maturity | **Call Date**



Period	Bond Maturity	Total %	Callable	Total %
1 to 3 Years	$ 52,132,110	100.00 %	$ 16,403,462	31.47 %

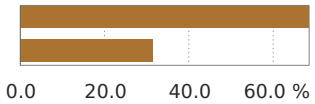
Bond Coupon Concentration [11]

$	
52,132,110	< 3%



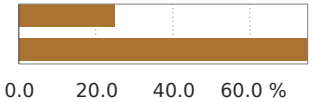
Bond Distribution by Type [1 12]

$	
35,728,649	Treasury bill/note
16,403,462	Agency Bond



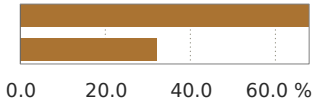
Bond Distribution by S&P Rating [1 13 14]

$	
13,047,612	AA
39,084,498	Not Available



Bond Distribution by Moody Rating [1 15 14]

$	
35,418,323	AAA
16,713,787	Not Available



1 Bond type, statistics and rating information is provided by Refinitiv.

2 Data is weighted and calculated, if information is available on at least 50% of holdings in total bond market value. If information is available on less than 50%, the data is shown as 'n/a'.

3 Average credit quality gives a snapshot of the portfolio's overall credit quality. It is an average of each bond's credit rating, adjusted for its relative weighting in the portfolio. Bonds with one year to maturity at the time of issuance are considered cash and are not include in the Average Credit ratings.

4 Average Bond Yield is an indication of the interest earned vs. the current market value of the holdings. The yield represents the current amount of income that is being generated from the portfolio without liquidating the principal or capital gains on the portfolio. The Average Bond Yield will fluctuate daily and current or past performance is not a guarantee of future results.

5 Average Yield to Maturity is the yield of the bonds taking into account the price discount or premium over face value. It is calculated with the cash-flow assumption that the instruments trade to maturity and is averaged with the corresponding weights of the constituent bonds.

6 Average Yield To Worst is an arithmetic average of the Daily Yield To Worst which is the lowest amount an investor could earn if the bond is purchased at the current price and held until the bond matures or is called.

7 Average Modified Duration is a measurement of change in the value of a bond to a change in interest rates; it determines the effect a 100 basis point (1%) change in interest rates will have on the price of the bond. It is calculated with the cash-flow assumption that the instrument trades to maturity and is averaged with the corresponding weights of the constituent bonds.

8 Average Effective Duration is a simulated measure of duration which measures change in price for given change in rates.It is calculated using an option based model that accounts for embedded options and is averaged with the corresponding weights of the constituent bonds.

9 Average Duration to Worst represents the percentage change in value per unit shift in the yield curve. It is calculated using certain cash flow assumptions and is averaged with the corresponding weights of the constituent bonds.

10 Convexity is the measure of the sensitivity of a bond's price to a change in yield. A high convexity bond is more sensitive to changes in interest rates and should consequently witness larger fluctuations in price when interest rates move. The opposite is true of low convexity bonds, whose prices don't fluctuate as much when interest rates change. Average convexity is calculated using certain cash flow assumptions and is averaged with the corresponding weights of the constituent bonds.

11	The Group By Bond Coupon Concentration Holdings Report includes only Bonds Holdings.
12	The Group By Bond Distribution by Type Holdings Report includes only Bonds Holdings.
13	The Group By Bond Distribution by S&P Rating Holdings Report includes only Bonds Holdings.
14	Parent style classifications are provided by Morningstar, Inc. and mapped into one of the style classifications supported on this platform. Sector information is provided by Morningstar. Bond type and rating information is provided by Refinitiv.
15	The Group By Bond Distribution by Moody Rating Holdings Report includes only Bonds Holdings.

ECTOR COUNTY HOSPITAL DISTRICT

Investment Portfolio
December 31, 2024
Charles Brown, Jarrod Patterson
Momentum Independent Network

All prices and values reflected in this report are captured from the current Hilltop Securities statements.

"This report is given as a courtesy to our clients. Hilltop Securities makes no warranties as to the completeness or accuracy of this information and specifically disclaims any liability arising from your use or reliance on this information. Hilltop Securities does not offer tax advice. You are solely responsible for the accuracy of cost basis and gain/loss information reported to tax authorities."

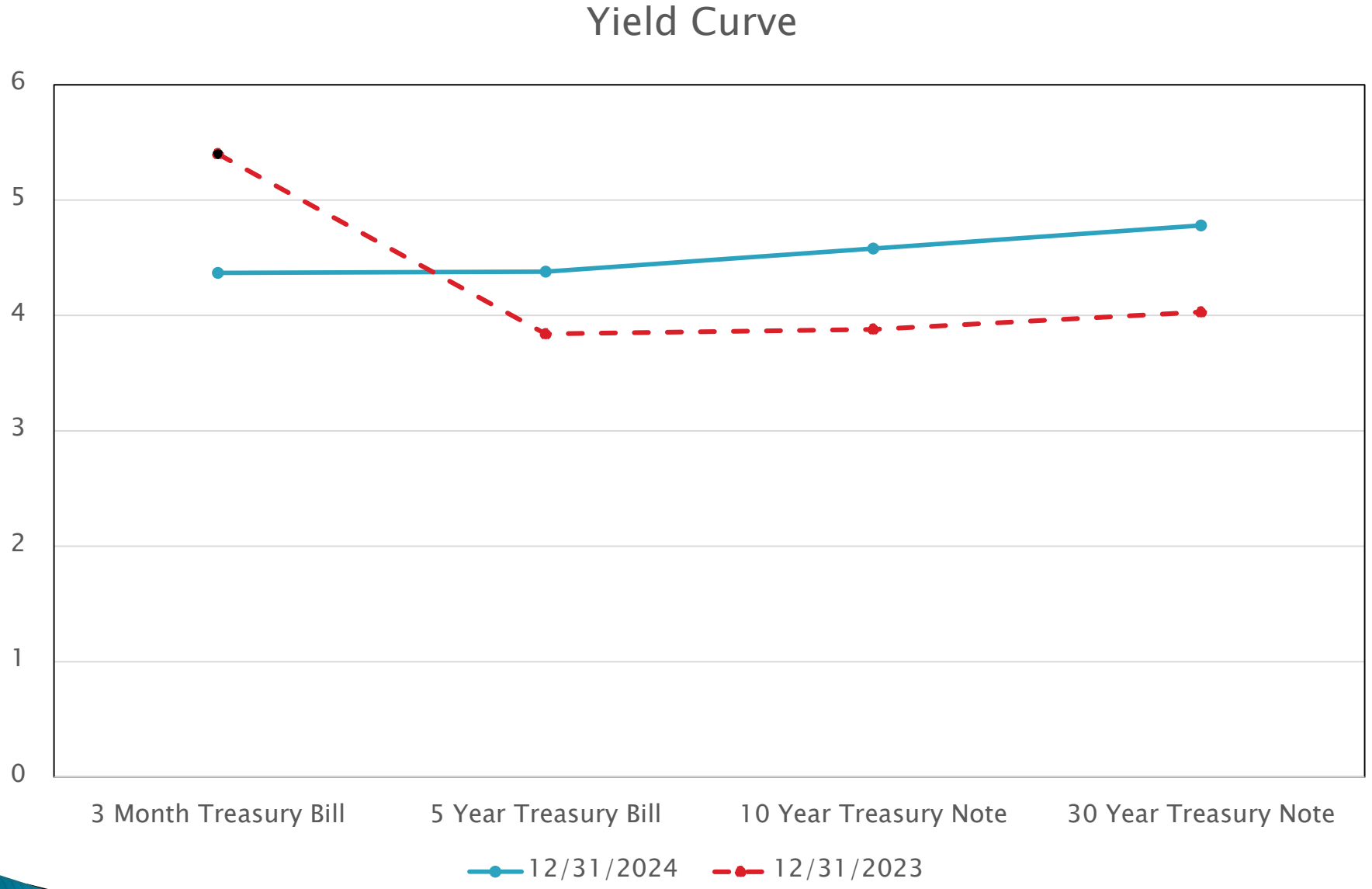
ECTOR COUNTY HOSPITAL DISTRICT
December 31, 2024

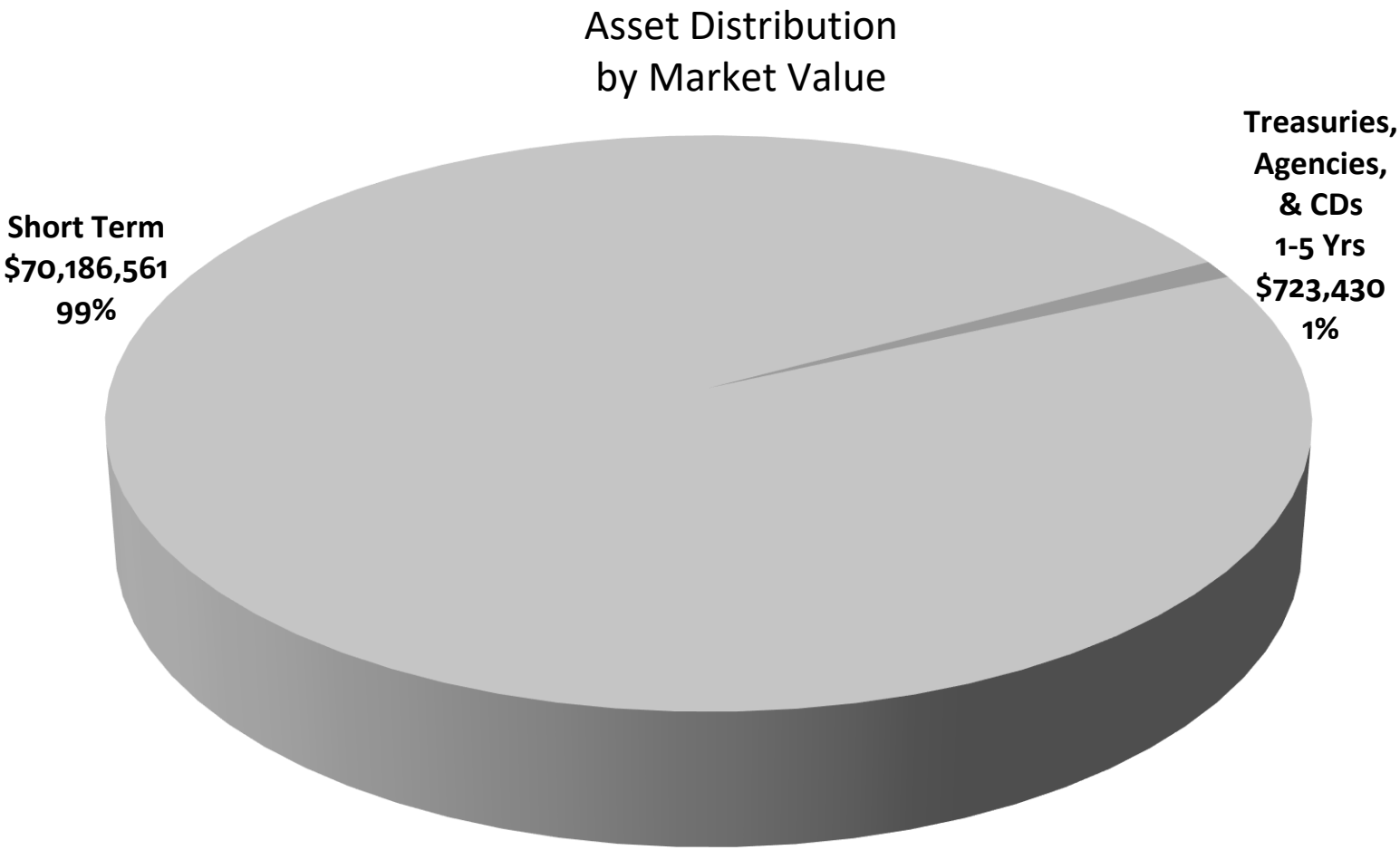
Yield Summary

Sector	Cost Basis	Weighted Avg Yield	Market Value	Unrealized Gain/Loss
Treasuries/Agencies/CDs	$ 53,123,775	2.80%	$ 53,064,436	$ -59,340
Money Market/Cash	$ 17,845,555	4.02%	$ 17,845,555	$ 0
Total	**$ 70,969,330**	**3.11%**	**$ 70,909,991**	**$ -59,340**

	12/31/2024	12/31/2023
3 MONTH TREASURY BILL	4.37%	5.40%
5 YEAR TREASURY BILL	4.38%	3.84%
10 YEAR TREASURY NOTE	4.58%	3.88%
30 YEAR TREASURY NOTE	4.78%	4.03%

The information is based on data received. Information supporting the recommendation is enclosed.
Mutual funds, ETFs and variable products are sold by prospectus. Please consider the investment objectives, risks, charges, and expenses of the investment company carefully before investing. The prospectus contains this and other information about the investment company. Prospectuses may be obtained from the investment company or from your registered representative. Please read the prospectus carefully before investing. Investors should consider their individual investment time horizon and income tax brackets, both current and anticipated, when making an investment decision. ETFs trade like a stock and may trade for less than their net asset value. Asset allocation and Diversification does not ensure a profit and may not protect against loss in declining markets. None of the named entities, herein, are affiliated.


Yield Curve
6
5
4
3
2
1
0
3 Month Treasury Bill
5 Year Treasury Bill
10 Year Treasury Note
30 Year Treasury Note
12/31/2024
12/31/2023


Asset Distribution
by Market Value
Short Term
$70,186,561
99%
Treasuries,
Agencies,
& CDs
1-5 Yrs
$723,430
1%

Charles Brown and Jarrod Patterson,
Financial Consultants
600 Strada Circle Suite 210
Mansfield, TX 76063
979-249-2545

This information is provided for informational purposes only and as a courtesy to the customer and may include assets that the firm does not hold on behalf of the customer and which are not included on the firm's books and records. It is important to review and save all source documents provided by a product sponsor or brokerage firm which may contain notices, disclosures and other information important to you and may also serve as a reference. All prices and values reflected in this report are captured from the current MIN statements.

The information contained herein is obtained from sources believed to be reliable, but its accuracy or completeness Is not guaranteed. This information should not be construed as an offer to sell or a solicitation of an offer to buy any security. Principal amounts and estimated distributions may change at any time and are not guaranteed and used only for discussion.

Should any conflict exist between this report and any report or confirmation provided by a product sponsor or brokerage firm, information provided by the product sponsor or brokerage firm shall prevail. You are solely responsible for the accuracy of cost basis and gain/loss information reported to tax authorities.

Offering general securities through Momentum Independent Network Inc. (MIN) 717 Harwood St, Suite 3400, Dallas, TX 75270 • 800-562-8041 • Member of FINRA & SIPC. MIN nor its Representatives offer tax or legal advice.

Momentum Independent Network

mch
Medical Center Health System
Your One Source for Health

MEMORANDUM

TO: Russell Tippin, President and Chief Executive Officer

FROM: Steve Ewing, Chief Financial Officer

RE: **Quarterly Investment Report – First Quarter 2025**

DATE: February 11, 2025

The Investment Report of Ector County Hospital District for the first quarter ended December 31, 2024, will be presented at the Finance Committee meeting February 11, 2025. This report was prepared to provide the Hospital President and Chief Financial Officer and Board of Directors information as required under the Public Funds Investment Act. Investments purchased during the first quarter of fiscal 2025 met the requirements of the Investment Policy and the Public Funds Investment Act.

To the best of my knowledge, as of December 31, 2024, the investment portfolio is in compliance with the Public Funds Investment Act and with the District's Investment Policy.

Russell Tippin
Investment Officer

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
DECEMBER 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	1,238	1,167	6.1%	1,184	4.6%	3,440	3,591	-4.2%	3,414	0.8%
Neonatal ICU (NICU)	22	18	22.2%	22	0.0%	61	54	13.0%	66	-7.6%
Total Admissions	1,260	1,185	6.3%	1,206	4.5%	3,501	3,645	-4.0%	3,480	0.6%
Patient Days										
Adult & Pediatric	4,380	4,278	2.4%	4,554	-3.8%	12,807	13,161	-2.7%	12,904	-0.8%
ICU	431	426	1.2%	472	-8.7%	1,312	1,310	0.2%	1,329	-1.3%
CCU	440	413	6.5%	461	-4.6%	1,289	1,270	1.5%	1,313	-1.8%
NICU	399	282	41.5%	256	55.9%	1,351	850	58.9%	835	61.8%
Total Patient Days	5,650	5,399	4.6%	5,743	-1.6%	16,759	16,591	1.0%	16,381	2.3%
Observation (Obs) Days	858	640	34.1%	662	29.6%	2,352	1,968	19.5%	1,938	21.4%
Nursery Days	286	279	2.5%	278	2.9%	833	858	-2.9%	913	-8.8%
Total Occupied Beds / Bassinets	6,794	6,318	7.5%	6,683	1.7%	19,944	19,417	2.7%	19,232	3.7%
Average Length of Stay (ALOS)										
Acute / Adult & Pediatric	4.24	4.38	-3.3%	4.63	-8.5%	4.48	4.38	2.2%	4.55	-1.6%
NICU	18.14	15.67	15.8%	11.64	55.9%	22.15	15.74	40.7%	12.65	75.1%
Total ALOS	4.48	4.56	-1.6%	4.76	-5.8%	4.79	4.55	5.2%	4.71	1.7%
Acute / Adult & Pediatric w/o OB	5.04			5.33	-5.4%	5.42			5.35	1.4%
Average Daily Census	182.3	174.2	4.6%	185.3	-1.6%	182.2	180.3	1.0%	178.1	2.3%
Hospital Case Mix Index (CMI)	1.7764	1.7180	3.4%	1.7146	3.6%	1.8029	1.7180	4.9%	1.6885	6.8%
CMI Adjusted LOS	2.52	2.65	-4.8%	2.78	-9.1%	2.66	2.65	0.2%	2.79	-4.8%
Medicare										
Admissions	502	477	5.2%	491	2.2%	1,369	1,467	-6.7%	1,356	1.0%
Patient Days	2,431	2,463	-1.3%	2,703	-10.1%	7,288	7,572	-3.8%	7,420	-1.8%
Average Length of Stay	4.84	5.16	-6.2%	5.51	-12.0%	5.32	5.16	3.1%	5.47	-2.7%
Case Mix Index	2.0435	1.9465	5.0%	2.0599	-0.8%	2.0575	1.9465	5.7%	1.9971	3.0%
Medicaid										
Admissions	150	118	27.1%	124	21.0%	340	364	-6.6%	373	-8.8%
Patient Days	583	458	27.3%	454	28.4%	1,637	1,410	16.1%	1,495	9.5%
Average Length of Stay	3.89	3.88	0.1%	3.66	6.2%	4.81	3.87	24.3%	4.01	20.1%
Case Mix Index	1.1652	1.1174	4.3%	1.1050	5.4%	1.2533	1.1174	12.2%	1.0588	18.4%
Commercial										
Admissions	377	374	0.8%	365	3.3%	1,167	1,151	1.4%	1,070	9.1%
Patient Days	1,667	1,551	7.5%	1,467	13.6%	5,151	4,770	8.0%	4,378	17.7%
Average Length of Stay	4.42	4.15	6.6%	4.02	10.0%	4.41	4.14	6.5%	4.09	7.9%
Case Mix Index	1.7170	1.6559	3.7%	1.5238	12.7%	1.6983	1.6559	2.6%	1.5912	6.7%
Self Pay										
Admissions	197	186	5.9%	203	-3.0%	521	572	-8.9%	592	-12.0%
Patient Days	785	782	0.4%	967	-18.8%	2,135	2,406	-11.3%	2,614	-18.3%
Average Length of Stay	3.98	4.20	-5.2%	4.76	-16.3%	4.10	4.21	-2.6%	4.42	-7.2%
Case Mix Index	1.6275	1.5885	2.5%	1.5749	3.3%	1.7578	1.5885	10.7%	1.5000	17.2%
All Other										
Admissions	34	30	13.3%	23	47.8%	104	91	14.3%	89	16.9%
Patient Days	184	144	27.8%	152	21.1%	548	436	25.7%	474	15.6%
Average Length of Stay	5.41	4.80	12.7%	6.61	-18.1%	5.27	4.79	10.0%	5.33	-1.1%
Case Mix Index	2.0870	2.0742	0.6%	2.2696	-8.0%	1.9907	2.0742	-4.0%	2.0266	-1.8%
Radiology										
InPatient	4,622	4,504	2.6%	4,998	-7.5%	13,622	13,839	-1.6%	13,777	-1.1%
OutPatient	8,402	8,357	0.5%	7,652	9.8%	26,219	25,718	1.9%	24,515	7.0%
Cath Lab										
InPatient	623	642	-3.0%	723	-13.8%	1,717	1,976	-13.1%	2,095	-18.0%
OutPatient	340	526	-35.4%	416	-18.3%	1,131	1,619	-30.1%	1,418	-20.2%
Laboratory										
InPatient	82,583	77,267	6.9%	81,856	0.9%	239,198	237,439	0.7%	234,902	1.8%
OutPatient	70,812	67,985	4.2%	66,311	6.8%	214,957	209,205	2.7%	203,797	5.5%
Other										
Deliveries	188	164	14.6%	176	6.8%	546	505	8.1%	558	-2.2%
Surgical Cases										
InPatient	249	238	4.6%	232	7.3%	733	733	0.0%	668	9.7%
OutPatient	476	511	-6.8%	490	-2.9%	1,667	1,572	6.0%	1,562	6.7%
Total Surgical Cases	725	749	-3.2%	722	0.4%	2,400	2,305	4.1%	2,230	7.6%
GI Procedures (Endo)										
InPatient	150	138	8.7%	129	16.3%	419	425	-1.4%	413	1.5%
OutPatient	136	181	-24.9%	208	-34.6%	547	558	-2.0%	608	-10.0%
Total GI Procedures	286	319	-10.3%	337	-15.1%	966	983	-1.7%	1,021	-5.4%

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
DECEMBER 2024

	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	5,211	4,959	5.1%	5,191	0.4%	15,603	15,260	2.2%	15,890	-1.8%
Observation Days	858	640	34.1%	662	29.6%	2,352	1,968	19.5%	1,938	21.4%
Other O/P Occasions of Service	19,182	18,878	1.6%	19,728	-2.8%	59,214	58,092	1.9%	60,976	-2.9%
Total O/P Occasions of Svc.	25,251	24,477	3.2%	25,581	-1.3%	77,169	75,320	2.5%	78,804	-2.1%
Hospital Operations										
Manhours Paid	297,485	284,822	4.4%	286,578	3.8%	890,275	866,100	2.8%	850,863	4.6%
FTE's	1,679.4	1,607.9	4.4%	1,617.8	3.8%	1,693.5	1,647.5	2.8%	1,618.5	4.6%
Adjusted Patient Days	10,583	10,447	1.3%	10,662	-0.7%	32,386	32,003	1.2%	31,529	2.7%
Hours / Adjusted Patient Day	28.11	27.26	3.1%	26.88	4.6%	27.49	27.06	1.6%	26.99	1.8%
Occupancy - Actual Beds	49.5%	49.9%	-0.8%	50.3%	-1.6%	49.5%	51.7%	-4.2%	48.4%	2.3%
FTE's / Adjusted Occupied Bed	4.9	4.8	3.1%	4.7	4.6%	4.8	4.7	1.6%	4.7	1.9%
Family Health Clinic - Clements										
Total Medical Visits	540	505	6.9%	359	50.4%	1,915	1,642	16.6%	1,574	21.7%
Manhours Paid	1,762	1,518	16.1%	2,035	-13.4%	5,367	4,937	8.7%	6,238	-14.0%
FTE's	9.9	8.6	16.1%	11.5	-13.4%	10.2	9.4	8.7%	11.9	-14.0%
Family Health Clinic - West University										
Total Medical Visits	675	641	5.3%	606	11.4%	2,221	1,899	17.0%	1,884	17.9%
Manhours Paid	1,598	1,379	15.8%	1,184	34.9%	4,579	4,086	12.1%	3,699	23.8%
FTE's	9.0	7.8	15.8%	6.7	34.9%	8.7	7.8	12.1%	7.0	23.8%
Family Health Clinic - JBS										
Total Medical Visits	916	732	25.1%	864	6.0%	3,019	2,497	20.9%	2,483	21.6%
Manhours Paid	1,387	1,472	-5.8%	1,605	-13.6%	4,078	5,022	-18.8%	4,828	-15.5%
FTE's	7.8	8.3	-5.8%	9.1	-13.6%	7.8	9.6	-18.8%	9.2	-15.5%
Family Health Clinic - Womens										
Total Medical Visits	1,445	1,719	-15.9%	1,374	5.2%	4,742	5,298	-10.5%	4,594	3.2%
Manhours Paid	3,429	2,627	30.5%	2,987	14.8%	10,258	8,095	26.7%	9,815	4.5%
FTE's	19.4	14.8	30.5%	16.9	14.8%	19.5	15.4	26.7%	18.7	4.5%
Total ECHD Operations										
Total Admissions	1,260	1,185	6.3%	1,206	4.5%	3,501	3,645	-4.0%	3,480	0.6%
Total Patient Days	5,650	5,399	4.6%	5,743	-1.6%	16,759	16,591	1.0%	16,381	2.3%
Total Patient and Obs Days	6,508	6,039	7.8%	6,405	1.6%	19,111	18,559	3.0%	18,319	4.3%
Total FTE's	1,725.5	1,647.4	4.7%	1,661.9	3.8%	1,739.6	1,689.6	3.0%	1,665.2	4.5%
FTE's / Adjusted Occupied Bed	5.1	4.9	3.4%	4.8	4.6%	4.9	4.9	1.8%	4.9	1.7%
Total Adjusted Patient Days	10,583	10,447	1.3%	10,662	-0.7%	32,386	32,003	1.2%	31,529	2.7%
Hours / Adjusted Patient Day	28.88	27.93	3.4%	27.61	4.6%	28.24	27.75	1.7%	27.77	1.7%
Outpatient Factor	1.8731	1.9349	-3.2%	1.8565	0.9%	1.9325	1.9290	0.2%	1.9247	0.4%
Blended O/P Factor	2.0407	2.1126	-3.4%	2.0402	0.0%	2.1238	2.1194	0.2%	2.1203	0.2%
Total Adjusted Admissions	2,360	2,293	2.9%	2,239	5.4%	6,766	7,031	-3.8%	6,698	1.0%
Hours / Adjusted Admisssion	129.51	127.27	1.8%	131.49	-1.5%	135.18	126.33	7.0%	130.70	3.4%
FTE's - Hospital Contract	42.3	52.2	-19.0%	50.3	-16.0%	44.9	54.1	-17.0%	50.3	-10.7%
FTE's - Mgmt Services	54.4	53.7	1.3%	52.2	4.2%	56.0	53.7	4.3%	52.9	5.9%
Total FTE's (including Contract)	1,822.2	1,753.3	3.9%	1,764.4	3.3%	1,840.5	1,797.4	2.4%	1,768.4	4.1%
Total FTE'S per Adjusted Occupied Bed (including Contract)	5.34	5.20	2.6%	5.13	4.0%	5.23	5.17	1.2%	5.16	1.3%
ProCare FTEs	203.6	237.8	-14.4%	199.8	1.9%	206.4	237.8	-13.2%	201.7	2.4%
TraumaCare FTEs	8.3	8.9	-6.6%	9.4	-11.1%	8.4	8.8	-5.2%	9.4	-11.2%
Total System FTEs	2,034.2	2,000.1	1.7%	1,973.6	3.1%	2,055.3	2,044.0	0.6%	1,979.5	3.8%
Urgent Care Visits										
JBS Clinic	1,554	1,260	23.3%	1,670	-6.9%	4,365	3,878	12.6%	4,489	-2.8%
West University	1,110	846	31.2%	1,233	-10.0%	2,896	2,603	11.3%	3,145	-7.9%
Total Urgent Care Visits	2,664	2,106	26.5%	2,903	-8.2%	7,261	6,481	12.0%	7,634	-4.9%
Retail Clinic Visits										
Retail Clinic	148	132	12.1%	126	17.5%	336	259	29.7%	247	36.0%

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
DECEMBER 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	$ 9,501,967	$ 39,080,496	$ 4,500	$ -	$ (29,583,029)
Investments	70,774,918	51,625,680	-	-	19,149,238
Patient Accounts Receivable - Gross	247,568,965	214,878,735	20,514,645	2,184,343	9,991,243
Less: 3rd Party Allowances	(153,190,329)	(137,537,477)	(11,562,038)	(1,672,339)	(2,418,475)
Bad Debt Allowance	(52,612,232)	(38,524,192)	(5,030,483)	(410,000)	(8,647,557)
Net Patient Accounts Receivable	41,766,404	38,817,066	3,922,124	102,004	(1,074,789)
Taxes Receivable	11,384,822	11,080,895	-	-	303,927
Accounts Receivable - Other	6,614,565	4,024,723	84,681	-	2,505,160
Inventories	10,681,651	9,707,477	481,637	-	492,537
Prepaid Expenses	5,984,203	5,310,963	154,463	24,531	494,245
Total Current Assets	156,708,529	159,647,300	4,647,405	126,535	(7,712,711)
CAPITAL ASSETS:					
Property and Equipment	526,352,186	521,685,955	403,173	-	4,263,058
Construction in Progress	18,222,224	17,368,743	-	-	853,481
	544,574,410	539,054,698	403,173	-	5,116,540
Less: Accumulated Depreciation and Amortization	(382,881,409)	(377,031,484)	(338,723)	-	(5,511,202)
Total Capital Assets	161,693,001	162,023,214	64,449	-	(394,663)
LEASE ASSETS					
Leased Assets	2,337,842	4,190,843	-	-	(1,853,000)
Less Accrumulated Amortization Lease Assets	(1,978,644)	(1,956,677)	-		(21,968)
Total Lease Assets	359,198	2,234,166	-	-	(1,874,968)
SUBSCRIPTION ASSETS					
Subscription Assets	8,658,409	8,410,917	-	-	247,492
Less Accrumulated Amortization Subscription Assets	(3,141,186)	(2,749,774)	-	-	(391,413)
Total Subscription Assets	5,517,223	5,661,144	-	-	(143,921)
LT Lease Recieivable	5,922,527	6,227,920	-	-	(305,392)
RESTRICTED ASSETS:					
Restricted Assets Held by Trustee	4,896	4,896	-	-	-
Restricted Assets Held in Endowment	6,499,074	6,469,359	-	-	29,715
Restricted TPC, LLC	1,707,903	1,707,903	-	-	-
Investment in PBBHC	30,997,988	30,997,988	-	-	-
Restricted MCH West Texas Services	2,376,478	2,356,263	-	-	20,215
Pension, Deferred Outflows of Resources	10,795,764	10,795,764	-	-	-
Assets whose use is Limited	308,215	-	271,068	6,480	30,668
TOTAL ASSETS	$ 382,890,796	$ 388,125,916	$ 4,982,922	$ 133,015	$ (10,351,058)
LIABILITIES AND FUND BALANCE					
CURRENT LIABILITIES:					
Current Maturities of Long-Term Debt	$ 1,880,000	$ 1,880,000	$ -	$ -	$ -
Self-Insurance Liability - Current Portion	2,941,169	3,640,526	-	-	(699,357)
Current Portion of Lease Liabilities	795,042	627,362	-	-	167,680
Current Portion of Subscription Liabilities	1,345,688	1,325,425	-	-	20,263
Accounts Payable	29,837,381	35,655,859	(1,957,165)	(531,939)	(3,329,374)
A/R Credit Balances	1,842,743	2,596,359	-	-	(753,616)
Accrued Interest	539,016	214,256	-	-	324,761
Accrued Salaries and Wages	15,296,140	5,947,335	6,995,870	232,095	2,120,840
Accrued Compensated Absences	5,120,575	5,326,543	-	-	(205,968)
Due to Third Party Payors	8,683,192	8,683,192	-	-	-
Deferred Revenue	(1,254,603)	261,004	(22,952)	-	(1,492,655)
Total Current Liabilities	67,026,343	66,157,860	5,015,753	(299,844)	(4,147,269)
ACCRUED POST RETIREMENT BENEFITS	30,402,368	31,003,241	-	-	(600,873)
LESSOR DEFFERED INFLOWS OF RESOUCES	6,713,626	7,050,609			(336,983)
SELF-INSURANCE LIABILITIES - Less Current Portion	1,799,851	2,422,562	-	-	(622,711)
LEASE LIABILITIES	(60,409)	2,097,459			(2,157,868)
SUBSCRIPTION LIABILITIES	3,707,941	3,919,443			(211,502)
LONG-TERM DEBT - Less Current Maturities	28,217,343	28,360,398	-	-	(143,055)
					-
Total Liabilities	137,807,064	141,011,572	5,015,753	(299,844)	(7,920,417)
FUND BALANCE	245,083,732	247,114,344	(32,831)	432,859	245,116,562
TOTAL LIABILITIES AND FUND BALANCE	$ 382,890,796	$ 388,125,916	$ 4,982,922	$ 133,015	$ (10,351,058)

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED OPERATIONS SUMMARY
DECEMBER 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	$ 58,127,157	$ 57,337,106	1.4%	$ 56,780,938	2.4%	$ 170,680,493	$ 175,795,009	-2.9%	$ 164,518,051	3.7%
Outpatient Revenue	60,491,751	63,793,321	-5.2%	59,065,486	2.4%	191,809,739	196,785,570	-2.5%	184,317,271	4.1%
TOTAL PATIENT REVENUE	$ 118,618,909	$ 121,130,427	-2.1%	$ 115,846,424	2.4%	$ 362,490,232	$ 372,580,579	-2.7%	$ 348,835,322	3.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 77,524,315	$ 79,031,106	-1.9%	$ 74,180,561	4.5%	$ 232,836,949	$ 243,197,061	-4.3%	$ 226,013,159	3.0%
Policy Adjustments	1,246,222	1,105,160	12.8%	1,001,901	24.4%	3,440,791	3,637,386	-5.4%	3,275,062	5.1%
Uninsured Discount	10,414,832	7,048,141	47.8%	9,069,564	14.8%	27,509,929	21,558,420	27.6%	25,709,784	7.0%
Indigent	1,310,494	1,005,641	30.3%	127,584	927.2%	4,219,160	3,078,366	37.1%	1,649,225	155.8%
Provision for Bad Debts	1,606,254	7,371,419	-78.2%	6,695,267	-76.0%	14,308,372	22,820,960	-37.3%	19,068,490	-25.0%
TOTAL REVENUE DEDUCTIONS	$ 92,102,118	$ 95,561,467	-3.6%	$ 91,074,878	1.1%	$ 282,315,201	$ 294,292,193	-4.1%	$ 275,715,720	2.4%
	77.65%	78.89%		78.62%		77.88%	78.99%		79.04%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 1,832,067	$ 1,810,333	1.2%	$ 1,551,832	18.1%	$ 5,452,733	$ 5,430,999	0.4%	$ 4,655,496	17.1%
DSRIP/CHIRP	361,353	494,167	-26.9%	1,611,687	-77.6%	(783,965)	1,482,501	-152.9%	4,018,451	-119.5%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OTHER PATIENT REVENUE	$ 2,193,421	$ 2,304,500	-4.8%	$ 3,163,519	-30.7%	$ 4,668,768	$ 6,913,500	-32.5%	$ 8,673,947	-46.2%
NET PATIENT REVENUE	$ 28,710,212	$ 27,873,460	3.0%	$ 27,935,065	2.8%	$ 84,843,799	$ 85,201,886	-0.4%	$ 81,793,549	3.7%
OTHER REVENUE										
Tax Revenue	$ 7,162,834	$ 6,693,589	7.0%	$ 5,831,823	22.8%	$ 20,442,192	$ 20,080,767	1.8%	$ 19,789,867	3.3%
Other Revenue	1,529,400	1,580,196	-3.2%	1,199,513	27.5%	4,635,762	4,762,073	-2.7%	4,781,587	-3.0%
TOTAL OTHER REVENUE	$ 8,692,234	$ 8,273,785	5.1%	$ 7,031,336	23.6%	$ 25,077,954	$ 24,842,840	0.9%	$ 24,571,453	2.1%
NET OPERATING REVENUE	$ 37,402,445	$ 36,147,245	3.5%	$ 34,966,401	7.0%	$ 109,921,753	$ 110,044,726	-0.1%	$ 106,365,002	3.3%
OPERATING EXPENSES										
Salaries and Wages	$ 16,019,424	$ 15,607,122	2.6%	$ 14,536,866	10.2%	$ 47,840,275	$ 47,415,921	0.9%	$ 44,326,707	7.9%
Benefits	2,887,507	2,236,237	29.1%	2,272,319	27.1%	7,086,945	6,283,261	12.8%	6,452,353	9.8%
Temporary Labor	1,301,635	1,414,999	-8.0%	1,869,725	-30.4%	4,076,753	4,332,380	-5.9%	5,442,572	-25.1%
Physician Fees	1,215,551	1,198,962	1.4%	1,062,564	14.4%	3,884,426	3,596,886	8.0%	3,252,307	19.4%
Texas Tech Support	1,002,268	1,002,447	0.0%	976,161	2.7%	3,012,493	3,007,341	0.2%	2,904,106	3.7%
Purchased Services	5,054,274	4,768,674	6.0%	4,966,543	1.8%	14,374,862	14,382,566	-0.1%	13,853,946	3.8%
Supplies	7,073,939	6,717,895	5.3%	6,333,375	11.7%	21,546,948	20,461,572	5.3%	19,838,269	8.6%
Utilities	323,807	351,111	-7.8%	330,950	-2.2%	1,014,377	1,132,917	-10.5%	1,051,524	-3.5%
Repairs and Maintenance	874,688	1,039,521	-15.9%	671,648	30.2%	2,627,500	3,119,238	-15.8%	2,235,618	17.5%
Leases and Rent	141,643	107,361	31.9%	98,888	43.2%	402,735	321,717	25.2%	337,747	19.2%
Insurance	243,691	207,411	17.5%	189,080	28.9%	708,801	622,233	13.9%	565,287	25.4%
Interest Expense	87,275	117,840	-25.9%	98,151	-11.1%	267,094	353,520	-24.4%	299,200	-10.7%
ECHDA	208,248	283,446	-26.5%	246,496	-15.5%	385,421	850,338	-54.7%	616,654	-37.5%
Other Expense	179,983	253,919	-29.1%	143,614	25.3%	602,685	777,283	-22.5%	426,838	41.2%
TOTAL OPERATING EXPENSES	$ 36,613,932	$ 35,306,945	3.7%	$ 33,796,381	8.3%	$ 107,831,314	$ 106,657,173	1.1%	$ 101,603,128	6.1%
Depreciation/Amortization	$ 2,067,037	$ 2,009,687	2.9%	$ 1,978,543	4.5%	$ 6,151,881	$ 6,010,604	2.4%	$ 5,927,775	3.8%
(Gain) Loss on Sale of Assets	-	-	0.0%	(1,000)	-100.0%	(300)	-	0.0%	(28,000)	-98.9%
TOTAL OPERATING COSTS	$ 38,680,970	$ 37,316,632	3.7%	$ 35,773,924	8.1%	$ 113,982,895	$ 112,667,777	1.2%	$ 107,502,903	6.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (1,278,524)**	**$ (1,169,387)**	**-9.3%**	**$ (807,524)**	**-58.3%**	**$ (4,061,142)**	**$ (2,623,051)**	**54.8%**	**$ (1,137,900)**	**256.9%**
Operating Margin	-3.42%	-3.24%	5.7%	-2.31%	48.0%	-3.69%	-2.38%	55.0%	-1.07%	245.3%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 241,976	$ 137,303	76.2%	$ 210,448	15.0%	$ 452,277	$ 411,909	9.8%	$ 511,743	-11.6%
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	-		(3,000)	-2241.4%
COVID-19 Stimulus	78,390	-	0.0%	-	0.0%	78,390	-	0.0%	-	0.0%
						2,436,222	3,741,073		5,089,075	
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (958,159)	$ (1,032,084)	7.2%	$ (597,075)	-60.5%	$ (3,466,232)	$ (2,211,142)	-56.8%	$ (629,158)	-450.9%
Unrealized Gain/(Loss) on Investments	$ 127,590	$ -	0.0%	$ 396,810	-67.8%	$ 255,102	$ -	0.0%	$ 924,959	-72.4%
Investment in Subsidiaries	122,331	96,879	26.3%	14,238	759.2%	134,946	290,637	-53.6%	9,558	1311.9%
CHANGE IN NET POSITION	**$ (708,238)**	**$ (935,205)**	**24.3%**	**$ (186,027)**	**-280.7%**	**$ (3,076,184)**	**$ (1,920,505)**	**-60.2%**	**$ 305,359**	**1107.4%**

ECTOR COUNTY HOSPITAL DISTRICT
HOSPITAL OPERATIONS SUMMARY
DECEMBER 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	$ 58,127,157	$ 57,337,106	1.4%	$ 56,780,938	2.4%	$ 170,680,493	$ 175,795,009	-2.9%	$ 164,518,051	3.7%
Outpatient Revenue	50,749,384	53,605,578	-5.3%	48,632,031	4.4%	159,155,753	163,306,632	-2.5%	152,131,784	4.6%
TOTAL PATIENT REVENUE	$ 108,876,541	$ 110,942,684	-1.9%	$ 105,412,969	3.3%	$ 329,836,246	$ 339,101,641	-2.7%	$ 316,649,835	4.2%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 72,999,147	$ 74,034,344	-1.4%	$ 68,508,333	6.6%	$ 216,360,969	$ 226,539,437	-4.5%	$ 209,596,260	3.2%
Policy Adjustments	45,108	75,673	-40.4%	54,645	-17.5%	111,925	231,627	-51.7%	140,828	-20.5%
Uninsured Discount	10,254,298	6,825,573	50.2%	8,962,718	14.4%	26,973,968	20,821,889	29.5%	25,007,329	7.9%
Indigent Care	1,297,903	996,580	30.2%	134,001	868.6%	4,184,137	3,047,883	37.3%	1,619,963	158.3%
Provision for Bad Debts	783,840	6,371,319	-87.7%	5,765,075	-86.4%	11,303,460	19,518,375	-42.1%	16,146,405	-30.0%
TOTAL REVENUE DEDUCTIONS	$ 85,380,297	$ 88,303,489	-3.3%	$ 83,424,772	2.3%	$ 258,934,460	$ 270,159,211	-4.2%	$ 252,510,785	2.5%
	78.42%	79.59%		79.14%		78.50%	79.67%		79.74%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ 1,832,067	$ 1,810,333	1.2%	$ 1,551,832	18.1%	$ 5,452,733	$ 5,430,999	0.4%	$ 4,655,496	17.1%
DSRIP/CHIRP	361,353	494,167	-26.9%	1,611,687	-77.6%	(783,965)	1,482,501	-152.9%	4,018,451	-119.5%
TOTAL OTHER PATIENT REVENUE	$ 2,193,421	$ 2,304,500	-4.8%	$ 3,163,519	-30.7%	$ 4,668,768	$ 6,913,500	-32.5%	$ 8,673,947	-46.2%
NET PATIENT REVENUE	$ 25,689,665	$ 24,943,695	3.0%	$ 25,151,715	2.1%	$ 75,570,554	$ 75,855,930	-0.4%	$ 72,812,997	3.8%
OTHER REVENUE										
Tax Revenue	$ 7,162,834	$ 6,693,589	7.0%	$ 5,831,823	22.8%	$ 20,442,192	$ 20,080,767	1.8%	$ 19,789,867	3.3%
Other Revenue	1,346,116	1,371,346	-1.8%	1,014,481	32.7%	3,919,177	4,098,198	-4.4%	4,121,752	-4.9%
TOTAL OTHER REVENUE	$ 8,508,950	$ 8,064,935	5.5%	$ 6,846,304	24.3%	$ 24,361,369	$ 24,178,965	0.8%	$ 23,911,619	1.9%
NET OPERATING REVENUE	$ 34,198,615	$ 33,008,630	3.6%	$ 31,998,020	6.9%	$ 99,931,923	$ 100,034,895	-0.1%	$ 96,724,616	3.3%
OPERATING EXPENSE										
Salaries and Wages	$ 11,252,892	$ 10,833,579	3.9%	$ 10,208,952	10.2%	$ 33,617,484	$ 32,980,301	1.9%	$ 31,158,367	7.9%
Benefits	2,340,270	1,680,257	39.3%	1,731,135	35.2%	5,867,912	5,001,978	17.3%	5,193,512	13.0%
Temporary Labor	598,528	831,607	-28.0%	823,647	-27.3%	2,071,425	2,557,204	-19.0%	2,464,653	-16.0%
Physician Fees	1,297,048	1,240,268	4.6%	1,160,162	11.8%	4,131,793	3,720,804	11.0%	3,447,274	19.9%
Texas Tech Support	1,002,268	1,002,447	0.0%	976,161	2.7%	3,012,493	3,007,341	0.2%	2,904,106	3.7%
Purchased Services	5,330,567	5,083,210	4.9%	5,280,618	0.9%	15,190,459	15,325,674	-0.9%	14,737,267	3.1%
Supplies	7,022,747	6,647,248	5.6%	6,250,645	12.4%	21,343,513	20,251,242	5.4%	19,637,636	8.7%
Utilities	322,945	350,507	-7.9%	329,700	-2.0%	1,011,655	1,131,011	-10.6%	1,049,221	-3.6%
Repairs and Maintenance	874,688	1,038,229	-15.8%	671,400	30.3%	2,627,500	3,115,362	-15.7%	2,231,800	17.7%
Leases and Rentals	(5,040)	(38,486)	-86.9%	(47,041)	-89.3%	(38,384)	(115,458)	-66.8%	(92,295)	-58.4%
Insurance	173,661	145,158	19.6%	128,970	34.7%	508,084	435,474	16.7%	383,948	32.3%
Interest Expense	87,275	117,840	-25.9%	98,151	-11.1%	267,094	353,520	-24.4%	299,200	-10.7%
ECHDA	208,248	283,446	-26.5%	246,496	-15.5%	385,421	850,338	-54.7%	616,654	-37.5%
Other Expense	121,919	174,009	-29.9%	81,966	48.7%	409,825	542,583	-24.5%	273,857	49.6%
TOTAL OPERATING EXPENSES	$ 30,628,016	$ 29,389,319	4.2%	$ 27,940,963	9.6%	$ 90,406,273	$ 89,157,374	1.4%	$ 84,305,202	7.2%
Depreciation/Amortization	$ 2,055,073	$ 1,997,460	2.9%	$ 1,972,502	4.2%	$ 6,116,056	$ 5,973,923	2.4%	$ 5,907,800	3.5%
(Gain)/Loss on Disposal of Assets	-	-	0.0%	(1,000)	-100.0%	(300)	-	0.0%	(28,000)	-98.9%
TOTAL OPERATING COSTS	$ 32,683,089	$ 31,386,779	4.1%	$ 29,912,464	9.3%	$ 96,522,029	$ 95,131,297	1.5%	$ 90,185,002	7.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ 1,515,526**	**$ 1,621,851**	**-6.6%**	**$ 2,085,555**	**27.3%**	**$ 3,409,894**	**$ 4,903,598**	**-30.5%**	**$ 6,539,615**	**47.9%**
Operating Margin	4.43%	4.91%	-9.8%	6.52%	-32.0%	3.41%	4.90%	-30.4%	6.76%	-49.5%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 241,976	$ 137,303	76.2%	$ 210,448	15.0%	$ 452,277	$ 411,909	9.8%	$ 511,743	-11.6%
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	-	-	0.0%	-	0.0%	64,243	-		(3,000)	-2241.4%
COVID-19 Stimulus	78,390	-	0.0%	-	0.0%	78,390	-		-	0.0%
CHANGE IN NET POSITION BEFORE CAPITAL CONTRIBUTION	$ 1,835,891	$ 1,759,154	4.4%	$ 2,296,004	-20.0%	$ 4,004,804	$ 5,315,507	-24.7%	$ 7,048,357	-43.2%
Procare Capital Contribution	(2,816,366)	(2,834,508)	-0.6%	(2,919,250)	-3.5%	(7,573,418)	(7,615,541)	-0.6%	(7,868,205)	-3.7%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (980,475)	$ (1,075,354)	8.8%	$ (623,247)	-57.3%	$ (3,568,614)	$ (2,300,034)	-55.2%	$ (819,848)	-335.3%
Unrealized Gain/(Loss) on Investments	$ 127,590	$ -	0.0%	$ 396,810	-67.8%	$ 255,102	$ -	0.0%	$ 924,959	-72.4%
Investment in Subsidiaries	122,331	96,879	26.3%	14,238	759.2%	134,946	290,637	-53.6%	9,558	1311.9%
CHANGE IN NET POSITION	**$ (730,554)**	**$ (978,475)**	**25.3%**	**$ (212,198)**	**-244.3%**	**$ (3,178,566)**	**$ (2,009,397)**	**-58.2%**	**$ 114,668**	**2872.0%**

ECTOR COUNTY HOSPITAL DISTRICT
PROCARE OPERATIONS SUMMARY
DECEMBER 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	$ 9,680,048	$ 9,933,576	-2.6%	$ 10,240,150	-5.5%	$ 32,286,749	$ 32,865,867	-1.8%	$ 31,518,938	2.4%
TOTAL PATIENT REVENUE	$ 9,680,048	$ 9,933,576	-2.6%	$ 10,240,150	-5.5%	$ 32,286,749	$ 32,865,867	-1.8%	$ 31,518,938	2.4%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 4,505,769	$ 4,874,709	-7.6%	$ 5,581,460	-19.3%	$ 16,295,986	$ 16,363,223	-0.4%	$ 16,147,356	0.9%
Policy Adjustments	1,192,992	990,632	20.4%	907,104	31.5%	3,286,528	3,312,038	-0.8%	3,038,294	8.2%
Uninsured Discount	160,534	222,568	-27.9%	106,846	50.2%	535,961	736,531	-27.2%	702,454	-23.7%
Indigent	12,592	9,061	39.0%	(6,417)	-296.2%	35,023	30,483	14.9%	29,262	19.7%
Provision for Bad Debts	815,605	961,081	-15.1%	908,845	-10.3%	2,964,493	3,208,468	-7.6%	2,847,559	4.1%
TOTAL REVENUE DEDUCTIONS	$ 6,687,492	$ 7,058,051	-5.3%	$ 7,497,838	-10.8%	$ 23,117,990	$ 23,650,743	-2.3%	$ 22,764,926	1.6%
	69.09%	71.05%		73.22%		71.60%	71.96%		72.23%	
NET PATIENT REVENUE	$ 2,992,556	$ 2,875,525	4.1%	$ 2,742,313	9.1%	$ 9,168,758	$ 9,215,124	-0.5%	$ 8,754,012	4.7%
OTHER REVENUE										
Other Income	$ 182,484	$ 207,775	-12.2%	$ 185,032	-1.4%	$ 711,989	$ 660,650	7.8%	$ 655,265	8.7%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 3,175,040	$ 3,083,300	3.0%	$ 2,927,344	8.5%	$ 9,880,748	$ 9,875,774	0.1%	$ 9,409,277	5.0%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 4,523,527	$ 4,527,738	-0.1%	$ 4,076,797	11.0%	$ 13,503,176	$ 13,700,595	-1.4%	$ 12,420,629	8.7%
Benefits	537,931	542,895	-0.9%	530,618	1.4%	1,193,517	1,230,504	-3.0%	1,224,773	-2.6%
Temporary Labor	703,107	583,392	20.5%	1,046,079	-32.8%	2,005,328	1,775,176	13.0%	2,977,919	-32.7%
Physician Fees	177,751	217,942	-18.4%	161,650	10.0%	530,378	653,826	-18.9%	582,776	-9.0%
Purchased Services	(277,984)	(316,039)	-12.0%	(316,110)	-12.1%	(820,176)	(947,617)	-13.4%	(887,195)	-7.6%
Supplies	50,006	70,416	-29.0%	82,731	-39.6%	202,041	209,741	-3.7%	199,814	1.1%
Utilities	862	604	42.7%	1,251	-31.1%	2,722	1,906	42.8%	2,303	18.2%
Repairs and Maintenance	-	1,292	-100.0%	247.05	-100.0%	-	3,876	-100.0%	3,818	-100.0%
Leases and Rentals	146,029	143,854	1.5%	143,935	1.5%	437,819	431,196	1.5%	424,061	3.2%
Insurance	60,309	54,021	11.6%	51,834	16.3%	171,552	162,063	5.9%	156,513	9.6%
Other Expense	57,904	79,466	-27.1%	61,522	-5.9%	191,985	233,368	-17.7%	152,096	26.2%
TOTAL OPERATING EXPENSES	$ 5,979,442	$ 5,905,581	1.3%	$ 5,840,553	2.4%	$ 17,418,341	$ 17,454,634	-0.2%	$ 17,257,508	0.9%
Depreciation/Amortization	$ 11,964	$ 12,227	-2.2%	$ 6,041	98.0%	$ 35,825	$ 36,681	-2.3%	$ 19,975	79.3%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 5,991,406	$ 5,917,808	1.2%	$ 5,846,595	2.5%	$ 17,454,166	$ 17,491,315	-0.2%	$ 17,277,483	1.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (2,816,366)**	**$ (2,834,508)**	**-0.6%**	**$ (2,919,250)**	**-3.5%**	**$ (7,573,418)**	**$ (7,615,541)**	**-0.6%**	**$ (7,868,205)**	**-3.7%**
Operating Margin	-88.70%	-91.93%	-3.5%	-99.72%	-11.1%	-76.65%	-77.11%	-0.6%	-83.62%	-8.3%
COVID-19 Stimulus	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
MCH Contribution	$ 2,816,366	$ 2,834,508	-0.6%	$ 2,919,250	-3.5%	$ 7,573,418	$ 7,615,541	-0.6%	$ 7,868,205	-3.7%
CAPITAL CONTRIBUTION	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Office Visits	6,452	7,308	-11.7%	6,764	-4.61%	22,102	23,081	-4.2%	21,700	1.85%
Total Hospital Visits	6,327	7,114	-11.1%	6,729	-5.97%	19,391	21,131	-8.2%	19,593	-1.03%
Total Procedures	11,339	12,218	-7.2%	11,234	0.93%	38,948	39,625	-1.7%	36,637	6.31%
Total Surgeries	797	757	5.3%	874	-8.81%	2,366	2,229	6.1%	2,353	0.55%
Total Provider FTE's	86.8	89.7	-3.3%	82.9	4.65%	87.2	89.7	-2.8%	84.2	3.60%
Total Staff FTE's	108.6	136.6	-20.5%	104.0	4.42%	111.0	136.6	-18.7%	105.2	5.49%
Total Administrative FTE's	8.3	11.5	-27.8%	12.9	-35.64%	8.2	11.5	-28.9%	12.2	-33.20%
Total FTE's	203.6	237.8	-14.4%	199.8	1.93%	206.4	237.8	-13.2%	201.7	2.35%

ECTOR COUNTY HOSPITAL DISTRICT
TRAUMACARE OPERATIONS SUMMARY
DECEMBER 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	$ 62,320	$ 254,167	-75.5%	$ 193,305	-67.8%	$ 367,237	$ 613,071	-40.1%	$ 666,548	-44.9%
TOTAL PATIENT REVENUE	$ 62,320	$ 254,167	-75.5%	$ 193,305	-67.8%	$ 367,237	$ 613,071	-40.1%	$ 666,548	-44.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 19,398	$ 122,053	-84.1%	$ 90,769	-78.6%	$ 179,994	$ 294,401	-38.9%	$ 269,543	-33.2%
Policy Adjustments	8,121	38,855	-79.1%	40,153	-79.8%	42,337	93,721	-54.8%	95,940	-55.9%
Uninsured Discount	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Indigent	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Provision for Bad Debts	6,809	39,019	-82.5%	21,347	-68.1%	40,419	94,117	-57.1%	74,525	-45.8%
TOTAL REVENUE DEDUCTIONS	$ 34,329	$ 199,927	-82.8%	$ 152,268	-77.5%	$ 262,751	$ 482,239	-45.5%	$ 440,009	-40.3%
	55.08%	78.66%		78.77%		71.55%	78.66%		66.01%	
NET PATIENT REVENUE	$ 27,991	$ 54,240	-48.4%	$ 41,037	-31.8%	$ 104,486	$ 130,832	-20.1%	$ 226,540	-53.9%
						28.5%				
OTHER REVENUE										
Other Income	$ 800	$ 1,075	-25.6%	$ -	100.0%	$ 4,595	$ 3,225	42.5%	$ 4,570	0.6%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 28,791	$ 55,315	-48.0%	$ 41,037	-29.8%	$ 109,082	$ 134,057	-18.6%	$ 231,109	-52.8%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 243,005	$ 245,805	-1.1%	$ 251,118	-3.2%	$ 719,615	$ 735,025	-2.1%	$ 747,711	-3.8%
Benefits	9,305	13,085	-28.9%	10,567	-11.9%	25,515	50,779	-49.8%	34,068	-25.1%
Temporary Labor	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Physician Fees	(259,248)	(259,248)	0.0%	(259,248)	0.0%	(777,744)	(777,744)	0.0%	(777,744)	0.0%
Purchased Services	1,691	1,503	12.5%	2,034	-16.9%	4,579	4,509	1.5%	3,874	18.2%
Supplies	1,186	231	413.5%	-	0.0%	1,394	589	136.7%	818	70.4%
Utilities	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Repairs and Maintenance	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Leases and Rentals	653	1,993	-67.2%	1,993	-67.2%	3,300	5,979	-44.8%	5,980	-44.8%
Insurance	9,722	8,232	18.1%	8,275	17.5%	29,165	24,696	18.1%	24,826	17.5%
Other Expense	160	444	-63.9%	125	28.1%	875	1,332	-34.3%	885	-1.1%
TOTAL OPERATING EXPENSES	$ 6,475	$ 12,045	-46.2%	$ 14,865	-56.4%	$ 6,700	$ 45,165	-85.2%	$ 40,418	-83.4%
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	$ 6,475	$ 12,045	-46.2%	$ 14,865	-56.4%	$ 6,700	$ 45,165	-85.2%	$ 40,418	-83.4%
NET GAIN (LOSS) FROM OPERATIONS	**$ 22,316**	**$ 43,270**	**-48.4%**	**$ 26,172**	**-14.7%**	**$ 102,382**	**$ 88,892**	**15.2%**	**$ 190,691**	**-46.3%**
Operating Margin	77.51%	78.22%	-0.9%	63.78%	21.5%	93.86%	66.31%	41.5%	82.51%	13.8%
COVID-19 Stimulus	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
MCH Contribution	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
CAPITAL CONTRIBUTION	**$ 22,316**	**$ 43,270**	**-48.4%**	**$ 26,172**	**-14.7%**	**$ 102,382**	**$ 88,892**	**15.2%**	**$ 190,691**	**-46.3%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Procedures	190	745	-74.50%	609	-68.80%	1,088	1,797	-39.45%	1,886	-42.31%
Total Provider FTE's	7.3	7.8	-5.92%	8.3	-11.98%	7.4	7.9	-6.81%	8.4	-12.34%
Total Staff FTE's	1.0	1.1	-11.43%	1.0	-4.09%	1.0	0.9	8.62%	1.0	-2.14%
Total FTE's	8.3	8.9	-6.61%	9.4	-11.10%	8.4	8.8	-5.20%	9.4	-11.23%

ECTOR COUNTY HOSPITAL DISTRICT
DIABETES SCREENING CLINIC - SOUTH - OPERATIONS SUMMARY
DECEMBER 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	$ 5,992	$ 3,787	58.2%	$ -	0.0%	$ 18,197	$ 11,652	56.2%	$ -	0.0%
TOTAL PATIENT REVENUE	$ 5,992	$ 3,787	58.2%	$ -	0.0%	$ 18,197	$ 11,652	56.2%	$ -	0.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ -	$ -	0.0%	$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
Self Pay Adjustments	-	2,439	-100.0%	-	0.0%	13,086	7,317	78.8%	-	0.0%
Bad Debts	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL REVENUE DEDUCTIONS	$ -	$ 2,439	-100.0%	$ -	0.0%	$ 13,086	$ 7,317	78.8%	$ -	0.0%
	0.0%	64.4%		#DIV/0!		71.9%	62.8%		#DIV/0!	
NET PATIENT REVENUE	$ 5,992	$ 1,348	344.5%	$ -	0.0%	$ 5,111	$ 4,335	17.9%	$ -	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	$ 5,992	$ 1,348	344.5%	$ -	0.0%	$ 5,111	$ 4,335	17.9%	$ -	0.0%
OPERATING EXPENSE										
Salaries and Wages	$ 485	$ 492	-1.4%	$ -	0.0%	$ 1,832	$ 1,514	21.0%	$ -	0.0%
Benefits	101	76	32.9%	-	0.0%	320	230	39.1%	-	0.0%
Physician Services	2,000	937	113.4%	-	0.0%	6,000	2,811	113.4%	-	0.0%
Cost of Drugs Sold	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Supplies	-	679	-100.0%	-	0.0%	399	2,080	-80.8%	-	0.0%
Utilities	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Repairs and Maintenance	-	3,061	-100.0%	-	0.0%	40	9,183	-99.6%	-	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	$ 2,586	$ 5,245	-50.7%	$ -	0.0%	$ 8,591	$ 15,818	-45.7%	$ -	0.0%
Depreciation/Amortization	$ 905	$ 2,137	-57.7%	$ 2,769	-67.3%	$ 2,715	$ 6,411	-57.7%	$ 8,308	-67.3%
TOTAL OPERATING COSTS	$ 3,491	$ 7,382	-52.7%	$ 2,769	26.1%	$ 11,305	$ 22,229	-49.1%	$ 8,308	36.1%
NET GAIN (LOSS) FROM OPERATIONS	**$ 2,501**	**$ (6,034)**	**141.4%**	**$ (2,769)**	**190.3%**	**$ (6,194)**	**$ (17,894)**	**65.4%**	**$ (8,308)**	**25.4%**
Operating Margin	41.73%	-447.63%	-109.3%	0.00%	0.0%	-121.18%	-412.78%	-70.6%	0.00%	0.0%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	20	13	53.8%	-	0.0%	62	40	55.0%	-	0.0%
Hospital FTE's (Salaries and Wages)	0.1	0.2	-40.2%	-	0.0%	0.1	0.2	-24.9%	-	0.0%

ECTOR COUNTY HOSPITAL DISTRICT
DECEMBER 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	$ 41,897,433	38.5%	$ 41,725,502	39.6%	$ 128,016,081	38.9%	123,991,562	39.1%
Medicaid	12,448,982	11.4%	12,774,642	12.1%	35,777,101	10.8%	39,448,529	12.5%
Commercial	40,090,485	36.8%	35,396,516	33.6%	122,673,934	37.2%	109,222,234	34.5%
Self Pay	10,549,087	9.7%	11,460,428	10.9%	31,495,041	9.5%	32,231,381	10.2%
Other	3,890,554	3.6%	4,055,881	3.8%	11,874,089	3.6%	11,756,129	3.7%
TOTAL	**$ 108,876,541**	**100.0%**	**$ 105,412,969**	**100.0%**	**$ 329,836,246**	**100.0%**	**316,649,835**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 9,191,903	37.9%	$ 7,903,864	36.8%	$ 27,427,788	39.1%	23,998,192	37.0%
Medicaid	2,656,712	11.0%	2,791,211	13.0%	6,114,659	8.7%	7,977,002	12.3%
Commercial	10,219,678	42.2%	8,330,214	38.8%	29,820,765	42.6%	26,646,094	41.0%
Self Pay	1,000,387	4.1%	1,154,408	5.4%	3,657,894	5.2%	3,568,395	5.5%
Other	1,160,537	4.8%	1,290,160	6.0%	3,090,225	4.4%	2,698,310	4.2%
TOTAL	**$ 24,229,217**	**100.0%**	**$ 21,469,857**	**100.0%**	**$ 70,111,331**	**100.0%**	**64,887,994**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
STATEMENT OF CASH FLOW
DECEMBER 2024

	Hospital	ProCare	TraumaCare	Blended
Cash Flows from Operating Activities and Nonoperating Revenue:				
Excess of Revenue over Expenses	$ (3,178,566)	-	102,382	$ (3,076,184)
Noncash Expenses:				
Depreciation and Amortization	6,099,981	3,924	-	6,103,906
Unrealized Gain/Loss on Investments	255,102	-	-	255,102
Accretion (Bonds) & COVID Funding	(143,055)	-	-	(143,055)
Changes in Assets and Liabilities				
Patient Receivables, Net	835,211	241,823	(2,244)	1,074,789
Taxes Receivable/Deferred	(1,788,024)	(8,558)	-	(1,796,581)
Inventories, Prepaids and Other	(3,195,713)	(13,052)	2,953	(3,205,813)
LT Lease Rec	305,392			
Deferred Inflow of Resources	-			
Accounts Payable	(5,202,284)	944,131	(103,265)	(4,361,417)
Accrued Expenses	3,423,795	(1,168,194)	174	2,255,776
Due to Third Party Payors	-	-	-	-
Accrued Post Retirement Benefit Costs	(1,848,216)	-	-	(1,848,216)
Net Cash Provided by Operating Activities	$ (4,436,376)	75	-	$ (4,436,301)
Cash Flows from Investing Activities:				
Investments	$ (19,404,340)	-	-	$ (19,404,340)
Acquisition of Property and Equipment	(5,364,031)	-	-	(5,364,031)
Net Cash used by Investing Activities	$ (24,768,371)	-	-	$ (24,768,371)
Cash Flows from Financing Activities:				
Current Portion Debt	$ -	-	-	$ -
Principal Paid on Subscription Liabitlities	$ 20,263			
Principal Paid on Lease Liabitlities	$ 240,568			
Intercompany Activities	-	-	-	-
LT Liab Subscriptions	(211,502)			
LT Liab Leases	(377,756)			
Net Repayment of Long-term Debt/Bond Issuance	-	-	-	-
Net Cash used by Financing Activities	(328,427)	-	-	(328,427)
Net Increase (Decrease) in Cash	(29,533,174)	75	-	(29,533,099)
Beginning Cash & Cash Equivalents @ 9/30/2024	49,618,916	4,500	-	49,623,416
Ending Cash & Cash Equivalents @ 12/31/2024	$ 20,085,742	$ 4,575	$ -	$ 20,090,317

ECTOR COUNTY HOSPITAL DISTRICT
MEDICAID SUPPLEMENTAL PAYMENTS
FISCAL YEAR 2025

CASH ACTIVITY	TAX (IGT) ASSESSED	GOVERNMENT PAYOUT	BURDEN ALLEVIATION	NET INFLOW
DSH				
1st Qtr	$ (4,984,427)	$ 12,442,343		$ 7,457,916
2nd Qtr	-	-		-
3rd Qtr	-	-		-
4th Qtr	-	-		-
DSH TOTAL	$ (4,984,427)	$ 12,442,343		$ 7,457,916
UC				
1st Qtr	$ (1,903)	$ -		(1,903)
2nd Qtr	-	-		-
3rd Qtr	-	-		-
4th Qtr	-	-		-
UC TOTAL	$ (1,903)	$ -		$ (1,903)
GME				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
GME TOTAL	$ -	$ -		$ -
CHIRP				
1st Qtr	$ (6,004,341)	$ 461,991		$ (5,542,350)
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
CHIRP TOTAL	$ (6,004,341)	$ 461,991		$ (5,542,350)
HARP				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
HARP TOTAL	$ -	$ -		$ -
TIPPS				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd .	-	-		-
4th Qtr	-	-		-
TIPPS TOTAL	$ -	$ -		$ -
MCH Cash Activity	**$ (10,990,671)**	**$ 12,904,334**		**$ 1,913,664**
ProCare Cash Activity	$ -	$ -	$ -	**$ -**
Blended Cash Activity	**$ (10,990,671)**	**$ 12,904,334**	**$ -**	**$ 1,913,664**

INCOME STATEMENT ACTIVITY:	**BLENDED**
FY 2025 Accrued / (Deferred) Adjustments:	
DSH	$ 2,451,734
UC	2,130,000
GME	429,000
CHIRP	(783,965)
HARP	372,000
TIPPS	69,999
Regional UPL Benefit	-
Medicaid Supplemental Payments	4,668,768
DSRIP Accrual	-
Total Adjustments	**$ 4,668,768**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF HOSPITAL TEMPORARY LABOR FTE'S
DECEMBER 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	8.3	10.9	-23.7%	12.9	-35.5%	10.6	11.3	-6.4%	13.1	-19.0%
Operating Room	8.7	11.4	-23.2%	12.5	-30.0%	9.9	11.8	-16.3%	11.8	-16.5%
Imaging - Diagnostics	3.4	3.1	9.9%	2.5	38.9%	4.1	3.2	27.6%	2.8	48.9%
Labor & Delivery	2.7	4.6	-40.6%	4.7	-41.7%	3.8	4.7	-19.0%	4.1	-6.3%
Laboratory - Chemistry	1.2	6.0	-80.2%	3.8	-68.6%	1.4	6.2	-77.6%	4.1	-65.9%
4 East - Post Partum	1.5	1.4	8.7%	1.5	-3.1%	1.2	1.4	-12.7%	1.3	-4.0%
7 Central	0.6	0.9	-29.7%	-	0.0%	1.2	0.9	28.5%	0.1	759.8%
Intensive Care Unit (CCU) 4	1.3	1.1	16.7%	0.2	513.5%	1.0	1.1	-12.7%	0.2	478.4%
Intensive Care Unit (ICU) 2	2.0	1.4	36.1%	0.5	298.6%	1.0	1.5	-34.6%	0.4	118.5%
UTILIZATION REVIEW	0.7	0.6	26.9%	0.4	65.2%	0.8	0.6	44.9%	0.1	466.0%
Imaging - Ultrasound	0.6	0.9	-30.8%	1.0	-39.5%	0.8	0.9	-15.0%	1.1	-28.3%
Imaging - Nuclear Medicine	0.8	-	0.0%	-	0.0%	0.7	-	0.0%	-	0.0%
Laboratory - Histology	1.0	0.8	19.4%	1.0	3.0%	0.6	0.9	-31.7%	1.1	-44.7%
Center for Health and Wellness - Sports Medici	0.8	1.5	-45.8%	0.9	-6.9%	0.5	1.6	-69.1%	0.8	-39.0%
Emergency Department	0.7	0.4	61.6%	-	0.0%	0.4	0.5	-12.3%	-	0.0%
Recovery Room	-	0.5	-100.0%	2.2	-100.0%	0.3	0.5	-39.7%	2.1	-86.1%
6 Central	0.1	0.3	-73.7%	-	0.0%	0.3	0.3	2.2%	0.1	190.4%
3 West Observation	0.3	0.5	-28.0%	-	0.0%	0.2	0.5	-47.3%	0.0	892.4%
Nursing Orientation	0.6	-	0.0%	-	0.0%	0.2	-	0.0%	0.2	-1.5%
PM&R - Physical	0.5	0.5	19.8%	-	0.0%	0.2	0.5	-61.0%	-	0.0%
4 Central	0.1	0.5	-84.7%	0.3	-74.7%	0.1	0.5	-75.6%	0.1	23.9%
9 Central	0.1	0.2	-68.8%	-	0.0%	0.1	0.2	-60.0%	0.1	-22.0%
5 Central	0.1	0.3	-69.3%	0.1	-29.9%	0.1	0.3	-76.0%	0.1	12.1%
6 West	0.1	0.1	14.3%	-	0.0%	0.0	0.1	-28.7%	0.2	-73.6%
Neonatal Intensive Care	-	-	0.0%	0.9	-100.0%	0.0	-	0.0%	0.7	-94.1%
5 West - Pediatrics	-	-	0.0%	-	0.0%	0.0	-	0.0%	-	0.0%
PM&R - Occupational	-	0.9	-100.0%	1.2	-100.0%	-	0.9	-100.0%	1.5	-100.0%
Imaging - Cat Scan	-	-	0.0%	0.6	-100.0%	-	-	0.0%	0.6	-100.0%
Care Management	-	-	0.0%	-	0.0%	-	-	0.0%	0.2	-100.0%
Laboratory - Hematology	-	1.9	-100.0%	-	0.0%	-	2.0	-100.0%	-	0.0%
Imaging - CVI	-	0.9	-100.0%	-	0.0%	-	0.9	-100.0%	-	0.0%
Cardiopulmonary - Neonatal Intensive Care Uni	-	0.6	-100.0%	-	0.0%	-	0.6	-100.0%	-	0.0%
SUBTOTAL	**37.3**	**52.2**	**-28.6%**	**47.3**	**-21.2%**	**40.0**	**54.1**	**-26.0%**	**46.9**	**-14.8%**
TRANSITION LABOR										
Laboratory - Chemistry	5.0	-	0.0%	3.1	62.8%	4.9	-	0.0%	3.3	46.9%
SUBTOTAL	**5.0**	**-**	**0.0%**	**3.1**	**62.8%**	**4.9**	**-**	**0.0%**	**3.3**	**46.9%**
GRAND TOTAL	**42.3**	**52.2**	**-19.0%**	**50.3**	**-16.0%**	**44.9**	**54.1**	**-17.0%**	**50.3**	**-10.7%**

Financial Presentation

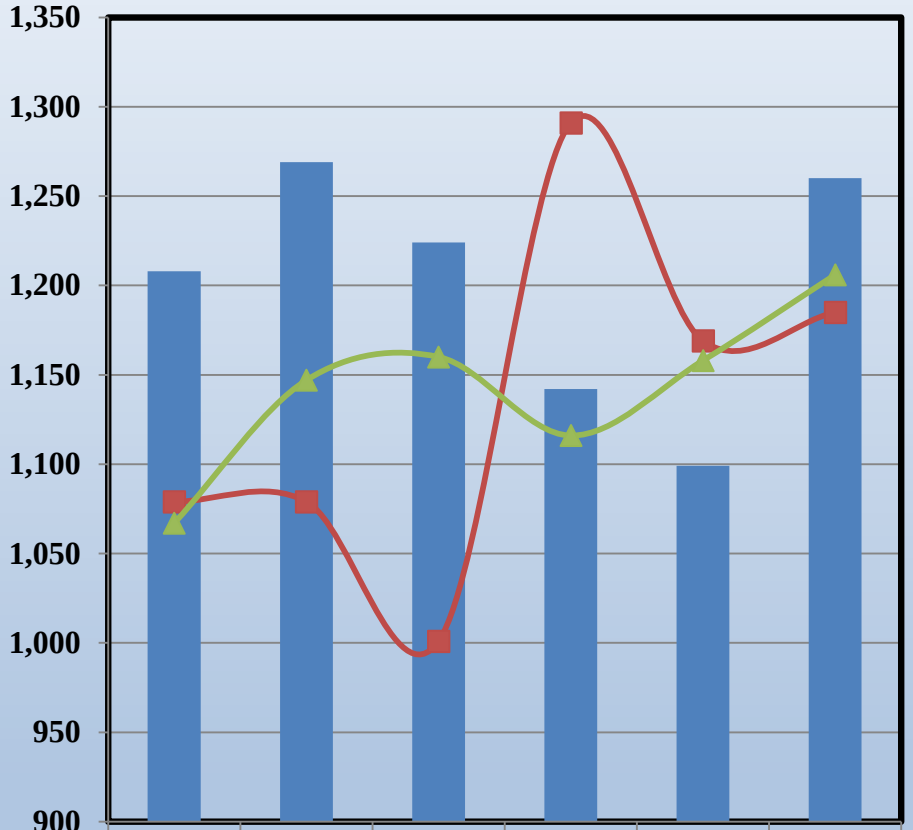
For the Month Ended

December 31, 2024


Volume
mch

Admissions

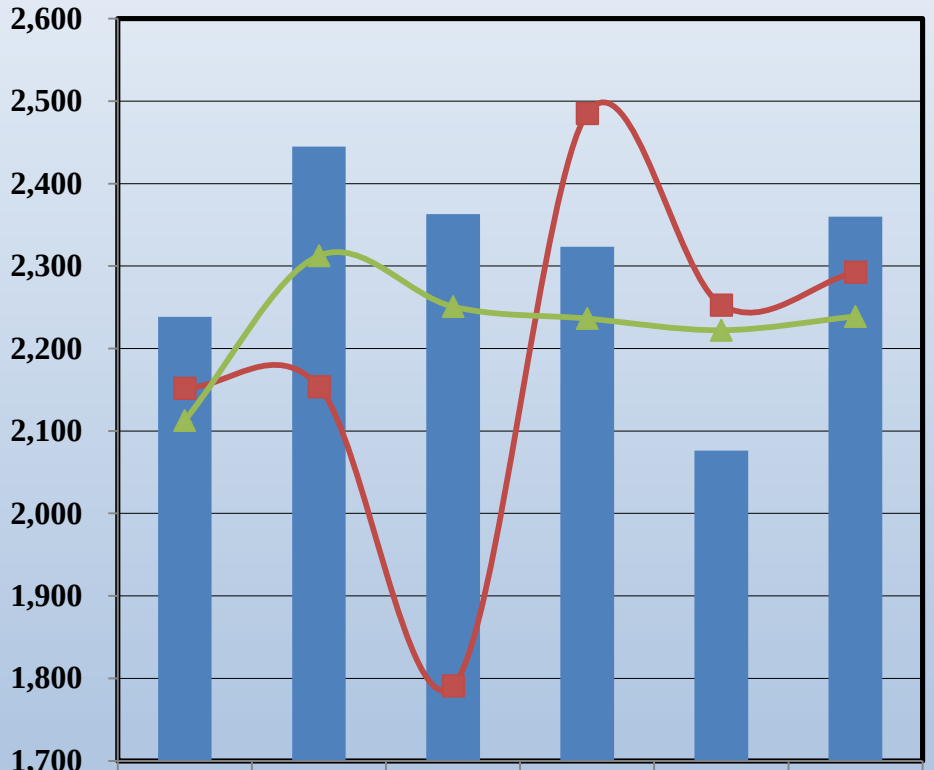
Total – Adults and NICU



	Jul	Aug	Sep	Oct	Nov	Dec
Act	1,208	1,269	1,224	1,142	1,099	1,260
Bud	1,079	1,079	1,001	1,291	1,169	1,185
Prior	1,067	1,147	1,160	1,116	1,158	1,206

	Actual	Budget	Prior Year
Month	1,260	1,185	1,206
Var %		6.3%	4.5%
Year-To-Date	3,501	3,645	3,480
Var %		-4.0%	0.6%
Annualized	14,436	13,657	13,290
Var %		5.7%	8.6%

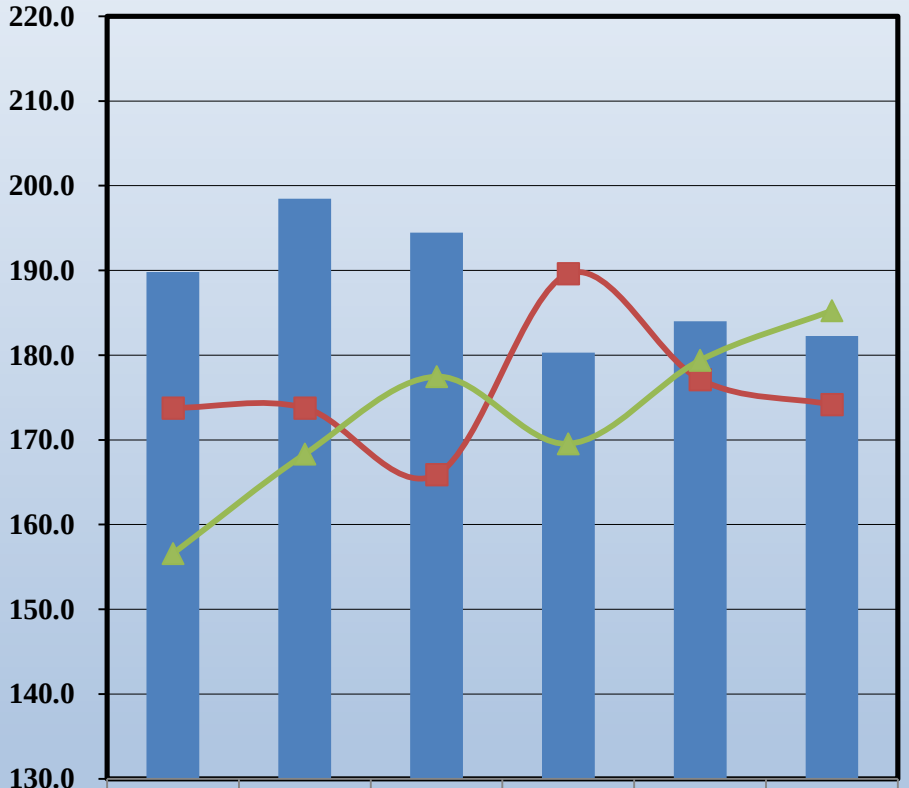
Adjusted Admissions



	Jul	Aug	Sep	Oct	Nov	Dec
Act	2,238	2,445	2,363	2,323	2,076	2,360
Bud	2,152	2,154	1,791	2,485	2,253	2,293
Prior	2,113	2,313	2,251	2,236	2,222	2,239

	Actual	Budget	Prior Year
Month	2,360	2,293	2,239
Var %		2.9%	5.4%
Year-To-Date	6,766	7,031	6,698
Var %		-3.8%	1.0%
Annualized	27,662	26,793	25,766
Var %		3.2%	7.4%

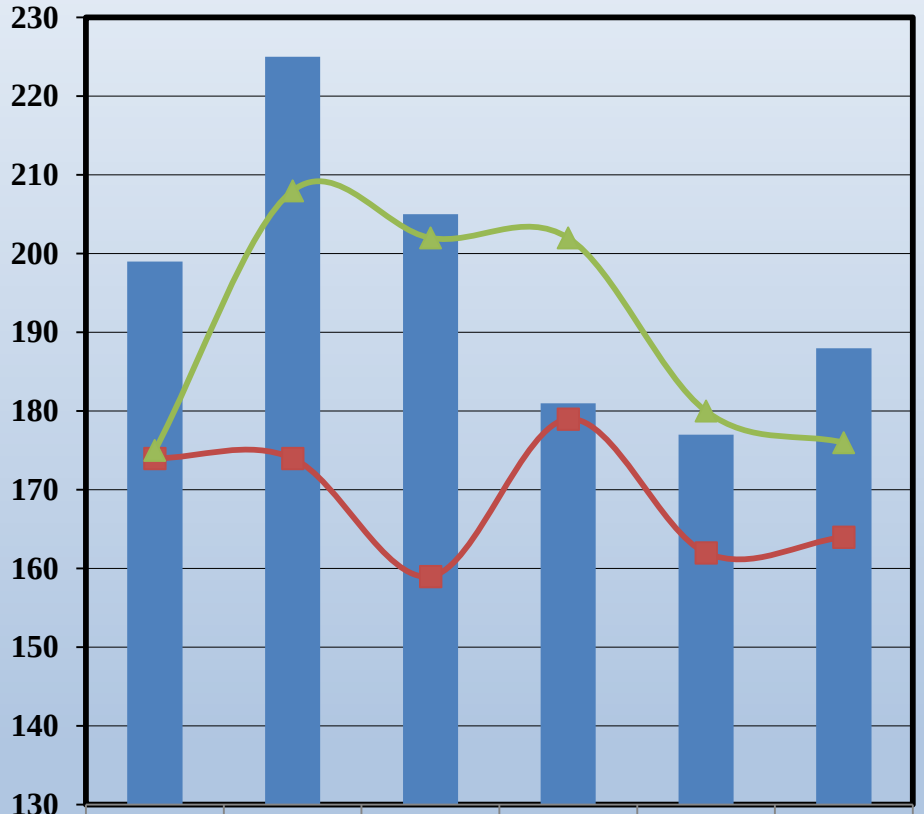
Average Daily Census



	Jul	Aug	Sep	Oct	Nov	Dec
Act	189.8	198.5	194.5	180.3	184.0	182.3
Bud	173.8	173.8	165.9	189.6	177.1	174.2
Prior	156.6	168.3	177.5	169.5	179.4	185.3

	Actual	Budget	Prior Year
Month	182.3	174.2	185.3
Var %		4.6%	-1.6%
Year-To-Date	182.2	180.3	178.1
Var %		1.0%	2.3%
Annualized	189.6	181.9	175.4
Var %		4.2%	8.0%

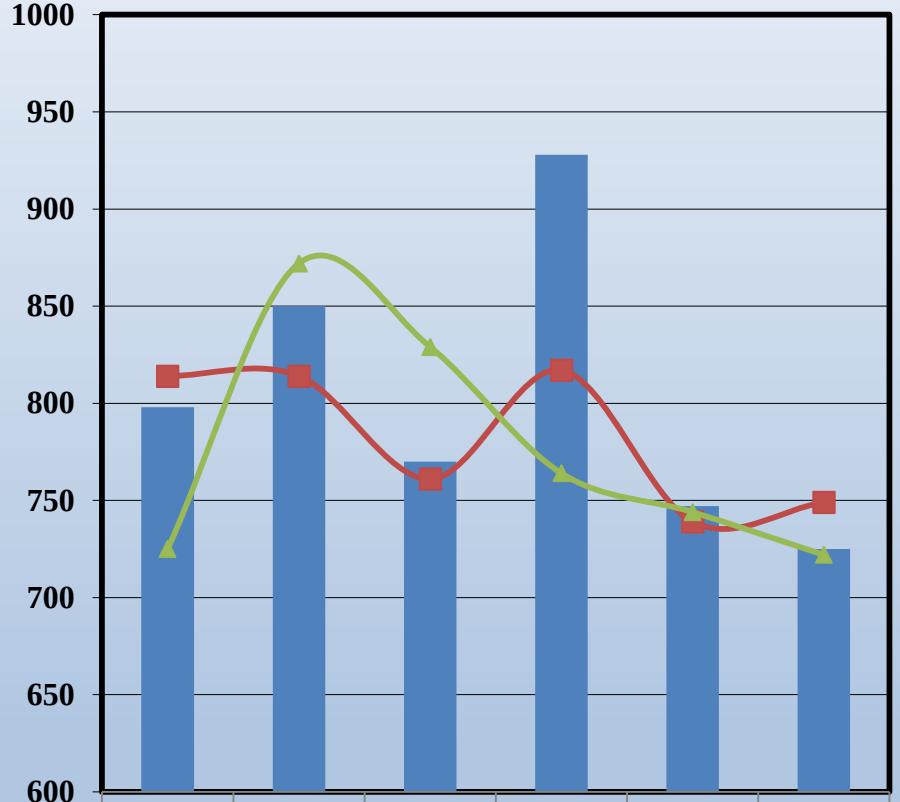
Deliveries



	Jul	Aug	Sep	Oct	Nov	Dec
Act	199	225	205	181	177	188
Bud	174	174	159	179	162	164
Prior	175	208	202	202	180	176

	Actual	Budget	Prior Year
Month	188	164	176
Var %		14.6%	6.8%
Year-To-Date	546	505	558
Var %		8.1%	-2.2%
Annualized	2,210	2,116	2,147
Var %		4.4%	2.9%

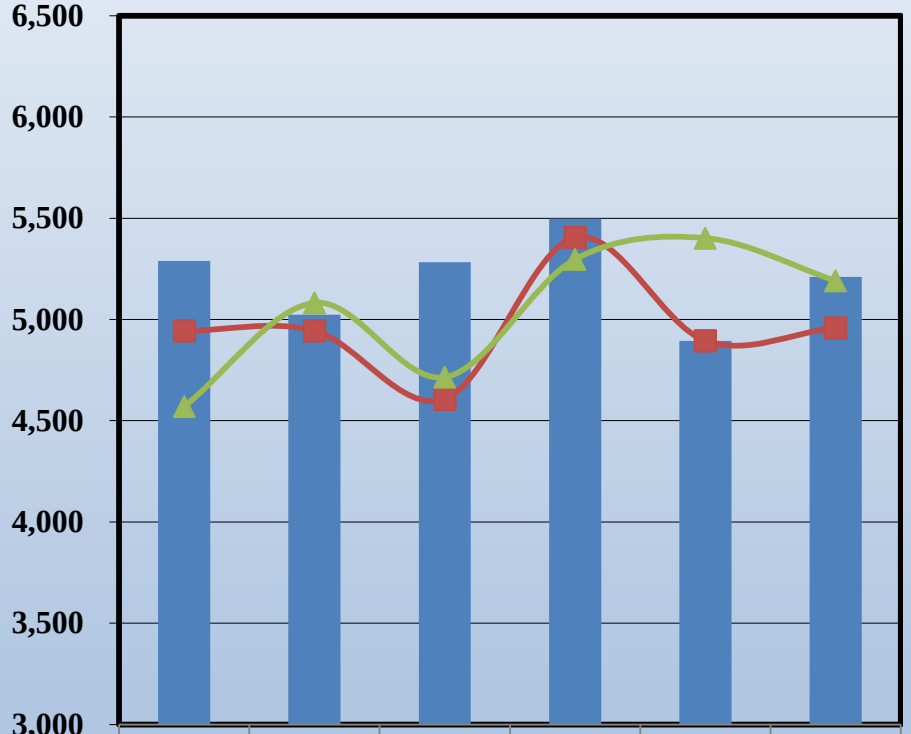
Total Surgical Cases



	Jul	Aug	Sep	Oct	Nov	Dec
Act	798	850	770	928	747	725
Bud	814	814	761	817	739	749
Prior	725	872	829	764	744	722

	Actual	Budget	Prior Year
Month	725	749	722
Var %		-3.2%	0.4%
Year-To-Date	2,400	2,305	2,230
Var %		4.1%	7.6%
Annualized	9,440	9,866	9,458
Var %		-4.3%	-0.2%

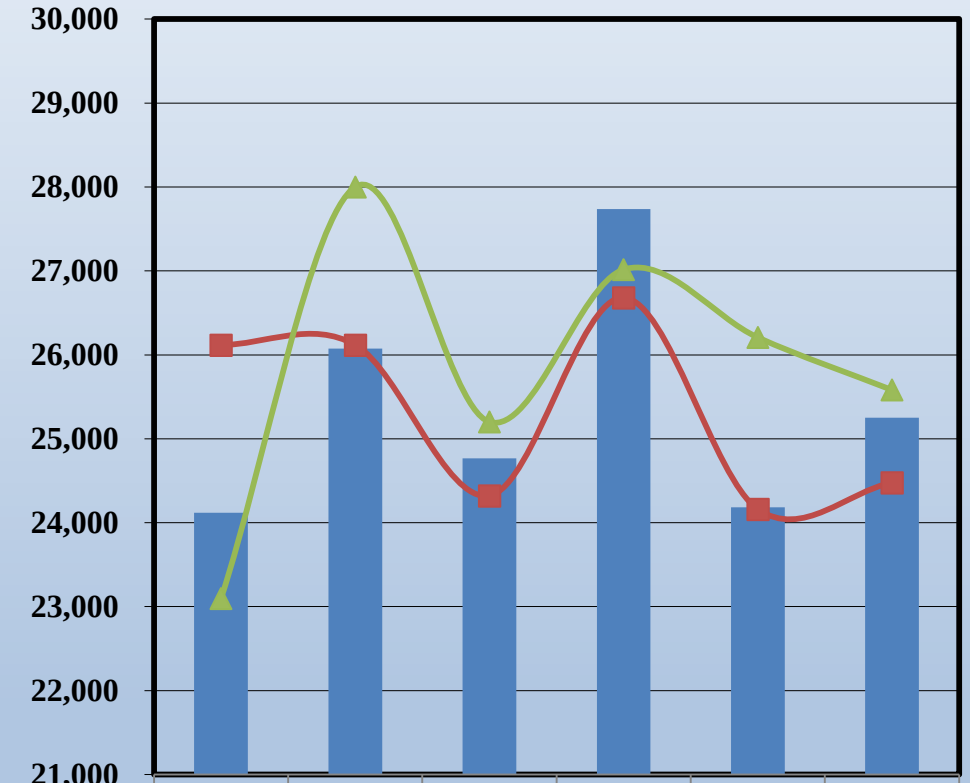
Emergency Room Visits



	Jul	Aug	Sep	Oct	Nov	Dec
Act	5,290	5,023	5,283	5,498	4,894	5,211
Bud	4,944	4,944	4,607	5,406	4,895	4,959
Prior	4,570	5,082	4,715	5,297	5,402	5,191

	Actual	Budget	Prior Year
Month	5,211	4,959	5,191
Var %		5.1%	0.4%
Year-To-Date	15,603	15,260	15,890
Var %		2.2%	-1.8%
Annualized	63,199	61,156	60,470
Var %		3.3%	4.5%

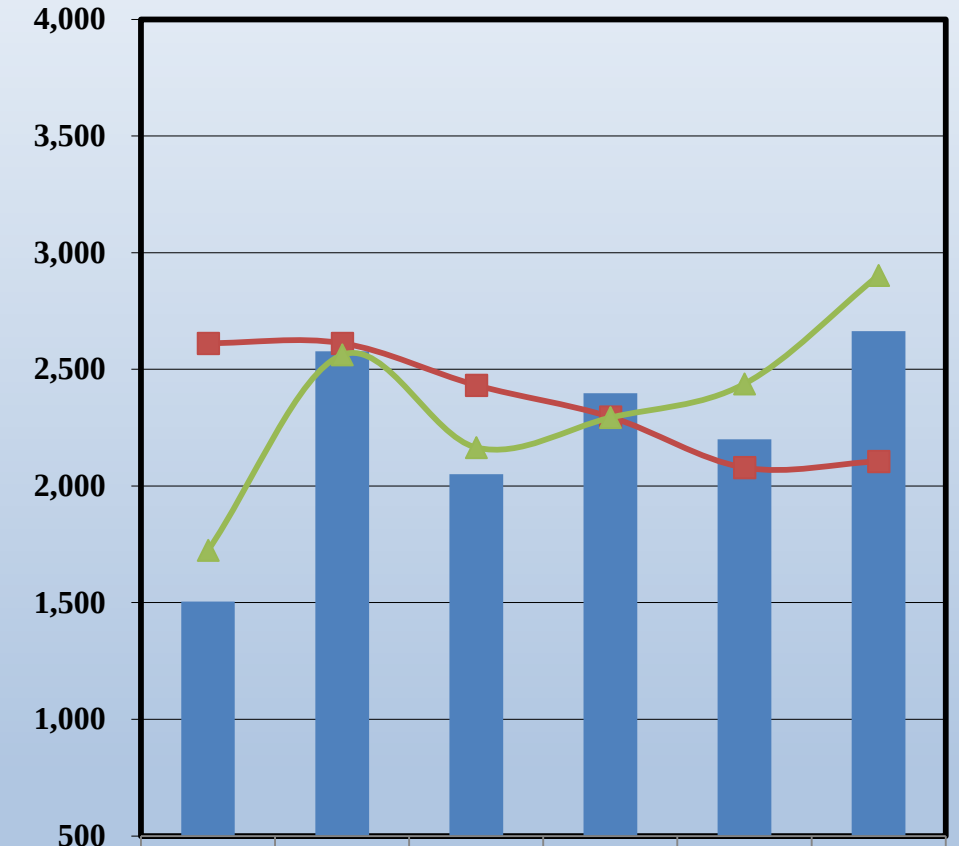
Total Outpatient Occasions of Service



	Jul	Aug	Sep	Oct	Nov	Dec
Act	24,118	26,074	24,766	27,736	24,182	25,251
Bud	26,118	26,118	24,322	26,682	24,161	24,477
Prior	23,097	28,001	25,201	27,016	26,207	25,581

	Actual	Budget	Prior Year
Month	25,251	24,477	25,581
Var %		3.2%	-1.3%
Year-To-Date	77,169	75,320	78,804
Var %		2.5%	-2.1%
Annualized	306,103	317,753	305,431
Var %		-3.7%	0.2%

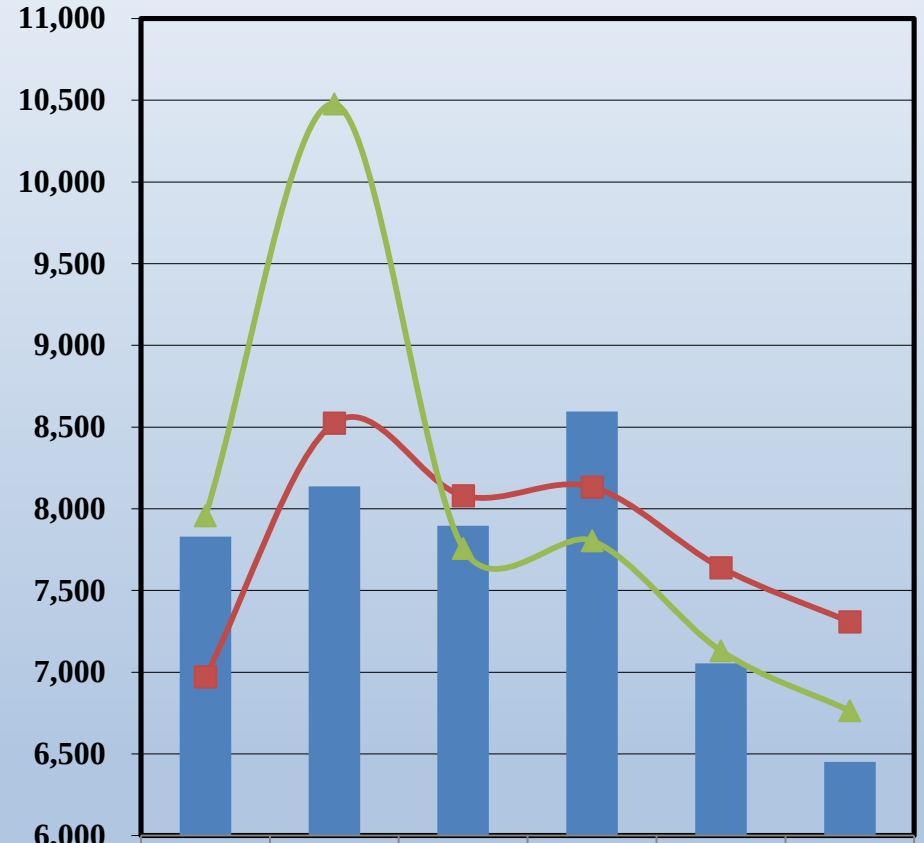
Urgent Care Visits



	Jul	Aug	Sep	Oct	Nov	Dec
Act	1,505	2,577	2,051	2,397	2,200	2,664
Bud	2,612	2,612	2,432	2,296	2,079	2,106
Prior	1,724	2,562	2,165	2,293	2,438	2,903

	Actual	Budget	Prior Year
Month	2,664	2,106	2,903
Var %		26.5%	-8.2%
Year-To-Date	7,261	6,481	7,634
Var %		12.0%	-4.9%
Annualized	26,535	30,722	27,384
Var %		-13.6%	-3.1%

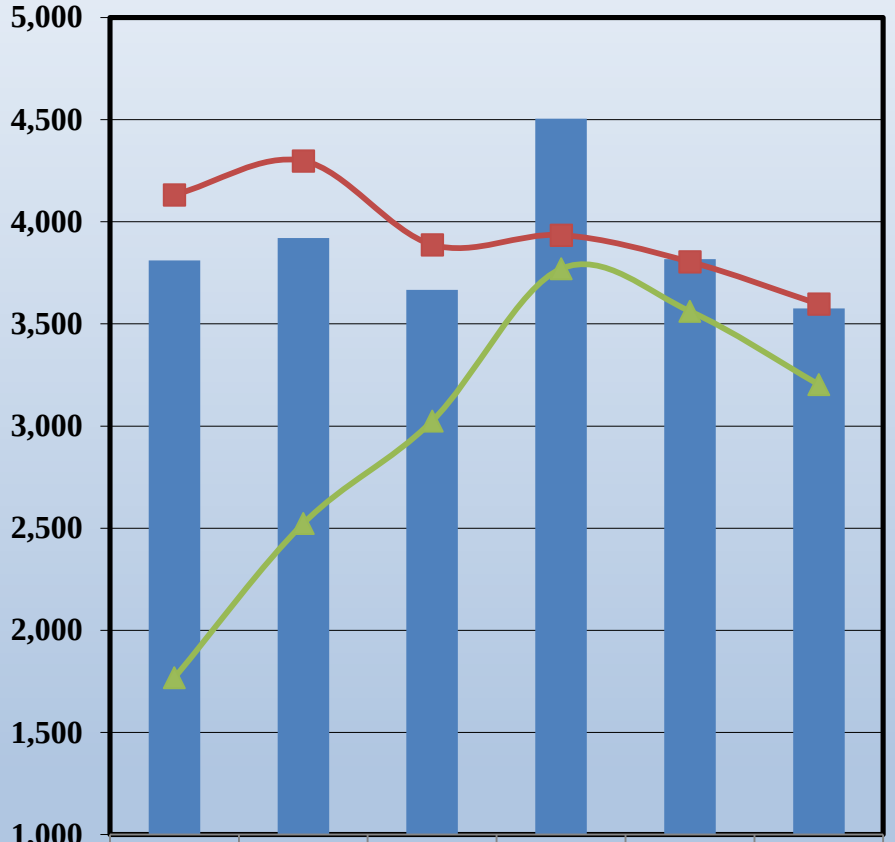
Total ProCare Office Visits



	Jul	Aug	Sep	Oct	Nov	Dec
Act	7,830	8,137	7,897	8,595	7,055	6,452
Bud	6,971	8,525	8,080	8,133	7,640	7,308
Prior	7,956	10,477	7,757	7,805	7,131	6,764

	Actual	Budget	Prior Year
Month	6,452	7,308	6,764
Var %		-11.7%	-4.6%
Year-To-Date	22,102	23,081	21,700
Var %		-4.2%	1.9%
Annualized	94,361	94,128	104,514
Var %		0.2%	-9.7%

Total Family Health Clinic Visits



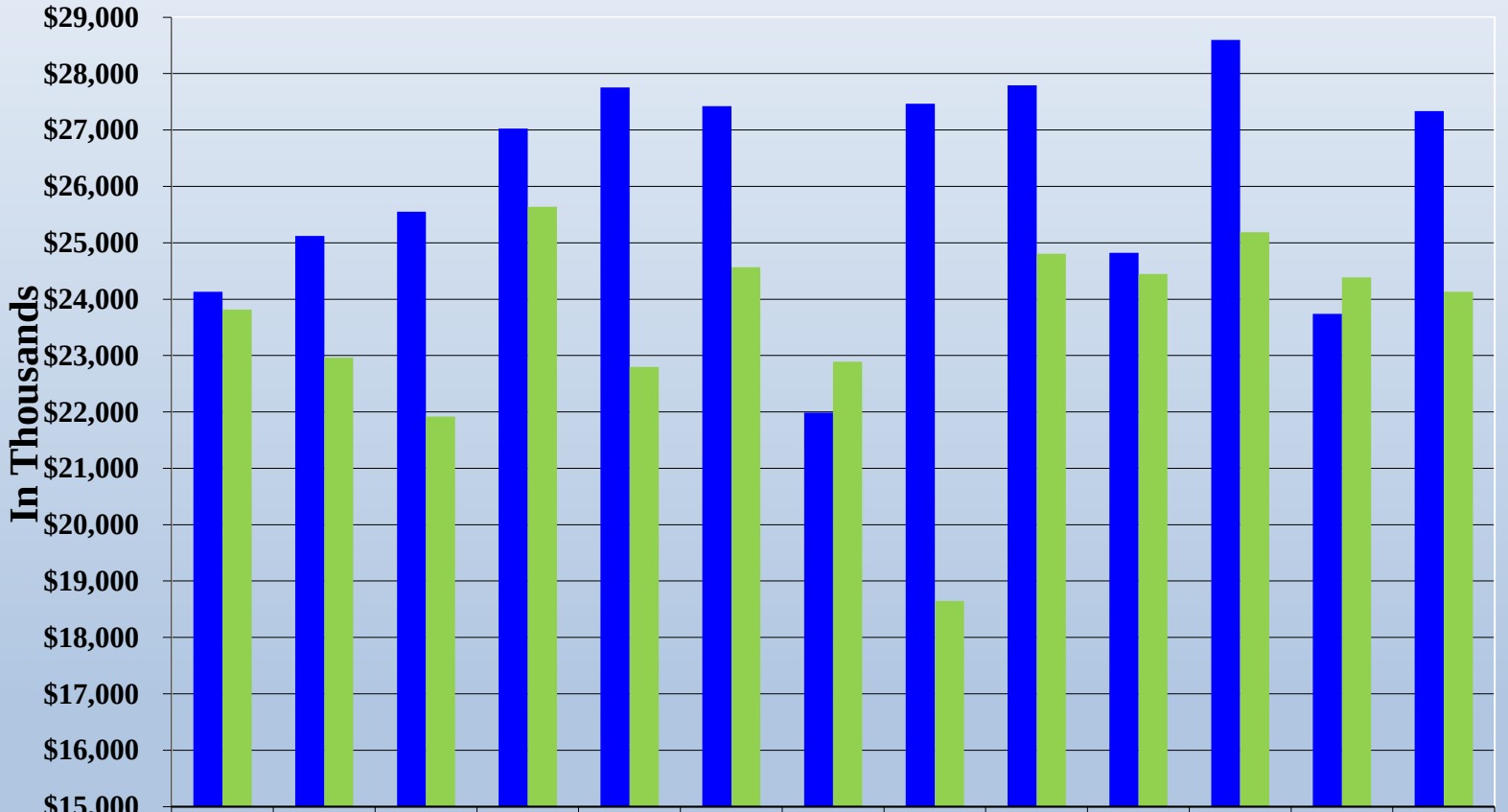
	Jul	Aug	Sep	Oct	Nov	Dec
Act	3,811	3,921	3,667	4,504	3,817	3,576
Bud	4,132	4,298	3,888	3,935	3,804	3,597
Prior	1,768	2,523	3,025	3,770	3,562	3,203

	Actual	Budget	Prior Year
Month	3,576	3,597	3,203
Var %		-0.6%	11.6%
Year-To-Date	11,897	11,336	10,535
Var %		4.9%	12.9%
Annualized	46,104	48,596	29,694
Var %		-5.1%	55.3%

Accounts Receivable

Total AR Cash Receipts

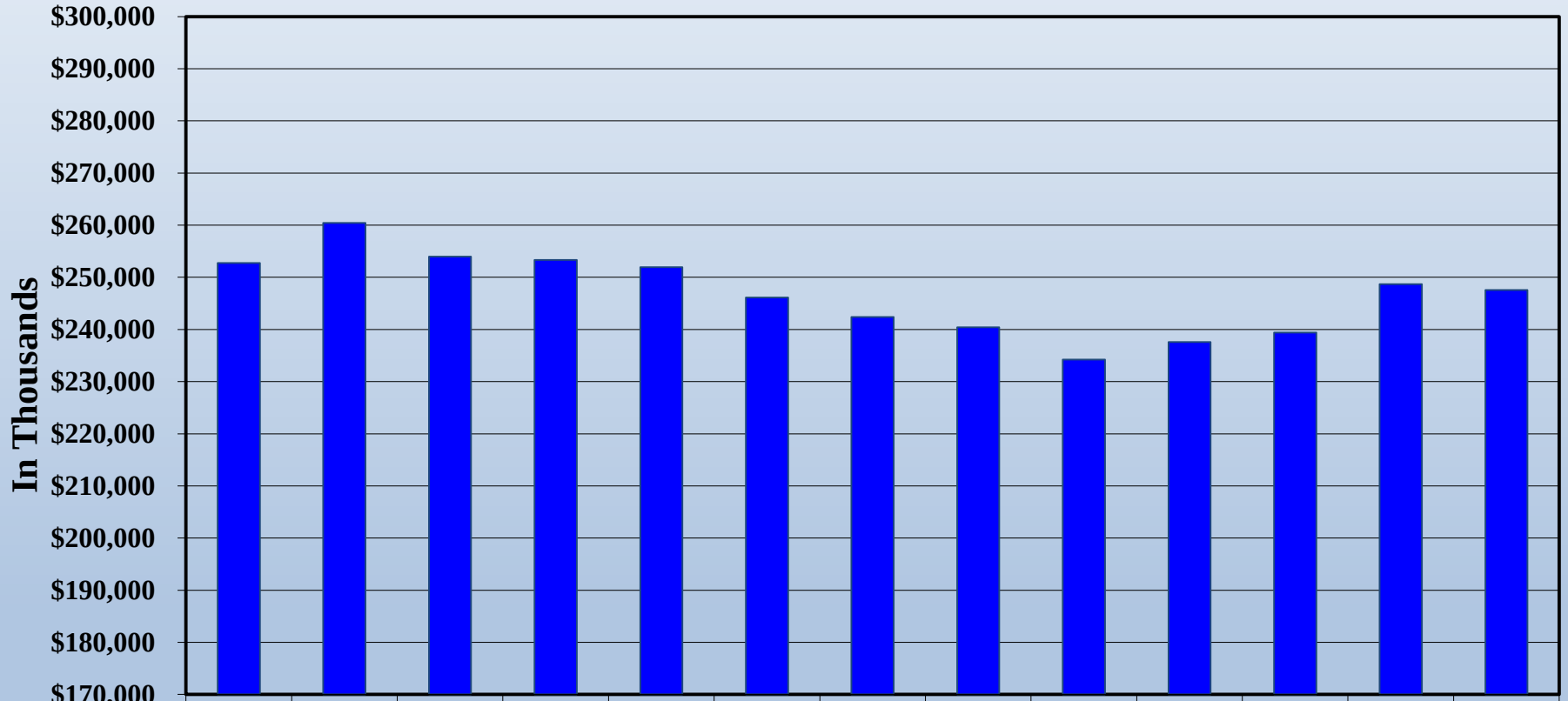
13 Month Trending



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CY	24,130	25,123	25,550	27,025	27,756	27,425	21,985	27,465	27,795	24,820	28,600	23,741	27,335
PY	23,814	22,960	21,915	25,637	22,799	24,568	22,889	18,648	24,808	24,445	25,185	24,385	24,130

Total Accounts Receivable – Gross

Thirteen Month Trending

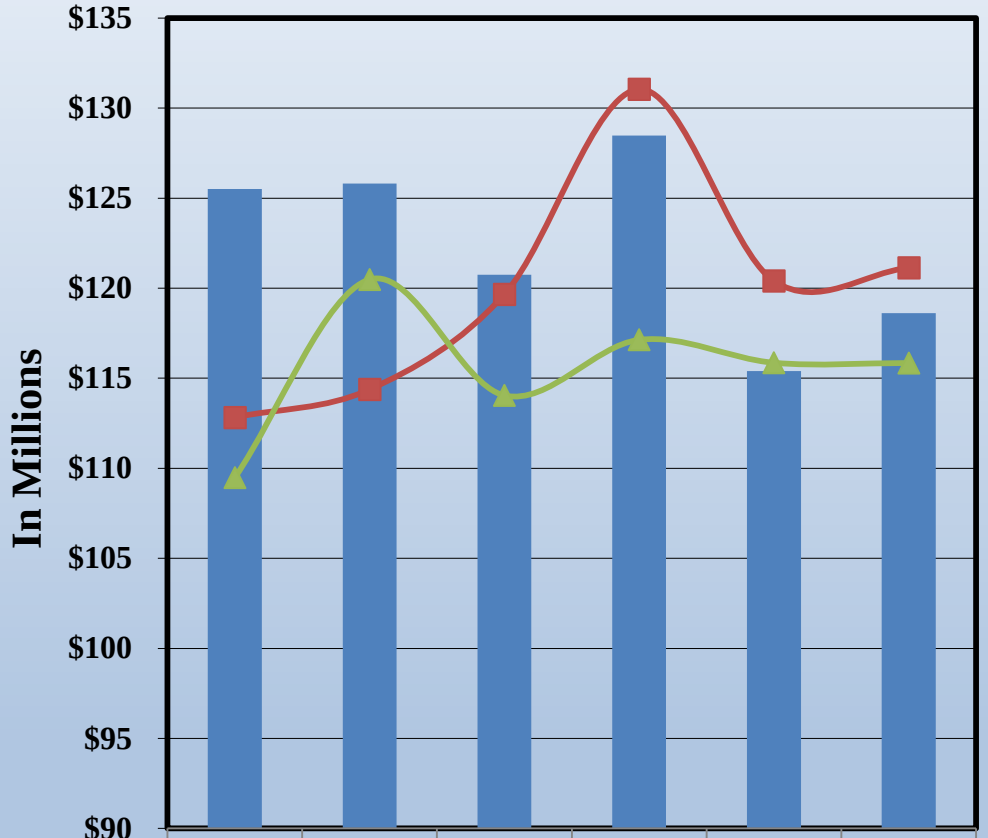


Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
252,748	260,413	253,993	253,322	251,940	246,104	242,372	240,446	234,253	237,578	239,395	248,701	247,569

Revenues & Revenue Deductions

Total Patient Revenues

(Ector County Hospital District)



	Jul	Aug	Sep	Oct	Nov	Dec
Act	$125.5	$125.8	$120.7	$128.5	$115.4	$118.6
Bud	$112.8	$114.4	$119.7	$131.0	$120.4	$121.1
Prior	$109.5	$120.5	$114.0	$117.1	$115.9	$115.8

	Actual	Budget	Prior Year
Month	$ 118.6	$ 121.1	$ 115.8
Var %		-2.1%	2.4%
Year-To-Date	$ 362.5	$ 372.6	$ 348.8
Var %		-2.7%	3.9%
Annualized	$ 1,465.4	$ 1,432.0	$ 1,372.9
Var %		2.3%	6.7%

Total Net Patient Revenues

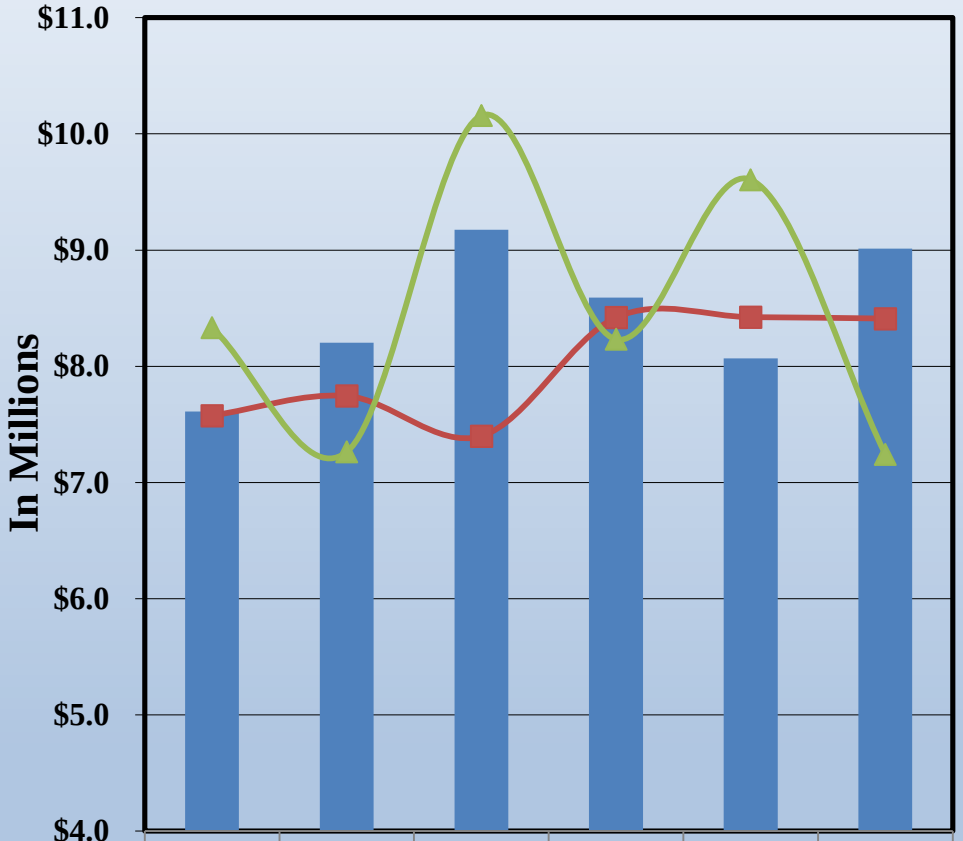
	Jul	Aug	Sep	Oct	Nov	Dec
Act	$28.5	$29.7	$45.5	$27.9	$28.3	$28.7
Bud	$27.5	$27.8	$26.3	$29.8	$27.6	$27.9
Prior	$27.2	$31.1	$28.5	$27.4	$26.5	$27.9

	Actual	Budget	Prior Year
Month	$ 28.7	$ 27.9	$ 27.9
Var %		3.0%	2.8%
Year-To-Date	$ 84.8	$ 85.2	$ 81.8
Var %		-0.4%	3.7%
Annualized	$ 354.2	$ 339.0	$ 327.7
Var %		4.5%	8.1%

Other Revenue

(Ector County Hospital District)

Including Tax Receipts, Interest & Other Operating Income



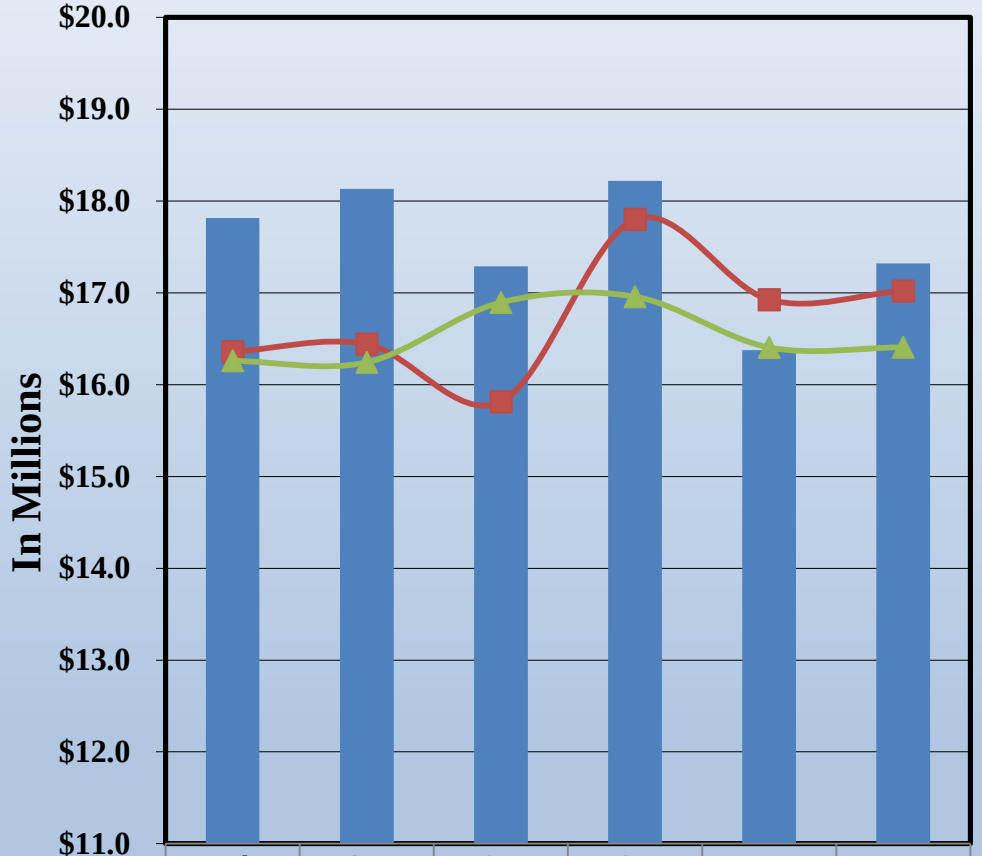
	Jul	Aug	Sep	Oct	Nov	Dec
Act	$7.6	$8.2	$9.2	$8.6	$8.1	$9.0
Bud	$7.6	$7.7	$7.4	$8.4	$8.4	$8.4
Prior	$8.3	$7.3	$10.2	$8.2	$9.6	$7.2

	Actual	Budget	Prior Year
Month	$ 9.0	$ 8.4	$ 7.2
Var %		7.2%	24.5%
Year-To-Date	$ 25.7	$ 25.3	$ 25.1
Var %		1.7%	2.4%
Annualized	$ 100.3	$ 93.9	$ 97.6
Var %		6.8%	2.8%

Operating Expenses

Salaries, Wages & Contract Labor

(Ector County Hospital District)

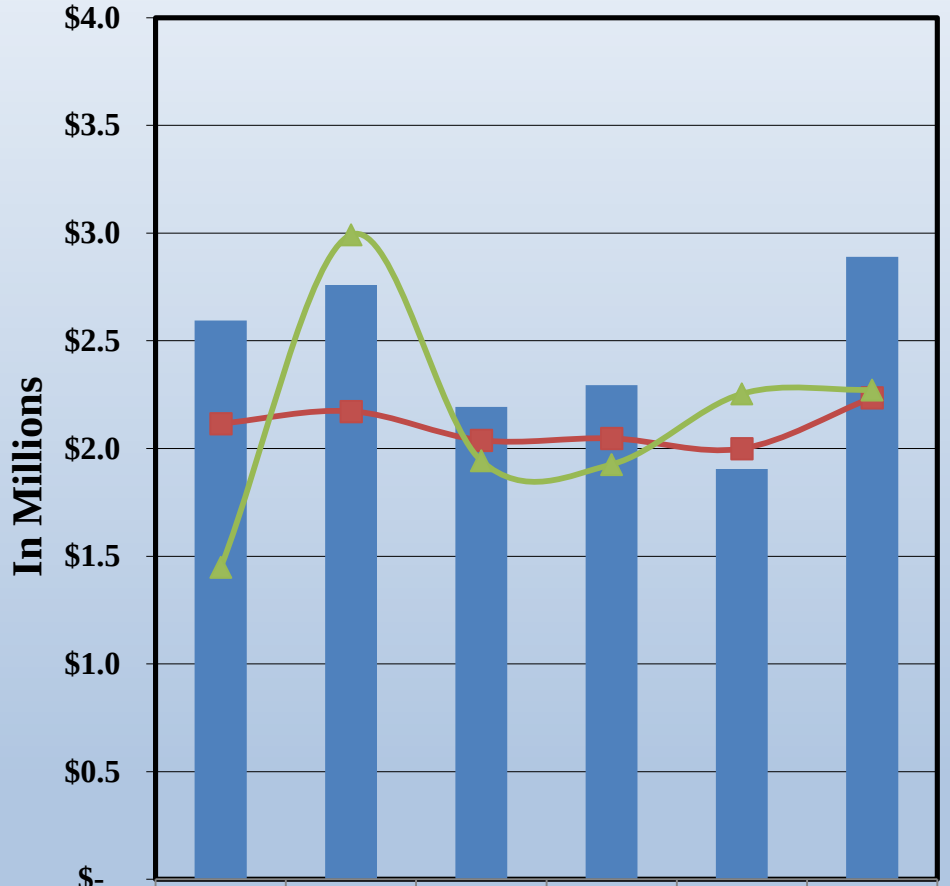


	Jul	Aug	Sep	Oct	Nov	Dec
Act	$17.8	$18.1	$17.3	$18.2	$16.4	$17.3
Bud	$16.4	$16.4	$15.8	$17.8	$16.9	$17.0
Prior	$16.3	$16.2	$16.9	$17.0	$16.4	$16.4

	Actual	Budget	Prior Year
Month	$ 17.3	$ 17.0	$ 16.4
Var %		1.8%	5.5%
Year-To-Date	$ 51.9	$ 51.7	$ 49.8
Var %		0.4%	4.2%
Annualized	$ 208.0	$ 200.6	$ 195.1
Var %		3.7%	6.6%

Employee Benefit Expense

(Ector County Hospital District)



	Jul	Aug	Sep	Oct	Nov	Dec
Act	$2.6	$2.8	$2.2	$2.3	$1.9	$2.9
Bud	$2.1	$2.2	$2.0	$2.0	$2.0	$2.2
Prior	$1.4	$3.0	$1.9	$1.9	$2.3	$2.3

	Actual	Budget	Prior Year
Month	$ 2.9	$ 2.2	$ 2.3
Var %		29.1%	27.1%
Year-To-Date	$ 7.1	$ 6.3	$ 6.5
Var %		12.8%	9.8%
Annualized	$ 24.2	$ 25.6	$ 29.0
Var %		-5.3%	-16.4%

Supply Expense

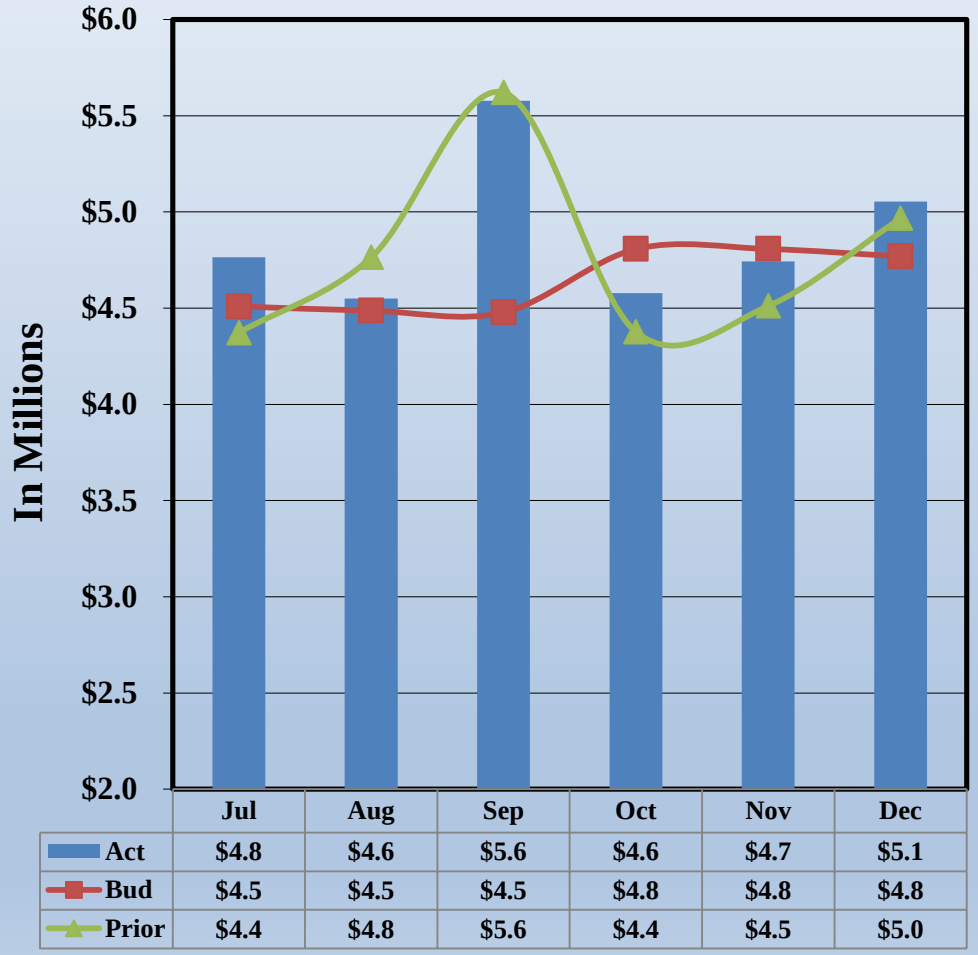
(Ector County Hospital District)

	Jul	Aug	Sep	Oct	Nov	Dec
Act	$7.0	$7.1	$6.3	$8.1	$6.4	$7.1
Bud	$6.1	$6.1	$5.8	$7.1	$6.7	$6.7
Prior	$5.4	$6.6	$5.0	$6.5	$7.0	$6.3

	Actual	Budget	Prior Year
Month	$ 7.1	$ 6.7	$ 6.3
Var %		5.3%	11.7%
Year-To-Date	$ 21.5	$ 20.5	$ 19.8
Var %		5.3%	8.6%
Annualized	$ 80.3	$ 76.5	$ 72.6
Var %		5.0%	10.6%

Purchased Services

(Ector County Hospital District)

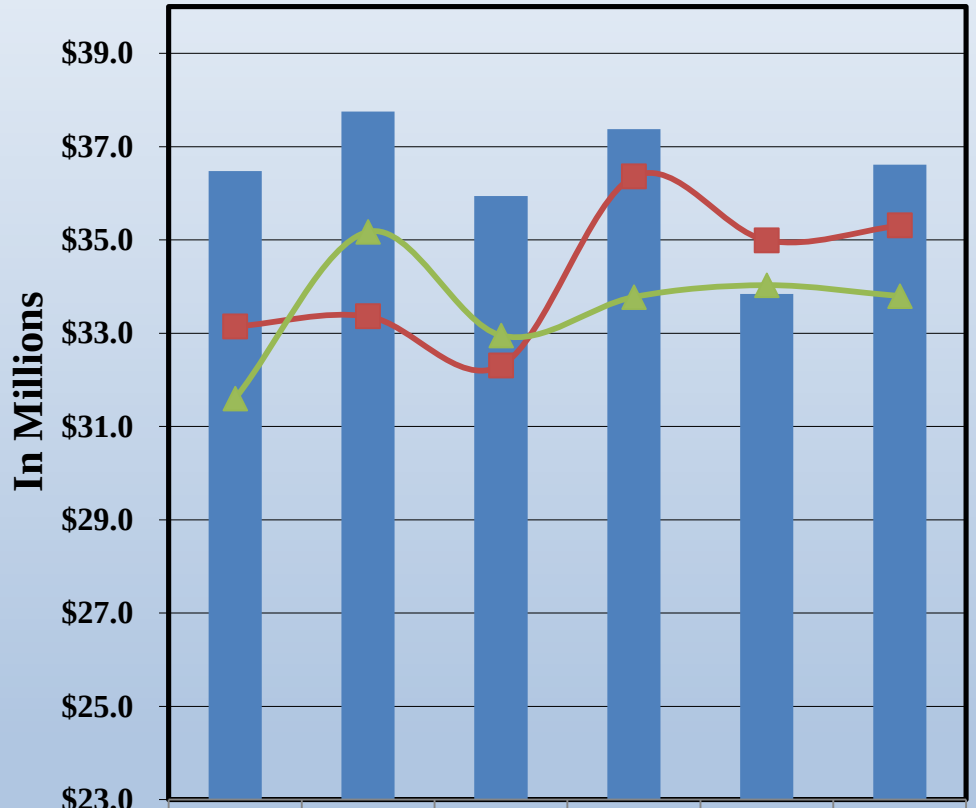


	Jul	Aug	Sep	Oct	Nov	Dec
Act	$4.8	$4.6	$5.6	$4.6	$4.7	$5.1
Bud	$4.5	$4.5	$4.5	$4.8	$4.8	$4.8
Prior	$4.4	$4.8	$5.6	$4.4	$4.5	$5.0

	Actual	Budget	Prior Year
Month	$ 5.1	$ 4.8	$ 5.0
Var %		6.0%	1.8%
Year-To-Date	$ 14.4	$ 14.4	$ 13.9
Var %		-0.1%	3.8%
Annualized	$ 57.2	$ 55.2	$ 54.6
Var %		4.2%	5.4%

Total Operating Expense

(Ector County Hospital District)

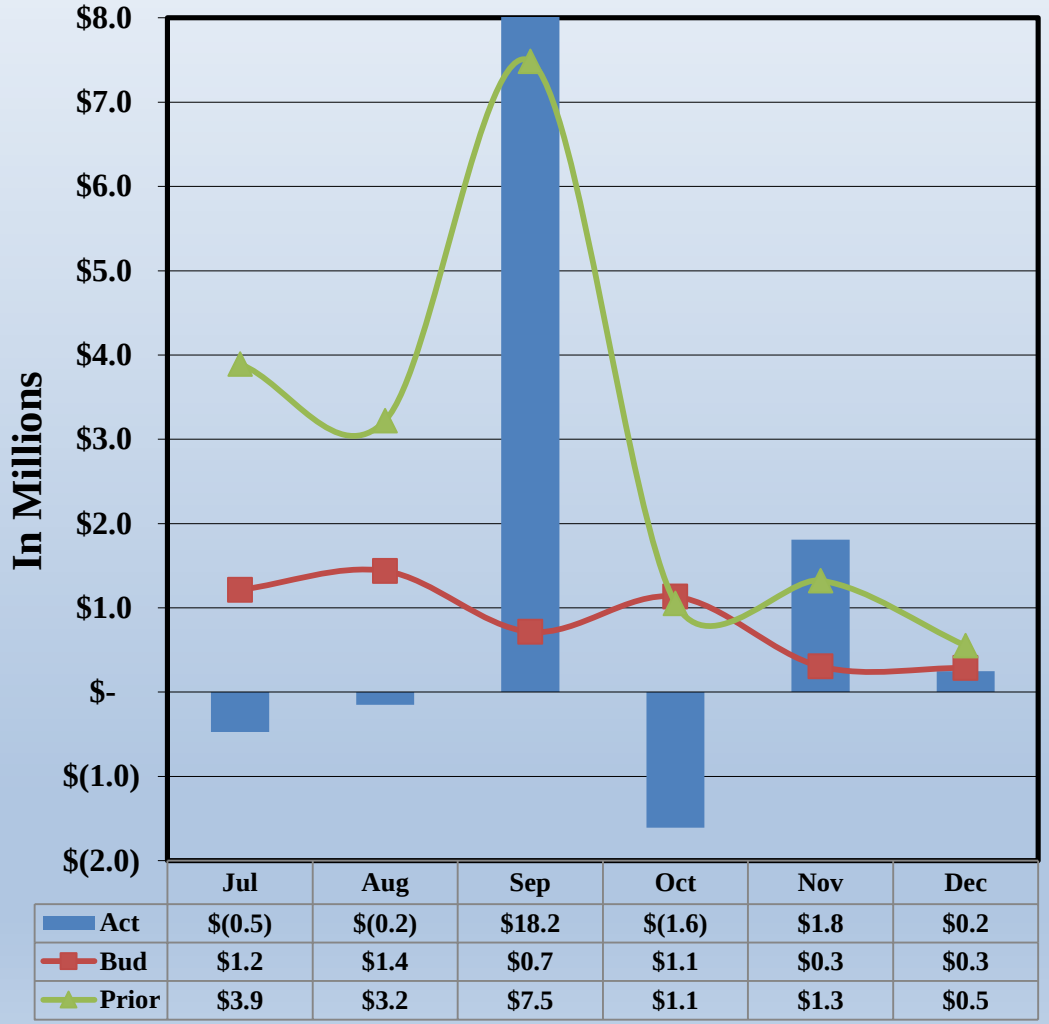


	Jul	Aug	Sep	Oct	Nov	Dec
Act	$36.5	$37.8	$35.9	$37.4	$33.8	$36.6
Bud	$33.1	$33.4	$32.3	$36.4	$35.0	$35.3
Prior	$31.6	$35.2	$33.0	$33.8	$34.0	$33.8

	Actual	Budget	Prior Year
Month	$ 36.6	$ 35.3	$ 33.8
Var %		3.7%	8.3%
Year-To-Date	$ 107.8	$ 106.7	$ 101.6
Var %		1.1%	6.1%
Annualized	$ 416.6	$ 409.5	$ 398.5
Var %		1.7%	4.5%

Adjusted Operating EBIDA

Ector County Hospital District Operations



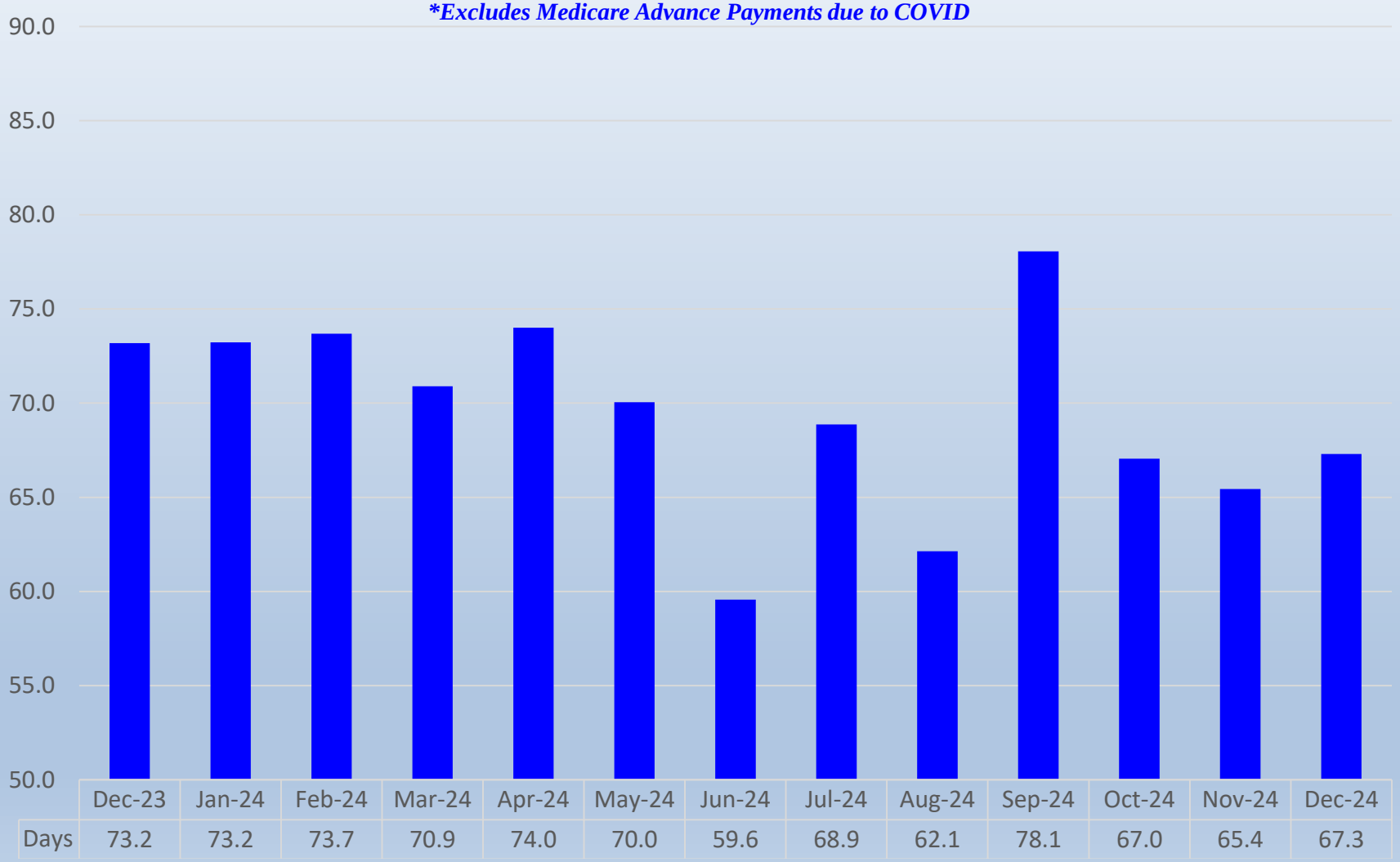
	Jul	Aug	Sep	Oct	Nov	Dec
Act	$(0.5)	$(0.2)	$18.2	$(1.6)	$1.8	$0.2
Bud	$1.2	$1.4	$0.7	$1.1	$0.3	$0.3
Prior	$3.9	$3.2	$7.5	$1.1	$1.3	$0.5

	Actual	Budget	Prior Year
Month	$ 0.2	$ 0.3	$ 0.5
Var %		-33.3%	-60.0%
Year-To-Date	$ 0.4	$ 1.7	$ 2.9
Var %		-76.5%	-86.2%
Annualized	$ 19.7	$ 13.7	$ 25.3
Var %		43.8%	-22.1%

Days Cash on Hand

Thirteen Month Trending

**Excludes Medicare Advance Payments due to COVID*



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Days	73.2	73.2	73.7	70.9	74.0	70.0	59.6	68.9	62.1	78.1	67.0	65.4	67.3


mch
mch

MEMORANDUM

TO: ECHD Board of Directors

FROM: Carlos Aguilar, Director of Engineering
Through Matt Collins, Chief Operating Officer

SUBJECT: TD Industries – Ice Machine Service Renewal

DATE: January 6,2025

REQUEST

The Engineering Department requests approval to renew the contract with TDI Industries for ice machine maintenance. Preventive maintenance of Ice Machines is a regulatory requirement for MCH and provides sanitary ice for patients, staff and other building occupants. Total contract cost for three-year agreement is $169,505.

OBJECTIVE

Agreement is to provide services Planned Maintenance coverage for ice machines. Early detection of adverse operating conditions are essential to providing sanitary product and helps to avoid costly equipment failures.

FINANCIAL CONSIDERATIONS

Ice Machine Maintenance (Year 1: 01/01/2025-12/31/2025)	**$54,840.28**
Ice Machine Maintenance (Year 2: 01/01/2026-12/31/2026)	**$56,485.49**
Ice Machine Maintenance (Year 3: 01/01/2027-12/31/2027)	**$58,180.05**
Contract Total	**$169,505.82**

FTE IMPACT
No additional FTEs are needed.

Medical Center Hospital
A Member of Medical Center Health System

Memorandum

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

Date: January 24, 2025

To: Ector County Hospital District Board of Directors

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

Re: Service agreement for Velys Robot for Total Knee Replacement

Total Cost over 5 years-non-budgeted **$325,000 ($65,000/yr)**

OBJECTIVE

Obtain Service agreement to cover maintenance and repair of Velys total knee robot and software maintenance.

HISTORY

We purchased the Velys Knee Robot to perform Total Knee Arthroplasty in January 2024. The robot had a one-year manufacturer warranty. This warranty will expire January 22, 2025. The service agreement which includes repairs and software updates is for 5 years at $65K per year.

PURCHASE CONSIDERATIONS

Cost for needed repairs and software updates could be significant if paying individually for each service call/repair or software upgrade.

INSTALLATION & TRAINING

Velys to maintain equipment and software. Velys will in-service staff when current processes change.

WARRANTY AND SERVICE CONTRACT

Manufacturer warranty was for one year and has expired.

DISPOSITION OF EXISTING EQUIPMENT
N/A

LIFE EXPECTANCY OF EQUIPMENT
5-7 years

MD BUYLINE INFORMATION
Meets MD Buyline and Vizient pricing recommendations.

COMMITTEE APPROVAL
ECHD Board

Medical Center Hospital
A Member of Medical Center Health System

TO: Matt Collins, COO

FROM: Jerry Hild, Divisional Director of Radiology

DATE: December 26, 2024

RE: **IsoRx contract – 2025 funds to PO 225832**

Contract: 001-7300-IRX-2016 - IsoRX
Term: 12/1/2020 – 11/30/2025
Action: PO needs additional funds
Amount: $650,000

This is a request for 2025 funds to be added to PO#225832. IsoRx produces and delivers all medications for our nuclear medicine department. There has not been a price increase, and this was a five-year contract initiated in 2020. Annual funds are forecasted, and this is included in the operational budget annually.

Average dose cost $300 x Annual exams 2,199 = $659,700 (this will vary as all doses are not equal and are volume based)

FY 2023				
COST CENTER	TOTAL IN-PX	TOTAL OUT-PX	GRAND TOTAL	TOTAL COST
7300	674	1023	1697	$509,100

FY 2024					
COST CENTER	TOTAL IN-PX	TOTAL OUT-PX	GRAND TOTAL	AVG PER DOSE	TOTAL COST
7300	880	1319	2199	$300	$659,700

Medical Center Hospital
A Member of Medical Center Health System

Memorandum

Date: February 6th, 2025

To: Ector County Hospital District Board of Directors

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

From: Vonda Lucero, MSN, RN, CWON

Re: Skytron Surgical Tables & Accessories

Total Cost – Foundation Funding- Approved **$117,397.07**

OBJECTIVE

Skytron Surgical Tables are designed with end-users in mind and to handle the many challenges staff face in the OR while keeping the patient safe.

The Skytron Ultraslide offers the most top slide and the lowest table height for ease of use and flexibility.

Our current OR tables are at end of life, and now we are unable to find parts to fix the tables when they go down. L&D is currently down two OR tables, leaving us with one working OR. The main OR has been gracious enough to allow us to borrow a table so that we can keep two functioning Operating Rooms. Two working OR rooms is the minimum we can survive with as our service line and deliveries continue to grow.

TO: ECHD Board of Directors

THROUGH: Russell Tippin, President & CEO

THROUGH: Steve Ewing, CFO

FROM: Eva Garcia, PT, MSPT, Div. Dir. Financial Operations

DATE: January 31, 2025

RE: **StrataJazz (Enterprise Performance Management System)**

Contingency Budget Project Cost FY25: $466,595

BACKGROUND

There are 3 overarching goals that have been stated on the MCHS Strategic Plan: Finance Pillar Plan that have yet to be fully met. These goals are as follows:

1. Develop and implement strategic, financial and human resource planning processes.
2. Evaluate cost management optimization opportunities.
3. Evaluate revenue capture opportunities (enhancement & integrity).

The reason that these goals are difficult to meet is because MCH currently does not have a comprehensive reporting tool that can extract data from multiple sources and then use this data to create meaningful reports that can be used by the MCH leadership team to move towards meeting these goals.

REQUEST & OBJECTIVES

The request of the Finance Department under the guidance of Steve Ewing, CFO, is that MCH enter a multi-year partnership with Strata using the StrataJazz platform to work towards meeting the goals of the finance pillar. StrataJazz is a comprehensive system that will provide an end-to-end platform to address financial planning needs, will offer organization-wide decision support analytics and will optimize performance management by delivering action-based accountability reports. It does this by integrating information from the GL/Financial system (Premier), the payroll system (Paycom) and the EMR (Cerner/Oracle) to create reports that will assist in meeting the following objectives:

- Integrate Planning with Decision Support - Automatically leverage volume, utilization, revenue and unit cost from Decision Support to drive a more automated and accurate budget.

- Drive a More Efficient Planning Process - Streamline planning and eliminate non-value-added activities - reducing the total time spent by 30% and the duration of the process by >1 mo. One client reduced the budget process by 10 weeks and eliminated $500k in non-value-added effort.

- Increase the Accuracy of Plan - Automatically leverages time-driven and supply acquisition cost from Cost Accounting to drive the budget, increasing modeling accuracy by 30-50% in variable departments.

- Eliminate Off-Line (and Manual) Excel Models - Eliminate off-line spreadsheets including rolling forecasts, long range plans and business plans with purpose-built, integrated models.

- Drive Visibility and Accountability - Sustain increased compliance on dept. budget variance commentary.

StrataJazz will be the cornerstone of developing a decision support team that will be instrumental in future financial, capital and strategic planning for MCH.

IT REQUIREMENTS/SECURITY
MCH IT Security Team has received confirmation from VISO at Fortified that Strata meets the security requirements based on security reports that were submitted to MCH.

ROI
The following ROI assumes that if MCH were to avoid a minimum of $375K per year on a "bad" financial decision, the hospital would see a Net Present Value (NPV) of $180K and an Internal Rate of Return (IRR) of 23% over a 5-year period.

	NPV Calc				Interest Rate =	8%
	Cash Flows (in Thousands K)					
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Implementation Fees	$ (284.2)	$ (284.2)	$ -	$ -	$ -	$ -
Subscription Fee	0	(182.4)	(187.9)	(193.5)	(199.4)	(205.3)
Add Rev / Saved Exp	-	375.0	375.0	375.0	375.0	375.0
Net Cash Flows	$ (284.2)	$ (91.6)	$ 187.1	$ 181.5	$ 175.6	$ 169.7
					NPV =	**$ 180.07**
					IRR =	**23.0%**

Medical Center Health System
Your One Source for Health

MEMORANDUM

FROM: Erica Wilson, Director of Pharmacy

TO: ECHD Board

THROUGH: Matt Collins, Chief Operating Officer

SUBJECT: Baxter Healthcare Corporation

DATE: 2/11/2025

Estimated Cost:
Year 1: approximately $366,280
Year 2: approximately $366,280
Year 3: approximately $366,280

Background:
MCH, as a part of TPC, moved from Baxter to BBraun for our primary vendor for fluids, which also includes some premix and nutritional products. This contract changes started January 2025.

During the review process with TPC, BBraun provided the product list that had direct cross matches from the previous Baxter contract to the health systems for review. Throughout the review it was known that there were some products that BBraun doesn't carry or didn't have a cross match, thus all TPC hospitals were going to have to choose to stay with Baxter or figure out another supplier for certain products.

This contract requires us to commit at least 90% of the annual volume committed for products we will continue to order from Baxter. This committed volume has been calculated based on the recent historical volume of only these chosen products and is unlikely to fluctuate based on our formulary and practices during the three-year contract. The contract will allow us to purchase these products from Baxter at a reduced price for the duration of the three-year contract if we maintain at least 90% of this committee volume each year.

Staffing:
No additional FTE's required.

Disposition of Existing Equipment:
none

Implementation Time Frame:
As soon as contract executed, new pricing will be available

Funding: operational budget

Thank you

Erica Wilson Pharm D
Director of Pharmacy

Medical Center Health System
Your One Source for Health

MEMORANDUM

TO: ECHD Board of Directors

FROM: Ted Crowe Nutrition Services Director
Through Matt Collins, Chief Operating Officer

SUBJECT: JUNUM MalnutritionCDS software

DATE: January 31, 2025

Cost:

Cost Year 1 (TPC pricing-eliminating implementation fee) *(Capital Budget)*	**$49,500.00**
Cost Year 2 (TPC pricing)	**$49,320.00**
Cost Year 3 (TPC pricing) (Yrs 2 & 3 Operations Budget)	**$43,920.00**
Project Total	**$142,740.00**
Projected Additional Revenue Yr. 1	**$489,000.00 to $576,000.00**

Background:
Hospital systems often under-diagnose and under-document inpatient malnutrition, leading to suboptimal care, manual workflows, **missed reimbursement,** and quality reporting opportunities. JUNUM MalnutritionCDS software's application is targeted for helping clinicians improve malnutrition care, makes it easier for physicians to identify and treat malnutrition patients directly and recover significant reimbursements through Oracle Cerner. JUNUM will also track all data components required by the new 2024 CMS Hospital Inpatient Quality Reporting program.

Staffing:
No additional FTE's required.

Additional Reimbursement:
Current Malnutrition Capture at MCH Rate 3.13%
Expected Malnutrition Capture Rate with JUNUM 6-9%
Estimated New Revenue (Year One) $489,000-$576,000
ROI 5-8X

Additional Information:
Implementation timeline: start to go live approximately 90 -120 days

Midland Memorial was the test site for this software for TPC and they exceeded their expected ROI.

To:	ECHD Board of Directors
Through:	Russell Tippin, CEO
Through:	Matt Collins, COO
From:	Carlos Aguilar, Director Engineering
Date:	2/11/25
RE:	Siemens Pressure Monitors

Cost: $120,518.00

REQUEST
The Engineering Department requests approval to purchase New Room Pressure Monitors. The monitors are a regulatory requirement. Total project cost is $120,518.

OBJECTIVE
Siemens Industry will provide and install 19 new Siemens room pressure monitors in locations as noted below. Siemens will include the room pressure monitors, tap plates, wire and wiring updating graphics, trending, alarming and reporting. We will provide patch and paint where needed.

9C ante room, 8C ante room, 7C Ante room, 5C Ante, CCU 3 Ante Room, CCU 11 Ante Room, ICU 11 Ante Room, ICU 12/13 Ante room, ER Room 28 Ante Room, Cath Lab 1, Cath lab 2, Cath lab 3, Cath lab 4, Rad Specials 8, Rad Specials 9, Endo 2, Endo 3, Endo 4 and 305

FINANCIAL CONSIDERATIONS

FTE IMPACT
No additional FTEs are needed.

WARRANTY & SERVICE COVERAGE

DISPOSITION OF EXISTING EQUIPMENT
No existing equipment

Medical Center Health System
Your One Source for Health

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.
ICARE Values:
Integrity | Customer Centered | Accountability | Respect | Excellence

Executive Policy Committee

Team Leader:	Crystal Sanchez	Date:	01/30/2025	Start Time:	1200
Location:	Admin Conference Room A			End Time:	1300

Agenda Item (Topic)	Time Allotted	Presenter	Notes
Meeting Called to Order			**Called to order at 1208 by Don Hallmark.**
Review of meeting minutes from previous meeting	5 min	All	Motion to approve by Gingie Sredanovich, seconded by Russell Tippin. All committee members in favor.
Old Business			
– N/A			
New Business			
– New policies from Business Office: ○ BO- Contract Management ○ BO- Payment Posting ○ BO- Statements ○ BO- Third Party Lien Management	10 min	Crystal Sanchez on behalf of Steve Ewing	• ***Required for the pre-service financial clearance initiative*** ○ Motion to approve by Gingie Sredanovich, seconded by Russell Tippin. All committee members in favor.
– Revised/New policies for ED: ○ MCH-2066 Psychiatric and Substance Abuse Services ○ Death of a Child in the ED ***(New)*** ○ Child Maltreatment Policy ***(New)***	10 min	Crystal Sanchez on behalf ED	• ***Required changes for Trauma Pediatric Readiness*** ○ Motion to approve by Gingie Sredanovich, seconded by Russell Tippin. All committee members in favor.

– Revised/New policies for Trauma: ○ TR-11 Interventional Radiology Call In Procedures ***(Changed policy name also)*** ○ TR-41 Trauma Operating Room (OR) Services ***(New)***	5 min	Crystal Sanchez on behalf Trauma	• ***Required changes to align with upcoming Trauma designation*** ○ Motion to approve by Gingie Sredanovich, seconded by Russell Tippin. All committee members in favor.
– Revised policy for Nursing (Maternal Child): ○ High Risk Patients in Labor and Delivery Policy ***(New)***	5 min	Crystal Sanchez/Kim Leftwich	• ***Policy required for Maternal Designation, requesting this to be approved and posted 1/30 for upcoming survey*** ○ Motion to approve by Gingie Sredanovich, seconded by Russell Tippin. All committee members in favor.
Open Forum	5 min	All	• ***Updated list of overdue policies***
Meeting Adjourned			**Meeting adjourned at 1220.**

Medical Center Health System
Facility Management Plan

Purpose

The physical environment and the range of patient care services provided to the patients served by Medical Center Hospital (MCH) present a wide range of applications and risks. The Facility Management Plan is designed to provide organizational oversight for the design and maintenance of the physical environment infrastructure and equipment. The plan was developed using various construction criteria, maintenance, testing, and inspection procedures to eliminate or reduce the probability of adverse patient outcomes. The plan also seeks to maintain appropriate policies and procedures to manage safe activities within the organization, as well as monitor the performance of the environment.

Scope

The program is applied to the Main Hospital Campus, FHC, and Urgent Care Sites.

Objectives

A) Maintain safe and adequate facilities for our services.
B) Adopt and adhere to the Life Safety Code (NFPA 101 and applicable amendments).
C) Develop and implement policies and procedures that maintain a safe environment.
D) Maintain an organizational-wide process for evaluating unfavorable events related to the physical environment
E) Monitor events, occurrences, and impairments to continually improve performance
F) Disseminate appropriate data to the Quality Management Committee

Program Management Structure

A. The Director of Facilities assures that an appropriate Facilities Maintenance program is implemented. The Director of Facilities also collaborates with the Safety Officer to develop reports of program performance for presentation to the Environment of Care Committee. The reports summarize organizational experience, performance management and improvement activities, and other physical environment issues.

B. The MCH Senior Leadership Team receives regular reports of the activities of the program through the Quality Management Committee. The Chief Operating Officer collaborates with the Director of Facilities, Safety Officer, and other appropriate staff to address system issues and concerns as well as capital infrastructure planning. The Chief Operating Officer also collaborates with the Director of Facilities, and Chief Financial Officer to develop a budget and operational objective for the program.

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE1 SR1	**The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients, visitors, and staff are assured.** Note:	• HEMS work order system • Life Safety Rounds • EOC Rounds
PE1 SR2	**The organization shall maintain safe and adequate facilities for its services.** Note: MCH follows numerous standards of safety requirements to ensure our facility and equipment are properly operating to fulfill the necessities of preserving human life.	• DNV Certification • TDH Requirements • NFPA
PE1 SR2a	**Diagnostic and therapeutic facilities shall be located for the safety of patients.** Note:	

PE1 SR2b	**Facilities, supplies, and equipment shall be maintained to ensure an acceptable level of safety and quality.** Note:	• DNV requirements • Biomed Rounds • Management Plans • HEMS work order system • MCHS Policy 4020
PE1 SR2c	**The extent and complexity of facilities shall be determined by the services offered.** Note:	• Critical equipment maintenance • HEMS work order procedures 540, 566, 578
PE1 SR3	**Except as otherwise provided in this section, the organization shall meet the applicable provisions and shall proceed in accordance with the 2012 Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6), and Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), when a new structure is built or when an existing structure or building is renovated.** Note: MCH follows healthcare guidelines for new constructions and renovations for all buildings in the system.	• MCHS follows Healthcare Facilities Occupancy Rules, Type II (222), TDH, DNV
PE1 SR3a	**Chapters 7 and 8 of the adopted Health Care Facilities Code do not apply to a hospital.** Note:	N/A
PE1 SR3b	**If application of the Health Care Facilities Code as required in PE.1, SR.3 would result in unreasonable hardship for the organization, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.** Note: MCH is currently not following any waivers and chose to continue with recommended maintenance requirements through the COVID pandemic.	N/A
PE1 SR4	**The organization shall have policies, procedures and processes, and management plans, in place to manage staff activities, as required and/or recommended by local, State, and national authorities or related professional organizations, to maintain a safe environment for the organization's patients, staff, and others.**	• See MCHS Policies 4000's • Continuing Education

	Note: MCH has the 4000 policy guides to assist employees with safety of the environment and continued education.	
PE1 SR5	**The organization shall have a documented processes, management plans, policies and procedures to define how unfavorable occurrences, incidents, or impairments in the facility's infrastructure, Life Safety, Safety, Security, Hazardous Material/Waste, Emergency, Medical Equipment, and Utilities Management Systems are prevented, controlled investigated, and reported throughout the organization.** Note: After action reports, patient safety event program, rounds, EOC committee	• EOC Committee, Patient Safety Event Program • Rounding
PE1 SR6	**The organization shall evaluate the effectiveness of the facility's physical environment management systems at least annually. This evaluation shall be forwarded to QMS oversight.** Note:	• Life Safety Rounds, Building & Ground Rounds scheduled PM's through HEMS system
PE1 SR7	**Occurrences, incidents, or impairments shall be measured and analyzed to identify any patterns or trends and used to evaluate the effectiveness of the organization's physical environmental management system.** Note: Utility disruptions and failures are documented and trended for repeated failures and areas for improvements	
PE1 SR8	**The organization, through its senior leadership shall ensure that the physical environment and associated management systems adequately address issues identified throughout the organization and there are prevention, correction, improvement and training programs to address these issues.** Note:	• EOC meeting minutes • QAPI meeting minutes • E-Team meeting minutes
PE1 SR9	**Significant physical environment data/information shall be disseminated regularly to Quality Management Oversight.** Note:	• QAPI Goals

PE1 SR10	**The organization, through its senior leadership shall ensure that a tobacco-free policy be developed and enforced campus-wide. Substantial progress toward complete conformity shall be demonstrated over time. DNV GL will permit temporary tobacco use in the areas of the hospital where patient visits may be abbreviated, in behavioral health units and other areas near the main campus that are not under hospital control. In order for this to be permissible the hospital shall obtain from the local and/or state fire prevention agencies (Authority Having Jurisdiction or AHJ) written documentation stating that these areas which are to be located outdoors, can be used for smoking while the hospital continues to demonstrate progression toward a tobacco-free campus over time. (See the PE.1 Interpretive Guidelines for specific direction on this procedure).** Note: MCH utilizes programs such as incentives through health insurance and other opportunities to promote a smoke-free campus as well as posted signs that have been placed throughout the campus.	• MCH 1033 Tobacco-free campus • MCHS Policy 1033

Evaluation of Plan

On an annual basis, the Engineering Director will evaluate the objectives, scope, effectiveness, and performance of the Facility Management Plan. Any changes in objectives will be addressed during the Annual evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The Engineering Director collaborates with the EOC Committee and other appropriate associates to convey and address facility issues and/or concerns.

The Annual evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary initiatives for minimizing the risk associated with the operations of a healthcare facility.

Performance Indicators

- **Goals 2024**

2024 Goals	Evaluation
• Routine work orders will be completed within 24 hours 65% of the time ○ Routine is defined as work orders dispatched for minor repairs and maintenance	Goal was met, increase goal to 85% next year

- **Goals 2025**

2025 Goal	Action Plan
QAPI: Increase compliance with the safety and storage of compressed gas cylinders from 83% to 98%	**Weekly rounding of two different teams, meeting with material management on PAR levels, and reviewing the contract with third party vendor**
• Promote Environmental Sustainability	• Reduce energy and resource consumption while managing costs effectively • Implement sustainable waste disposal and recycling practices
• Incorporate more data-driven decision making	• Use performance metrics and KPIs to guide facility management strategies

Medical Center Health System
Hazardous Material (HAZMAT) Management Plan

Purpose

The Environment of Care (EC) poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Hazardous Materials and Wastes (HMW) Program is designed to identify and manage the risks related to the presence of hazardous materials and wastes present in the buildings and portions of buildings operated and owned by Medical Center Health System. The specific risks of each environment are identified by applying appropriate criteria to materials and wastes to determine which have hazards.

Scope

The Hazardous Materials and Waste Management Plan describes the risks and daily management activities put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and visitors, coming to the organization. The Hazardous and Waste Management Program is based on applicable laws, regulations, and accreditation standards and designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services.

This plan covers activities performed in the various locations of the organization, including the hospital and hospital-based clinic operations of Medical Center Health System.

Principles

- The activities of the hazardous materials and waste management program are designed based on applicable national, state, and local codes and regulations and the inventory of materials in use and wastes generated at each location housing healthcare services.
- The specific activities, environments, protective equipment, and engineering controls required to the risk of adverse human or environmental impact related to the handling, use, storage, or disposal of materials and wastes are determined from Safety Data Sheets (SDS), which replaces the Material Safety Data Sheet (MSDS) or other documents provided by suppliers and manufacturers.
- The four basic management requirements for assuring the minimum potential of adverse human or environmental impact of HMW

include:

- Appropriate design of space, including installation and maintenance of engineering control systems and other equipment to manage the hazards of the types of materials or wastes to be stored in the area
- Regular inspection and maintenance of the spaces where HMW is stored, handled, held for disposal, etc. to assure that all engineering controls are working properly, that proper procedures and controls for the separation, storing, and handling of HMW are being implemented, and that other equipment is used effectively.
- Education and training of staff responsible for handling and using any HMW that addresses the specific hazards of each type of HMW and the procedures and controls required to manage those hazards.
- Development and testing of emergency response procedures designed to minimize the human and environmental impact of any exposure to, release of, or spill of HMW.

Objectives

The objectives of the Hazardous Materials and Waste Management Plan include:

- Comply with standards and regulation pertaining to hazardous materials and waste
- Develop and enforce current hazardous materials and waste practices for patients, staff, students and visitors
- Provide hazardous materials and waste education and training as appropriate
- Identify and implement opportunities to improve hazardous materials and waste management

Program Management Structure

- The Environmental Services Director conducts a risk assessment of hazardous materials and wastes throughout the organization. The results of the risk assessment are used to develop appropriate procedures and controls as the foundation of an appropriate HMW management program is implemented. The HMW Manager also collaborates with the Safety Officer to develop reports of HMW performance for presentation to the EC Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other HMW issues.

- The Administrative Leadership Team receives regular reports of the activities of the HMW program from the EC Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of the HMW and appropriate clinical staff. The Administrative Leadership Team collaborates with senior managers to assure budget and staffing resources are available to support the HMW program.

- Leadership receives regular reports of the activities of the HMW program. Leadership collaborates with the HMW Manager and other appropriate staff to address HMW issues and concerns. Leadership also assists in the development of a budget and operational objectives for the HMW program.

- Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE5 SR1	**The organization shall provide a Hazardous Material (HAZMAT) Management System to manage hazardous materials and waste.** Note: The management plan describes the procedures and controls in place to minimize the risks of exposure to hazardous material and waste to patients, staff, and other people coming to the facilities.	
PE5 SR2	**The HAZMAT Management System shall provide processes to manage the environment, selection, handling, storing, transporting, using, and disposing of hazardous materials and waste.** Note:	• MCH-4021 • NUCMED-0027 • NUCMED-0025
PE5 SR3	**The HAZMAT Management System shall provide processes to manage reporting and investigation of all spills, exposures, and other incidents.** Note: MCH utilizes the Patient Safety Event Reporting System to document all spills, exposures, and other incidents. The Patient Safety Events are completed by the staff member or	• MCH 4012 -

	members involved in the event and forwarded to the Risk Manager and those department directors related to the event. They will also be forwarded to the appropriate Executive member.	
PE5 SR4	**The organization monitors staff exposure levels in hazardous environments and report the results of the monitoring to the QMS.** Note: Radiation Safety Committee reports exposure levels and trends to the Quality Committee quarterly,	• RS-0042
PE5 SR5	**All compressed gas cylinders in service and in storage shall be individually secured and located to prevent abnormal mechanical shock or other damage to the cylinder valve or safety device.** Note: All gas cylinders are stored in rack barricades to monitor amount depending on the area and room size as well as the protection of the cylinder themselves against damage to the valve or safety device.	• MCH-2013
PE5 SR6	**In anesthetizing locations, which use alcohol-based skin preparations, the organization shall implement effective fire risk reductions measures which include:** Note: Before every surgery a fire risk evaluation is performed, a checklist that includes draping procedures were performed correctly, no pooling or spilled antiseptic solutions, and appropriate protocol for the use of electrosurgery/electrocautery or laser equipment.	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR6a	**The use of unit dose skin prep solutions;** Note:	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR6b	**Application of skin prep follows manufacture/supplier instructions and warnings;** Note: All manufacturer's guidelines are followed for the use of all skin prep solutions including dry times, appropriate locations, as well as appropriate procedures for pooling and removal of solution-soaked materials.	• Annual OR Assessment tool • SSMOR-6620-028

PE5 SR6c	**Sterile towels are used to absorb drips and runs during the application and then removed from the anesthetizing location prior to draping; and,** Note: Any pooling of antiseptic solution must be avoided. Should pooling occur, this must be blotted out using proper aseptic technique	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR6d	**Verifying that all of the above has occurred prior to initiating the surgical procedure.** Note: Before every surgery a fire risk evaluation is performed, a checklist that includes draping procedures were performed correctly, no pooling or spilled antiseptic solutions, and appropriate protocol for the use of electrosurgery/electrocautery or laser equipment.	• Annual OR Assessment tool • SSMOR-6620-028
PE5 SR7	**An organization may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access and in accordance with NFPA 101, Life Safety Code, 2012 edition.** Note: All dispensers will be locked and EVS staff will be responsible for replacement of the alcohol-based hand rub. There will be 5 replacement containers of the hand rub in each of the supply rooms in patient care areas with one key. These replacements will be used if the dispenser runs out before the staff is able to replace the used containers.	• Alcohol based sanitizer program

Evaluation of Plan

On an annual basis, the safety and hazardous materials teams will evaluate the objectives, scope, effectiveness, and performance of the Hazardous Materials Management Plan. Any changes in objectives will be addressed during the Annual Assessment and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The Safety Department collaborates with the EOC Committee and other appropriate associates to convey and address hazardous material issues and/or concerns.

The Annual Assessment objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with the use of hazardous materials.

Performance Indicators

- Goals 2024

2024 Goal Performance	Evaluation
• Appropriate location and security of O2 e-cylinders. ○ Monitor: EOC gas cylinder rounding assessment	Goal is being followed in QAPI and LEM due to inability to meet and sustain goal

- Goals 2025

2025 Goal	Action Plan
QAPI: increasing hand sanitizer compliance from 94% to 96%	**Physically auditing hand sanitizer so product is always available**
• Enhance SDS data program in the hospital • Continue gas cylinder revamping program	• Determine if a software upgrade is necessary and a clean-up of the software • Reducing the amount of gas cylinders in the organization, remove bottles that are not in use, ensure all signage is up to date and present, and weekly rounding

Medical Center Health System
Security Management Plan

Purpose

Each environment of care poses unique risks to the patients served, the employees and medical staff who manage it, and to others who enter the environment. The security program is designated to identify and manage the risks of the environment of care operated and owned by Medical Center Health System. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental security program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or potions of buildings housing healthcare services, parking lots and parking structures operated by Medical Center Health System.

The Management Plan for Environmental Security describes the risks, safety, security and daily management activities that Medical Center Health System has put into place to achieve the lowest potential for adverse impact on the security and health of patients, staff and other people, coming to the organization's facilities. The management plan and security program is evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The Security Management Program is designed to manage the security risks the environment of MCHS presents to patients, staff, and visitors. The program is designed to assure identification of general and high security risks and to develop effective responses.

Scope

The program is applied to the Main Hospital Campus, FHC, Urgent Care Sites, and any property owned by the Ector County Hospital District.

Principles

- A visible security/police presence in the hospital helps reduce crime and increase feelings of security by patients, visitors, and staff.
- Assessment of risks to identify potential problems is key to reducing crime, injury, and other incidents.
- Analysis of security incidents provides information to predict and prevent crime, injury, and other incidents.
- Training hospital staff is critical to their performance. Staff members are trained to recognize and report either potential or actual incidents to ensure a timely response. Staff members in sensitive areas are trained about the protective measures designed for those areas and their responsibilities to assist in protection of patients, visitors, staff and property.
- Violence in the workplace is a growing problem in healthcare. It is necessary to develop a program to address workplace violence.

Objectives

- Patrol the hospital buildings and property on a consistent basis, to identify and document potential or actual problems.
- Take appropriate and timely action to prevent crime, injury, or property loss.
- Establish and maintain security/police policies and procedures to direct staff performance when responding to security incidents. Security policies are reviewed annually.
- Provide timely response to emergencies and requests for assistance. Report any fire, injury, or other incidents. Communicate externally with local, state, or federal law enforcement and other civil authorities. Provide internal communications, as needed.
- Control vehicle movement on system grounds, including control of parking and access to the Emergency Department.
- Provide timely response to reports of violent activity or requests for assistance in restraining violent or aggressive patients, visitors, and/or staff.

- Limit access to the grounds, building, and sensitive areas by enforcement of staff identification policies and by assisting in the removal of persons from unauthorized areas.
- Provide timely response to requests for escort, keys and door openings, or other routine requests for assistance.
- Provide Security Management Training of all new employees including what types of incidents Police or Security Department staff can respond to, how to report incidents and obtain assistance in an emergency and training for staff in designated sensitive areas.
- Manage a documentation system for security incidents.
- Document police department activity; including investigations, routine patrol activity, special and routine requests for assistance, and other activities.
- Identify problems, failures, and user errors that require attention and action. These are reported to the Safety Committee monthly.
- Identify performance improvement opportunities.
- Conduct an annual evaluation of the scope, objectives, performance, and effectiveness of the program.
- Evaluate the potential for workplace violence and develop an appropriate program to deal with it.

Program Management Structure

- The ECHD Board of Directors receives regular reports on the activities of the Security Program from the Safety Committee and Patient Safety and Quality Council. The Board of Directors reviews, reports and, as appropriate, communicates concerns about identified issues and regulatory compliance. The Board of Directors provides support to facilitate the ongoing activities of the Security Program.
- The CEO receives regular reports on the activities of the Security Program. The CEO reviews reports and, as appropriate, communicates concerns about key issues and regulatory compliance to the Chairman of the Safety Committee or other appropriate personnel. The Chief Operating Officer collaborates with the Chief of Police to establish operating and capital budgets of the Security Program.

- The Chief of Police works under the general direction of the Chief Operating Officer. The Chief of Police in collaboration with other department heads, and the Safety Committee, manages all aspects of the Security Program. The Chief of Police advises the Safety Committee regarding security issues which may necessitate changes to policies, orientation or education, or purchase of equipment.

- Department heads will assure orientation of all new personnel to the department and, as appropriate, to job and task specific security procedures. Department heads with security sensitive areas are responsible for training their personnel in any special security procedures or precautions. Where necessary, the Chief of Police assists department heads in developing department security programs or policies.

- Individual personnel are responsible for learning and following hospital and departmental procedures for security.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE4 SR 1	**The organization shall develop a Security Management System that provides for a secure environment.** Note:	• Annual review of crime statistics submitted to the Board • Annual report submitted to the EOC Committee • MCH-4010
PE4 SR 2	**The organization shall meet the requirements set forth in NFPA 99, 2012 Chapter 13, Security Management**. Note:	• Each element is identified in the Annual Security Vulnerability Assessment
PE4 SR 3	**The Security Management System shall require that the organization conduct a security vulnerability assessment (SVA) and shall implement procedures and controls in accordance with the risks identified by the SVA.** Note:	• Security Vulnerability Assessment

PE4 SR 4	**The Security Management System shall at a minimum:** Note:	
PE4 SR 4a	**Provide for identification of patients, employees and others.** Note:	• MCH-4037 • MCH-3000
PE4 SR 4b	**Address issues related to abduction, elopement, visitors, workplace violence, cybersecurity, and investigation of property losses.** Note:	• MCH-4013 • NADM-0009 • MCH-4015 • MCH-4031 • HPD-1022 • HPD-1003 • HPD-1011 • MCH-1046
PE4 SR 4c	**Develop and implement a written, comprehensive workplace violence control and prevention program based on the current edition of OSHA Publication 3148 Guidelines for Preventing Workplace Violence for Healthcare and Social Workers.** Note:	• MCH-4015
PE4 SR 4d	**Establish emergency security procedures to include all hazard events identified in the SVA.** Note:	
PE4 SR 4e	**Require vehicular access to emergency service areas.** Note:	• See HPD-1010 • HPD-1061
PE$ SR 4f	**Require a process for reporting and investigating security related issues.** Note:	• MCH-4001

Evaluation of Plan

On an annual basis, the Security Department will evaluate the objectives, scope, effectiveness, and performance of the Security Management Plan. Any changes in objectives will be addressed during the Annual Evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The Security Department collaborates with the EOC Committee and other appropriate associates to convey and address any security issues and/or concerns.

The Annual Evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with security of the facility.

Performance Indicators

- Goal 2024

2024 Goal	**Evaluation**

• As recognized by DNV, enhance the work place violence program and reporting system
  ○ Hands on training
  ○ Analysis
  ○ Education
  ○ Annual review
	• Provided mandatory in-person training to all staff on de-escalation and Civilian Response to Active Shooter Events (CRASE)
	• Online mandatory Workplace Violence training for all staff through mynetlearning.
	• Review workplace violence submissions and results quarterly through workplace violence committee.

• Improve and sustain campus lighting in designated areas
  ○ Monthly rounding
  ○ Report to facilities for repair
	• Police/security conducted monthly rounds of the parking structures and outer clinics for light functionality.
	• Reported monthly in the EOC

- Goals 2025

2025 Goal	**How to……**
QAPI: IN FY 25, the PBX Department will reduce the number of dropped calls monthly from 4.5% to 3% on a rolling average for the year	**In FY25, the ECHD PD will increase their presence and rounding in the ED to 95% or better**
• Maintain a visibility of police security presence in the Emergency Department (ED) by rounding at a minimum of once an hour, to deter workplace violence incidents.	• CCure guard tour established throughout the ED • Reviewed monthly through the CCure guard report and officers/guard's daily logs. • Review performance with all staff during department meetings.
• Maintain the proper functionality of all silent panic alarms throughout MCHS properties, to provide a better response to incidents to reduce workplace violence.	• Quarterly testing of all MCHS silent panic alarms by police supervisors • All malfunctioning silent panic alarms will be reported to the Chief of Police. • The Chief of Police will work with the vendor to have all repairs completed as quickly as possible.

Medical Center Health System
Utility Management Plan

Purpose

The environment of care and the range of patient care services provided to the patients served by Medical Center Hospital (MCH) present unique challenges. A utility management plan (UMP) is in place and is developed using various risk criteria to establish selection, maintenance, testing, and inspection procedures to eliminate or reduce the probability of adverse patient outcomes.

The Utility Systems Management Plan describes the management activities that MCH has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The management plan and its utility systems management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

Scope

The Utility Systems Management Plan and programs apply to all facilities, Main Hospital Campus, FHC, Urgent Care Sites and to all processes, activities and departments, as well as to patients, staff, and visitors at Medical Center Health System.

All critical elements of the utility systems used for life support, infection control, environmental support, equipment support, and communications will be included in the program. The Utility Systems Management Plan addresses the safe operation, maintenance, and emergency response procedures for these critical operating systems. Utilities include systems for electrical distribution, emergency power, heating, ventilating, and air conditioning, plumbing, boiler and steam, medical gas, medical/surgical vacuum, and communication systems.

Principles

- Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.

- Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe effective

care and treatments are rendered to persons receiving services.

- Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

Objectives

The objectives of the Utility Systems Management Plan include:

- Comply with all relevant safety standards and regulations.
- Provide a safe, controlled, and comfortable environment for patients, staff, and visitors.
- Ensure the operational reliability of the utility systems:
    - Direct Life Support systems
    - Infection Control systems
    - Non-Life Support utility support systems
- Reduce the potential for hospital-acquired illness.
- Assess special risks of the utility systems.
- Provide a plan for response to utility systems failures.
- Effect essential coordination for scheduled utility systems interruptions.
- Establish and maintain a program of policies and procedures consistent with the organization's mission, vision, and values.
- Enhance of maintenance of the utility systems to reduce and minimize system failures and/or interruptions.

Program Management Structure

- The Director of Facilities assures that an appropriate utility system maintenance program is implemented. The Director of Facilities also collaborates with the Safety Officer to develop reports of UMP performance for presentation to the Environment of Care Committee on a quarterly basis. The reports summarize organizational experience, performance management, improvement activities, and other utility systems issues.

- The MCH Senior Leadership Team receives regular reports of the activities of the USM program through the Quality Council. The Chief Operating Officer collaborates with the Director of Facilities and other appropriate staff to address utility system issues and concerns. The Chief Operating Officer also collaborates with the Director of Facilities to develop a budget and operational objective for the program.

- The facility maintenance technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

- Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE8 SR1	**The organization shall require a Utility Management System that provides for a safe and efficient facility that reduces the opportunity for organization-acquired illnesses.** Note:	HEMS work order: Procedures 528, 540, 545, 546, 559, 584
PE8 SR1a	**The Utility Management System shall have a water management program to reduce the risk of growth and spread of legionella and other opportunistic pathogens in building water systems.**	MCH-1204
PE8 SR2	**The Utility Management System shall provide for a process to evaluate critical operating components, to include, but not limited to cybersecurity issues.** Note:	All critical operating components are inventoried & scheduled PM's are in HEMS System
PE8 SR3	**The Utility Management System shall develop maintenance, testing, and inspection processes for critical utilities.** Note:	All critical utilities are inventoried & scheduled PM's are in HEMS System
PE8 SR4	**The Utility Management System shall contain a process to address medical gas systems and HVAC systems (e.g., includes areas for negative pressure).**	HEMS work order: Procedure 545

	Note:	
PE8 SR5	**The Utility Management System shall provide for emergency processes for utility system failures or disruptions.** Note:	HEMS work order: Procedure 543
PE8 SR6	**The Utility Management System shall provide for reliable emergency power sources with appropriate maintenance as required. The organization shall implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.** Note:	HEMS work order: Procedure 51, 542, 543
PE8 SR7	**The Utility Management System shall require proper ventilation, light and temperature controls in patient care areas, operating rooms, sterile supply rooms, special procedures, isolation and protective isolation rooms, pharmaceutical, food preparation, and other appropriate areas.** Note:	HEMS work order: Procedures 523, 533, 545, 575
PE8 SR8	**There shall be emergency power and lighting in at least the operating, recovery, intensive care, emergency rooms, and in other areas where invasive procedures are conducted, stairwells, and other areas identified by the organization (e.g., blood bank refrigerator, etc.). In all other areas not serviced by the emergency supply source, battery lamps and flashlights shall be available.** Note:	HEMS work order: Procedures 523, 533
PE8 SR8a	**Emergency lighting standards shall comply with Section 7.9 of the Life Safety Code, 101-2012, and applicable references, such as, NFPA-99, 2012: Health Care Facilities, for emergency lighting and emergency power.** Note:	HEMS work order: Procedures 86, 523, 533, 541, 542, 543
PE8 SR8b	**NFPA 99, 2012 6.3.2.2.11 Battery-Powered Lighting Units, shall apply to new and existing healthcare facilities and shall be installed in accordance with NFPA 70, National Electric Code, 2011 edition.**	Installation is in accordance with IBC NFPA occupancy Type

	Note:	Group 1. Construction Type 1B Sprinkled
PE8 SR9	**There shall be facilities for emergency gas and water supply.** Note:	Emergency water supply is under an MOU with Culligan
PE8 SR10	**All relevant utility systems shall be maintained inspected, and, tested.** Note: Please refer to documents	Please refer to HEMS System & testing schedule

Evaluation of Plan

On an annual basis, the Engineering Director will evaluate the objectives, scope, effectiveness, and performance of the utility Management Plan. Any changes in objectives will be addressed during the Annual Evaluation and incorporated into the updated plan.

The EOC Committee receives regular reports of the program activities monthly basis. The engineering director collaborates with the EOC Committee and other appropriate associates to convey and address any utility issues and/or concerns.

The Annual Evaluation objectives are developed through interactions with the EOC Committee and hospital administration. These objectives will address the primary operational initiatives for minimizing the risk associated with utility safety.

Performance Indicators

- Goals 2024

2024 Goal Performance	**Evaluation**
○ Improve preparation time for the utility disruption assessment process by assessing each disruption 3 days prior to planned utility shutdown. ▪ Complete 95% of scheduled utility disruption assessments at a minimum of 72 hours prior to project start.	Goal was completed and the practice will continue in order to stay compliant with utility processes and mitigation for clinical staff.

- Goal 2025

Goal 2025	**Action Plan**
QAPI: Increase the compliance of pressure relations rooms from current to 95% compliance	**Utilizing weekly team rounding, improving the documentation and tracking, installing more continuous monitoring equipment, and having third party vendors onsite**
Develop and implement a program designed to monitor all major utilities up time and costs related to maintenance and upkeep	• Create a list of all major utilities • Create graphs to display uptime versus downtime • Align costs with equipment to monitor all dollars spent on each piece of equipment