ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING
SEPTEMBER 82022 – 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 ..... Bryn Dodd, President

II. INVOCATION ..... Chaplain Doug Herget

III. PLEDGE OF ALLEGIANCE ..... Bryn Dodd

IV. MISSION / VISION / VALUES OF MEDICAL CENTER HEALTH SYSTEM ..... David Dunn (p.3)

V. AWARDS AND RECOGNITION

A. September 2022 Associates of the Month ..... Russell Tippin

- Clinical - Rikki Bradley
- Non-Clinical - Catalina Morales
- Nurse – Megan Escontrias

B. Unit HCHAPS High Performers ..... Russell Tippin

- CCU
- Dr. Raymond Martinez
- Jackie Lehr, NP
- MCH Wound Care
- WSMP OR

VI. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

VII. PUBLIC COMMENTS ON AGENDA ITEMS

VIII. CONSENT AGENDA ..... Bryn Dodd (p.4-34)
(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, August 2, 2022
B. Consider Approval of Joint Conference Committee, August 23, 2022
C. Consider Approval of Federally Qualified Health Center Monthly Report, July 2022

IX. COMMITTEE REPORTS

A. Finance Committee ..... Wallace Dunn (p.35-98)
1. Financial Report for Month Ended July 31, 2022
2. Capital Expenditure Budget Update
3. Consent Agenda
    a. Consider Approval of Culligan Agreement Renewal
    b. Consider Approval of Breakaway PromisePoint Access/Community Services Contract Extension
    c. Consider Approval of Invita Healthcare Tissue Tracking System Amendment
4. Consider Ratification of Emergency Purchase of Police Patrol Vehicle

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

XI. QAPI 2023 ANNUAL GOALS AND SAFETY PLANS ..... Christin Timmons (p.99-190)

XII. CMS STAR RATING UPDATE ..... Christin Timmons (p.191-209)

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

A. Staff Update
B. Budget Presentation & Ad Valorem Tax Rate Meeting Date
C. CDC Update – Monkey Pox
D. Ad hoc Report(s)

XIV. 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 Real Property pursuant to Section 551.072 of the Texas Government Code; and (3) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code.

XV. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. CONSIDER APPROVAL OF MCH PROCARE PROVIDER AGREEMENT(S)
B. CONSIDER APPROVAL OF MCH PROPERTY LEASE AGREEMENT(S)
C. CONSIDER APPROVAL OF MCH ON-CALL AGREEMENT

XVI. ADJOURNMENT ..... Bryn Dodd

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
AUGUST 2, 2022 – 5:30 p.m.

MINUTES OF THE MEETING

MEMBERS PRESENT:	Bryn Dodd, President Mary Lou Anderson Richard Herrera Don Hallmark Kathy Rhodes
MEMBERS ABSENT:	Wallace Dunn David Dunn
OTHERS PRESENT:	Russell Tippin, President/Chief Executive Officer Steve Steen, Chief Legal Counsel Steve Ewing, Chief Financial Officer Matt Collins, Chief Operating Officer Christin Timmons, Chief Nursing Officer Adiel Alvarado, President MCH ProCare Kerstin Connolly, Paralegal Lisa Russell, Executive Assistant to the CEO
OTHERS PRESENT:	Various other interested members of the Medical Staff, employees, and citizens

I. CALL TO ORDER

Bryn Dodd, 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. INVOCATION

Chaplain Doug Herget offered the invocation.

III. PLEDGE OF ALLEGIANCE

Bryn Dodd led the Pledge of Allegiance to the United States and Texas flags.

IV. MISSION/VISION OF MEDICAL CENTER HEALTH SYSTEM

Richard Herrera presented the Mission, Vision and Values of Medical Center Health System.

V. AWARDS AND RECOGNITION

A. August 2022 Associates of the Month

Russell Tippin, President/Chief Executive Officer, introduced the August 2022 Associates of the Month as follows:

- Clinical – Maria Torres
- Non-Clinical – Sophie Pangan
- Nurse – David Cotter, RN

B. Unit HCAHPS High Performers

Russell Tippin, Chief Executive Officer, introduced the Unit HCAHPS High Performer(s)

- ProCare Cardio - Crane, Andrews, Pecos, and MC
- Dr. Farber

VI. CONFLICT OF INTEREST DISCLOSURE BY ANY BOARD MEMBER

No conflicts were disclosed.

VII. PUBLIC COMMENTS ON AGENDA ITEMS

No comments from the public were received.

VIII. CONSENT AGENDA

A. Consider Approval of Regular Meeting Minutes, July 7, 2022
B. Consider Approval of Joint Conference Committee, July 26, 2022
C. Consider Approval of Federally Qualified Health Center Monthly Report, June 2022
D. Consider Approval of *Updated* Annual ECHD Board Committee Appointments by Board President

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

IX. COMMITTEE REPORTS

A. Finance Committee

1. Quarterly Investment Report – Quarter 3, FY 2022
2. Quarterly Investment Officer's Certification
3. Financial Report for Month Ended June 30, 2022
4. Capital Expenditure Budget Update
5. Consider Approval of R1 Amendment for CDI Management Services
6. Consider Ratification of Healthfuse Agreement

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

X. TTUHSC AT THE PERMIAN BASIN REPORT

No report was provided.

XI. COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

Christin Timmons, Chief Nursing Officer, presented the Community Health Needs Assessment and Implementation Plan to the Board.

Kathy Rhodes moved, and Mary Lou Anderson seconded the motion to approve the Community Health Needs Assessment and Implementation Plan as presented. The motion carried.

XII. UTILIZATION REVIEW PLAN

Christin Timmons, Chief Nursing Officer, presented the Utilization Review Plan for approval.

Richard Herrera moved, and Kathy Rhodes seconded the motion to approve the Utilization Review Plan as presented. The motion carried.

XIII. NURSING WORKFORCE UPDATE

Christin Timmons, Chief Nursing Officer, presented the Nursing Workforce Update for approval.

Kathy Rhodes moved, and Mary Lou Anderson seconded the motion to approve the Nursing Workforce Update as presented. The motion carried.

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

A. Review of Certified Property Values

Russell Tippin reported that there was a 13% increase in the property values, up to $17 billion dollars. The tax rate for the Hospital will remain the same at $0.15, no new revenue.

This report was informational only. No action was taken.

B. CMO Search Update

Russel Tippin reported to the Board that Dr. Meredith Hulsey has accepted the position for Chief Medical Officer.

This report was informational only. No action was taken.

C. Charity Care Valuation

Steve Ewing, Chief Financial Officer, provided information from a Wall Street Journal article to the board about the levels of charity care that for-profit hospitals provide compared to not-for-profit hospital. MCH reported providing $29 million dollars in one year.

This report was informational only. No action was taken.

D. Ad hoc Report(s)

There are 18 Covid-19 patients in house today.

The THT Conference was in Fort Worth last week

An article in the Odessa American reports that MCH and MMH are moving and consolidating. MCH has been downtown for 75 years and no one at the Hospital or on the Board has the authority to move MCH – only the voters have that authority.

MCH was recipient of the OA Reader's Choice Award.

The Regional Services Report was provided.

These reports were informational only. No action was taken.

The Policy to consolidate the various Covid-19 polices was discussed.

Don Hallmark moved, and Kathy Rhodes seconded the motion to approve the consolidation of the Covid-19 policies. The motion carried.

XV. EXECUTIVE SESSION

Bryn Dodd stated that the Board would go into Executive Session for the meeting held in closed session involving any of the following: (1) Consultation with attorney regarding legal matters and legal issues pursuant to Section 551.071 of the Texas Government Code; (2) Deliberation Regarding Real Property pursuant to Section 551.072 of the Texas Government Code; (3) Deliberation regarding negotiations for health care services, pursuant to Section 551.085 of the Texas Government Code; and (4) Deliberation and evaluation of officers and employees of Ector County Hospital District pursuant to Section 551.074 of the Texas Government Code.

ATTENDEES for the entire Executive Session: ECHD Board members, Bryn Dodd, Mary Lou Anderson, Richard Herrera, Don Hallmark, Kathy Rhodes, Russell Tippin, President and CEO, Steve Steen, Chief Legal Counsel and Kerstin Connolly, Paralegal.

Adiel Alvarado, President of MCH ProCare, presented the provider agreements 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 a property lease agreement to the ECHD Board of Directors, reported to the board about the Lincoln Ave Property and led the board in discussion about the Strategic Plan during Executive Session and then was excused from the remainder of Executive Session.

Russell Tippin, President/Chief Executive Officer, led the board in discussion about the budget meetings in September during Executive Session.

Steve Steen, Chief Legal Counsel, led the board in discussion in modifying the CEO's agreement.

Executive Session began at 6:34 p.m.
Executive Session ended at 8:15 p.m.

XVI. ITEMS FOR CONSIDERATION FROM EXECUTIVE SESSION

A. Consider Approval of MCH ProCare Provider Agreement(s).

Bryn Dodd presented the following new agreements:

- Chineme Chima-Niewem, MPAS, PA-C – This a three (3) year agreement for a Pain Management Contract.
- Gaybrielle Marquez, FNP – This is a three (3) year Cardiology Contract.
- Genevieve Okafor, M.D.. – This is a three (3) year agreement for a Family Medicine Contract.
- Equity Anesthesia Staffing, LLC – This is three (3) year Anesthesia Contract.

Bryn Dodd presented the following amendments:

- Raymond Martinez, M.D. – This is an amendment to an OB/GYN Contract.
- Jackie Lehr, WHNP – This is an amendment to OB/GYN Contract.
- Mandeep Othee, M.D. – This is an amendment to a Pain Management Contract.
- Kalyan Chakrala, M.D. – This is an amendment to a Gastroenterology Contact.
- Elliana Wiesner, M.D. – This is an amendment to a Hospitalist Contract.
- West Texas Ear, Nose, Throat & Sinus Institute – This is an amendment to the Lease Agreement.

Bryn Dodd presented the following renewal agreements:

- Jorge Alamo, M.D. – This is a three (3) year renewal of a Family/Occ Med Contract.
- Christi Tucker, N.P. – This is a three (3) year renewal of a Hospitalist Contract.
- Fouzia Tabasam, M.D. – This is a three (3) year renewal of an Hospitalist Contract
- Sindhu Kaitha, M.D. – This is a three (3) year renewal of a Gastroenterology Contract.

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

B. Consider Approval of MCH Property Lease Agreement

Bryn Dodd presented the following MCH Property Lease Agreement:

- West Texas Urology, PA – This is a one (1) year lease agreement.

Richard Herrera moved, and Mary Lou Anderson seconded the motion to approve the MCH Property Lease Agreement as presented. The motion carried.

C. Sale of MCH Property

This item was tabled. No action was taken.

D. Chief Executive Officer Agreement

The $250.00 monthly cell phone reimbursement expense will now be included in the annual salary figure.

Don Hallmark moved, and Richard Herrera seconded the motion to include the $250.00 monthly amount for the cell phone expense in the annual salary figure. The motion carried.

XVII. ADJOURNMENT

There being no further business to come before the Board, Bryn Dodd adjourned the meeting at 8:20 p.m.

Respectfully submitted,

Steve Steen, Chief Legal Counsel
Ector County Hospital District

Medical Center Hospital
A Member of Medical Center Health System

September 8, 2022

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

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

Statement of Pertinent Facts:
Pursuant to Article 3 of the Medical Staff Bylaws, 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
*Lakshmi Alahari, MD	Hospitalist	Hospitalist	ProCare	09/08/2022-09/07/2023
Kevin Harbourne, MD	Anesthesia	Anesthesia	ProCare	09/08/2022-09/07/2023
Sonya Kella, MD	Radiology	Telemedicine	VRAD	09/08/2022-09/07/2023
Blane Womack, MD	Emergency Medicine	Emergency Medicine	BEPO	09/08/2022-09/07/2023

Allied Health:

Applicant	Department	AHP Category	Specialty/ Privileges	Group	Sponsoring Physician(s)	Dates
Ashlyn Duncan, NP	Medicine	AHP	Nurse Practitioner	ProCare	Dr. Ayyagari and Dr. Azarov	09/08/2022-09/07/2024
*Catherine Eaton, NP	Medicine	AHP	Nurse Practitioner		Dr. Spellman	09/08/2022-09/07/2024

*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.

Donald Davenport, DO Chief of Staff
Executive Committee Chair
/MM

Medical Center Hospital
A Member of Medical Center Health System

September 8, 2022

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 Staff as 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
Mumtaz Suleman, MD	Medicine	Yes	Associate	Psychiatry	Amwell	None	10/1/2022-09/30/2023
Pauravi Rana, MD	Medicine	Yes	Associate	Psychiatry	Amwell	None	10/1/2022-09/30/2023
Wojciech Zolcik, MD	Medicine	Yes	Associate	Psychiatry	Amwell	None	10/1/2022-09/30/2023
Asif Ansari, MD	Medicine	Yes	Active	Nephrology		None	10/1/2022-09/30/2024
Manuel Castillo, MD	Pediatric	Yes	Active	Pediatrics		None	10/1/2022-09/30/2024
Charles Henry, MD	Radiology	Yes	Telemedicine	Telemedicine	VRAD	None	10/1/2022-09/30/2024
Mary Huff, MD	Radiology	Yes	Telemedicine	Telemedicine	VRAD	None	10/1/2022-09/30/2024
Steven Irving, MD	Emergency Medicine	Yes	Active	Emergency Medicine	BEPO	None	10/1/2022-09/30/2024
Sindhu Kaitha, MD	Medicine	Yes	Active	Gastroenterology	ProCare	None	10/1/2022-09/30/2024
Joshua Levinger, MD	Surgery	Yes	Associate to Active	Otolaryngology	ProCare	None	10/1/2022-09/30/2024
Donald Nicell, MD	Radiology	Yes	Telemedicine	Telemedicine	VRAD	None	10/1/2022-09/30/2024
Ikemefuna Okwuwa, MD	Family Medicine	Yes	Active	Family Medicine	TTUHSC	None	10/1/2022-09/30/2024
Martin Ortega, MD	Family Medicine	Yes	Active	Family Medicine	TTUHSC	None	10/1/2022-09/30/2024
Abbie Schuster, MD	Surgery	Yes	Associate to Active	General Surgery		None	10/1/2022-09/30/2024
Shelton Viney, MD	Surgery	Yes		General Surgery	TTUHSC	None	10/1/2022-09/30/2024
Michelle Melotti, MD	Radiology	Yes	Telemedicine	Telemedicine	VRAD	None	11/1/2022-10/31/2024
Arlene Sussman, MD	Radiology	Yes	Telemedicine	Telemedicine	VRAD	None	11/1/2022-10/31/2024

Medical Center Hospital
A Member of Medical Center Health System

Allied Health Professionals:

Applicant	Department	AHP Category	Specialty / Privileges	Group	Sponsoring Physician(s)	Changes to Privileges	Dates
Rhoena Obafial, CRNA	Anesthesia	AHP	CRNA	ProCare	Dr. Gillala, Dr. Bhari, Dr. Bryan, Dr. Reddy, Dr. Hwang, Dr. Batch Dr. Bangalore	None	10/1/2022-09/30/2024
Pedro Torres, PA	Emergency Medicine	AHP	Physician Assistant	BEPO	Dr. Shipkey and Dr. Slater	None	10/1/2022-09/30/2024

***Requesting Temporary Privileges**

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.

Donald Davenport, DO Chief of Staff Executive Committee Chair
/MM

Medical Center Hospital
A Member of Medical Center Health System

September 8, 2022

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
Glen Bennion, MD	OB/GYN	**ADDING: DaVinci Surgical System**
Judith Birungi, MD	Surgery	**ADDING: DaVinci Surgical System**
Mary Bridges, MD	OB/GYN	**ADDING: DaVinci Surgical System**
*Gaybrielle Marquez, NP	Cardiology	**ADDING: Exercise Stress ECG Testing**
Abbie Schuster, MD	Surgery	**ADDING: Alimentary Tract Surgery**

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.

Donald Davenport, DO Chief of Staff
Executive Committee Chair
/MM

Medical Center Hospital
A Member of Medical Center Health System

September 8, 2022

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
Michael Auringer, MD	Affiliate	Family Medicine	7/31/2022	Resignation
James Burks, MD	Active	Medicine	1/11/2022	Resignation
Malik Farooq, MD	Associate	Psychiatry	07/13/2022	Resignation
Marie Gue, CRNA	AHP	Anesthesia	08/08/2022	Resignation
Mark Hinton, MD	Associate	Psychiatry	07/13/2022	Resignation
Roger Joe, MD	Associate	Psychiatry	07/13/2022	Resignation

Advice, Opinions, Recommendations and Motion:

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

Donald Davenport, DO Chief of Staff
Executive Committee Chair
/MM

September 8, 2022

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 change as noted below.

Staff Category Change:

Staff Member	Department	Category
Abbie Schuster, MD	Surgery	Associate to Active

Changes to Credentialing Dates:

Staff Member	Staff Category	Department	Dates
Putta Shankar Bangalore Annaiah, MD	Associate	Anesthesia	08/01/2022 – 07/31/2023*

Changes of Supervising Physician(s):

Staff Member	Group	Department
None		

Leave of Absence:

Staff Member	Staff Category	Department	Effective Date	Action
Abbie Schuster, MD	Associate	Surgery		Extend LOA - 9/30/2022

Removal of I-FPPE

Staff Member	Department	Removal/Extension
None		

September 8, 2022

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Proctoring Request(s)/Removal(s)

Staff Member	Department	Privilege(s)
None		

Change in Privileges

Staff Member	Department	Privilege
None		

September 8, 2022

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

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 staff category changes, changes to the credentialing dates, changes of supervising physicians, leave of absence, removal of I-FPPE, proctoring requests/removals, and change in privileges.

Donald Davenport, DO Chief of Staff
Executive Committee Chair
/MM

September 8, 2022

ECTOR COUNTY HOSPITAL DISTRICT
BOARD OF DIRECTORS

Item to be considered:

QAPI Plan

Statement of Pertinent Facts:
The Medical Executive Committee and the Joint Conference Committee recommends approval of the following:

QAPI 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 QAPI Plan

Donald Davenport, DO, Chief of Staff
Executive Committee Chair
/MM

Family Health Clinic
September 2022
ECHD Board Packet

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CENTERS COMBINED - OPERATIONS SUMMARY
JULY 2022

	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	$ 512,360	$ 651,582	-21.4%	$ 500,409	2.4%	$ 5,566,671	$ 6,918,728	-19.5%	$ 5,154,836	8.0%
TOTAL PATIENT REVENUE	$ 512,360	$ 651,582	-21.4%	$ 500,409	2.4%	$ 5,566,671	$ 6,918,728	-19.5%	$ 5,154,836	8.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 268,984	$ 337,933	-20.4%	$ 278,700	-3.5%	$ 3,148,660	$ 3,543,013	-11.1%	$ 2,793,173	12.7%
Self Pay Adjustments	8,605	91,247	-90.6%	23,721	-63.7%	450,053	960,657	-53.2%	682,638	-34.1%
Bad Debts	34,382	13,972	146.1%	54,772	-37.2%	158,530	150,618	5.3%	248,785	-36.3%
TOTAL REVENUE DEDUCTIONS	$ 311,971	$ 443,152	-29.6%	$ 357,193	-12.7%	$ 3,757,244	$ 4,654,288	-19.3%	$ 3,724,596	0.9%
	60.89%	68.01%		71.38%		67.50%	67.27%		72.25%	
NET PATIENT REVENUE	$ 200,388	$ 208,430	-3.9%	$ 143,216	39.9%	$ 1,809,427	$ 2,264,440	-20.1%	$ 1,430,240	26.5%
OTHER REVENUE										
FHC Other Revenue	$ 40,046	$ 25,436	57.4%	$ 64,349	-37.8%	$ 278,257	$ 254,360	9.4%	$ 407,773	-31.8%
TOTAL OTHER REVENUE	$ 40,046	$ 25,436	57.4%	$ 64,349	-37.8%	$ 278,257	$ 254,360	9.4%	$ 407,773	-31.8%
NET OPERATING REVENUE	$ 240,434	$ 233,866	2.8%	$ 207,565	15.8%	$ 2,087,684	$ 2,518,800	-17.1%	$ 1,838,013	13.6%
OPERATING EXPENSE										
Salaries and Wages	$ 103,890	$ 108,092	-3.9%	$ 84,377	23.1%	$ 953,930	$ 1,119,809	-14.8%	$ 932,491	2.3%
Benefits	10,591	31,719	-66.6%	15,211	-30.4%	79,783	320,207	-75.1%	255,039	-68.7%
Physician Services	148,482	156,823	-5.3%	138,363	7.3%	1,669,489	1,568,230	6.5%	1,363,876	22.4%
Cost of Drugs Sold	2,606	13,629	-80.9%	3,118	-16.4%	194,548	134,521	44.6%	84,786	129.5%
Supplies	7,341	19,991	-63.3%	15,158	-51.6%	72,067	225,802	-68.1%	138,514	-48.0%
Utilities	2,990	10,425	-71.3%	5,356	-44.2%	55,610	86,349	-35.6%	56,178	-1.0%
Repairs and Maintenance	1,642	2,216	-25.9%	19,232	-91.5%	32,679	22,160	47.5%	28,291	15.5%
Leases and Rentals	484	977	-50.4%	468	3.4%	4,864	9,770	-50.2%	4,944	-1.6%
Other Expense	1,000	1,542	-35.1%	5,253	-81.0%	14,012	15,420	-9.1%	41,164	-66.0%
TOTAL OPERATING EXPENSES	$ 279,026	$ 345,414	-19.2%	$ 286,536	-2.6%	$ 3,076,980	$ 3,502,268	-12.1%	$ 2,905,284	5.9%
Depreciation/Amortization	$ 28,692	$ 33,792	-15.1%	$ 32,079	-10.6%	$ 287,279	$ 331,386	-13.3%	$ 329,762	-12.9%
TOTAL OPERATING COSTS	$ 307,718	$ 379,206	-18.9%	$ 318,615	-3.4%	$ 3,364,259	$ 3,833,654	-12.2%	$ 3,235,046	4.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (67,284)**	**$ (145,340)**	**-53.7%**	**$ (111,050)**	**-39.4%**	**$ (1,276,575)**	**$ (1,314,854)**	**-2.9%**	**$ (1,397,033)**	**-8.6%**
Operating Margin	-27.98%	-62.15%	-55.0%	-53.50%	-47.7%	-61.15%	-52.20%	17.1%	-76.01%	-19.6%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	1,656	2,005	-17.4%	1,670	-0.8%	18,455	21,352	-13.6%	15,404	19.8%
Average Revenue per Office Visit	309.40	324.98	-4.8%	299.65	3.3%	301.63	324.03	-6.9%	334.64	-9.9%
Hospital FTE's (Salaries and Wages)	25.7	26.0	-1.3%	19.2	33.4%	22.8	28.1	-18.9%	20.5	11.1%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - SOUTH - OPERATIONS SUMMARY
JULY 2022

	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	$ 121,922	$ 330,349	-63.1%	$ 385,240	-68.4%	$ 1,630,401	$ 3,362,492	-51.5%	$ 4,543,757	-64.1%
TOTAL PATIENT REVENUE	$ 121,922	$ 330,349	-63.1%	$ 385,240	-68.4%	$ 1,630,401	$ 3,362,492	-51.5%	$ 4,543,757	-64.1%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 75,929	$ 179,671	-57.7%	$ 218,334	-65.2%	$ 986,901	$ 1,828,802	-46.0%	$ 2,463,628	-59.9%
Self Pay Adjustments	2,561	51,543	-95.0%	23,525	-89.1%	257,959	524,632	-50.8%	612,861	-57.9%
Bad Debts	4,729	10,557	-55.2%	41,155	-88.5%	(68,730)	107,458	-164.0%	278,806	-124.7%
TOTAL REVENUE DEDUCTIONS	$ 83,219	$ 241,771	-65.6%	$ 283,015	-70.6%	$ 1,176,129	$ 2,460,892	-52.2%	$ 3,355,295	-64.9%
	68.3%	73.2%		73.5%		72.1%	73.2%		73.8%	
NET PATIENT REVENUE	$ 38,703	$ 88,578	-56.3%	$ 102,226	-62.1%	$ 454,271	$ 901,600	-49.6%	$ 1,188,462	-61.8%
OTHER REVENUE										
FHC Other Revenue	$ 40,046	$ 25,436	0.0%	$ 64,349	-37.8%	$ 278,257	$ 254,360	0.0%	$ 407,773	-31.8%
TOTAL OTHER REVENUE	$ 40,046	$ 25,436	57.4%	$ 64,349	-37.8%	$ 278,257	$ 254,360	9.4%	$ 407,773	-31.8%
NET OPERATING REVENUE	$ 78,749	$ 114,014	-30.9%	$ 166,574	-52.7%	$ 732,529	$ 1,155,960	-36.6%	$ 1,596,234	-54.1%
OPERATING EXPENSE										
Salaries and Wages	$ 71,437	$ 59,260	20.5%	$ 70,859	0.8%	$ 744,215	$ 592,458	25.6%	$ 857,702	-13.2%
Benefits	7,282	17,390	-58.1%	12,774	-43.0%	62,243	169,412	-63.3%	234,584	-73.5%
Physician Services	56,661	68,581	-17.4%	97,533	-41.9%	839,817	685,810	22.5%	1,131,152	-25.8%
Cost of Drugs Sold	330	2,996	-89.0%	3,118	-89.4%	33,084	30,499	8.5%	65,328	-49.4%
Supplies	(2,898)	4,444	-165.2%	8,267	-135.0%	29,240	45,040	-35.1%	128,269	-77.2%
Utilities	443	3,965	-88.8%	2,649	-83.3%	29,300	29,686	-1.3%	28,370	3.3%
Repairs and Maintenance	1,642	1,799	-8.7%	19,232	-91.5%	32,679	17,990	81.7%	28,291	15.5%
Leases and Rentals	484	477	1.5%	468	3.4%	4,864	4,770	2.0%	4,944	-1.6%
Other Expense	1,000	1,125	-11.1%	5,253	-81.0%	14,012	11,250	24.5%	41,164	-66.0%
TOTAL OPERATING EXPENSES	$ 136,382	$ 160,037	-14.8%	$ 220,153	-38.1%	$ 1,789,455	$ 1,586,915	12.8%	$ 2,519,804	-29.0%
Depreciation/Amortization	$ 2,625	$ 4,002	-34.4%	$ 3,807	-31.0%	$ 26,267	$ 39,249	-33.1%	$ 38,697	-32.1%
TOTAL OPERATING COSTS	$ 139,007	$ 164,039	-15.3%	$ 223,960	-37.9%	$ 1,815,722	$ 1,626,164	11.7%	$ 2,558,500	-29.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (60,258)**	**$ (50,025)**	**-20.5%**	**$ (57,386)**	**-5.0%**	**$ (1,083,193)**	**$ (470,204)**	**-130.4%**	**$ (962,266)**	**12.6%**
Operating Margin	-76.52%	-43.88%	74.4%	-34.45%	122.1%	-147.87%	-40.68%	263.5%	-60.28%	145.3%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	467	963	-51.5%	1,286	-63.7%	6,425	9,802	-34.5%	13,417	-52.1%
Average Revenue per Office Visit	261.08	343.04	-23.9%	299.56	-12.8%	253.76	343.04	-26.0%	338.66	-25.1%
Hospital FTE's (Salaries and Wages)	15.7	12.4	26.5%	14.8	6.3%	15.3	12.9	18.3%	17.8	-14.4%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WEST UNIVERSITY - OPERATIONS SUMMARY
JULY 2022

	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	$ 162,564	$ 176,358	-7.8%	$ 100,657	61.5%	$ 1,537,517	$ 1,725,321	-10.9%	$ 596,567	157.7%
TOTAL PATIENT REVENUE	$ 162,564	$ 176,358	-7.8%	$ 100,657	61.5%	$ 1,537,517	$ 1,725,321	-10.9%	$ 596,567	157.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 100,227	$ 100,142	0.1%	$ 49,864	101.0%	$ 840,590	$ 979,692	-14.2%	$ 319,042	163.5%
Self Pay Adjustments	(103)	23,031	-100.4%	195	-152.7%	115,440	225,311	-48.8%	69,777	65.4%
Bad Debts	11,007	-	0.0%	13,617	-19.2%	71,347	-	0.0%	(30,020)	-337.7%
TOTAL REVENUE DEDUCTIONS	$ 111,131	$ 123,173	-9.8%	$ 63,676	74.5%	$ 1,027,377	$ 1,205,003	-14.7%	$ 358,799	186.3%
	68.36%	69.84%		63.26%		66.82%	69.84%		60.14%	
NET PATIENT REVENUE	$ 51,433	$ 53,185	-3.3%	$ 36,980	39.1%	$ 510,140	$ 520,318	-2.0%	$ 237,768	114.6%
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	$ 51,433	$ 53,185	-3.3%	$ 36,980	39.1%	$ 510,140	$ 520,318	-2.0%	$ 237,768	114.6%
OPERATING EXPENSE										
Salaries and Wages	$ 13,190	$ 27,928	-52.8%	$ 10,793	22.2%	$ 69,541	$ 268,514	-74.1%	$ 72,064	-3.5%
Benefits	1,345	8,195	-83.6%	1,946	-30.9%	5,816	76,781	-92.4%	19,710	-70.5%
Physician Services	44,932	45,750	-1.8%	40,830	10.0%	391,116	457,500	-14.5%	232,725	68.1%
Cost of Drugs Sold	-	10,633	-100.0%	-	0.0%	33,752	104,022	-67.6%	19,458	73.5%
Supplies	3,792	5,520	-31.3%	309	1129.2%	21,211	54,042	-60.8%	3,219	558.8%
Utilities	2,547	3,671	-30.6%	2,707	-5.9%	26,309	28,773	-8.6%	27,808	-5.4%
Repairs and Maintenance	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 65,806	$ 101,697	-35.3%	$ 56,585	16.3%	$ 547,745	$ 989,632	-44.7%	$ 374,985	46.1%
Depreciation/Amortization	$ 25,992	$ 29,790	-12.7%	$ 28,197	-7.8%	$ 260,263	$ 292,137	-10.9%	$ 290,991	-10.6%
TOTAL OPERATING COSTS	$ 91,798	$ 131,487	-30.2%	$ 84,783	8.3%	$ 808,008	$ 1,281,769	-37.0%	$ 665,975	21.3%
NET GAIN (LOSS) FROM OPERATIONS	**$ (40,366)**	**$ (78,302)**	**-48.4%**	**$ (47,802)**	**-15.6%**	**$ (297,868)**	**$ (761,451)**	**-60.9%**	**$ (428,207)**	**-30.4%**
Operating Margin	-78.48%	-147.23%	-46.7%	-129.26%	-39.3%	-58.39%	-146.34%	-60.1%	-180.09%	-67.6%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	552	567	-2.6%	337	63.8%	5,556	5,547	0.2%		0.0%
Average Revenue per Office Visit	294.50	311.04	-5.3%	298.68	-1.4%	276.73	311.04	-11.0%	307.51	-10.0%
Hospital FTE's (Salaries and Wages)	4.4	7.3	-39.4%	3.5	25.6%	2.7	7.3	-63.6%	2.6	3.3%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - JBS - OPERATIONS SUMMARY
JULY 2022

	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	$ 227,873	$ 144,875	57.3%	$ 14,512	1470.2%	$ 2,398,753	$ 1,830,915	31.0%	$ 14,512	16429.1%
TOTAL PATIENT REVENUE	$ 227,873	$ 144,875	57.3%	$ 14,512	1470.2%	$ 2,398,753	$ 1,830,915	31.0%	$ 14,512	16429.1%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 92,828	$ 58,120	59.7%	$ 10,502	783.9%	$ 1,321,170	$ 734,519	79.9%	$ 10,502	12479.9%
Self Pay Adjustments	6,147	16,673	-63.1%	-	100.0%	76,654	210,714	-63.6%	-	100.0%
Bad Debts	18,646	3,415	446.0%	-	100.0%	155,913	43,160	261.2%	-	100.0%
TOTAL REVENUE DEDUCTIONS	$ 117,621	$ 78,208	50.4%	$ 10,502	1020.0%	$ 1,553,738	$ 988,393	57.2%	$ 10,502	14694.4%
	51.62%	53.98%		72.37%		64.77%	53.98%		72.37%	
NET PATIENT REVENUE	$ 110,253	$ 66,667	65.4%	$ 4,010	2649.3%	$ 845,015	$ 842,522	0.3%	$ 4,010	20972.0%
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	$ 110,253	$ 66,667	65.4%	$ 4,010	2649.3%	$ 845,015	$ 842,522	0.3%	$ 4,010	20972.0%
OPERATING EXPENSE										
Salaries and Wages	$ 19,263	$ 20,904	-7.9%	$ 2,725	606.9%	$ 140,174	$ 258,837	-45.8%	$ 2,725	5044.1%
Benefits	1,964	6,134	-68.0%	491	300.0%	11,724	74,014	-84.2%	745	1473.7%
Physician Services	46,889	42,492	10.3%	-	100.0%	438,555	424,920	3.2%	-	100.0%
Cost of Drugs Sold	2,275	-	0.0%	-	100.0%	127,711	-	100.0%	-	100.0%
Supplies	6,446	10,027	-35.7%	6,582	-2.1%	21,616	126,720	-82.9%	7,026	207.7%
Utilities	-	2,789	-100.0%	-	100.0%	-	27,890	-100.0%	-	100.0%
Repairs and Maintenance	-	417	-100.0%	-	100.0%	-	4,170	-100.0%	-	100.0%
Other Expense	-	417	-100.0%	-	0.0%	-	4,170	-100.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 76,838	$ 83,680	-8.2%	$ 9,798	684.3%	$ 739,781	$ 925,721	-20.1%	$ 10,496	6948.5%
Depreciation/Amortization	$ 75	$ -	0.0%	$ 75	0.0%	$ 749	$ -	0.0%	$ 75	899.9%
TOTAL OPERATING COSTS	$ 76,912	$ 83,680	-8.1%	$ 9,872	679.1%	$ 740,529	$ 925,721	-20.0%	$ 10,570	6905.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ 33,340**	**$ (17,013)**	**-296.0%**	**$ (5,862)**	**-668.7%**	**$ 104,486**	**$ (83,199)**	**-225.6%**	**$ (6,560)**	**-1692.7%**
Operating Margin	30.24%	-25.52%	-218.5%	-146.19%	-120.7%	12.37%	-9.87%	-225.2%	-163.59%	-107.6%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	637	475	34.1%	47	1255.3%	6,474	6,003	7.8%	47	13674.5%
Total Visits	637	475	34.1%	47	1255.3%	6,474	6,003	7.8%		0.0%
Average Revenue per Office Visit	357.73	305.00	17.3%	308.77	15.9%	370.52	305.00	21.5%	308.77	20.0%
Hospital FTE's (Salaries and Wages)	5.5	6.3	-12.0%	0.9	492.8%	4.9	7.9	-38.5%	0.1	5003.0%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC COMBINED
JULY 2022

	MONTHLY REVENUE					YTD REVENUE				
	Clements	**West**	**JBS**	**Total**	**%**	**Clements**	**West**	**JBS**	**Total**	**%**
Medicare	$ 27,952	$ 42,246	$ -	$ 70,199	13.7%	$ 348,889	$ 349,578	$ (809)	$ 697,659	12.5%
Medicaid	43,585	39,749	140,354	223,689	43.7%	418,685	403,127	1,464,708	2,286,520	41.1%
FAP	-	-	-	-	0.0%	-	-	-	-	0.0%
Commercial	17,717	42,134	80,919	140,770	27.5%	262,120	367,618	858,522	1,488,260	26.7%
Self Pay	30,131	30,238	5,544	65,913	12.9%	544,015	336,141	54,727	934,884	16.8%
Other	2,538	8,196	1,056	11,789	2.3%	56,692	81,051	21,605	159,348	2.9%
Total	**$ 121,922**	**$ 162,564**	**$ 227,873**	**$ 512,360**	**100.0%**	**$ 1,630,401**	**$ 1,537,517**	**$ 2,398,753**	**$ 5,566,671**	**100.0%**

	MONTHLY PAYMENTS					YEAR TO DATE PAYMENTS				
	Clements	**West**	**JBS**	**Total**	**%**	**Clements**	**West**	**JBS**	**Total**	**%**
Medicare	$ 3,387	$ 6,870	-	$ 10,257	5.5%	$ 129,009	$ 112,890	$ -	$ 241,899	11.4%
Medicaid	21,721	20,000	48,356	90,077	48.7%	205,270	169,489	634,967	1,009,725	47.5%
FAP	-	-	-	-	0.0%	-	-	-	-	0.0%
Commercial	4,086	21,273	35,653	61,011	33.0%	92,629	133,212	386,369	612,210	28.8%
Self Pay	8,412	6,736	4,256	19,404	10.5%	97,209	68,745	58,155	224,108	10.6%
Other	1,566	1,517	1,286	4,370	2.4%	13,016	15,120	7,899	36,036	1.7%
Total	**$ 39,173**	**$ 56,395**	**$ 89,551**	**$ 185,119**	**100.0%**	**$ 537,132**	**$ 499,456**	**$ 1,087,390**	**$ 2,123,978**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
JULY 2022

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	$ 27,952	22.9%	$ 74,563	19.4%	$ 348,889	21.4%	$ 699,130	15.4%
Medicaid	43,585	35.8%	178,396	46.3%	418,685	25.7%	1,987,264	43.8%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	17,717	14.5%	72,556	18.8%	262,120	16.1%	678,555	14.9%
Self Pay	30,131	24.7%	50,505	13.1%	544,015	33.3%	1,022,506	22.5%
Other	2,538	2.1%	9,220	2.4%	56,692	3.5%	156,301	3.4%
TOTAL	**$ 121,922**	**100.0%**	**$ 385,240**	**100.0%**	**$ 1,630,401**	**100.0%**	**$ 4,543,757**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	3,387	8.6%	$ 12,079	8.6%	$ 129,009	24.0%	$ 250,415	17.7%
Medicaid	21,721	55.5%	90,750	64.7%	205,270	38.3%	732,587	51.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	4,086	10.4%	22,235	15.8%	92,629	17.2%	223,340	15.8%
Self Pay	8,412	21.5%	12,426	8.8%	97,209	18.1%	176,175	12.5%
Other	1,566	4.0%	2,972	2.1%	13,016	2.4%	28,951	2.1%
TOTAL	**$ 39,173**	**100.0%**	**$ 140,462**	**100.0%**	**$ 537,132**	**100.0%**	**$ 1,411,468**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
JULY 2022

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	$ 42,246	26.0%	$ 38,580	38.3%	$ 349,578	22.7%	$ 158,973	26.9%
Medicaid	39,749	24.5%	$ 29,475	29.3%	403,127	26.3%	158,973	26.9%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	42,134	25.9%	$ 25,513	25.3%	367,618	23.9%	157,688	26.7%
Self Pay	30,238	18.6%	$ 6,778	6.7%	336,141	21.8%	107,807	18.2%
Other	8,196	5.0%	$ 310	0.3%	81,051	5.3%	7,355	1.2%
TOTAL	**$ 162,564**	**100.0%**	**$ 100,657**	**100.0%**	**$ 1,537,517**	**100.0%**	**$ 590,796**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 6,870	12.2%	$ 12,062	31.3%	$ 112,890	22.6%	$ 63,970	26.3%
Medicaid	20,000	35.5%	12,472	32.3%	$ 169,489	33.9%	60,396	24.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	21,273	37.7%	9,412	24.4%	133,212	26.7%	81,036	33.4%
Self Pay	6,736	11.9%	4,348	11.3%	68,745	13.8%	33,851	13.9%
Other	1,517	2.7%	269	0.7%	15,120	3.0%	3,617	1.5%
TOTAL	**$ 56,395**	**100.0%**	**$ 38,563**	**100.0%**	**$ 499,455**	**100.0%**	**$ 242,871**	**100.0%**

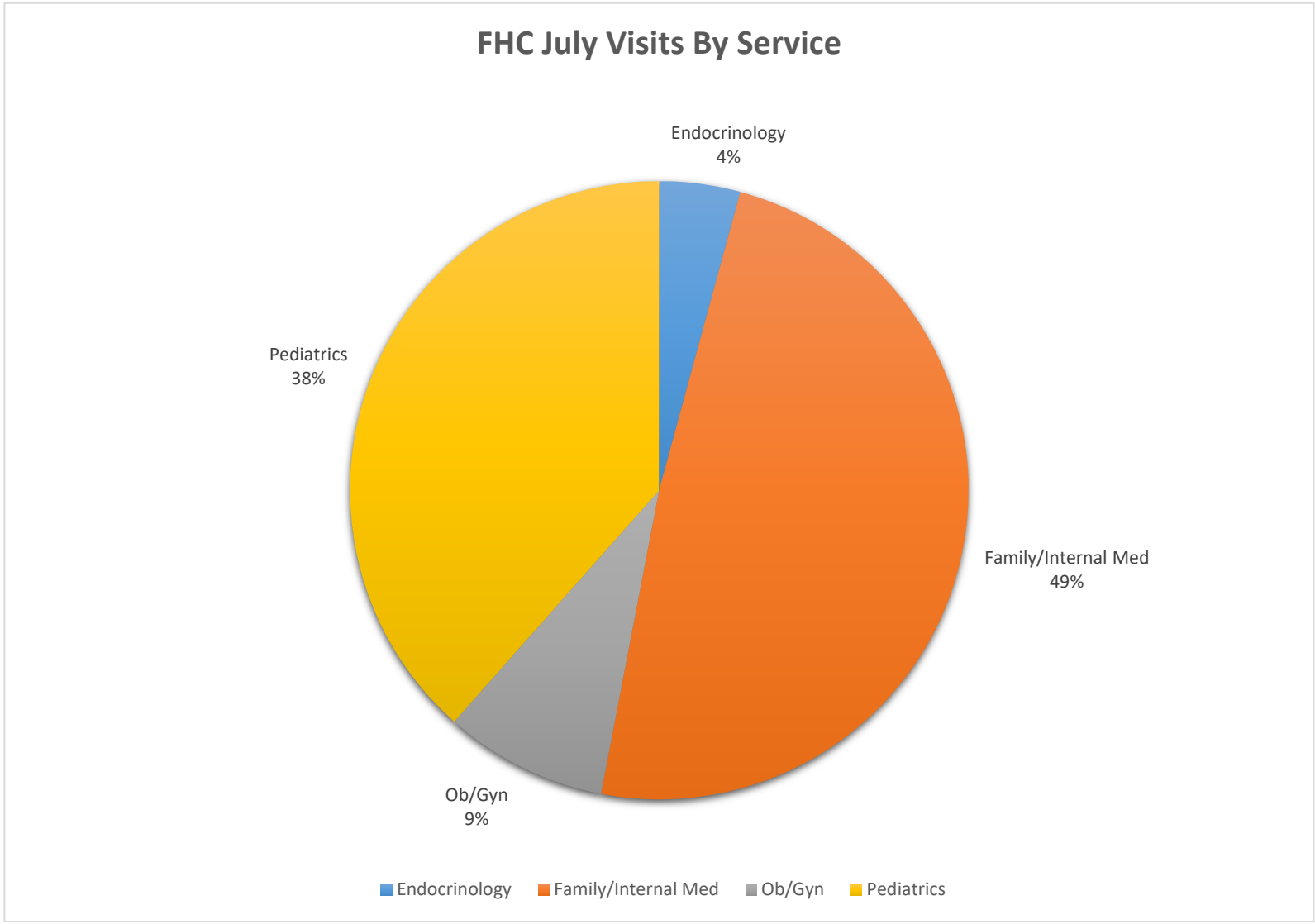
ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC JBS
JULY 2022

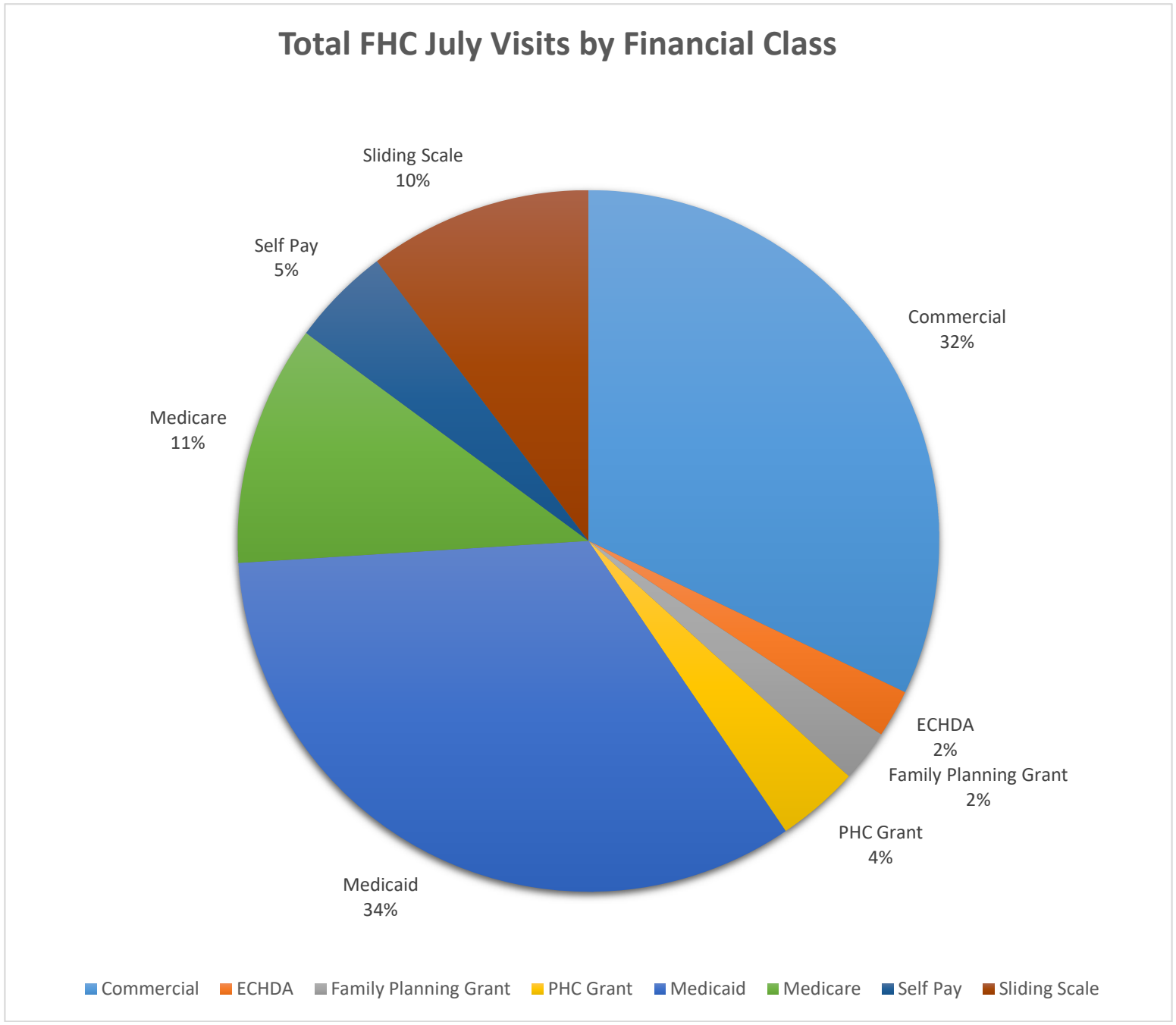
REVENUE BY PAYOR

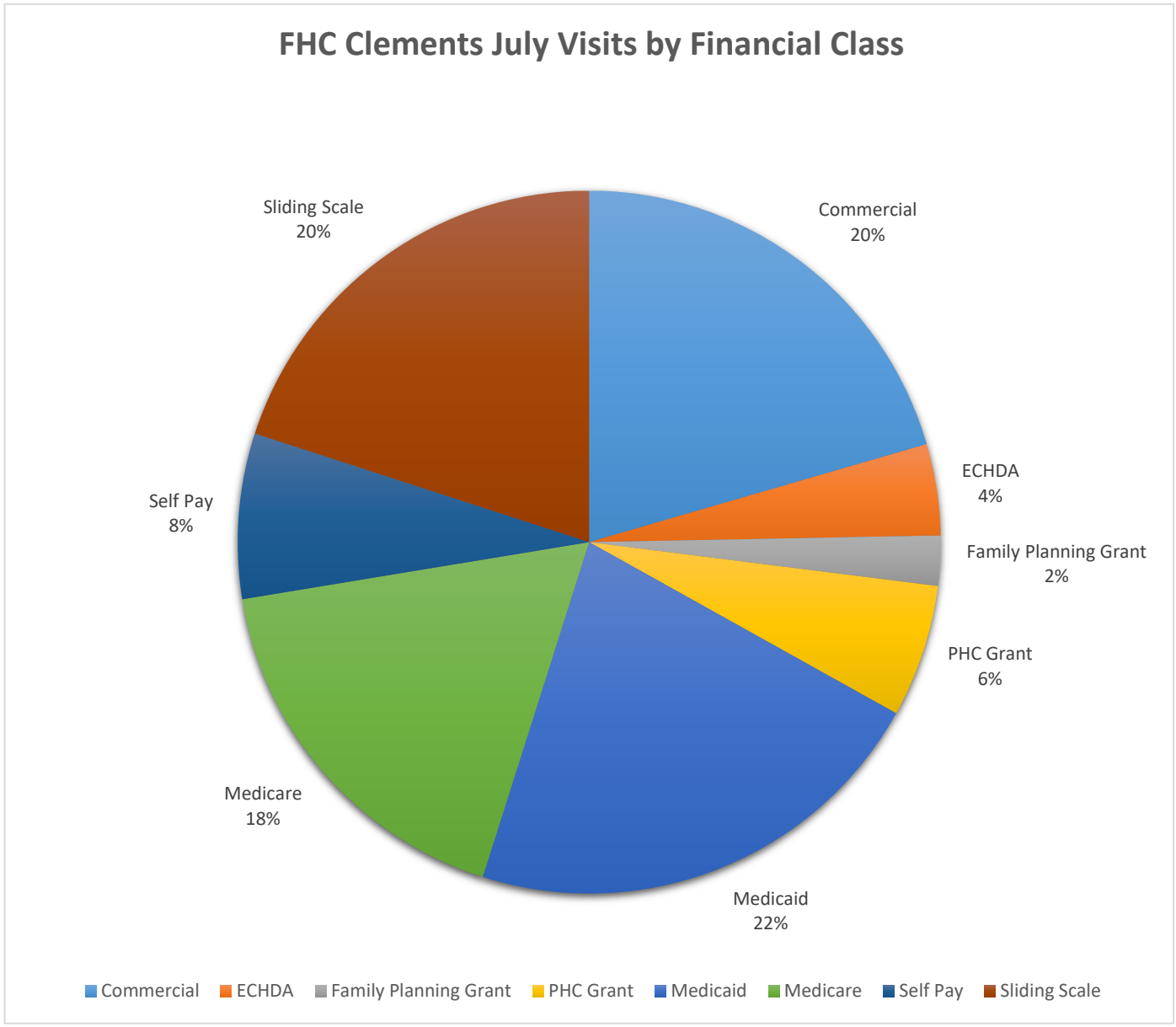
	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ -	0.0%	$ -	0.0%	$ (809)	0.0%	$ -	0.0%
Medicaid	140,354	61.6%	$ 683	4.7%	1,464,708	61.0%	-	0.0%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	80,919	35.5%	$ 13,675	94.2%	858,522	35.8%	-	0.0%
Self Pay	5,544	2.4%	$ 154	1.1%	54,727	2.3%	-	0.0%
Other	1,056	0.5%	$ -	0.0%	21,605	0.9%	-	0.0%
TOTAL	**$ 227,873**	**100.0%**	**$ 14,512**	**100.0%**	**$ 2,398,753**	**100.0%**	**$ -**	**0.0%**

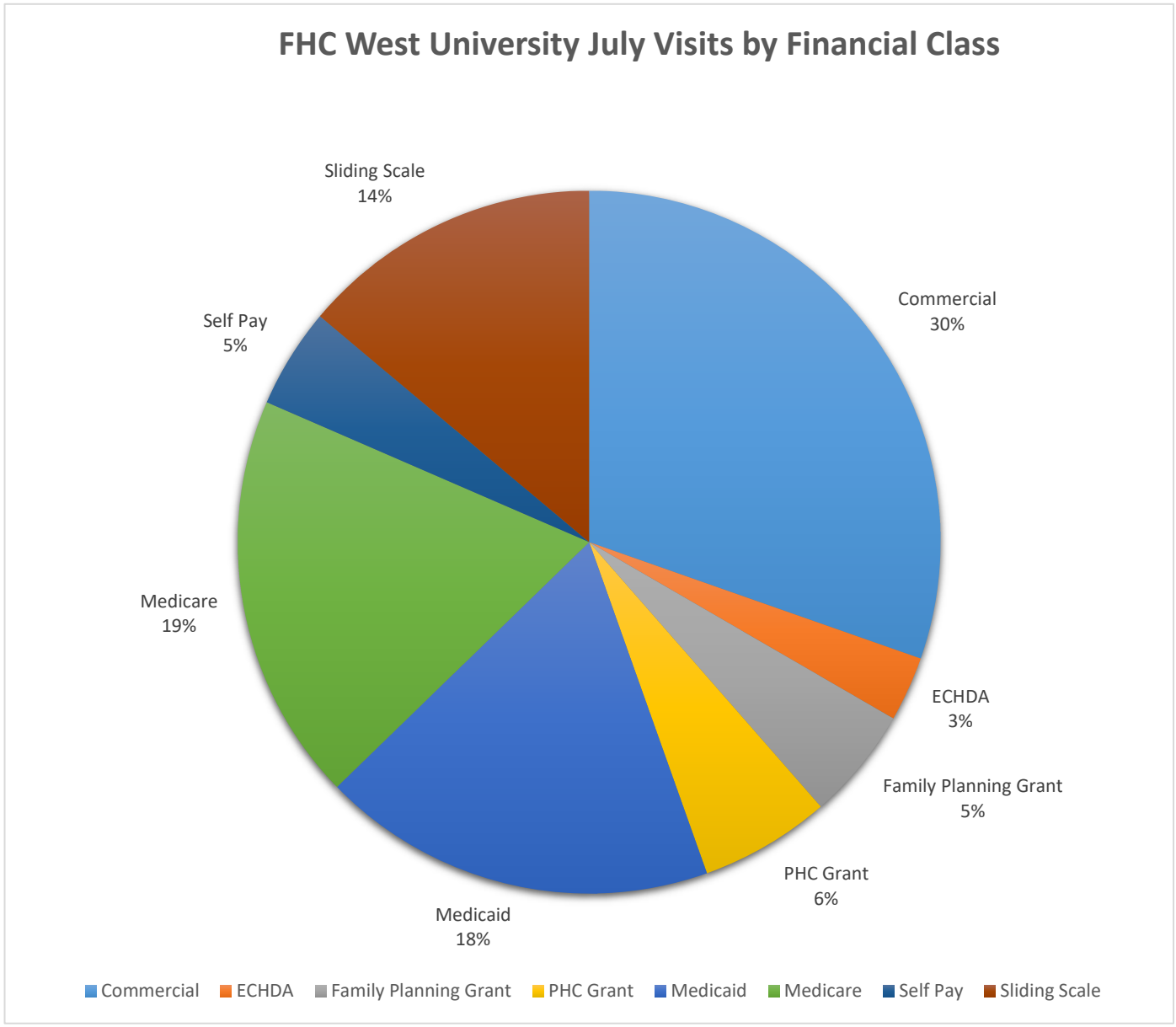
PAYMENTS BY PAYOR

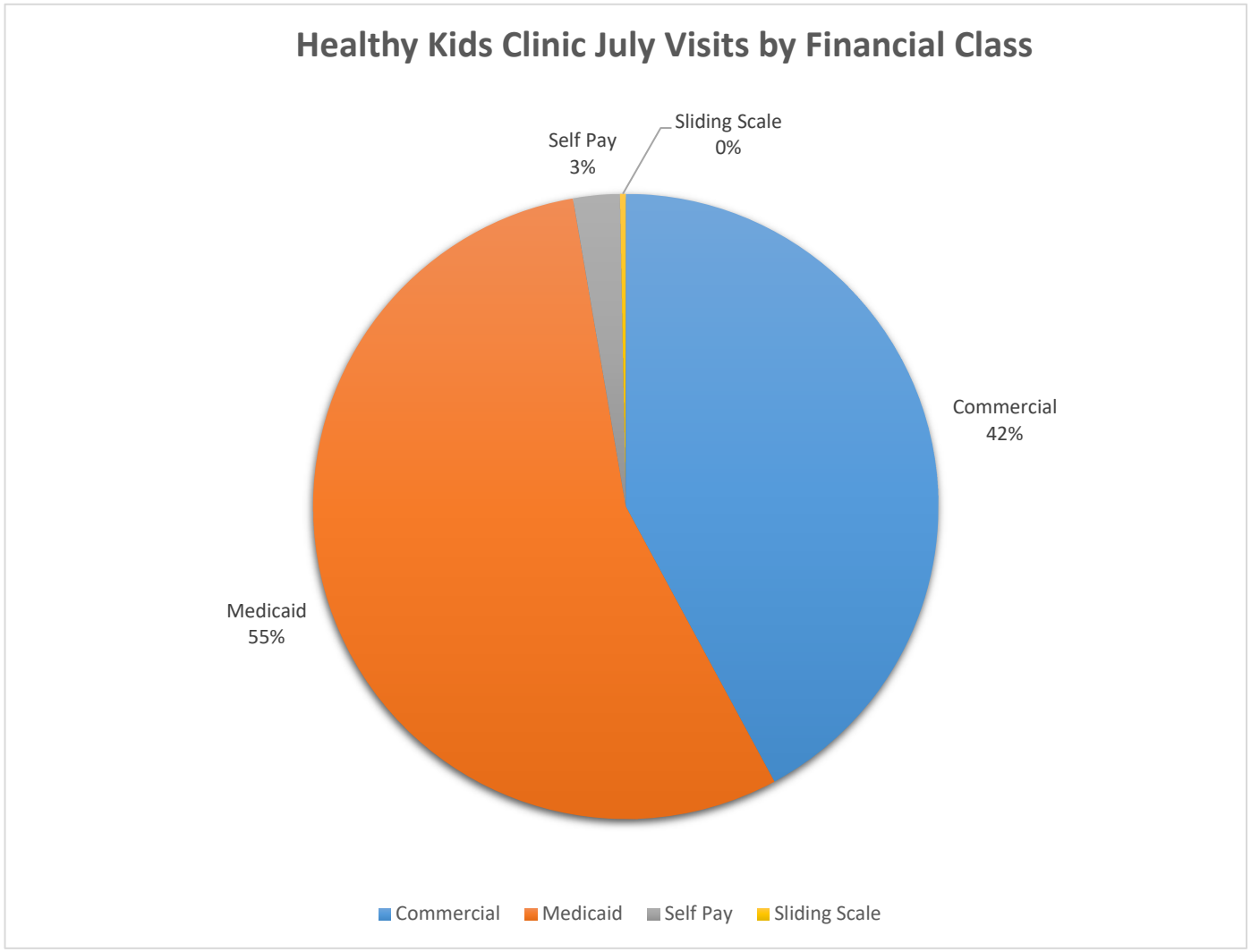
	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ -	0.0%	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	48,356	54.0%	-	0.0%	634,967	58.5%	-	0.0%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	35,653	39.8%	-	0.0%	386,369	35.5%	-	0.0%
Self Pay	4,256	4.8%	350	100.0%	58,155	5.3%	350	100.0%
Other	1,286	1.4%	-	0.0%	7,899	0.7%	-	0.0%
TOTAL	**$ 89,551**	**100.0%**	**$ 350**	**100.0%**	**$ 1,087,391**	**100.0%**	**$ 350**	**100.0%**


FHC July Visits By Service
Endocrinology
4%
Family/Internal Med
49%
Ob/Gyn
9%
Pediatrics
38%
Endocrinology
Family/Internal Med
Ob/Gyn
Pediatrics


Total FHC July Visits by Financial Class
Sliding Scale
10%
Self Pay
5%
Commercial
32%
Medicare
11%
ECHDA
2%
Family Planning Grant
2%
PHC Grant
4%
Medicaid
34%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC Clements July Visits by Financial Class
Sliding Scale
20%
Commercial
20%
ECHDA
4%
Family Planning Grant
2%
PHC Grant
6%
Medicaid
22%
Medicare
18%
Self Pay
8%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


FHC West University July Visits by Financial Class
Sliding Scale
14%
Commercial
30%
Self Pay
5%
Medicare
19%
ECHDA
3%
Family Planning Grant
5%
PHC Grant
6%
Medicaid
18%
Commercial
ECHDA
Family Planning Grant
PHC Grant
Medicaid
Medicare
Self Pay
Sliding Scale


Healthy Kids Clinic July Visits by Financial Class
Self Pay
3%
Sliding Scale
0%
Commercial
42%
Medicaid
55%
Commercial
Medicaid
Self Pay
Sliding Scale

FHC Executive Director's Report-September 2022

- **Staffing Update**: The Family Health Clinic has no open positions; all positions are currently filled.
- **Telehealth Update**: For the month of July, telehealth visits accounted for less than 2% of the Clinic's total visits. We continue to provide telehealth services as an alternative option for sick and follow up visits.
- **Provider Update**: Bertha Nunez, FNP, started at the Healthy Kids Clinic August 3, 2022. We have begun the search for Dr Poudel's replacement.
- **Community Events**: The Family Health Clinic participated in the following community events during the month of August:
  8/23: FHC West University: Free blood pressure and glucose screenings, Tuesdays 3pm-5pm.
  8/26: **Moonlight Marke**t: Blood pressure checks and promotional items

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
JULY 2022

	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	955	954	0.1%	1,066	-10.4%	9,488	9,993	-5.1%	10,040	-5.5%
Neonatal ICU (NICU)	35	24	45.8%	26	34.6%	246	251	-2.0%	228	7.9%
Total Admissions	990	978	1.2%	1,092	-9.3%	9,734	10,244	-5.0%	10,268	-5.2%
Patient Days										
Adult & Pediatric	3,798	3,507	8.3%	4,632	-18.0%	43,083	36,747	17.2%	42,446	1.5%
ICU	469	381	23.1%	406	15.5%	4,591	3,990	15.1%	4,390	4.6%
CCU	361	274	31.8%	393	-8.1%	3,841	2,870	33.8%	3,891	-1.3%
NICU	617	367	68.1%	368	67.7%	3,337	3,847	-13.3%	3,091	8.0%
Total Patient Days	5,245	4,529	15.8%	5,799	-9.6%	54,852	47,454	15.6%	53,818	1.9%
Observation (Obs) Days	388	448	-13.4%	517	-25.0%	4,151	4,558	-8.9%	5,262	-21.1%
Nursery Days	328	197	66.5%	298	10.1%	2,789	1,970	41.6%	2,664	4.7%
Total Occupied Beds / Bassinets	5,961	5,174	15.2%	6,614	-9.9%	61,792	53,982	14.5%	61,744	0.1%
Average Length of Stay (ALOS)										
Acute / Adult & Pediatric	4.85	4.36	11.1%	5.09	-4.9%	5.43	4.36	24.4%	5.05	7.5%
NICU	17.63	15.29	15.3%	14.15	24.5%	13.57	15.33	-11.5%	13.56	0.1%
Total ALOS	5.30	4.63	14.4%	5.31	-0.2%	5.64	4.63	21.6%	5.24	7.5%
Acute / Adult & Pediatric w/o OB	6.15			5.78	6.4%	6.37			5.89	8.1%
Average Daily Census	169.2	146.1	15.8%	187.1	-9.6%	180.4	156.1	15.6%	176.5	2.3%
Hospital Case Mix Index (CMI)	1.6649	1.5386	8.2%	1.5977	4.2%	1.7041	1.5386	10.8%	1.7239	-1.1%
Medicare										
Admissions	326	351	-7.1%	399	-18.3%	3,389	3,683	-8.0%	3,699	-8.4%
Patient Days	1,899	1,793	5.9%	2,420	-21.5%	22,676	18,781	20.7%	21,689	4.6%
Average Length of Stay	5.83	5.11	14.0%	6.07	-4.0%	6.69	5.10	31.2%	5.86	14.1%
Case Mix Index	1.9298	1.9446	-1%	1.8007	7.2%	1.9797	1.9446	2%	2.0036	-1.2%
Medicaid										
Admissions	130	122	6.6%	150	-13.3%	1,264	1,281	-1.3%	1,312	-3.7%
Patient Days	737	508	45.1%	807	-8.7%	6,335	5,324	19.0%	6,144	3.1%
Average Length of Stay	5.67	4.16	36.2%	5.38	5.4%	5.01	4.16	20.6%	4.68	7.0%
Case Mix Index	1.3569	0.9632	41%	1.3250	2.4%	1.2344	0.9632	28%	1.2056	2.4%
Commercial										
Admissions	273	261	4.6%	270	1.1%	2,740	2,735	0.2%	2,743	-0.1%
Patient Days	1,345	1,092	23.2%	1,243	8.2%	13,216	11,442	15.5%	12,942	2.1%
Average Length of Stay	4.93	4.18	17.8%	4.60	7.0%	4.82	4.18	15.3%	4.72	2.2%
Case Mix Index	1.5805	1.5059	5.0%	1.6050	-1.5%	1.6314	1.5059	8.3%	1.6824	-3.0%
Self Pay										
Admissions	238	218	9.2%	247	-3.6%	2,114	2,282	-7.4%	2,243	-5.8%
Patient Days	1,151	1,015	13.4%	1,169	-1.5%	11,306	10,635	6.3%	11,535	-2.0%
Average Length of Stay	4.84	4.66	3.9%	4.73	2.2%	5.35	4.66	14.8%	5.14	4.0%
Case Mix Index	1.5319	1.5823	-3.2%	1.3801	11.0%	1.5628	1.5823	-1.2%	1.5488	0.9%
All Other										
Admissions	23	25	-8.0%	26	-11.5%	227	262	-13.4%	271	-16.2%
Patient Days	113	121	-6.6%	160	-29.4%	1,319	1,271	3.8%	1,508	-12.5%
Average Length of Stay	4.91	4.84	1.5%	6.15	-20.2%	5.81	4.85	19.8%	5.56	4.4%
Case Mix Index	2.3253	1.8985	22.5%	1.8859	23.3%	2.0712	1.8985	9.1%	1.9774	4.7%
Radiology										
InPatient	3,983	3,424	16.3%	4,602	-13.5%	41,579	35,872	15.9%	40,826	1.8%
OutPatient	7,390	6,934	6.6%	7,766	-4.8%	73,172	70,542	3.7%	70,382	4.0%
Cath Lab										
InPatient	329	453	-27.4%	561	-41.4%	5,191	4,745	9.4%	5,533	-6.2%
OutPatient	543	643	-15.6%	564	-3.7%	4,925	6,544	-24.7%	6,021	-18.2%
Laboratory										
InPatient	71,213	58,357	22.0%	76,286	-6.6%	754,330	611,439	23.4%	743,233	1.5%
OutPatient	59,017	52,212	13.0%	55,266	6.8%	596,291	531,356	12.2%	540,349	10.4%
Other										
Deliveries	206	143	44.1%	175	17.7%	1,802	1,498	20.3%	1,601	12.6%
Surgical Cases										
InPatient	197	238	-17.2%	220	-10.5%	2,102	2,498	-15.9%	2,235	-6.0%
OutPatient	551	538	2.4%	579	-4.8%	5,200	5,468	-4.9%	4,777	8.9%
Total Surgical Cases	748	776	-3.6%	799	-6.4%	7,302	7,966	-8.3%	7,012	4.1%
GI Procedures (Endo)										
InPatient	122	135	-9.6%	166	-26.5%	1,302	1,416	-8.1%	1,185	9.9%
OutPatient	209	212	-1.4%	131	59.5%	1,572	2,154	-27.0%	1,199	31.1%
Total GI Procedures	331	347	-4.6%	297	11.4%	2,874	3,570	-19.5%	2,384	20.6%

ECTOR COUNTY HOSPITAL DISTRICT
MONTHLY STATISTICAL REPORT
JULY 2022

	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	4,830	3,890	24.2%	3,619	33.5%	43,494	39,804	9.3%	33,804	28.7%
Observation Days	388	448	-13.4%	517	-25.0%	4,151	4,558	-8.9%	5,262	-21.1%
Other O/P Occasions of Service	18,372	17,095	7.5%	19,661	-6.6%	189,838	173,975	9.1%	176,026	7.8%
Total O/P Occasions of Svc.	23,590	21,433	10.1%	23,797	-0.9%	237,483	218,337	8.8%	215,092	10.4%
Hospital Operations										
Manhours Paid	278,955	261,942	6.5%	270,459	3.1%	2,615,503	2,699,182	-3.1%	2,563,660	2.0%
FTE's	1,574.7	1,478.7	6.5%	1,526.8	3.1%	1,505.6	1,553.8	-3.1%	1,475.5	2.0%
Adjusted Patient Days	10,252	8,470	21.0%	10,543	-2.8%	100,216	87,859	14.1%	96,796	3.5%
Hours / Adjusted Patient Day	27.21	30.92	-12.0%	25.65	6.1%	26.10	30.72	-15.0%	27.00	-3.3%
Occupancy - Actual Beds	48.5%	41.9%	15.8%	52.5%	-7.7%	51.7%	44.7%	15.6%	50.6%	2.3%
FTE's / Adjusted Occupied Bed	4.8	5.4	-12.0%	4.5	6.1%	4.6	5.4	-15.0%	4.7	-3.3%
InPatient Rehab Unit										
Admissions	-	-	0.0%	-	0.0%	-	-	0.0%	56	-100.0%
Patient Days	-	-	0.0%	-	0.0%	-	-	0.0%	880	-100.0%
Average Length of Stay	-	-	0.0%	-	0.0%	-	-	0.0%	15.7	-100.0%
Manhours Paid	-	-	0.0%	-	0.0%	-	-	0.0%	18,075	-100.0%
FTE's	-	-	0.0%	-	0.0%	-	-	0.0%	5.8	-100.0%
Center for Primary Care - Clements										
Total Medical Visits	467	963	-51.5%	1,286	-63.7%	6,425	9,802	-34.5%	13,417	-52.1%
Manhours Paid	2,782	2,200	26.5%	2,616	6.3%	26,503	22,396	18.3%	30,969	-14.4%
FTE's	15.7	12.4	26.5%	14.8	6.3%	15.3	12.9	18.3%	17.8	-14.1%
Center for Primary Care - West University										
Total Medical Visits	552	567	-2.6%	337	63.8%	5,556	5,547	0.2%	1,940	186.4%
Manhours Paid	785	1,295	-39.4%	625	25.6%	4,616	12,679	-63.6%	4,471	3.3%
FTE's	4.4	7.3	-39.4%	3.5	25.6%	2.7	7.3	-63.6%	2.6	3.6%
Center for Primary Care - JBS										
Total Medical Visits	637	475	34.1%	47	1255.3%	6,474	6,003	7.8%	47	13674.5%
Manhours Paid	979	1,113	-12.0%	165	492.8%	8,427	13,696	-38.5%	165	5003.0%
FTE's	5.5	6.3	-12.0%	1	492.8%	4.9	7.9	-38.5%	0	5019.7%
Total ECHD Operations										
Total Admissions	990	978	1.2%	1,092	-9.3%	9,734	10,244	-5.0%	10,324	-5.7%
Total Patient Days	5,245	4,529	15.8%	5,799	-9.6%	54,852	47,454	15.6%	54,698	0.3%
Total Patient and Obs Days	5,633	4,977	13.2%	6,316	-10.8%	59,003	52,012	13.4%	59,960	-1.6%
Total FTE's	1,600.4	1,504.7	6.4%	1,546.0	3.5%	1,528.4	1,581.9	-3.4%	1,501.8	1.8%
FTE's / Adjusted Occupied Bed	4.8	5.5	-12.1%	4.5	6.5%	4.6	5.5	-15.3%	4.7	-2.0%
Total Adjusted Patient Days	10,252	8,470	21.0%	10,543	-2.8%	100,216	87,859	14.1%	96,796	3.5%
Hours / Adjusted Patient Day	27.65	31.47	-12.1%	25.98	6.5%	26.49	31.28	-15.3%	27.04	-2.0%
Outpatient Factor	1.9547	1.8702	4.5%	1.8181	7.5%	1.8270	1.8514	-1.3%	1.7696	3.2%
Blended O/P Factor	2.1650	2.0697	4.6%	2.0183	7.3%	2.0297	2.0700	-1.9%	1.9908	2.0%
Total Adjusted Admissions	1,935	1,829	5.8%	1,985	-2.5%	17,784	18,966	-6.2%	18,270	-2.7%
Hours / Adjusted Admisssion	146.50	145.73	0.5%	137.95	6.2%	149.29	144.89	3.0%	143.26	4.2%
FTE's - Hospital Contract	68.9	41.4	66.6%	41.3	67.0%	99.6	46.5	114.4%	36.0	176.5%
FTE's - Mgmt Services	39.6	53.4	-25.9%	61.5	-35.7%	43.2	53.4	-19.2%	53.0	-18.6%
Total FTE's (including Contract)	1,708.9	1,599.5	6.8%	1,648.8	3.6%	1,671.1	1,681.7	-0.6%	1,590.8	5.1%
Total FTE'S per Adjusted Occupied Bed (including Contract)	5.2	5.9	-11.7%	4.8	6.6%	5.1	5.8	-12.9%	5.0	1.1%
ProCare FTEs	216.2	240.5	-10.1%	215.2	0.5%	213.2	238.6	-10.6%	208.9	2.1%
TraumaCare FTEs	9.3	0.0	0.0%	0.0	0.0%	1.9	0.0	0.0%	0.0	0.0%
Total System FTEs	1,934.4	1,840.0	5.1%	1,864.0	3.8%	1,886.2	1,920.3	-1.8%	1,799.7	4.8%
Urgent Care Visits										
JBS Clinic	1,446	1,725	-16.2%	1,655	-12.6%	18,170	17,547	3.6%	7,720	135.4%
West University	863	1,887	-54.3%	1,290	-33.1%	12,885	19,203	-32.9%	8,628	49.3%
42nd Street	2	2,493	-99.9%	851	-99.8%	12	25,365	-100.0%	10,063	-99.9%
Total Urgent Care Visits	2,311	6,105	-62.1%	3,796	-39.1%	31,067	62,115	-50.0%	26,411	17.6%
Wal-Mart Clinic Visits										
East Clinic	196	235	-16.6%	319	-38.6%	2,332	1,779	31.1%	1,863	25.2%
West Clinic	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Total Wal-Mart Visits	196	235	-16.6%	319	-38.6%	2,332	1,779	31.1%	1,863	25.2%

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
JULY 2022

	CURRENT YEAR	PRIOR FISCAL YEAR END HOSPITAL Audited	PRO CARE Audited	TRAUMA CARE Audited	CURRENT YEAR CHANGE
ASSETS					
CURRENT ASSETS:					
Cash and Cash Equivalents	$ 41,367,778	$ 51,186,029	$ 4,500	$ -	$ (9,822,751)
Investments	69,640,597	63,929,700	-	-	5,710,897
Patient Accounts Receivable - Gross	258,338,822	238,367,515	23,207,991	-	(3,236,683)
Less: 3rd Party Allowances	(162,482,172)	(153,865,506)	(10,248,128)	-	1,631,462
Bad Debt Allowance	(62,014,209)	(53,122,125)	(8,592,762)	-	(299,322)
Net Patient Accounts Receivable	33,842,442	31,379,884	4,367,101	-	(1,904,543)
Taxes Receivable	10,132,961	8,121,560	-	-	2,011,401
Accounts Receivable - Other	6,567,474	15,670,402	36,244	-	(9,139,173)
Inventories	8,976,353	7,642,276	420,138	-	913,940
Prepaid Expenses	3,785,799	3,223,336	159,539	-	402,925
Total Current Assets	174,313,404	181,153,187	4,987,522	-	(11,827,305)
CAPITAL ASSETS:					
Property and Equipment	500,423,625	494,009,653	393,970	-	6,020,003
Construction in Progress	4,982,310	886,158	-	-	4,096,152
	505,405,936	494,895,810	393,970	-	10,116,155
Less: Accumulated Depreciation and Amortization	(339,834,105)	(324,671,790)	(288,301)	-	(14,874,014)
Total Capital Assets	165,571,831	170,224,021	105,668	-	(4,757,858)
INTANGIBLE ASSETS / GOODWILL - NET	-	-	-	-	-
RESTRICTED ASSETS:					
Restricted Assets Held by Trustee	4,896	4,896	-	-	-
Restricted Assets Held in Endowment	6,146,690	6,303,870	-	-	(157,180)
Restricted MCH West Texas Services	2,338,491	2,322,472	-	-	16,020
Pension, Deferred Outflows of Resources	16,918,101	29,138,210	-	-	(12,220,109)
Assets whose use is Limited	110,133	-	97,008	-	13,125
TOTAL ASSETS	$ 366,847,070	$ 391,022,321	$ 5,190,198	$ -	$ (29,365,448)
LIABILITIES AND FUND BALANCE					
CURRENT LIABILITIES:					
Current Maturities of Long-Term Debt	$ 2,233,789	$ 2,556,272	$ -	$ -	$ (322,483)
Self-Insurance Liability - Current Portion	2,551,188	2,551,189	-	-	(1)
Accounts Payable	28,956,338	16,754,399	720,459	-	11,481,480
A/R Credit Balances	2,408,281	2,342,858	-	-	65,423
Accrued Interest	520,380	19,294	-	-	501,086
Accrued Salaries and Wages	14,543,050	4,066,267	4,173,631	-	6,303,152
Accrued Compensated Absences	4,211,464	4,151,036	-	-	60,428
Due to Third Party Payors	3,406,952	15,144,253	-	-	(11,737,301)
Deferred Revenue	4,822,193	1,110,947	328,939	-	3,382,307
Total Current Liabilities	63,653,635	48,696,516	5,223,028	-	9,734,091
ACCRUED POST RETIREMENT BENEFITS	60,833,248	84,851,830	-	-	(24,018,582)
SELF-INSURANCE LIABILITIES - Less Current Portion	1,476,505	1,476,505	-	-	-
LONG-TERM DEBT - Less Current Maturities	52,940,197	54,100,003	-	-	(1,159,807)
Total Liabilities	178,903,584	189,124,854	5,223,028	-	(15,444,298)
FUND BALANCE	187,943,486	201,897,467	(32,831)	-	(13,921,150)
TOTAL LIABILITIES AND FUND BALANCE	$ 366,847,070	$ 391,022,321	$ 5,190,198	$ -	$ (29,365,448)

ECTOR COUNTY HOSPITAL DISTRICT
BALANCE SHEET - BLENDED
JULY 2022

	HOSPITAL	PRO CARE	TRAUMA CARE	ECTOR COUNTY HOSPITAL DISTRICT
ASSETS				
CURRENT ASSETS:				
Cash and Cash Equivalents	$ 41,362,703	$ 5,075	$ -	$ 41,367,778
Investments	69,640,597	-	-	69,640,597
Patient Accounts Receivable - Gross	233,882,297	24,456,525	278,083	258,338,822
Less: 3rd Party Allowances	(153,708,061)	(8,774,111)	(212,288)	(162,482,172)
Bad Debt Allowance	(52,348,914)	(9,665,295)	(23,588)	(62,014,209)
Net Patient Accounts Receivable	27,825,322	6,017,120	42,208	33,842,442
Taxes Receivable	10,132,961	-	-	10,132,961
Accounts Receivable - Other	6,532,913	34,561	-	6,567,474
Inventories	8,544,543	431,810	-	8,976,353
Prepaid Expenses	3,630,726	155,073	16,760	3,785,799
Total Current Assets	167,669,765	6,643,639	58,968	174,313,404
CAPITAL ASSETS:				
Property and Equipment	500,029,656	393,970	-	500,423,625
Construction in Progress	4,982,310	-	-	4,982,310
	505,011,966	393,970	-	505,405,936
Less: Accumulated Depreciation and Amortization	(339,531,662)	(302,443)	-	(339,834,105)
Total Capital Assets	165,480,304	91,527	-	165,571,831
RESTRICTED ASSETS:				
Restricted Assets Held by Trustee	4,896	-	-	4,896
Restricted Assets Held in Endowment	6,146,690	-	-	6,146,690
Restricted TPC, LLC	1,443,525	-	-	1,443,525
Restricted MCH West Texas Services	2,338,491	-	-	2,338,491
Pension, Deferred Outflows of Resources	16,918,101	-	-	16,918,101
Assets whose use is Limited	-	110,133	-	110,133
TOTAL ASSETS	$ 360,001,771	$ 6,845,299	$ 58,968	$ 366,847,070
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES:				
Current Maturities of Long-Term Debt	$ 2,233,789	$ -	$ -	$ 2,233,789
Self-Insurance Liability - Current Portion	2,551,188	-	-	2,551,188
Accounts Payable	29,075,260	(118,922)	(213,379)	28,956,338
A/R Credit Balances	2,408,281	-	-	2,408,281
Accrued Interest	520,380	-	-	520,380
Accrued Salaries and Wages	7,867,625	6,675,425	291,344	14,543,050
Accrued Compensated Absences	4,211,464	-	-	4,211,464
Due to Third Party Payors	3,406,952	-	-	3,406,952
Deferred Revenue	4,500,566	321,627	-	4,822,193
Total Current Liabilities	56,775,505	6,878,130	77,965	63,653,635
ACCRUED POST RETIREMENT BENEFITS	60,833,248	-	-	60,833,248
SELF-INSURANCE LIABILITIES - Less Current Portion	1,476,505	-	-	1,476,505
LONG-TERM DEBT - Less Current Maturities	52,940,197	-	-	52,940,197
Total Liabilities	172,025,455	6,878,130	77,965	178,903,584
FUND BALANCE	187,976,317	(32,831)	(18,997)	187,943,486
TOTAL LIABILITIES AND FUND BALANCE	$ 360,001,771	$ 6,845,299	$ 58,968	$ 366,847,070

ECTOR COUNTY HOSPITAL DISTRICT
BLENDED OPERATIONS SUMMARY
JULY 2022

	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	$ 49,573,499	$ 49,231,818	0.7%	$ 55,157,702	-10.1%	$ 539,910,976	$ 509,919,247	5.9%	$ 536,300,201	0.7%
Outpatient Revenue	57,752,407	52,665,486	9.7%	56,165,858	2.8%	555,947,286	545,590,038	1.9%	531,376,341	4.6%
TOTAL PATIENT REVENUE	$ 107,325,906	$ 101,897,304	5.3%	$ 111,323,560	-3.6%	$ 1,095,858,262	$ 1,055,509,285	3.8%	$ 1,067,676,543	2.6%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 62,574,761	$ 62,253,139	0.5%	$ 70,926,039	-11.8%	$ 692,490,293	$ 645,403,922	7.3%	$ 656,885,092	5.4%
Policy Adjustments	1,983,001	1,746,658	13.5%	(3,064,120)	-164.7%	17,449,782	19,220,736	-9.2%	18,521,014	-5.8%
Uninsured Discount	9,177,639	9,500,127	-3.4%	15,404,419	-40.4%	91,024,557	98,190,915	-7.3%	100,331,808	-9.3%
Indigent	3,838,453	1,645,889	133.2%	1,329,359	188.7%	11,551,518	16,913,825	-31.7%	17,426,310	-33.7%
Provision for Bad Debts	7,131,668	5,331,476	33.8%	6,736,019	5.9%	66,486,704	56,544,848	17.6%	57,798,894	15.0%
TOTAL REVENUE DEDUCTIONS	$ 84,705,523	$ 80,477,289	5.3%	$ 91,331,716	-7.3%	$ 879,002,853	$ 836,274,246	5.1%	$ 850,963,117	3.3%
	78.92%	78.98%		82.04%		80.21%	79.23%		79.70%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ (361,099)	$ 1,892,772	-119.1%	$ 1,557,475	-123.2%	$ 15,673,546	$ 18,927,720	-17.2%	$ 17,942,239	-12.6%
DSRIP	(44,234)	1,282,780	-103.4%	3,334,144	-101.3%	9,241,855	12,827,800	-28.0%	8,258,701	11.9%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	(5,812)	-	0.0%	-	0.0%
TOTAL OTHER PATIENT REVENUE	$ (405,333)	$ 3,175,552	-112.8%	$ 4,891,619	-108.3%	$ 24,909,589	$ 31,755,520	-21.6%	$ 26,200,940	-4.9%
NET PATIENT REVENUE	$ 22,215,050	$ 24,595,567	-9.7%	$ 24,883,462	-10.7%	$ 241,764,999	$ 250,990,559	-3.7%	$ 242,914,366	-0.5%
OTHER REVENUE										
Tax Revenue	$ 6,933,093	$ 5,070,802	36.7%	$ 6,051,971	14.6%	$ 62,931,934	$ 53,694,426	17.2%	$ 53,339,539	18.0%
Other Revenue	916,128	862,371	6.2%	996,203	-8.0%	9,269,860	8,699,831	6.6%	9,140,602	1.4%
TOTAL OTHER REVENUE	$ 7,849,221	$ 5,933,173	32.3%	$ 7,048,175	11.4%	$ 72,201,794	$ 62,394,257	15.7%	$ 62,480,140	15.6%
NET OPERATING REVENUE	$ 30,064,272	$ 30,528,740	-1.5%	$ 31,931,637	-5.8%	$ 313,966,793	$ 313,384,816	0.2%	$ 305,394,506	2.8%
OPERATING EXPENSES										
Salaries and Wages	$ 14,773,900	$ 13,051,669	13.2%	$ 13,525,075	9.2%	$ 135,135,677	$ 131,566,019	2.7%	$ 128,325,958	5.3%
Benefits	1,419,400	2,948,461	-51.9%	2,051,278	-30.8%	12,133,686	29,786,426	-59.3%	28,405,073	-57.3%
Temporary Labor	2,085,226	924,599	125.5%	1,037,916	100.9%	30,592,840	9,981,077	206.5%	8,780,664	248.4%
Physician Fees	1,323,880	1,260,589	5.0%	1,390,892	-4.8%	13,757,956	12,602,230	9.2%	14,038,049	-2.0%
Texas Tech Support	878,312	885,637	-0.8%	817,623	7.4%	8,626,575	8,856,370	-2.6%	8,552,809	0.9%
Purchased Services	4,428,538	4,309,045	2.8%	4,370,479	1.3%	43,812,695	43,247,147	1.3%	39,805,582	10.1%
Supplies	4,919,235	4,907,033	0.2%	4,978,019	-1.2%	52,985,079	49,752,061	6.5%	49,562,701	6.9%
Utilities	271,257	345,341	-21.5%	295,635	-8.2%	3,367,847	3,206,852	5.0%	3,135,048	7.4%
Repairs and Maintenance	683,750	801,372	-14.7%	810,398	-15.6%	8,512,205	8,026,020	6.1%	7,636,621	11.5%
Leases and Rent	173,812	154,006	12.9%	132,417	31.3%	2,409,379	1,530,600	57.4%	1,605,834	50.0%
Insurance	157,735	156,479	0.8%	217,730	-27.6%	1,538,227	1,562,992	-1.6%	1,513,931	1.6%
Interest Expense	70,033	132,249	-47.0%	107,715	-35.0%	820,360	1,330,864	-38.4%	1,075,409	-23.7%
ECHDA	183,672	200,924	-8.6%	284,107	-35.4%	1,871,423	2,009,240	-6.9%	2,256,754	-17.1%
Other Expense	132,052	157,915	-16.4%	143,625	-8.1%	1,906,951	1,749,946	9.0%	1,400,737	36.1%
TOTAL OPERATING EXPENSES	$ 31,500,803	$ 30,235,319	4.2%	$ 30,162,908	4.4%	$ 317,470,900	$ 305,207,844	4.0%	$ 296,095,171	7.2%
Depreciation/Amortization	$ 1,660,184	$ 1,611,589	3.0%	$ 1,629,440	1.9%	$ 16,600,916	$ 15,805,577	5.0%	$ 15,908,563	4.4%
(Gain) Loss on Sale of Assets	(7,000)	681	-1127.9%	-	0.0%	515	6,810	-92.4%	8,173	-93.7%
TOTAL OPERATING COSTS	$ 33,153,987	$ 31,847,589	4.1%	$ 31,792,348	4.3%	$ 334,072,331	$ 321,020,231	4.1%	$ 312,011,908	7.1%
NET GAIN (LOSS) FROM OPERATIONS	**$ (3,089,715)**	**$ (1,318,849)**	**-134.3%**	**$ 139,289**	**2318.2%**	**$ (20,105,538)**	**$ (7,635,415)**	**163.3%**	**$ (6,617,402)**	**203.8%**
Operating Margin	-10.28%	-4.32%	137.9%	0.44%	-2456.0%	-6.40%	-2.44%	162.8%	-2.17%	195.5%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 95,138	$ 17,785	434.9%	$ 6,780	1303.3%	$ 481,220	$ 177,850	170.6%	$ 47,706	908.7%
Tobacco Settlement	-	-	0.0%	-	0.0%	1,158,055	1,284,940	-9.9%	1,171,633	-1.2%
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	-	11,772	-100.0%	-		-	117,720	-100.0%	141,275	-100.0%
COVID-19 Stimulus	-	-	0.0%	-	0.0%	6,113,607	-	0.0%	-	0.0%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (2,994,577)	$ (1,289,292)	-132.3%	$ 146,068	2150.1%	$ (12,352,656)	$ (6,054,905)	-104.0%	$ (5,256,788)	-135.0%
Unrealized Gain/(Loss) on Investments	$ 232,365	$ (9,360)	0.0%	$ 33,736	588.8%	$ (2,295,709)	$ (93,600)	0.0%	$ (39,215)	5754.2%
Investment in Subsidiaries	(6,395)	124,344	-105.1%	4,151	-254.1%	708,218	1,243,440	-43.0%	1,431,433	-50.5%
CHANGE IN NET POSITION	**$ (2,768,607)**	**$ (1,174,308)**	**-135.8%**	**$ 183,955**	**1605.0%**	**$ (13,940,147)**	**$ (4,905,065)**	**-184.2%**	**$ (3,864,570)**	**-260.7%**

ECTOR COUNTY HOSPITAL DISTRICT
HOSPITAL OPERATIONS SUMMARY
JULY 2022

	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 Ancillary Revenue	-	-		$ -	0.0%	-	-		-	0.0%
Inpatient Revenue	$ 49,573,499	$ 49,231,818	0.7%	$ 55,157,702	-10.1%	$ 539,910,976	$ 509,919,247	5.9%	$ 536,300,201	0.7%
Outpatient Revenue	47,327,483	42,843,057	10.5%	45,122,281	4.9%	446,523,311	434,169,508	2.8%	412,756,882	8.2%
TOTAL PATIENT REVENUE	$ 96,900,982	$ 92,074,875	5.2%	$ 100,279,983	-3.4%	$ 986,434,288	$ 944,088,755	4.5%	$ 949,057,083	3.9%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 57,341,109	$ 58,030,678	-1.2%	$ 65,126,259	-12.0%	$ 638,697,626	$ 594,960,595	7.4%	$ 599,673,226	6.5%
Policy Adjustments	1,006,810	908,776	10.8%	(3,489,757)	-128.9%	9,973,268	9,389,039	6.2%	7,719,562	29.2%
Uninsured Discount	8,710,250	8,953,996	-2.7%	15,082,594	-42.2%	86,096,611	91,629,662	-6.0%	93,656,860	-8.1%
Indigent Care	3,828,697	1,633,452	134.4%	1,326,153	188.7%	11,478,661	16,776,948	-31.6%	17,259,609	-33.5%
Provision for Bad Debts	6,741,198	4,663,544	44.6%	5,532,771	21.8%	58,042,215	47,812,865	21.4%	47,990,884	20.9%
TOTAL REVENUE DEDUCTIONS	$ 77,628,064	$ 74,190,446	4.6%	$ 83,578,021	-7.1%	$ 804,288,381	$ 760,569,109	5.7%	$ 766,300,141	5.0%
	80.11%	80.58%		83.34%		81.53%	80.56%		80.74%	
OTHER PATIENT REVENUE										
Medicaid Supplemental Payments	$ (361,099)	$ 1,892,772	-119.1%	$ 1,557,475	-123.2%	$ 15,673,546	$ 18,927,720	-17.2%	$ 17,942,239	-12.6%
DSRIP	(44,234)	1,282,780	-103.4%	3,334,144	-101.3%	9,241,855	12,827,800	-28.0%	8,258,701	11.9%
Medicare Meaningful Use Subsidy	-	-	0.0%	-	0.0%	(5,812)	-	0.0%	-	0.0%
TOTAL OTHER PATIENT REVENUE	$ (405,333)	$ 3,175,552	-112.8%	$ 4,891,619	-108.3%	$ 24,909,589	$ 31,755,520	-21.6%	$ 26,200,940	-4.9%
NET PATIENT REVENUE	$ 18,867,585	$ 21,059,981	-10.4%	$ 21,593,581	-12.6%	$ 207,055,495	$ 215,275,166	-3.8%	$ 208,957,882	-0.9%
OTHER REVENUE										
Tax Revenue	$ 6,933,093	$ 5,070,802	36.7%	$ 6,051,971	14.6%	$ 62,931,934	$ 53,694,426	17.2%	$ 53,339,539	18.0%
Other Revenue	675,149	671,709	0.5%	815,242	-17.2%	7,113,767	6,695,761	6.2%	7,091,310	0.3%
TOTAL OTHER REVENUE	$ 7,608,242	$ 5,742,511	32.5%	$ 6,867,214	10.8%	$ 70,045,700	$ 60,390,187	16.0%	$ 60,430,849	15.9%
NET OPERATING REVENUE	$ 26,475,827	$ 26,802,492	-1.2%	$ 28,460,794	-7.0%	$ 277,101,195	$ 275,665,353	0.5%	$ 269,388,731	2.9%
OPERATING EXPENSE										
Salaries and Wages	$ 10,317,977	$ 8,773,634	17.6%	$ 9,417,083	9.6%	$ 94,036,052	$ 89,312,928	5.3%	$ 88,977,959	5.7%
Benefits	1,051,782	2,574,572	-59.1%	1,697,651	-38.0%	7,864,741	25,538,821	-69.2%	24,335,740	-67.7%
Temporary Labor	1,871,375	723,482	158.7%	737,209	153.8%	27,779,147	7,969,907	248.6%	6,514,166	326.4%
Physician Fees	1,211,459	1,144,616	5.8%	1,190,475	1.8%	12,301,559	11,446,160	7.5%	12,723,889	-3.3%
Texas Tech Support	878,312	885,637	-0.8%	817,623	7.4%	8,626,575	8,856,370	-2.6%	8,552,809	0.9%
Purchased Services	4,424,536	4,322,774	2.4%	4,348,938	1.7%	44,463,222	43,213,483	2.9%	40,052,591	11.0%
Supplies	4,810,236	4,791,571	0.4%	4,857,741	-1.0%	51,837,176	48,529,210	6.8%	48,379,114	7.1%
Utilities	270,692	344,836	-21.5%	294,544	-8.1%	3,362,647	3,201,802	5.0%	3,127,982	7.5%
Repairs and Maintenance	677,118	801,267	-15.5%	810,398	-16.4%	8,500,669	8,018,970	6.0%	7,635,745	11.3%
Leases and Rentals	(3,559)	(7,470)	-52.4%	(33,184)	-89.3%	820,743	(74,700)	-1198.7%	(53,623)	-1630.6%
Insurance	119,168	103,977	14.6%	182,135	-34.6%	1,040,028	1,039,770	0.0%	1,030,521	0.9%
Interest Expense	70,033	132,249	-47.0%	107,715	-35.0%	820,360	1,330,864	-38.4%	1,075,409	-23.7%
ECHDA	183,672	200,924	-8.6%	284,107	-35.4%	1,871,423	2,009,240	-6.9%	2,256,754	-17.1%
Other Expense	72,769	93,289	-22.0%	58,741	23.9%	1,429,430	1,044,221	36.9%	792,579	80.4%
TOTAL OPERATING EXPENSES	$ 25,955,567	$ 24,885,358	4.3%	$ 24,771,176	4.8%	$ 264,753,771	$ 251,437,046	5.3%	$ 245,401,633	7.9%
Depreciation/Amortization	$ 1,654,912	$ 1,603,443	3.2%	$ 1,622,918	2.0%	$ 16,550,634	$ 15,724,117	5.3%	$ 15,840,821	4.5%
(Gain)/Loss on Disposal of Assets	(7,000)	681	-1127.9%	-	0.0%	(7,000)	6,810	100.0%	8,173	-185.6%
TOTAL OPERATING COSTS	$ 27,603,479	$ 26,489,482	4.2%	$ 26,394,094	4.6%	$ 281,297,404	$ 267,167,973	5.3%	$ 261,250,628	7.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ (1,127,652)**	**$ 313,010**	**-460.3%**	**$ 2,066,700**	**154.6%**	**$ (4,196,209)**	**$ 8,497,380**	**-149.4%**	**$ 8,138,104**	**-151.6%**
Operating Margin	-4.26%	1.17%	-464.7%	7.26%	-158.7%	-1.51%	3.08%	-149.1%	3.02%	-150.1%
NONOPERATING REVENUE/EXPENSE										
Interest Income	$ 95,138	$ 17,785	434.9%	$ 6,780	1303.3%	$ 481,220	$ 177,850	170.6%	$ 47,706	908.7%
Tobacco Settlement	-	-	0.0%	-	0.0%	1,158,055	1,284,940	-9.9%	1,171,633	-1.2%
Trauma Funds	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
Donations	-	11,772	-100.0%	-	0.0%	-	117,720	-100.0%	141,275	-100.0%
COVID-19 Stimulus	-	-	0.0%	-	0.0%	6,113,607	-		-	0.0%
CHANGE IN NET POSITION BEFORE CAPITAL CONTRIBUTION	$ (1,032,514)	$ 342,567	-401.4%	$ 2,073,480	-149.8%	$ 3,556,673	$ 10,077,890	-64.7%	$ 9,498,718	-62.6%
Procare & Trauma Care Capital Contribution	(1,948,411)	(1,631,859)	19.4%	(1,927,412)	1.1%	(15,890,332)	(16,132,795)	-1.5%	(14,755,505)	7.7%
CHANGE IN NET POSITION BEFORE INVESTMENT ACTIVITY	$ (2,980,925)	$ (1,289,292)	-131.2%	$ 146,068	2140.8%	$ (12,333,659)	$ (6,054,905)	-103.7%	$ (5,256,788)	-134.6%
Unrealized Gain/(Loss) on Investments	$ 232,365	$ (9,360)	-2582.5%	$ 33,736	588.8%	$ (2,295,709)	$ (93,600)	2352.7%	$ (39,215)	5754.2%
Investment in Subsidiaries	(6,395)	124,344	-105.1%	4,151	-254.1%	708,218	1,243,440	-43.0%	1,431,433	-50.5%
CHANGE IN NET POSITION	**$ (2,754,954)**	**$ (1,174,308)**	**-134.6%**	**$ 183,955**	**1597.6%**	**$ (13,921,150)**	**$ (4,905,065)**	**-183.8%**	**$ (3,864,570)**	**-260.2%**

ECTOR COUNTY HOSPITAL DISTRICT
PROCARE OPERATIONS SUMMARY
JULY 2022

	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	$ 10,274,923	$ 9,822,429	4.6%	$ 11,043,577	-7.0%	$ 109,145,892	$ 111,420,530	-2.0%	$ 118,619,460	-8.0%
TOTAL PATIENT REVENUE	$ 10,274,923	$ 9,822,429	4.6%	$ 11,043,577	-7.0%	$ 109,145,892	$ 111,420,530	-2.0%	$ 118,619,460	-8.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 5,144,402	$ 4,222,461	21.8%	$ 5,799,780	-11.3%	$ 53,627,554	$ 50,443,327	6.3%	$ 57,211,866	-6.3%
Policy Adjustments	950,691	837,882	13.5%	425,637	123.4%	7,429,338	9,831,697	-24.4%	10,801,451	-31.2%
Uninsured Discount	467,389	546,131	-14.4%	321,825	45.2%	4,927,946	6,561,253	-24.9%	6,674,948	-26.2%
Indigent	9,756	12,437	-21.6%	3,206	204.3%	72,856	136,877	-46.8%	166,702	-56.3%
Provision for Bad Debts	377,720	667,932	-43.4%	1,203,247	-68.6%	8,420,901	8,731,983	-3.6%	9,808,010	-14.1%
TOTAL REVENUE DEDUCTIONS	$ 6,949,959	$ 6,286,843	10.5%	$ 7,753,695	-10.4%	$ 74,478,596	$ 75,705,137	-1.6%	$ 84,662,976	-12.0%
	67.64%	64.00%		70.21%		68.24%	67.95%		71.37%	
NET PATIENT REVENUE	$ 3,324,965	$ 3,535,586	-6.0%	$ 3,289,882	1.1%	$ 34,667,296	$ 35,715,393	-2.9%	$ 33,956,483	2.1%
						31.8%				
OTHER REVENUE										
Other Income	$ 240,980	$ 190,662	26.4%	$ 180,961	33.2%	$ 2,156,094	$ 2,004,070	7.6%	$ 2,049,291	5.2%
TOTAL OTHER REVENUE										
NET OPERATING REVENUE	$ 3,565,944	$ 3,726,248	-4.3%	$ 3,470,843	2.7%	$ 36,823,390	$ 37,719,463	-2.4%	$ 36,005,775	2.3%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 4,191,759	$ 4,278,035	-2.0%	$ 4,107,992	2.0%	$ 40,592,694	$ 42,253,091	-3.9%	$ 39,347,999	3.2%
Benefits	349,090	373,889	-6.6%	353,627	-1.3%	4,210,417	4,247,605	-0.9%	4,069,334	3.5%
Temporary Labor	213,852	201,117	6.3%	300,706	-28.9%	2,813,693	2,011,170	39.9%	2,266,498	24.1%
Physician Fees	371,669	115,973	220.5%	200,417	85.4%	1,974,893	1,156,070	70.8%	1,314,161	50.3%
Purchased Services	3,794	(13,729)	-127.6%	21,541	-82.4%	(650,735)	33,664	-2033.0%	(247,009)	163.4%
Supplies	107,572	115,462	-6.8%	120,277	-10.6%	1,146,476	1,222,851	-6.2%	1,183,588	-3.1%
Utilities	566	505	12.0%	1,091	-48.1%	5,200	5,050	3.0%	7,066	-26.4%
Repairs and Maintenance	6,632	105	6216.4%	-	100.0%	11,536	7,050	63.6%	876	1216.8%
Leases and Rentals	177,371	161,476	9.8%	165,601	7.1%	1,588,635	1,605,300	-1.0%	1,659,457	-4.3%
Insurance	27,736	52,502	-47.2%	35,595	-22.1%	485,835	523,222	-7.1%	483,410	0.5%
Other Expense	59,042	64,626	-8.6%	84,884	-30.4%	477,279	705,725	-32.4%	608,158	-21.5%
TOTAL OPERATING EXPENSES	$ 5,509,083	$ 5,349,961	3.0%	$ 5,391,732	2.2%	$ 52,655,924	$ 53,770,798	-2.1%	$ 50,693,538	3.9%
Depreciation/Amortization	$ 5,273	$ 8,146	-35.3%	$ 6,522	-19.2%	$ 50,283	$ 81,460	-38.3%	$ 67,742	-25.8%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	0.0%	7,515	-	0.0%	-	0.0%
TOTAL OPERATING COSTS	$ 5,514,355	$ 5,358,107	2.9%	$ 5,398,254	2.2%	$ 52,713,722	$ 53,852,258	-2.1%	$ 50,761,280	3.8%
NET GAIN (LOSS) FROM OPERATIONS	**$ (1,948,411)**	**$ (1,631,859)**	**-19.4%**	**$ (1,927,412)**	**1.1%**	**$ (15,890,332)**	**$ (16,132,795)**	**1.5%**	**$ (14,755,505)**	**-7.7%**
Operating Margin	-54.64%	-43.79%	24.8%	-55.53%	-1.6%	-43.15%	-42.77%	0.9%	-40.98%	5.3%
COVID-19 Stimulus	$ -	$ -		$ -	0.0%	$ -	$ -	0.0%	$ -	0.0%
MCH Contribution	$ 1,948,411	$ 1,631,859	19.4%	$ 1,927,412	1.1%	$ 15,890,332	$ 16,132,795	-1.5%	$ 14,755,505	7.7%
CAPITAL CONTRIBUTION	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**$ -**	**0.0%**	**$ -**	**0.0%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH					YEAR TO DATE				
Total Office Visits	8,256	8,999	-8.26%	8,884	-7.07%	87,120	87,935	-0.93%	84,574	3.01%
Total Hospital Visits	5,322	5,538	-3.90%	5,978	-10.97%	57,398	55,885	2.71%	54,386	5.54%
Total Procedures	11,152	10,262	8.67%	12,438	-10.34%	117,611	119,629	-1.69%	119,227	-1.36%
Total Surgeries	764	790	-3.29%	749	2.00%	7,534	7,653	-1.55%	7,056	6.77%
Total Provider FTE's	86.7	100.4	-13.64%	92.9	-6.65%	90.0	99.0	-9.12%	91.9	-2.14%
Total Staff FTE's	116.5	127.1	-8.37%	108.9	6.94%	110.2	126.6	-12.98%	104.4	5.56%
Total Administrative FTE's	13.0	13.0	0.31%	13.4	-2.50%	13.1	13.0	0.45%	12.5	4.09%
Total FTE's	216.2	240.5	-10.10%	215.2	0.48%	213.2	238.6	-10.64%	208.9	2.08%

ECTOR COUNTY HOSPITAL DISTRICT
TRAUMACARE OPERATIONS SUMMARY
JULY 2022

	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	$ 150,000	$ -		$ -	100.0%	$ 278,083	$ -		$ -	100.0%
TOTAL PATIENT REVENUE	$ 150,000	$ -		$ -	100.0%	$ 278,083	$ -		$ -	100.0%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 89,250	$ -		$ -	100.0%	$ 165,113	$ -		$ -	100.0%
Policy Adjustments	25,500	-		-	100.0%	47,175	-		-	100.0%
Uninsured Discount	-	-		-	100.0%	-	-		-	100.0%
Indigent	-	-		-	100.0%	-	-		-	100.0%
Provision for Bad Debts	12,750	-		-	100.0%	23,588	-		-	100.0%
TOTAL REVENUE DEDUCTIONS	$ 127,500	$ -		$ -	100.0%	$ 235,875	$ -		$ -	100.0%
	85.00%	#DIV/0!		#DIV/0!		84.82%	#DIV/0!		#DIV/0!	
NET PATIENT REVENUE	$ 22,500	$ -		$ -	100.0%	$ 42,208	$ -		$ -	100.0%
						15.2%				
OTHER REVENUE										
Other Income	$ -	$ -		$ -	100.0%	$ -	$ -		$ -	100.0%
TOTAL OTHER REVENUE										
					100.0%					100.0%
NET OPERATING REVENUE	$ 22,500	$ -		$ -	100.0%	$ 42,208	$ -		$ -	100.0%
						-				
OPERATING EXPENSE										
Salaries and Wages	$ 264,164	$ -		$ -	100.0%	$ 506,930	$ -		$ -	100.0%
Benefits	18,528	-		-	100.0%	58,528	-		-	100.0%
Temporary Labor	-	-		-	100.0%	-	-		-	100.0%
Physician Fees	(259,248)	-		-	100.0%	(518,496)	-		-	100.0%
Purchased Services	208	-		-	100.0%	208	-		-	100.0%
Supplies	1,428	-		-	100.0%	1,428	-		-	100.0%
Utilities	-	-		-	100.0%	-	-		-	100.0%
Repairs and Maintenance	-	-		-	100.0%	-	-		-	100.0%
Leases and Rentals	-	-		-	100.0%	-	-		-	100.0%
Insurance	10,831	-		-	100.0%	12,365	-		-	100.0%
Other Expense	242	-		-	100.0%	242	-		-	100.0%
TOTAL OPERATING EXPENSES	$ 36,152	$ -		$ -	100.0%	$ 61,205	$ -		$ -	100.0%
Depreciation/Amortization	$ -	$ -		$ -	100.0%	$ -	$ -	0.0%	$ -	100.0%
(Gain)/Loss on Sale of Assets	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
TOTAL OPERATING COSTS	$ 36,152	$ -		$ -	100.0%	$ 61,205	$ -		$ -	100.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (13,652)**	**$ -**		**$ -**	**100.0%**	**$ (18,997)**	**$ -**		**$ -**	**100.0%**
Operating Margin	-60.68%	#DIV/0!	#DIV/0!	#DIV/0!	-100.0%	-45.01%	#DIV/0!	#DIV/0!	#DIV/0!	-100.0%
COVID-19 Stimulus	$ -	$ -		$ -	100.0%	$ -	$ -	0.0%	$ -	100.0%
MCH Contribution	$ -	$ -		$ -	100.0%	$ -	$ -		$ -	100.0%
CAPITAL CONTRIBUTION	**$ (13,652)**	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ (18,997)**	**$ -**	**0.0%**	**$ -**	**0.0%**

MONTHLY STATISTICAL REPORT

	CURRENT MONTH				YEAR TO DATE			
Total Procedures	399	0	0	100.00%	909	0	0	100.00%
Total Provider FTE's	8.4	0.0	0.0	100.00%	1.7	0.0	0.0	100.00%
Total Staff FTE's	0.9	0.0	0.0	100.00%	0.2	0.0	0.0	100.00%
Total FTE's	9.3	0.0	0.0	100.00%	1.9	0.0	0.0	100.00%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - WEST UNIVERSITY - OPERATIONS SUMMARY
JULY 2022

	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	$ 162,564	$ 176,358	-7.8%	$ 100,657	61.5%	$ 1,537,517	$ 1,725,321	-10.9%	$ 596,567	157.7%
TOTAL PATIENT REVENUE	$ 162,564	$ 176,358	-7.8%	$ 100,657	61.5%	$ 1,537,517	$ 1,725,321	-10.9%	$ 596,567	157.7%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 100,227	$ 100,142	0.1%	$ 49,864	101.0%	$ 840,590	$ 979,692	-14.2%	$ 319,042	163.5%
Self Pay Adjustments	(103)	23,031	-100.4%	195	-152.7%	115,440	225,311	-48.8%	69,777	65.4%
Bad Debts	11,007	-	0.0%	13,617	-19.2%	71,347	-	0.0%	(30,020)	-337.7%
TOTAL REVENUE DEDUCTIONS	$ 111,131	$ 123,173	-9.8%	$ 63,676	74.5%	$ 1,027,377	$ 1,205,003	-14.7%	$ 358,799	186.3%
	68.36%	69.84%		63.26%		66.82%	69.84%		60.14%	
NET PATIENT REVENUE	$ 51,433	$ 53,185	-3.3%	$ 36,980	39.1%	$ 510,140	$ 520,318	-2.0%	$ 237,768	114.6%
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	$ 51,433	$ 53,185	-3.3%	$ 36,980	39.1%	$ 510,140	$ 520,318	-2.0%	$ 237,768	114.6%
OPERATING EXPENSE										
Salaries and Wages	$ 13,190	$ 27,928	-52.8%	$ 10,793	22.2%	$ 69,541	$ 268,514	-74.1%	$ 72,064	-3.5%
Benefits	1,345	8,195	-83.6%	1,946	-30.9%	5,816	76,781	-92.4%	19,710	-70.5%
Physician Services	44,932	45,750	-1.8%	40,830	10.0%	391,116	457,500	-14.5%	232,725	68.1%
Cost of Drugs Sold	-	10,633	-100.0%	-	0.0%	33,752	104,022	-67.6%	19,458	73.5%
Supplies	3,792	5,520	-31.3%	309	1129.2%	21,211	54,042	-60.8%	3,219	558.8%
Utilities	2,547	3,671	-30.6%	2,707	-5.9%	26,309	28,773	-8.6%	27,808	-5.4%
Repairs and Maintenance	-	-	0.0%	-	100.0%	-	-	0.0%	-	100.0%
Other Expense	-	-	0.0%	-	0.0%	-	-	0.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 65,806	$ 101,697	-35.3%	$ 56,585	16.3%	$ 547,745	$ 989,632	-44.7%	$ 374,985	46.1%
Depreciation/Amortization	$ 25,992	$ 29,790	-12.7%	$ 28,197	-7.8%	$ 260,263	$ 292,137	-10.9%	$ 290,991	-10.6%
TOTAL OPERATING COSTS	$ 91,798	$ 131,487	-30.2%	$ 84,783	8.3%	$ 808,008	$ 1,281,769	-37.0%	$ 665,975	21.3%
NET GAIN (LOSS) FROM OPERATIONS	**$ (40,366)**	**$ (78,302)**	**-48.4%**	**$ (47,802)**	**-15.6%**	**$ (297,868)**	**$ (761,451)**	**-60.9%**	**$ (428,207)**	**-30.4%**
Operating Margin	-78.48%	-147.23%	-46.7%	-129.26%	-39.3%	-58.39%	-146.34%	-60.1%	-180.09%	-67.6%

	CURRENT MONTH					YEAR TO DATE				
Total Visits	552	567	-2.6%	337	63.8%	5,556	5,547	0.2%		0.0%
Average Revenue per Office Visit	294.50	311.04	-5.3%	298.68	-1.4%	276.73	311.04	-11.0%	307.51	-10.0%
Hospital FTE's (Salaries and Wages)	4.4	7.3	-39.4%	3.5	25.6%	2.7	7.3	-63.6%	2.6	3.3%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - SOUTH - OPERATIONS SUMMARY
JULY 2022

	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	$ 121,922	$ 330,349	-63.1%	$ 385,240	-68.4%	$ 1,630,401	$ 3,362,492	-51.5%	$ 4,543,757	-64.1%
TOTAL PATIENT REVENUE	$ 121,922	$ 330,349	-63.1%	$ 385,240	-68.4%	$ 1,630,401	$ 3,362,492	-51.5%	$ 4,543,757	-64.1%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 75,929	$ 179,671	-57.7%	$ 218,334	-65.2%	$ 986,901	$ 1,828,802	-46.0%	$ 2,463,628	-59.9%
Self Pay Adjustments	2,561	51,543	-95.0%	23,525	-89.1%	257,959	524,632	-50.8%	612,861	-57.9%
Bad Debts	4,729	10,557	-55.2%	41,155	-88.5%	(68,730)	107,458	-164.0%	278,806	-124.7%
TOTAL REVENUE DEDUCTIONS	$ 83,219	$ 241,771	-65.6%	$ 283,015	-70.6%	$ 1,176,129	$ 2,460,892	-52.2%	$ 3,355,295	-64.9%
	68.3%	73.2%		73.5%		72.1%	73.2%		73.8%	
NET PATIENT REVENUE	$ 38,703	$ 88,578	-56.3%	$ 102,226	-62.1%	$ 454,271	$ 901,600	-49.6%	$ 1,188,462	-61.8%
OTHER REVENUE										
FHC Other Revenue	$ 40,046	$ 25,436	0.0%	$ 64,349	-37.8%	$ 278,257	$ 254,360	0.0%	$ 407,773	-31.8%
TOTAL OTHER REVENUE	$ 40,046	$ 25,436	57.4%	$ 64,349	-37.8%	$ 278,257	$ 254,360	9.4%	$ 407,773	-31.8%
NET OPERATING REVENUE	$ 78,749	$ 114,014	-30.9%	$ 166,574	-52.7%	$ 732,529	$ 1,155,960	-36.6%	$ 1,596,234	-54.1%
OPERATING EXPENSE										
Salaries and Wages	$ 71,437	$ 59,260	20.5%	$ 70,859	0.8%	$ 744,215	$ 592,458	25.6%	$ 857,702	-13.2%
Benefits	7,282	17,390	-58.1%	12,774	-43.0%	62,243	169,412	-63.3%	234,584	-73.5%
Physician Services	56,661	68,581	-17.4%	97,533	-41.9%	839,817	685,810	22.5%	1,131,152	-25.8%
Cost of Drugs Sold	330	2,996	-89.0%	3,118	-89.4%	33,084	30,499	8.5%	65,328	-49.4%
Supplies	(2,898)	4,444	-165.2%	8,267	-135.0%	29,240	45,040	-35.1%	128,269	-77.2%
Utilities	443	3,965	-88.8%	2,649	-83.3%	29,300	29,686	-1.3%	28,370	3.3%
Repairs and Maintenance	1,642	1,799	-8.7%	19,232	-91.5%	32,679	17,990	81.7%	28,291	15.5%
Leases and Rentals	484	477	1.5%	468	3.4%	4,864	4,770	2.0%	4,944	-1.6%
Other Expense	1,000	1,125	-11.1%	5,253	-81.0%	14,012	11,250	24.5%	41,164	-66.0%
TOTAL OPERATING EXPENSES	$ 136,382	$ 160,037	-14.8%	$ 220,153	-38.1%	$ 1,789,455	$ 1,586,915	12.8%	$ 2,519,804	-29.0%
Depreciation/Amortization	$ 2,625	$ 4,002	-34.4%	$ 3,807	-31.0%	$ 26,267	$ 39,249	-33.1%	$ 38,697	-32.1%
TOTAL OPERATING COSTS	$ 139,007	$ 164,039	-15.3%	$ 223,960	-37.9%	$ 1,815,722	$ 1,626,164	11.7%	$ 2,558,500	-29.0%
NET GAIN (LOSS) FROM OPERATIONS	**$ (60,258)**	**$ (50,025)**	**-20.5%**	**$ (57,386)**	**-5.0%**	**$ (1,083,193)**	**$ (470,204)**	**-130.4%**	**$ (962,266)**	**12.6%**
Operating Margin	-76.52%	-43.88%	74.4%	-34.45%	122.1%	-147.87%	-40.68%	263.5%	-60.28%	145.3%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	467	963	-51.5%	1,286	-63.7%	6,425	9,802	-34.5%	13,417	-52.1%
Average Revenue per Office Visit	261.08	343.04	-23.9%	299.56	-12.8%	253.76	343.04	-26.0%	338.66	-25.1%
Hospital FTE's (Salaries and Wages)	15.7	12.4	26.5%	14.8	6.3%	15.3	12.9	18.3%	17.8	-14.4%

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC - JBS - OPERATIONS SUMMARY
JULY 2022

	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	$ 227,873	$ 144,875	57.3%	$ 14,512	1470.2%	$ 2,398,753	$ 1,830,915	31.0%	$ 14,512	16429.1%
TOTAL PATIENT REVENUE	$ 227,873	$ 144,875	57.3%	$ 14,512	1470.2%	$ 2,398,753	$ 1,830,915	31.0%	$ 14,512	16429.1%
DEDUCTIONS FROM REVENUE										
Contractual Adjustments	$ 92,828	$ 58,120	59.7%	$ 10,502	783.9%	$ 1,321,170	$ 734,519	79.9%	$ 10,502	12479.9%
Self Pay Adjustments	6,147	16,673	-63.1%	-	100.0%	76,654	210,714	-63.6%	-	100.0%
Bad Debts	18,646	3,415	446.0%	-	100.0%	155,913	43,160	261.2%	-	100.0%
TOTAL REVENUE DEDUCTIONS	$ 117,621	$ 78,208	50.4%	$ 10,502	1020.0%	$ 1,553,738	$ 988,393	57.2%	$ 10,502	14694.4%
	51.62%	53.98%		72.37%		64.77%	53.98%		72.37%	
NET PATIENT REVENUE	$ 110,253	$ 66,667	65.4%	$ 4,010	2649.3%	$ 845,015	$ 842,522	0.3%	$ 4,010	20972.0%
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	$ 110,253	$ 66,667	65.4%	$ 4,010	2649.3%	$ 845,015	$ 842,522	0.3%	$ 4,010	20972.0%
OPERATING EXPENSE										
Salaries and Wages	$ 19,263	$ 20,904	-7.9%	$ 2,725	606.9%	$ 140,174	$ 258,837	-45.8%	$ 2,725	5044.1%
Benefits	1,964	6,134	-68.0%	491	300.0%	11,724	74,014	-84.2%	745	1473.7%
Physician Services	46,889	42,492	10.3%	-	100.0%	438,555	424,920	3.2%	-	100.0%
Cost of Drugs Sold	2,275	-	0.0%	-	100.0%	127,711	-	100.0%	-	100.0%
Supplies	6,446	10,027	-35.7%	6,582	-2.1%	21,616	126,720	-82.9%	7,026	207.7%
Utilities	-	2,789	-100.0%	-	100.0%	-	27,890	-100.0%	-	100.0%
Repairs and Maintenance	-	417	-100.0%	-	100.0%	-	4,170	-100.0%	-	100.0%
Other Expense	-	417	-100.0%	-	0.0%	-	4,170	-100.0%	-	0.0%
TOTAL OPERATING EXPENSES	$ 76,838	$ 83,680	-8.2%	$ 9,798	684.3%	$ 739,781	$ 925,721	-20.1%	$ 10,496	6948.5%
Depreciation/Amortization	$ 75	$ -	0.0%	$ 75	0.0%	$ 749	$ -	0.0%	$ 75	899.9%
TOTAL OPERATING COSTS	$ 76,912	$ 83,680	-8.1%	$ 9,872	679.1%	$ 740,529	$ 925,721	-20.0%	$ 10,570	6905.7%
NET GAIN (LOSS) FROM OPERATIONS	**$ 33,340**	**$ (17,013)**	**-296.0%**	**$ (5,862)**	**-668.7%**	**$ 104,486**	**$ (83,199)**	**-225.6%**	**$ (6,560)**	**-1692.7%**
Operating Margin	30.24%	-25.52%	-218.5%	-146.19%	-120.7%	12.37%	-9.87%	-225.2%	-163.59%	-107.6%

	CURRENT MONTH					YEAR TO DATE				
Medical Visits	637	475	34.1%	47	1255.3%	6,474	6,003	7.8%	47	13674.5%
Total Visits	637	475	34.1%	47	1255.3%	6,474	6,003	7.8%		0.0%
Average Revenue per Office Visit	357.73	305.00	17.3%	308.77	15.9%	370.52	305.00	21.5%	308.77	20.0%
Hospital FTE's (Salaries and Wages)	5.5	6.3	-12.0%	0.9	492.8%	4.9	7.9	-38.5%	0.1	5003.0%

ECTOR COUNTY HOSPITAL DISTRICT
JULY 2022

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	$ 33,595,510	34.6%	$ 40,745,130	40.7%	$ 382,141,031	38.7%	$ 376,199,175	39.5%
Medicaid	14,040,004	14.5%	13,573,266	13.5%	130,014,246	13.2%	115,313,898	12.2%
Commercial	28,935,333	29.9%	28,306,895	28.2%	289,872,312	29.4%	272,947,227	28.8%
Self Pay	16,500,405	17.0%	14,726,109	14.7%	118,749,893	12.0%	117,582,767	12.4%
Other	3,829,731	4.0%	2,928,583	2.9%	65,656,805	6.7%	67,014,016	7.1%
TOTAL	**$ 96,900,982**	**100.0%**	**$ 100,279,983**	**100.0%**	**$ 986,434,288**	**100.0%**	**$ 949,057,083**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 6,651,020	38.3%	$ 6,408,950	38.7%	$ 69,936,694	38.0%	$ 70,464,040	39.5%
Medicaid	3,496,755	20.1%	1,892,654	11.4%	20,738,751	11.3%	20,424,562	11.4%
Commercial	5,645,238	32.5%	6,544,729	39.5%	69,050,054	37.6%	65,619,998	36.8%
Self Pay	877,950	5.1%	1,030,464	6.2%	11,499,211	6.2%	10,418,819	5.8%
Other	693,518	4.0%	703,170	4.2%	12,950,063	7.0%	11,635,968	6.5%
TOTAL	**$ 17,364,482**	**100.0%**	**$ 16,579,968**	**100.0%**	**$ 184,174,772**	**100.1%**	**$ 178,563,388**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC CLEMENTS
JULY 2022

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	$ 27,952	22.9%	$ 74,563	19.4%	$ 348,889	21.4%	$ 699,130	15.4%
Medicaid	43,585	35.8%	178,396	46.3%	418,685	25.7%	1,987,264	43.8%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	17,717	14.5%	72,556	18.8%	262,120	16.1%	678,555	14.9%
Self Pay	30,131	24.7%	50,505	13.1%	544,015	33.3%	1,022,506	22.5%
Other	2,538	2.1%	9,220	2.4%	56,692	3.5%	156,301	3.4%
TOTAL	**$ 121,922**	**100.0%**	**$ 385,240**	**100.0%**	**$ 1,630,401**	**100.0%**	**$ 4,543,757**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	3,387	8.6%	$ 12,079	8.6%	$ 129,009	24.0%	$ 250,415	17.7%
Medicaid	21,721	55.5%	90,750	64.7%	205,270	38.3%	732,587	51.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	4,086	10.4%	22,235	15.8%	92,629	17.2%	223,340	15.8%
Self Pay	8,412	21.5%	12,426	8.8%	97,209	18.1%	176,175	12.5%
Other	1,566	4.0%	2,972	2.1%	13,016	2.4%	28,951	2.1%
TOTAL	**$ 39,173**	**100.0%**	**$ 140,462**	**100.0%**	**$ 537,132**	**100.0%**	**$ 1,411,468**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC WEST UNIVERSITY
JULY 2022

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	$ 42,246	26.0%	$ 38,580	38.3%	$ 349,578	22.7%	$ 179,257	30.0%
Medicaid	39,749	24.5%	$ 29,475	29.3%	403,127	26.3%	158,290	26.5%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	42,134	25.9%	$ 25,513	25.3%	367,618	23.9%	144,013	24.1%
Self Pay	30,238	18.6%	$ 6,778	6.7%	336,141	21.8%	107,653	18.0%
Other	8,196	5.0%	$ 310	0.3%	81,051	5.3%	7,355	1.2%
TOTAL	**$ 162,564**	**100.0%**	**$ 100,657**	**100.0%**	**$ 1,537,517**	**100.0%**	**$ 596,567**	**100.0%**

PAYMENTS BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%	PAYMENTS	%
Medicare	$ 6,870	12.2%	$ 12,062	31.3%	$ 112,890	22.6%	$ 63,970	26.3%
Medicaid	20,000	35.5%	12,472	32.3%	$ 169,489	33.9%	60,396	24.9%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	21,273	37.7%	9,412	24.4%	133,212	26.7%	81,036	33.4%
Self Pay	6,736	11.9%	4,348	11.3%	68,745	13.8%	33,851	13.9%
Other	1,517	2.7%	269	0.7%	15,120	3.0%	3,617	1.5%
TOTAL	**$ 56,395**	**100.0%**	**$ 38,563**	**100.0%**	**$ 499,455**	**100.0%**	**$ 242,871**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
FAMILY HEALTH CLINIC JBS
JULY 2022

REVENUE BY PAYOR

	CURRENT MONTH				YEAR TO DATE			
	CURRENT YEAR		PRIOR YEAR		CURRENT YEAR		PRIOR YEAR	
	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%	GROSS REVENUE	%
Medicare	$ -	0.0%	$ -	0.0%	$ (809)	0.0%	$ -	0.0%
Medicaid	140,354	61.6%	$ 683	4.7%	1,464,708	61.0%	-	0.0%
PHC	-	0.0%	$ -	0.0%	-	0.0%	-	0.0%
Commercial	80,919	35.5%	$ 13,675	94.2%	858,522	35.8%	-	0.0%
Self Pay	5,544	2.4%	$ 154	1.1%	54,727	2.3%	-	0.0%
Other	1,056	0.5%	$ -	0.0%	21,605	0.9%	-	0.0%
TOTAL	**$ 227,873**	**100.0%**	**$ 14,512**	**100.0%**	**$ 2,398,753**	**100.0%**	**$ -**	**0.0%**

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	48,356	54.0%	-	0.0%	634,967	58.5%	-	0.0%
PHC	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	35,653	39.8%	-	0.0%	386,369	35.5%	-	0.0%
Self Pay	4,256	4.8%	350	100.0%	58,155	5.3%	350	100.0%
Other	1,286	1.4%	-	0.0%	7,899	0.7%	-	0.0%
TOTAL	**$ 89,551**	**100.0%**	**$ 350**	**100.0%**	**$ 1,087,391**	**100.0%**	**$ 350**	**100.0%**

ECTOR COUNTY HOSPITAL DISTRICT
STATEMENT OF CASH FLOW
JULY 2022

	Hospital	ProCare	TraumaCare	Blended
Cash Flows from Operating Activities and Nonoperating Revenue:				
Excess of Revenue over Expenses	$ (13,921,150)	-	(18,997)	$ (13,940,147)
Noncash Expenses:				
Depreciation and Amortization	14,859,872	14,141	-	14,874,014
Unrealized Gain/Loss on Investments	(2,295,709)	-	-	(2,295,709)
Accretion (Bonds) & COVID Funding	(563,737)	-	-	(563,737)
Changes in Assets and Liabilities				
Patient Receivables, Net	3,554,562	(1,650,019)	(42,208)	1,862,335
Taxes Receivable/Deferred	1,378,218	(7,312)	-	1,370,906
Inventories, Prepaids and Other	7,827,832	(5,523)	(16,760)	7,805,549
Accounts Payable	12,386,283	(839,381)	(213,379)	11,333,523
Accrued Expenses	4,362,872	2,488,669	291,344	7,142,884
Due to Third Party Payors	(11,737,301)	-	-	(11,737,301)
Accrued Post Retirement Benefit Costs	(11,798,473)	-	-	(11,798,473)
Net Cash Provided by Operating Activities	$ 4,053,269	575	-	$ 4,053,844
Cash Flows from Investing Activities:				
Investments	$ (3,415,188)	-	-	$ (3,415,188)
Acquisition of Property and Equipment	(10,116,155)	-	-	(10,116,155)
Net Cash used by Investing Activities	$ (13,531,344)	-	-	$ (13,531,344)
Cash Flows from Financing Activities:				
Current Portion Debt	$ (322,483)	-	-	$ (322,483)
Net Repayment of Long-term Debt/Bond Issuance	(596,070)	-	-	(596,070)
Net Cash used by Financing Activities	(918,553)	-	-	(918,553)
Net Increase (Decrease) in Cash	(10,396,627)	575	-	(10,396,052)
Beginning Cash & Cash Equivalents @ 9/30/2021	61,692,933	4,500	-	61,697,433
Ending Cash & Cash Equivalents @ 7/31/2022	$ 51,296,305	$ 5,075	$ -	$ 51,301,380
Balance Sheet				
Cash and Cash Equivalents	$ 21,421,767	5,075	-	$ 21,426,842
Restricted Assets	29,874,539	-	-	29,874,539
Ending Cash & Cash Equivalents @ 7/31/2022	$ 51,296,305	5,075	-	$ 51,301,380

ECTOR COUNTY HOSPITAL DISTRICT
TAX COLLECTIONS
FISCAL 2022

	ACTUAL COLLECTIONS	BUDGETED COLLECTIONS	VARIANCE	PRIOR YEAR COLLECTIONS	VARIANCE
AD VALOREM					
OCTOBER	$ 215,347	$ 1,918,187	$ (1,702,840)	$ 251,630	$ (36,283)
NOVEMBER	1,231,030	1,918,187	(687,157)	1,075,295	155,735
DECEMBER	6,614,568	1,918,187	4,696,381	6,840,747	(226,179)
JANUARY	5,169,442	1,918,187	3,251,255	7,131,638	(1,962,196)
FEBRUARY	6,692,218	1,918,187	4,774,031	4,756,484	1,935,735
MARCH	2,057,908	1,918,187	139,721	2,415,426	(357,517)
APRIL	426,742	1,918,187	(1,491,445)	464,788	(38,046)
MAY	406,640	1,918,187	(1,511,547)	239,559	167,082
JUNE	239,780	1,918,187	(1,678,407)	322,185	(82,405)
JULY	156,013	1,918,187	(1,762,174)	107,495	48,518
TOTAL	$ 23,209,689	$ 19,181,870	$ 4,027,819	$ 23,605,246	$ (395,557)
SALES					
OCTOBER	$ 3,421,981	$ 3,511,415	$ (89,434)	$ 2,929,377	$ 492,604
NOVEMBER	3,326,676	3,556,241	(229,565)	3,099,131	227,545
DECEMBER	4,147,133	3,557,673	589,460	2,855,097	1,292,036
JANUARY	3,621,391	3,414,673	206,718	2,796,371	825,019
FEBRUARY	4,399,256	3,907,638	491,618	4,354,021	45,235
MARCH	4,537,253	3,299,902	1,237,351	2,721,819	1,815,434
APRIL	4,669,784	3,195,073	1,474,711	2,650,606	2,019,178
MAY	4,733,959	3,761,529	972,430	3,668,808	1,065,151
JUNE	4,218,782	3,155,797	1,062,985	3,276,521	942,261
JULY	4,414,843	3,152,615	1,262,228	3,406,244	1,008,599
SUB TOTAL	41,491,057	34,512,556	6,978,501	31,757,994	9,733,062
ACCRUAL	2,259,007	-	2,259,007	-	2,259,007
TOTAL	$ 43,750,064	$ 34,512,556	$ 9,237,508	$ 31,757,994	$ 11,992,069
TAX REVENUE	**$ 66,959,752**	**$ 53,694,426**	**$ 13,265,326**	**$ 55,363,240**	**$ 11,596,512**

ECTOR COUNTY HOSPITAL DISTRICT
MEDICAID SUPPLEMENTAL PAYMENTS
FISCAL YEAR 2022

CASH ACTIVITY	TAX (IGT) ASSESSED	GOVERNMENT PAYOUT	BURDEN ALLEVIATION	NET INFLOW
DSH				
1st Qtr	$ (1,848,293)	$ 5,600,889		$ 3,752,596
2nd Qtr	(1,571,837)	4,763,143		3,191,306
3rd Qtr	-	-		-
4th Qtr	(2,733,190)	-		(2,733,190)
DSH TOTAL	$ (6,153,320)	$ 10,364,032		$ 4,210,712
UC				
1st Qtr	$ (4,129,344)	$ 12,908,233		8,778,889
2nd Qtr	(6,170,974)	18,699,982		12,529,008
3rd Qtr	-	-		-
4th Qtr	-	-		-
UC TOTAL	$ (10,300,318)	$ 31,608,215		$ 21,307,897
DSRIP				
1st Qtr	$ -	$ -		$ -
2nd Qtr	(64,999)	129,998		64,999
3rd Qtr	-	-		-
4th Qtr	(4,585,964)	13,762,820		9,176,856
DSRIP UPL TOTAL	$ (4,650,963)	$ 13,892,817		$ 9,241,855
UHRIP				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd Qtr	-	-		-
4th Qtr	-	-		-
UHRIP TOTAL	$ -	$ -		$ -
GME				
1st Qtr	$ -	$ -		$ -
2nd Qtr	(222,893)	675,433		452,540
3rd .	-	-		-
4th Qtr	(222,893)	675,433		452,540
GME TOTAL	$ (445,786)	$ 1,350,866		$ 905,080
CHIRP				
1st Qtr	$ -	$ -		$ -
2nd Qtr	-	-		-
3rd .	(3,231,090)	-		(3,231,090)
4th Qtr	-	-		-
CHIRP TOTAL	$ (3,231,090)	$ -		$ (3,231,090)
MCH Cash Activity	**$ (24,781,477)**	**$ 57,215,931**		**$ 32,434,454**
ProCare Cash Activity	$ -	$ -	$ -	**$ -**
Blended Cash Activity	**$ (24,781,477)**	**$ 57,215,931**	**$ -**	**$ 32,434,454**

INCOME STATEMENT ACTIVITY:	**BLENDED**
FY 2022 Accrued / (Deferred) Adjustments:	
DSH Accrual	$ 8,504,004
Uncompensated Care Accrual	10,850,909
URIP	-
GME	719,336
CHIRP	(4,400,702)
Regional UPL Benefit	-
Medicaid Supplemental Payments	15,673,546
DSRIP Accrual	9,241,855
Total Adjustments	**$ 24,915,401**

ECTOR COUNTY HOSPITAL DISTRICT
SCHEDULE OF CASH AND INVESTMENTS - HOSPITAL ONLY
JULY 2022

Cash and Cash Equivalents	Frost	Hilltop	Total
Operating	$ 20,606,212	$ -	$ 20,606,212
Mission Fitness	387,938	-	387,938
Petty Cash	8,850	-	8,850
Dispro	-	70,704	70,704
General Liability	-	27,175	27,175
Professional Liability	-	27,865	27,865
Funded Worker's Compensation	-	100,694	100,694
Funded Depreciation	-	90,561	90,561
Designated Funds	-	101,768	101,768
Total Cash and Cash Equivalents	$ 21,003,000	$ 418,767	**$ 21,421,767**

Investments	Other	Hilltop	Total
Dispro	$ -	$ 5,350,000	$ 5,350,000
Funded Depreciation	-	35,086,000	35,086,000
Funded Worker's Compensation	-	2,200,000	2,200,000
General Liability	-	3,000,000	3,000,000
Professional Liability	-	3,100,000	3,100,000
Designated Funds	133,165	23,200,000	23,333,165
Allowance for Change in Market Values		(2,428,568)	(2,428,568)
Total Investments	$ 133,165	$ 69,507,432	**$ 69,640,597**
Total Unrestricted Cash and Investments			**$ 91,062,363**

Restricted Assets	Reserves	Prosperity	Total
Assets Held By Trustee - Bond Reserves	$ 4,896	$ -	$ 4,896
Assets Held In Endowment-Board Designated	-	6,146,690	6,146,690
Advanced Medicare Payment	19,940,937	-	19,940,937
Restricted TPC, LLC-Equity Stake	1,443,525	-	1,443,525
Restricted MCH West Texas Services-Equity Stake	2,338,491	-	2,338,491
Total Restricted Assets	$ 23,727,849	$ 6,146,690	**$ 29,874,539**
Total Cash & Investments			**$ 120,936,902**

ECTOR COUNTY HOSPITAL DISTRICT
CONSTRUCTION IN PROGRESS - HOSPITAL ONLY
AS OF JULY 31, 2022

ITEM	CIP BALANCE AS OF 6/30/2022	JULY "+" ADDITIONS	JULY "-" ADDITIONS	JULY TRANSFERS	CIP BALANCE AS OF 7/31/2022	ADD: AMOUNTS CAPITALIZED	PROJECT TOTAL	BUDGETED AMOUNT	UNDER/(OVER) APRVD/BUDGET
RENOVATIONS									
FIRST FLOOR COMMON AREAS	350,899	-	-	-	350,899	-	350,899	720,000	369,101
RELOCATE SPD	120,643	6,954	-	-	127,596	-	127,596	4,000,000	3,872,404
SPECIAL PROCEDURES ROOM 8	-	16,387	-	-	16,387	-	16,387	250,000	233,613
SUB-TOTAL	$ 471,541	$ 23,341	$ -	$ -	$ 494,882	$ -	$ 494,882	$ 4,970,000	$ 4,475,118
MINOR BUILDING IMPROVEMENT									
RETAIL PHARMACY PROJECT	154,611	45,977	-	-	200,588	-	200,588	250,000	49,412
STERILE PROCESS REMODEL	78,155	14,157	-	-	92,312		92,312	49,000	(43,312)
SUITE 330 ID	51,213	-	-	(51,213)	-		-	35,000	35,000
SUB-TOTAL	$ 283,979	$ 60,134	$ -	$ (51,213)	$ 292,900	$ -	$ 292,900	$ 334,000	$ 41,100
EQUIPMENT & SOFTWARE PROJECTS - CIP INCOMPLETE									
VARIOUS CAPITAL EXPENDITURE PROJECTS	$ 2,840,218	$ 1,555,002	$ (200,692)	$ -	$ 4,194,528	$ -	$ 4,194,528	$ 8,750,000	$ 4,555,472
SUB-TOTAL	$ 2,840,218	$ 1,555,002	$ (200,692)	$ -	$ 4,194,528	$ -	$ 4,194,528	$ 8,750,000	$ 4,555,472
TOTAL CONSTRUCTION IN PROGRESS	**$ 3,595,738**	**$ 1,638,476**	**$ (200,692)**	**$ (51,213)**	**$ 4,982,310**	**$ -**	**$ 4,982,310**	**$ 14,054,000**	**$ 9,071,690**

ECTOR COUNTY HOSPITAL DISTRICT
CAPITAL PROJECT & EQUIPMENT EXPENDITURES
JULY 2022

ITEM	CLASS	BOOKED AMOUNT
TRANSFERRED FROM CONSTRUCTION IN PROGRESS/RENOVATION PROJECTS		
Suite 330 Renovation	Building	$ 51,213
TOTAL PROJECT TRANSFERS		**$ 51,213**
EQUIPMENT PURCHASES		
None		$ -
TOTAL EQUIPMENT PURCHASES		**$ -**
TOTAL TRANSFERS FROM CIP/EQUIPMENT PURCHASES		**$ 51,213**

ECTOR COUNTY HOSPITAL DISTRICT
FISCAL 2022 CAPITAL EQUIPMENT
CONTINGENCY FUND
JULY 2022

MONTH/ YEAR	DESCRIPTION	DEPT NUMBER	BUDGETED AMOUNT	P.O AMOUNT	ACTUAL AMOUNT	TO/(FROM) CONTINGENCY
	Available funds from budget		**$ 600,000**	**$ -**	**$ -**	**$ 600,000**
Oct-21	ThinPrep 2000 Processor	7040	-	-	46,000	(46,000)
Oct-21	Convection Steamer	8020	-	-	8,570	(8,570)
Oct-21	Roll Around Monitor	8420	-	-	5,094	(5,094)
Oct-21	Replacement Wall Monitor	7300	-	-	4,916	(4,916)
Oct-21	Reach In Freezer	8020	-	-	3,815	(3,815)
Oct-21	Surgical Instruments	6620	-	-	16,940	(16,940)
Oct-21	Surgical Instruments	6620	-	-	16,940	(16,940)
Oct-21	Surgical Instruments	6620	-	-	16,940	(16,940)
Oct-21	Surgical Instruments	6620	-	-	16,940	(16,940)
Oct-21	Surgical Instruments	6620	-	-	9,720	(9,720)
Oct-21	Olympic Brain Monitor	6550	-	-	23,186	(23,186)
Nov-21	Four Stack Gym 5 Stations	7430	-	-	12,622	(12,622)
Nov-21	Dishwasher Flight Type	8020	-	-	94,698	(94,698)
Nov-21	Jaco Carts	9100	-	-	24,955	(24,955)
Nov-21	Bar Code Scanners	6790	-	-	16,137	(16,137)
Nov-21	Kangaroo ePump	6760	-	-	6,875	(6,875)
Dec-21	CHW Flooring	7480	60,000	-	62,519	(2,519)
Dec-21	Stretchers	6850	-	-	309,396	(309,396)
Dec-21	Iris Camera Kit	6550	-	-	44,025	(44,025)
Dec-21	Refrigerator	7050	-	-	4,725	(4,725)
Dec-21	Clinical System	7060	-	-	228,649	(228,649)
Dec-21	Latitude 5320	7070	-	-	4,377	(4,377)
Dec-21	Pharmacy Refrigerator	7050	-	-	15,140	(15,140)
Dec-21	Clickline Surgical Instruments	6620	-	-	16,940	(16,940)
Jan-22	Badge Access Upgrade	8410	45,000	-	23,505	21,495
Jan-22	Pyxis Anesthesia System	7330	-	-	38,440	(38,440)
Jan-22	Prime Transport Chair	6090	-	-	2,784	(2,784)
Jan-22	Convection Oven	8020	-	-	20,413	(20,413)
Jan-22	Kinevo 90	6620	-	-	567,820	(567,820)
Jan-22	CareAware MDI	7060	-	-	6,000	(6,000)
Jan-22	Digital Front Door Solution	9100	-	-	110,325	(110,325)
Jan-22	Film Array Torch Module Box	7060	-	-	49,500	(49,500)
Jan-22	Neo Blue Units	6170	-	-	22,799	(22,799)
Jan-22	Fiber Optic Cables	9100	-	-	13,715	(13,715)
Jan-22	Tims 2000	7260	21,495	-	21,495	-
Feb-22	XN-9100 Hematology Analyzer	7050	-	-	431,537	(431,537)
Feb-22	UPS Battery Replacement	9100	-	-	15,895	(15,895)
Feb-22	Axon Body 3	8380	-	-	45,279	(45,279)
Feb-22	Outreach Devices/Software	9100	7,727	-	7,727	-
Feb-22	Blood Pressure Monitor	7430	-	-	4,767	(4,767)
Feb-22	Convection Oven	8020	47,106	-	47,106	-
Mar-22	Mac Lab	7220	-	-	271,204	(271,204)
Mar-22	Fire Alarm Upgrade	8200	-	-	149,750	(149,750)
Mar-22	CareAware	7060	-	-	4,500	(4,500)
Mar-22	Rolling Monitors	7310	10,333	-	10,218	115
Mar-22	Carto 3 System	7220	-	-	358,000	(358,000)
Mar-22	CVSM 6800 Blood Pressure Machine	6300	8,182	-	8,182	-
Mar-22	IV Poles	7440	-	-	3,319	(3,319)
Apr-22	Roche Cobas Liat PCR System	7140	-	-	25,124	(25,124)
Apr-22	Mobile Dart Evolution	7260	113,500	-	113,500	-
Apr-22	Galaxy 5 Table	7480	-	-	5,873	(5,873)
Apr-22	Medrad Stellant Flex Injection System	7230	47,950	-	47,950	-
Apr-22	Medrad Stellant Flex Injection System	7270	14,510	-	14,510	-
Apr-22	Medrad Stellant Flex Injection System	8420	14,510	-	14,510	-
Apr-22	Hydrocollator Heating Units	7430	-	-	2,238	(2,238)
Apr-22	Pigg-O-Stat Positioner	7260	5,450	-	5,450	-
Apr-22	Task Stool	7440	2,984	-	2,984	-
Apr-22	Ortho/Cast Cart	7270	-	-	6,019	(6,019)
Apr-22	Optim Entity XL Nasopharyngoscope	7390	8,575	-	5,955	2,620
Apr-22	Vein Visualization System	7440	3,958	-	5,645	(1,687)
Apr-22	Microscope	7060	14,072	-	14,072	-
Apr-22	Visipitch Speech Lab Software	7390	6,250	-	6,250	-
Apr-22	Microscope	7060	17,938	-	17,938	-
Apr-22	Innowave Pro Sonic	6790	-	-	140,589	(140,589)
Apr-22	50 Dell Monitors	9100	11,500	-	11,500	-
Apr-22	Vital Signs Machines	6190	35,105	-	35,105	1
Apr-22	EZ Front Protection Aprons	7260	3,051	-	3,051	-
Apr-22	Portable Rhinolaryngoscope	9300	15,650	-	15,652	(2)
Apr-22	Temporary Pacemaker	6310	19,609	-	19,609	-
Apr-22	Stealth Station Surgical Navigation System	6620	452,794	-	452,794	-
Apr-22	Sleep Study Modules	7420	-	-	8,400	(8,400)
Apr-22	Standard Chair w/Oxygen Tank Holder	6850	-	-	12,646	(12,646)
May-22	IC200 Tonometer	6850	4,740	-	4,740	-
May-22	Carto 3 System	7220	-	-	139,941	(139,941)
May-22	Treadmills	9310	41,090	-	41,090	-
May-22	Guest Chairs	6850	30,661	-	30,661	-
May-22	Thin Pro	9100	28,650	-	28,650	-
May-22	Vein Visualization System	6150	15,696	-	15,696	-
May-22	Renasys Touch Pump	7460	151,800	-	151,800	-
May-22	Ferromagnetic Portal Detector	7270	25,913	-	25,913	-
May-22	OBM Kit	6550	37,446	-	23,186	14,261
May-22	Venue R3 Ultrasound Unit	6850	55,843	-	55,843	-
May-22	Clarity RM Console	6310	82,000	-	91,184	(9,184)
May-22	Neoprobe Console	6620	81,720	-	81,720	-
May-22	Scout Console & Guide	6620	62,495	-	-	62,495
May-22	ACIST CVI	7220	105,000	-	105,000	-
May-22	SPI 3 Upgrade	6620	-	-	28,026	(28,026)
May-22	Bariatric Pool Lift	7480	18,772	-	18,772	-
Jun-22	Water Chiller Epoxy Coating	8200	29,055	-	29,055	-
Jun-22	Heated Cabinet and Refrigerator	8020	-	-	31,414	(31,414)
Jun-22	Chairs	7230	4,381	-	4,381	0
Jun-22	Doctor's View Station	6850	-	-	15,470	(15,470)
Jun-22	Range	8020	12,768	-	11,920	848
Jun-22	RS85 Prestige Ultrasound	7240	130,567	-	130,567	0
Jun-22	Clarity RM Console	6330	82,000	-	91,184	(9,184)
Jun-22	Scrubbers/Burnisher	8270	65,645	-	65,645	0
Jun-22	Clinical Imaging Access	9100	91,000	-	91,000	-
Jun-22	Sharp NEC Display	9100	-	-	8,728	(8,728)
Jun-22	Dell Monitors	9100	11,500	-	11,500	-
Jun-22	Ryzen Thin Pro	9100	28,650	-	28,650	-
Jun-22	Blood Pressure Monitor	6950	4,487	-	4,487	(0)
Jun-22	Blood Pressure Monitor	6950	4,487	-	4,487	(0)
Jun-22	Blood Pressure Monitor	6960	4,487	-	4,487	(0)
Jun-22	Piccolo Lab Chemistry Analyzer	7030	-	-	15,634	(15,634)
Jun-22	Electric Food Cutter	8020	7,543	-	7,543	-
Jun-22	Hana Table	6620	-	-	16,080	(16,080)
Jun-22	Cables	9100	635	-	635	-
Jun-22	Data Cabling	9100	12,386	-	12,386	-
Jun-22	Mayfield Ultra Base Unit	6620	-	-	11,610	(11,610)
Jun-22	Aruba Network Switches	9100	-	-	6,151	(6,151)
Jun-22	CHW Pool Re-plaster	8200	150,000	-	85,488	64,512
Jul-22	Suite 330 ID Renovation	9300	35,000	-	51,213	(16,213)
Jul-22	A/C Units	8510	-	-	35,770	(35,770)
Jul-22	Network Upgrade	9100	-	-	162,611	(162,611)
Jul-22	Artis Axiom	6620	-	-	970,000	(970,000)
Jul-22	Hematek 3000 System	7050	-	-	7,400	(7,400)
Jul-22	ED Outdoor Seating	6850	-	-	9,668	(9,668)
Jul-22	ENT Chair	6850	7,548	-	7,548	0
Jul-22	Nellcor Transport Incubator	6550	33,951	-	33,951	-
Jul-22	Nurse Charting Stools	6140	4,973	-	4,973	0
Jul-22	MRI Chair	7210	3,475	-	3,475	0
Jul-22	Overbed Tables	6090	220,129	-	220,129	0
Jul-22	OptiPlex 7090	9100	32,200	-	32,200	-
Jul-22	Overbed Tables	7220	5,417	-	5,417	-
Jul-22	Tono Pen	6850	-	-	5,390	(5,390)
Jul-22	Dell 5530 Monitors	9100	11,500	-	22,476	(10,976)
Jul-22	OptiPlex 7000	9100	32,200	-	31,772	428
Jul-22	Cath Lab Software	7220	-	-	9,247	(9,247)
Jul-22	S3 Stryker Beds	6700	185,179	-	659,010	(473,831)
Jul-22	Versatrak Wireless Hub	8200	16,117	-	16,117	-
Jul-22	Artic Sun Temperature Management	6330	23,500	-	120,190	(96,690)
Jul-22	Artic Sun Temperature Management	6310	120,190	-	120,190	-
			$ 3,700,045	**$ -**	**$ 8,291,233**	**$ (4,591,188)**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF ACCOUNTS RECEIVABLE - OTHER
JULY 2022

	CURRENT YEAR	PRIOR YEAR HOSPITAL Audited	PRIOR YEAR PRO CARE Audited	CURRENT YEAR CHANGE
AR DISPRO/UPL	$ 4,293,292	$ -	$ -	$ 4,293,292
AR UNCOMPENSATED CARE	(1,734,878)	8,778,889	-	(10,513,767)
AR DSRIP	-	0	-	(0)
AR CHIRP	1,507,647	2,677,259	-	(1,169,612)
AR UHRIP	-	-	-	-
AR GME	(185,744)	-	-	(185,744)
AR PHYSICIAN GUARANTEES	576,309	518,647	-	57,662
AR ACCRUED INTEREST	124,376	5,863	-	118,513
AR OTHER:	1,025,841	(1,663,343)	36,244	2,652,940
Procare On-Call Fees	-	-	6,846	(6,846)
Procare A/R - FHC	-	-	-	-
Other Misc A/R	1,025,841	(1,663,343)	29,398	2,659,786
AR DUE FROM THIRD PARTY PAYOR	2,893,766	5,353,086	-	(2,459,320)
TOTAL ACCOUNTS RECEIVABLE - OTHER	$ 6,567,474	$ 15,670,402	$ 36,244	$ (9,139,173)

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF HOSPITAL TEMPORARY LABOR FTE'S
JULY 2022

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	CURRENT MONTH					YEAR TO DATE				
TEMPORARY LABOR			**BUDGET**		**PRIOR**			**BUDGET**		**PRIOR**
DEPARTMENT	**ACTUAL**	**BUDGET**	**VAR**	**PRIOR YR**	**YR VAR**	**ACTUAL**	**BUDGET**	**VAR**	**PRIOR YR**	**YR VAR**
Cardiopulmonary	13.8	11.0	25.6%	10.8	27.3%	14.5	11.7	24.1%	6.8	113.5%
Intensive Care Unit (CCU) 4	3.6	6.5	-44.0%	4.6	-21.5%	12.5	6.9	80.4%	7.2	74.3%
Intensive Care Unit (ICU) 2	2.2	5.0	-55.4%	3.3	-32.9%	10.5	5.3	96.4%	3.2	229.8%
3 West Observation	2.4	2.1	10.6%	3.4	-30.9%	6.8	2.2	209.6%	0.4	1537.9%
Operating Room	7.5	2.5	200.9%	2.3	217.4%	6.5	2.6	149.1%	2.1	211.4%
4 Central	2.8	0.7	291.2%	1.6	78.8%	5.8	0.8	639.9%	1.3	345.8%
Emergency Department	2.4	-	0.0%	-	0.0%	4.9	-	0.0%	0.0	34001.7%
6 Central	0.5	1.4	-66.8%	1.4	-65.2%	4.9	1.5	214.8%	1.0	403.8%
7 Central	1.6	1.8	-7.9%	2.1	-22.1%	4.3	1.9	124.2%	1.4	214.6%
8 Central	1.4	0.8	82.3%	0.6	124.5%	4.2	0.8	398.2%	1.4	200.2%
5 Central	1.0	2.4	-55.6%	3.3	-68.3%	3.9	2.5	55.1%	2.5	58.9%
9 Central	1.2	-	0.0%	1.8	-30.2%	3.2	2.5	29.4%	1.4	133.6%
Imaging - Diagnostics	1.9	1.8	3.9%	1.0	85.4%	2.0	1.9	4.2%	1.0	99.9%
Labor & Delivery	1.7	0.4	373.7%	-	0.0%	1.9	0.4	395.1%	1.1	72.9%
Care Management	11.0	-	0.0%	-	0.0%	1.7	-	0.0%	-	0.0%
Imaging - Ultrasound	2.4	0.5	410.1%	-	0.0%	1.5	0.5	206.7%	-	0.0%
Recovery Room	-	-	0.0%	-	0.0%	1.2	-	0.0%	-	0.0%
6 West	0.1	0.2	-44.7%	0.2	-35.9%	1.0	0.3	290.7%	0.2	467.6%
4 EAST	2.6	-	0.0%	-	0.0%	0.9	-	0.0%	-	0.0%
2 Central	-	-	0.0%	-	0.0%	0.9	-	0.0%	0.6	39.6%
NURSING ORIENTATION	0.1	-	0.0%	0.9	-88.1%	0.8	-	0.0%	0.4	106.4%
Laboratory - Chemistry	4.4	3.3	31.9%	-	0.0%	0.7	3.5	-79.8%	-	0.0%
Imaging - MRI	-	0.5	-100.0%	-	0.0%	0.6	0.5	29.7%	-	0.0%
CHW - Sports Medicine	0.9	-	0.0%	-	0.0%	0.5	-	0.0%	-	0.0%
Imaging - Special Procedures	0.9	-	0.0%	-	0.0%	0.4	-	0.0%	-	0.0%
PM&R - Physical	0.2	-	0.0%	-	0.0%	0.3	-	0.0%	-	0.0%
Sterile Processing	-	-	0.0%	-	0.0%	0.1	-	0.0%	-	0.0%
Human Resources	-	-	0.0%	0.2	-100.0%	0.1	-	0.0%	0.1	25.4%
Imaging - CVI	-	0.5	-100.0%	-	0.0%	0.0	0.5	-90.6%	-	0.0%
5 West	-	-	0.0%	-	0.0%	0.0	-	0.0%	0.0	294.2%
Cath Lab	-	-	0.0%	-	0.0%	-	-	0.0%	0.2	-100.0%
Disaster & Emergency Operations	-	-	0.0%	-	0.0%	-	-	0.0%	0.2	-100.0%
SUBTOTAL	**67.7**	**41.4**	**63.8%**	**37.7**	**79.6%**	**97.0**	**46.5**	**108.9%**	**32.3**	**200.1%**
TRANSITION LABOR										
Laboratory - Chemistry	1.2	-	0.0%	3.5	-67.0%	2.6	-	0.0%	3.7	-30.9%
SUBTOTAL	**1.2**	**-**	**0.0%**	**3.5**	**-67.0%**	**2.6**	**-**	**0.0%**	**3.7**	**-30.9%**
GRAND TOTAL	**68.9**	**41.4**	**66.6%**	**41.3**	**67.0%**	**99.6**	**46.5**	**114.4%**	**36.0**	**176.3%**

ECTOR COUNTY HOSPITAL DISTRICT
SUPPLEMENTAL SCHEDULE OF TEMPORARY LABOR, TRANSITION LABOR & PURCHASED SERVICES - HOSPITAL ONLY
JULY 2022

	CURRENT MONTH					YEAR TO DATE				
	ACTUAL	BUDGET	$ VAR	% VAR	PRIOR YR	% VAR	ACTUAL	BUDGET	$ VAR	% VAR	PRIOR YR	% VAR
ICU2 TEMPORARY LABOR	$ 84,811	$ 99,019	$ (14,208)	-14.3%	$ 73,671	15.1%	$ 3,796,640	$ 1,036,972	$ 2,759,668	266.1%	$ 731,590	419.0%
ICU4 TEMPORARY LABOR	162,890	128,272	34,618	27.0%	92,135	76.8%	3,713,442	1,343,581	2,369,861	176.4%	1,592,678	133.2%
ED TEMPORARY LABOR	80,656.26	-	80,656	100.0%	-	100.0%	1,770,673.12	-	1,770,673	100.0%	3,246	54447.7%
TEMPORARY LABOR	107,212.41	32,534	74,678	229.5%	61,742	73.6%	2,028,505.58	331,478	1,697,028	512.0%	74,619	2618.5%
IMCU4 TEMPORARY LABOR	91,075	14,168	76,907	542.8%	30,273	200.8%	1,708,848	148,596	1,560,252	1050.0%	227,538	651.0%
RT TEMPORARY LABOR	349,960.19	228,419	121,541	53.2%	214,281	63.3%	3,675,114.25	2,389,307	1,285,807	53.8%	1,292,791	184.3%
OR TEMPORARY LABOR	187,882	31,822	156,060	490.4%	35,218	433.5%	1,465,190	328,857	1,136,333	345.5%	323,866	352.4%
6C TEMPORARY LABOR	25,850.22	22,067	3,783	17.1%	26,561	-2.7%	1,342,777.93	231,194	1,111,584	480.8%	157,876	750.5%
8C TEMPORARY LABOR	44,289	12,047	32,242	267.6%	11,075	299.9%	1,197,643	126,289	1,071,354	848.3%	240,872	397.2%
7C TEMPORARY LABOR	55,604	32,797	22,807	69.5%	34,132	62.9%	1,277,533	343,882	933,651	271.5%	236,972	439.1%
L & D TEMPORARY LABOR	38,648	5,600	33,048	590.1%	-	100.0%	598,421	58,658	539,763	920.2%	182,042	228.7%
TEMPORARY LABOR	-	-	-	100.0%	-	100.0%	503,793.03	-	503,793	100.0%	140,408	258.8%
IMCU9 TEMPORARY LABOR	35,333	-	35,333	100.0%	31,732	11.4%	803,118	421,838	381,280	90.4%	239,839	234.9%
COMM HEALTH TEMPORARY LABOR	213,055.20	-	213,055	100.0%	-	100.0%	329,897.23	-	329,897	100.0%	-	100.0%
RR TEMPORARY LABOR	(7,306.22)	-	(7,306)	100.0%	-	100.0%	315,629.13	-	315,629	100.0%	-	100.0%
Temp Labor - Productive Salaries	8,276.15	-	8,276	100.0%	15,043	-45.0%	274,363.99	-	274,364	100.0%	67,978	303.6%
US TEMPORARY LABOR	59,109.46	8,972	50,137	558.8%	-	100.0%	352,831.47	92,072	260,759	283.2%	-	100.0%
4E TEMPORARY LABOR	57,336.10	-	57,336	100.0%	-	100.0%	259,787.69	-	259,788	100.0%	-	100.0%
ORTHO/NEURO TEMPORARY LABOR	5,959.20	3,710	2,249	60.6%	4,060	46.8%	248,353.85	38,864	209,490	539.0%	32,825	656.6%
TEMPORARY LABOR	33,116	-	33,116	100.0%	-	100.0%	135,027	-	135,027	100.0%	-	100.0%
ALL OTHER	65,890	27,552	38,338	139.1%	18,409	257.9%	466,276	284,165	182,111	64.1%	242,324	92.4%
MRI TEMPORARY LABOR	-	7,935	(7,935)	-100.0%	-	100.0%	142,735.35	81,640	61,095	74.8%	-	100.0%
OP PM&R-CHW TEMPORARY LABOR	12,599.65	-	12,600	100.0%	-	100.0%	52,243.55	-	52,244	100.0%	-	100.0%
CHEM TEMPORARY LABOR	121,302.90	24,238	97,065	400.5%	-	100.0%	182,144.10	250,381	(68,237)	-27.3%	(8,844)	-2159.5%
TOTAL TEMPORARY LABOR	$ 1,860,842	$ 723,482	$ 1,137,360	157.2%	$ 707,132	163.2%	$ 27,550,819	$ 7,969,907	$ 19,580,912	245.7%	$ 6,187,691	345.3%
CHEM TRANSITION LABOR	$ 10,533	$ -	$ 10,533	100.0%	$ 30,077	-65.0%	$ 228,328	$ -	$ 228,328	100.0%	$ 326,475	-30.1%
ALL OTHER	-	-	-	100.0%	-	100.0%	-	-	-	100.0%	-	100.0%
TOTAL TRANSITION LABOR	$ 10,533	$ -	$ 10,533	0%	$ 30,077	-65.0%	$ 228,328	$ -	$ 228,328	0.0%	$ 326,475	-30.1%
GRAND TOTAL TEMPORARY LABOR	$ 1,871,375	$ 723,482	$ 1,147,893	158.7%	$ 737,209	153.8%	$ 27,779,147	$ 7,969,907	$ 19,809,240	248.6%	$ 6,514,166	326.4%
OTHER PURCH SVCS	$ 109,955	$ 53,134	$ 56,821	106.9%	$ 951	11458.2%	$ 1,309,102	$ 531,340	$ 777,762	146.4%	$ 466,882	180.4%
ADM CONTRACT STRYKER	18,913	11,407	7,506	65.8%	29,397	-35.7%	737,805.32	114,070	623,735	546.8%	188,529	291.3%
CONSULTANT FEES	81,941	8,053	73,888	917.5%	12,256	568.6%	629,800.05	80,530	549,270	682.1%	188,893	233.4%
FIN ACCT COST REPORT/CONSULTANT FEES	99,919	3,674	96,245	2619.6%	1,034	9567.6%	508,420.77	36,740	471,681	1283.8%	32,203	1478.8%
CREDIT CARD FEES	92,192	33,898	58,294	172.0%	31,239	195.1%	629,966	338,980	290,986	85.8%	310,537	102.9%
UC-WEST CLINIC - PURCH SVCS-OTHER	41,058	25,063	15,995	63.8%	37,049	10.8%	559,190	250,630	308,560	123.1%	278,227	101.0%
UC-CPC JBS PARKWAY PURCH SVCS-OTHER	70,371	45,006	25,365	56.4%	57,418	22.6%	694,575	450,060	244,515	54.3%	506,836	37.0%
DIET OTHER PURCH SVCS	36,434	16,021	20,413	127.4%	33,599	8.4%	333,057.13	160,210	172,847	107.9%	196,135	69.8%
HK SVC CONTRACT PURCH SVC	122,345	81,855	40,490	49.5%	91,251	34.1%	990,837	818,550	172,287	21.0%	764,800	29.6%
ADM PHYS RECRUITMENT	16,420	15,883	537	3.4%	42,337	-61.2%	308,880.03	158,830	150,050	94.5%	281,853	9.6%
HISTOLOGY SERVICES	32,770	25,732	7,038	27.4%	35,579	-7.9%	390,036	257,320	132,716	51.6%	279,335	39.6%
ADMIN OTHER FEES	23,663	12,019	11,644	96.9%	16,242	45.7%	245,408.37	120,190	125,218	104.2%	137,014	79.1%
FHC PHC OTHER PURCH SVCS	4,975	-	4,975	100.0%	7,783	-36.1%	98,381.11	-	98,381	100.0%	68,127	44.4%
ADM LEGAL SETTLEMENT FEES	75,000	-	75,000	100.0%	-	100.0%	75,650.00	-	75,650	100.0%	-	100.0%
FA EXTERNAL AUDIT FEES	17,000	16,246	754	4.6%	-	100.0%	231,770.00	162,460	69,310	42.7%	175,243	32.3%
SERV EXC SURVEY SERVICES	17,817	12,618	5,199	41.2%	23,371	-23.8%	194,221.04	126,180	68,041	53.9%	188,697	2.9%
4E OTHER PURCH SVCS	11,129	10,079	1,050	10.4%	10,377	7.2%	167,527.47	100,790	66,737	66.2%	91,401	83.3%
ENGINEERING OTHER PURCH SVCS	14,178	9,353	4,825	51.6%	11,696	21.2%	152,712.51	93,530	59,183	63.3%	100,058	52.6%
ADM APPRAISAL DIST FEE	24,964	26,061	(1,097)	-4.2%	84,487	-70.5%	311,807	260,610	51,197	19.6%	325,465	-4.2%
AMBULANCE FEES	17,689	9,804	7,885	80.4%	17,292	2.3%	148,567.90	98,040	50,528	51.5%	57,243	159.5%
NSG OTHER PURCH SVCS	9,147	5,304	3,843	72.5%	4,460	105.1%	98,490.24	53,040	45,450	85.7%	51,319	91.9%
OBLD OTHER PURCH SVCS	21,376	15,825	5,551	35.1%	16,315	31.0%	197,786	158,250	39,536	25.0%	177,298	11.6%
LAB ADMIN OTHER PURCH SVCS	1,210	5,186	(3,976)	-76.7%	3,956	-69.4%	75,090.00	51,860	23,230	44.8%	57,661	30.2%
HIM CODING SERVICES	7,153	9,759	(2,606)	-26.7%	35,154	-79.7%	119,803.66	97,590	22,214	22.8%	303,498	-60.5%
PH CONTRACT PURCH SVC	9,215	6,542	2,673	40.9%	7,065	30.4%	79,966.21	65,420	14,546	22.2%	81,333	-1.7%
MED STAFF REVIEW FEES	11,625	8,333	3,292	39.5%	13,400	-13.2%	96,022.51	83,330	12,693	15.2%	77,427	24.0%
CVS CONTRACT PURCH SVC	4,702	7,027	(2,325)	-33.1%	9,099	-48.3%	81,948.90	70,270	11,679	16.6%	82,759	-1.0%
NSG ED OTHER PURCH SVCS	7,607	11,839	(4,232)	-35.7%	9,577	-20.6%	99,582.54	118,390	(18,807)	-15.9%	97,759	1.9%
COMP PURCH SVCS CONTRACT	4,646	10,192	(5,546)	-54.4%	8,588	-45.9%	80,304.83	101,920	(21,615)	-21.2%	61,016	31.6%
FA AUDIT FEES - INTERNAL	12,978	13,742	(764)	-5.6%	10,480	23.8%	78,046.79	137,420	(59,373)	-43.2%	153,750	-49.2%
COMM REL ADVERTISMENT PURCH SVCS	25,007	28,066	(3,059)	-10.9%	18,705	33.7%	202,966	280,660	(77,694)	-27.7%	386,401	-47.5%
UC-CPC 42ND STREET PURCH SVCS-OTHER	16	44,207	(44,191)	-100.0%	53,337	-100.0%	358,908	442,070	(83,162)	-18.8%	477,338	-24.8%
ADMIN LEGAL FEES	24,188	45,954	(21,766)	-47.4%	110,258	-78.1%	334,601	459,540	(124,939)	-27.2%	485,647	-31.1%
HR RECRUITING FEES	85,991	31,152	54,839	176.0%	13,441	539.7%	177,022	311,520	(134,498)	-43.2%	236,383	-25.1%
MISSION FITNESS CONTRACT PURCH SVC	66,282	69,094	(2,812)	-4.1%	56,368	17.6%	543,602.84	683,168	(139,565)	-20.4%	611,361	-11.1%
IT INFORMATION SOLUTIONS SVCS	37,668	44,692	(7,024)	-15.7%	13,948	170.1%	279,558	446,920	(167,362)	-37.4%	327,714	-14.7%
FHC OTHER PURCH SVCS	44,807	67,686	(22,879)	-33.8%	88,417	-49.3%	523,092	676,860	(153,768)	-22.7%	1,049,615	-50.2%
PT ACCTS COLLECTION FEES	46,104	70,569	(24,465)	-34.7%	58,551	-21.3%	489,060	705,690	(216,630)	-30.7%	680,513	-28.1%
DIALYSIS SERVICES	128,648	145,960	(17,312)	-11.9%	97,752	31.6%	1,192,269.31	1,459,600	(267,331)	-18.3%	1,246,348	-4.3%
OR FEES (PERFUSION SERVICES)	25,334	68,819	(43,485)	-63.2%	29,214	-13.3%	331,220	688,190	(356,970)	-51.9%	503,261	-34.2%
ALL OTHERS	2,922,102	3,196,920	(274,818)	-8.6%	3,147,496	-7.2%	30,128,637	31,962,715	(1,834,078)	-5.7%	28,266,714	6.6%
TOTAL PURCHASED SERVICES	$ 4,424,536	$ 4,322,774	$ 101,762	2.4%	$ 4,348,938	1.7%	$ 44,463,222	$ 43,213,483	$ 1,249,739	2.9%	$ 40,052,591	11.0%

Financial Presentation

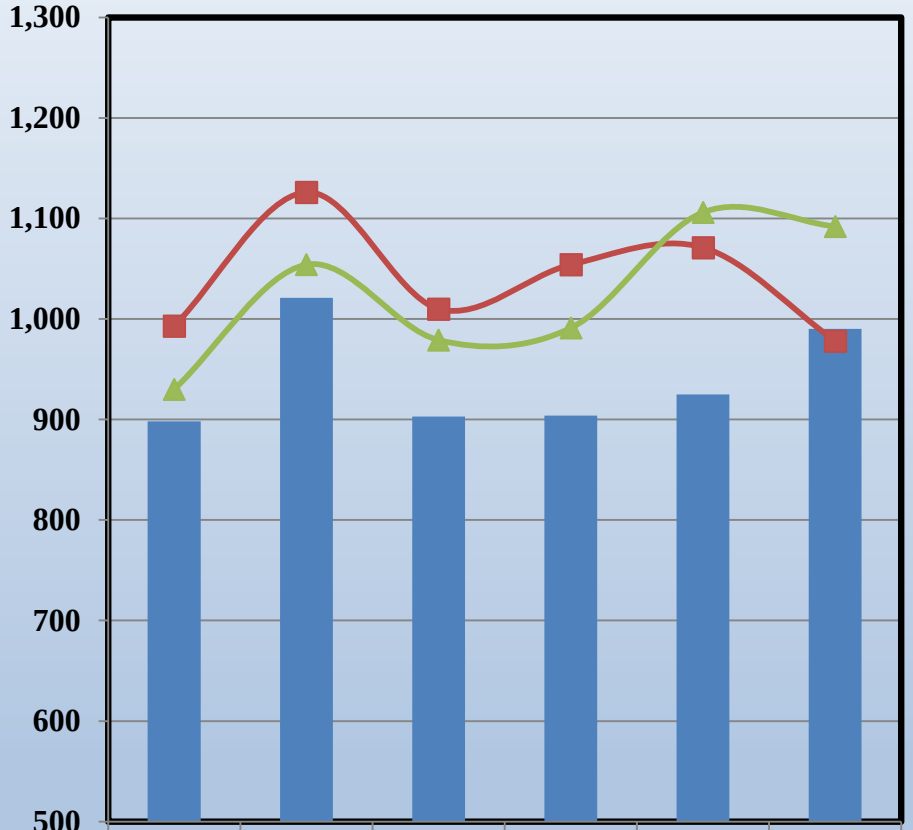
For the Month Ended

July 31, 2022

Volume

Admissions

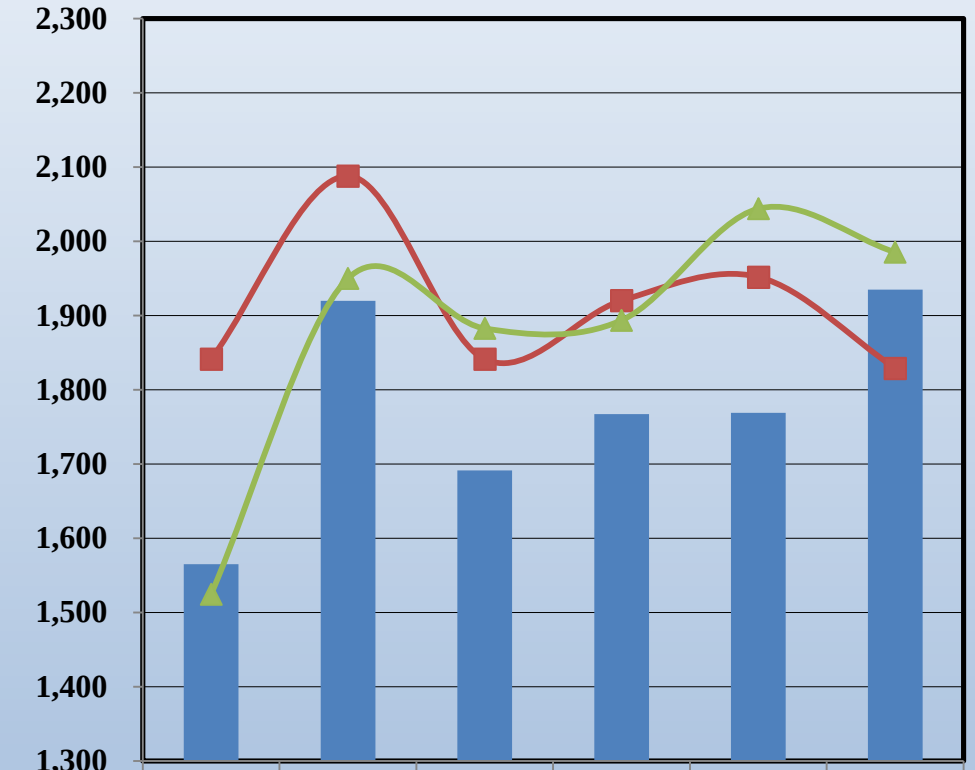
Total – Adults and NICU



	Feb	Mar	Apr	May	Jun	Jul
Act	898	1,021	903	904	925	990
Bud	993	1,126	1,010	1,054	1,071	978
Prior	930	1,054	979	991	1,106	1,092

	Actual	Budget	Prior Year
Month	990	978	1,092
Var %		1.2%	-9.3%
Year-To-Date	9,734	10,244	10,268
Var %		-5.0%	-5.2%
Annualized	11,785	12,396	12,359
Var %		-4.9%	-4.6%

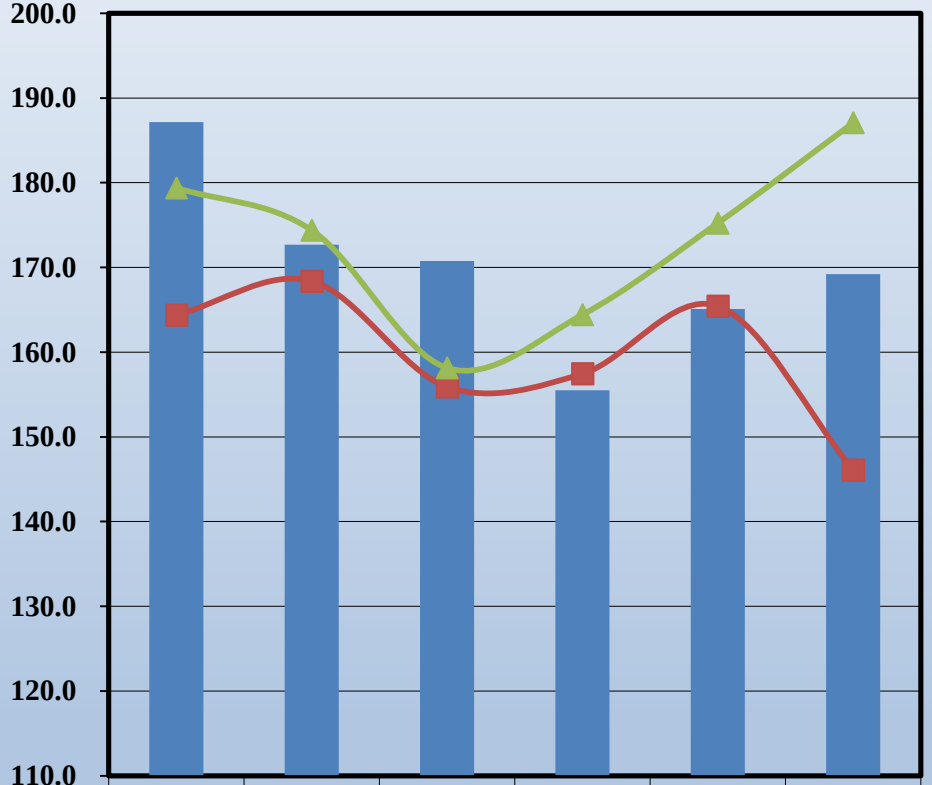
Adjusted Admissions



	Feb	Mar	Apr	May	Jun	Jul
Act	1,565	1,920	1,691	1,767	1,769	1,935
Bud	1,841	2,088	1,841	1,920	1,952	1,829
Prior	1,525	1,950	1,883	1,894	2,044	1,985

	Actual	Budget	Prior Year
Month	1,935	1,829	1,985
Var %		5.8%	-2.5%
Year-To-Date	17,784	18,966	18,270
Var %		-6.2%	-2.7%
Annualized	21,195	23,075	22,158
Var %		-8.2%	-4.3%

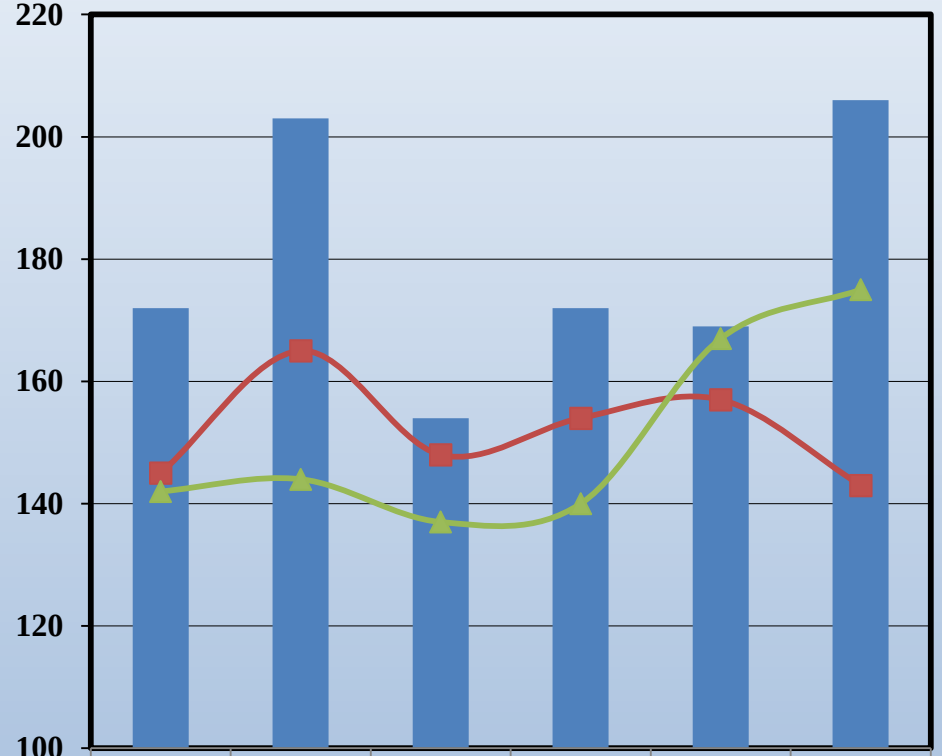
Average Daily Census



	Feb	Mar	Apr	May	Jun	Jul
Act	187.1	172.7	170.8	155.5	165.1	169.2
Bud	164.4	168.4	155.9	157.5	165.4	146.1
Prior	179.4	174.4	158.1	164.4	175.2	187.1

	Actual	Budget	Prior Year
Month	169.2	146.1	187.1
Var %		15.8%	-9.6%
Year-To-Date	180.4	156.1	176.5
Var %		15.6%	2.3%
Annualized	184.5	157.4	174.0
Var %		17.2%	6.0%

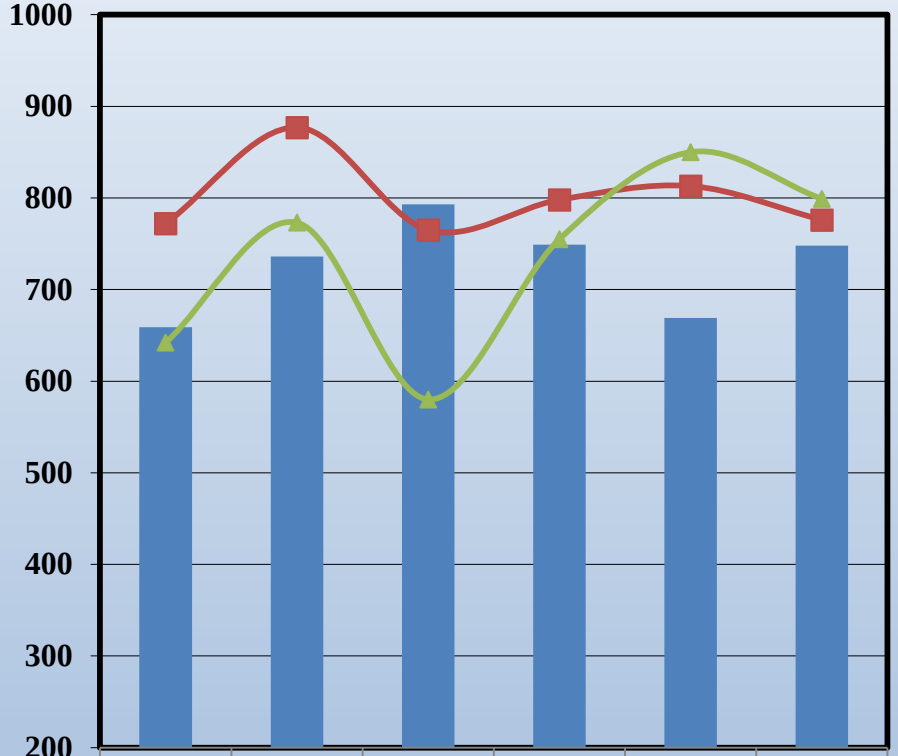
Deliveries



	Feb	Mar	Apr	May	Jun	Jul
Act	172	203	154	172	169	206
Bud	145	165	148	154	157	143
Prior	142	144	137	140	167	175

	Actual	Budget	Prior Year
Month	206	143	175
Var %		44.1%	17.7%
Year-To-Date	1,802	1,498	1,601
Var %		20.3%	12.6%
Annualized	2,178	1,846	1,957
Var %		18.0%	11.3%

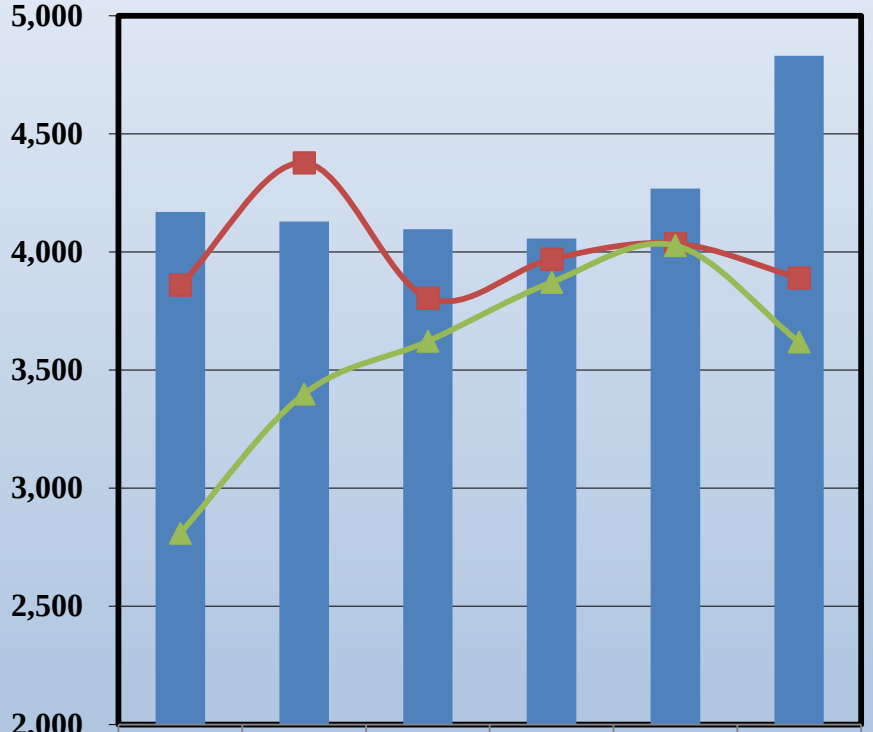
Total Surgical Cases



	Feb	Mar	Apr	May	Jun	Jul
Act	659	736	793	749	669	748
Bud	772	877	765	798	813	776
Prior	642	773	580	755	850	799

	Actual	Budget	Prior Year
Month	748	776	799
Var %		-3.6%	-6.4%
Year-To-Date	7,302	7,966	7,012
Var %		-8.3%	4.1%
Annualized	8,315	9,453	8,423
Var %		-12.0%	-1.3%

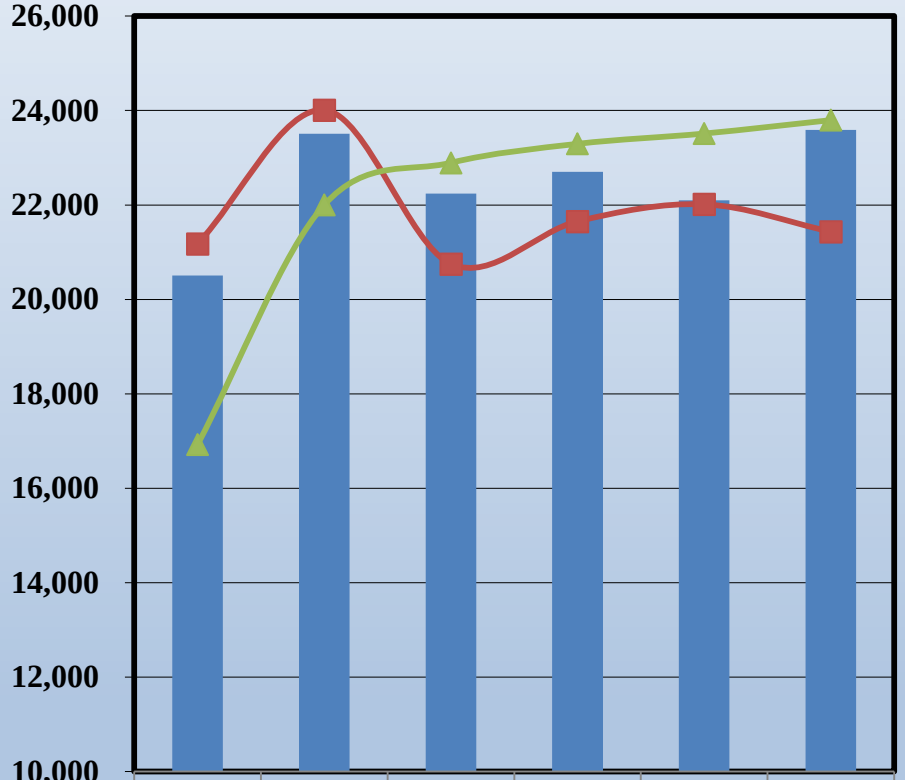
Emergency Room Visits



	Feb	Mar	Apr	May	Jun	Jul
Act	4,169	4,129	4,097	4,057	4,269	4,830
Bud	3,861	4,378	3,805	3,970	4,036	3,890
Prior	2,810	3,399	3,622	3,872	4,027	3,619

	Actual	Budget	Prior Year
Month	4,830	3,890	3,619
Var %		24.2%	33.5%
Year-To-Date	43,494	39,804	33,804
Var %		9.3%	28.7%
Annualized	53,458	47,124	39,991
Var %		13.4%	33.7%

Total Outpatient Occasions of Service

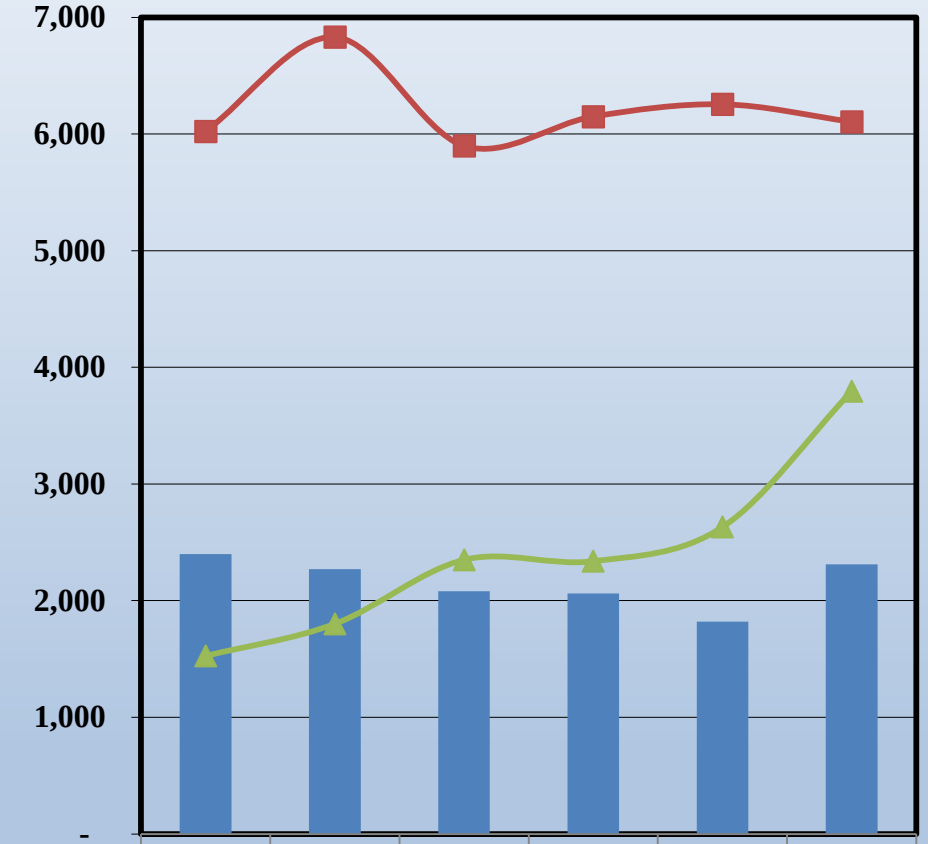


	Feb	Mar	Apr	May	Jun	Jul
Act	20,504	23,506	22,243	22,701	22,101	23,590
Bud	21,177	24,013	20,752	21,653	22,014	21,433
Prior	16,924	22,001	22,894	23,295	23,513	23,797

	Actual	Budget	Prior Year
Month	23,590	21,433	23,797
Var %		10.1%	-0.9%
Year-To-Date	237,483	218,337	215,092
Var %		8.8%	10.4%
Annualized	292,630	261,706	254,910
Var %		11.8%	14.8%

Urgent Care Visits

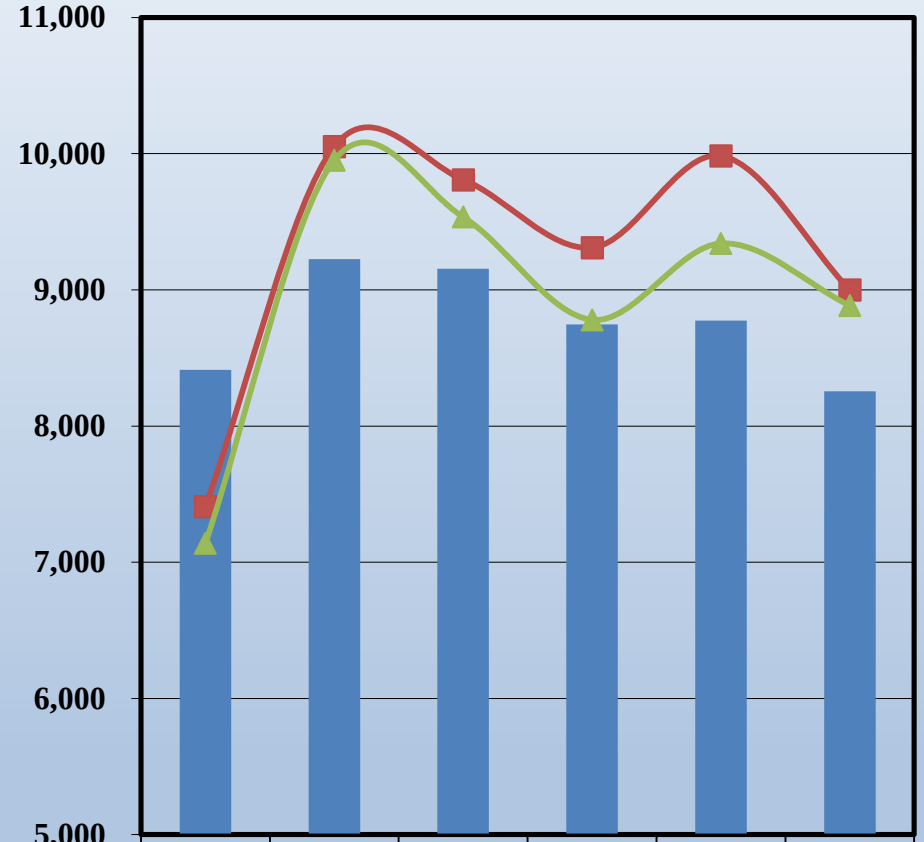
(JBS Clinic, West University & 42nd Street)



	Feb	Mar	Apr	May	Jun	Jul
Act	2,400	2,270	2,082	2,061	1,820	2,311
Bud	6,024	6,831	5,898	6,150	6,255	6,105
Prior	1,526	1,801	2,350	2,338	2,631	3,796

	Actual	Budget	Prior Year
Month	2,311	6,105	3,796
Var %		-62.1%	-39.1%
Year-To-Date	31,067	62,115	26,411
Var %		-50.0%	17.6%
Annualized	43,537	65,407	29,590
Var %		-33.4%	47.1%

Total ProCare Office Visits



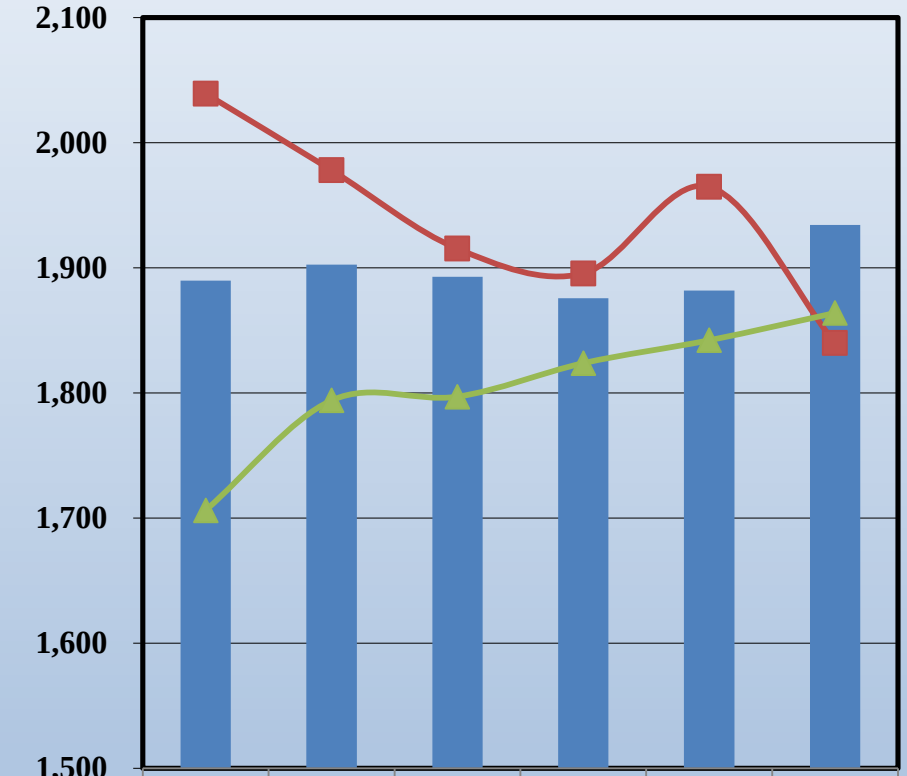
	Feb	Mar	Apr	May	Jun	Jul
Act	8,412	9,225	9,156	8,747	8,775	8,256
Bud	7,409	10,053	9,809	9,310	9,984	8,999
Prior	7,138	9,952	9,535	8,780	9,341	8,884

	Actual	Budget	Prior Year
Month	8,256	8,999	8,884
Var %		-8.3%	-7.1%
Year-To-Date	87,120	87,935	84,574
Var %		-0.9%	3.0%
Annualized	106,434	107,796	101,623
Var %		-1.3%	4.7%

Staffing

Blended FTE's

Including Contract Labor and Management Services

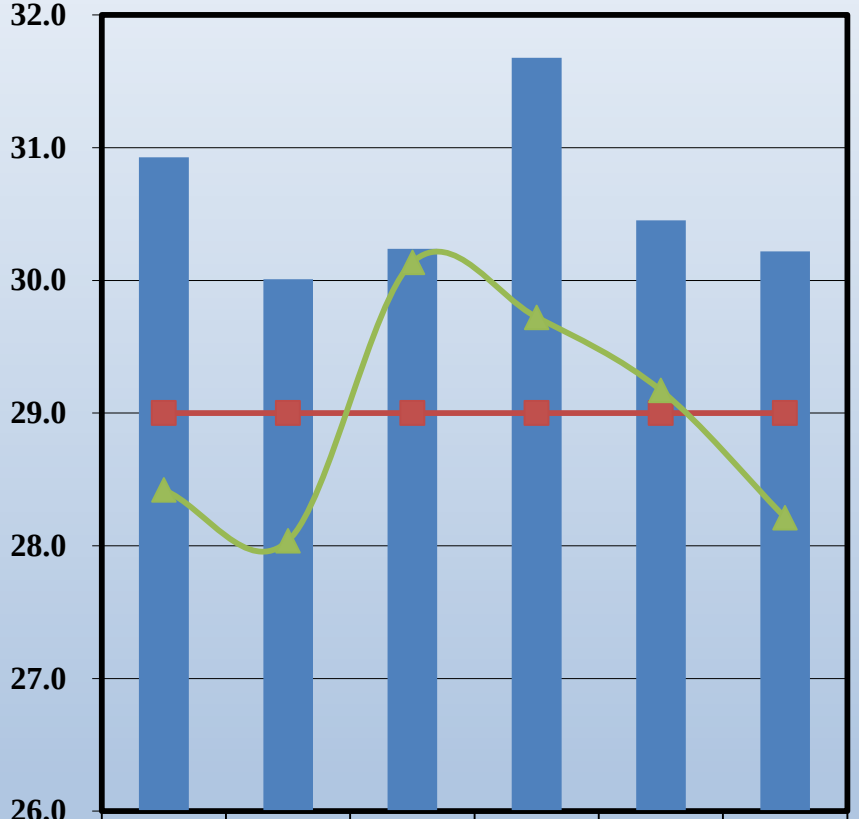


	Feb	Mar	Apr	May	Jun	Jul
Act	1,890	1,903	1,893	1,876	1,882	1,934
Bud	2,039	1,978	1,915	1,896	1,965	1,840
Prior	1,706	1,794	1,797	1,824	1,842	1,864

	Actual	Budget	Prior Year
Month	1,934	1,840	1,864
Var %		5.1%	3.8%
Year-To-Date	1,886	1,920	1,800
Var %		-1.8%	4.8%
Annualized	1,891	1,920	1,796
Var %		-1.5%	5.3%

Paid Hours per Adjusted Patient Day

(Ector County Hospital District)



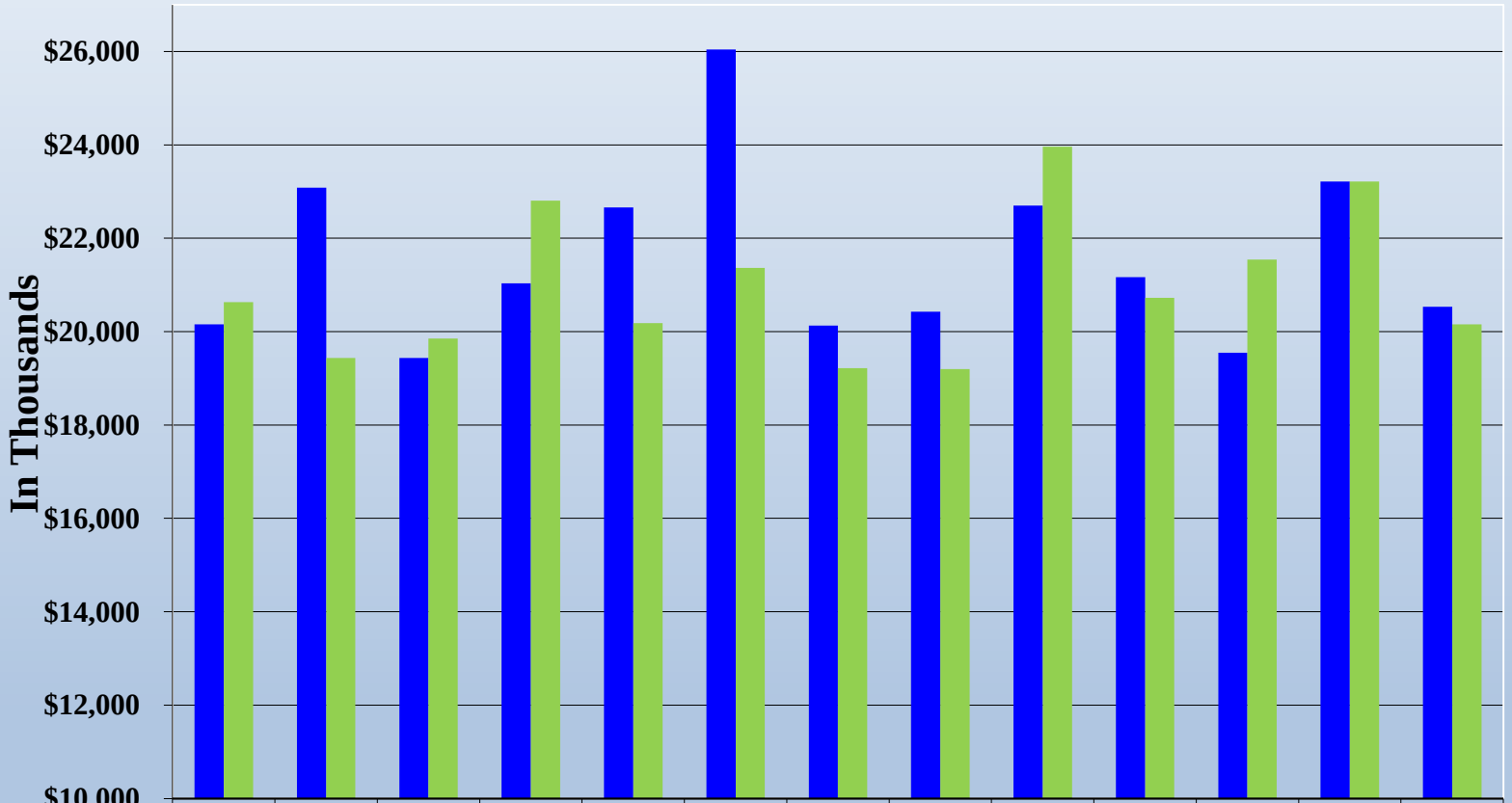
	Feb	Mar	Apr	May	Jun	Jul
Act	30.9	30.0	30.2	31.7	30.5	30.2
Bud	29.0	29.0	29.0	29.0	29.0	29.0
Prior	28.4	28.0	30.1	29.7	29.2	28.2

	Actual	Budget	Prior Year
Month	30.2	29.0	28.2
Var %		4.2%	7.1%
Year-To-Date	29.6	29.0	28.8
Var %		2.1%	2.8%
Annualized	29.6	29.1	28.6
Var %		1.7%	3.5%

Accounts Receivable

Total AR Cash Receipts

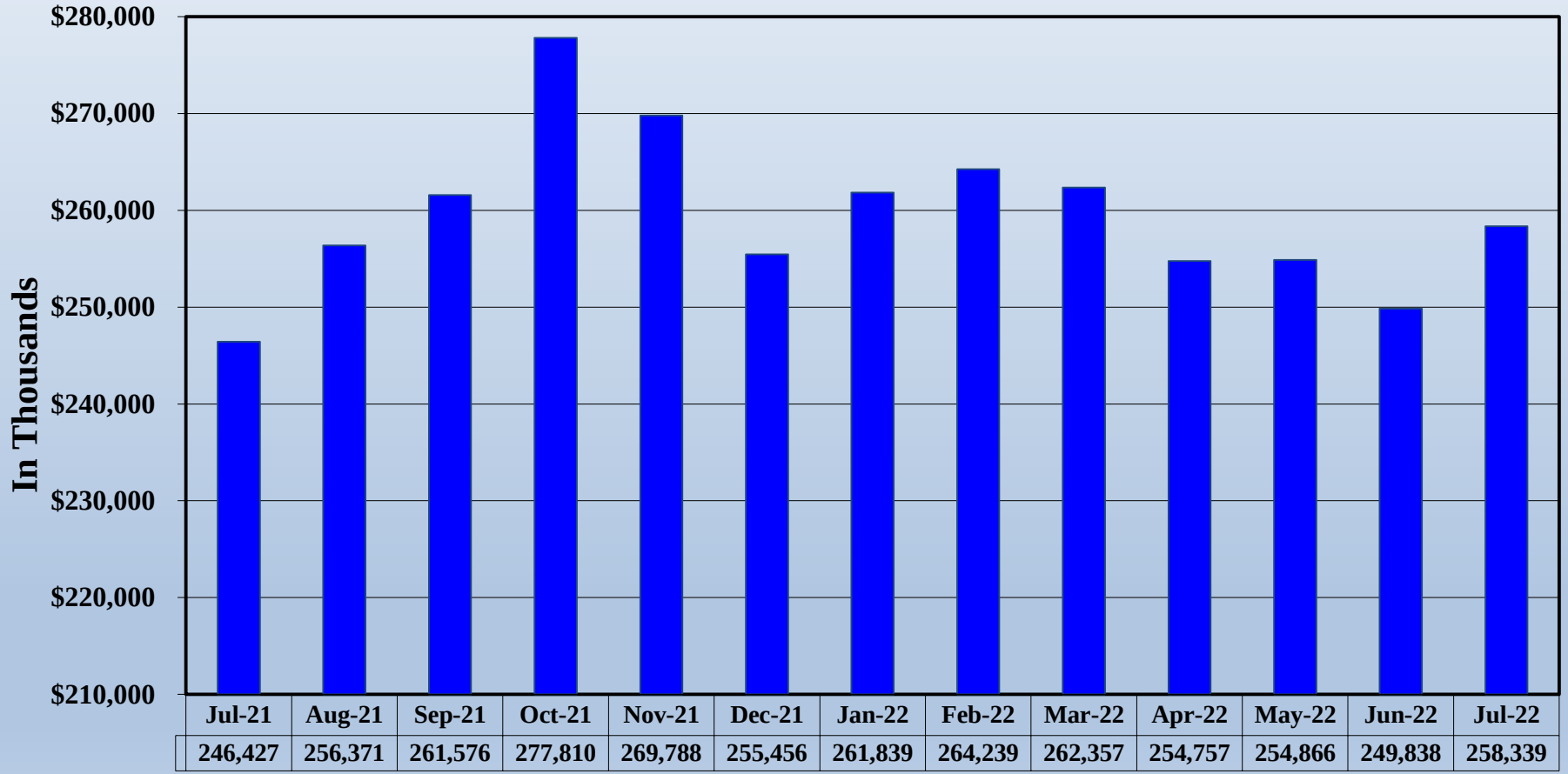
13 Month Trending



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
CY	20,154	23,086	19,439	21,035	22,661	26,042	20,130	20,428	22,700	21,165	19,547	23,212	20,534
PY	20,633	19,435	19,850	22,802	20,182	21,363	19,218	19,197	23,960	20,724	21,546	23,214	20,154

Total Accounts Receivable – Gross

Thirteen Month Trending

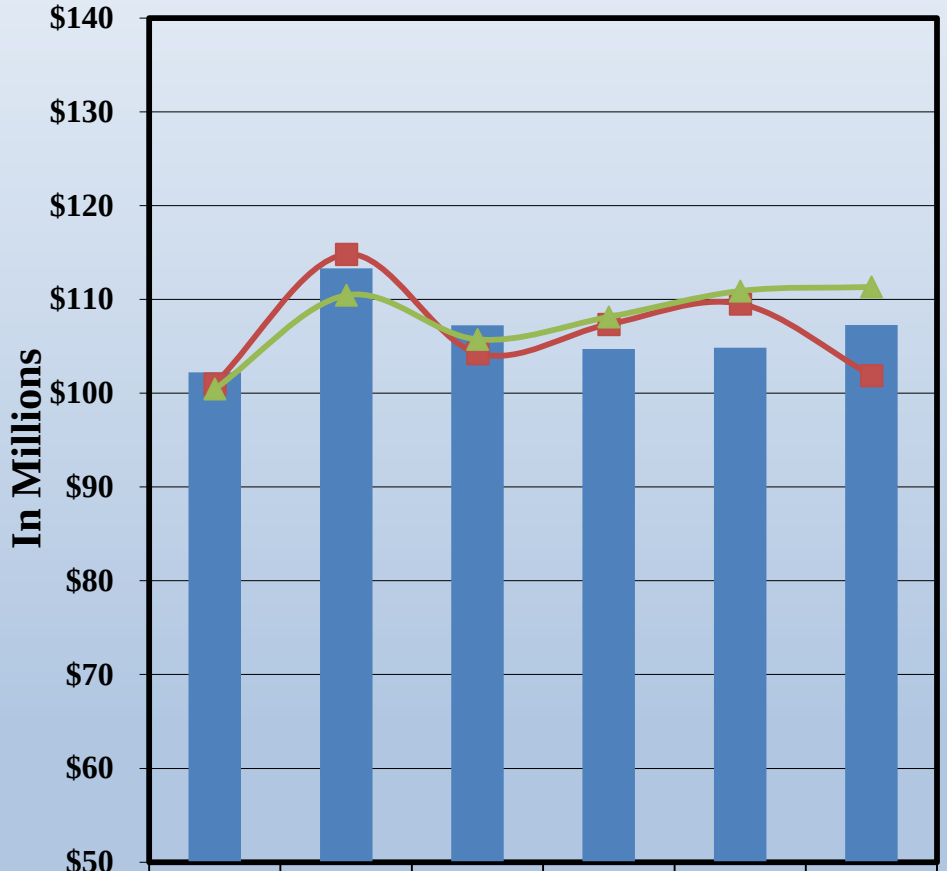


Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
246,427	256,371	261,576	277,810	269,788	255,456	261,839	264,239	262,357	254,757	254,866	249,838	258,339

Revenues & Revenue Deductions

Total Patient Revenues

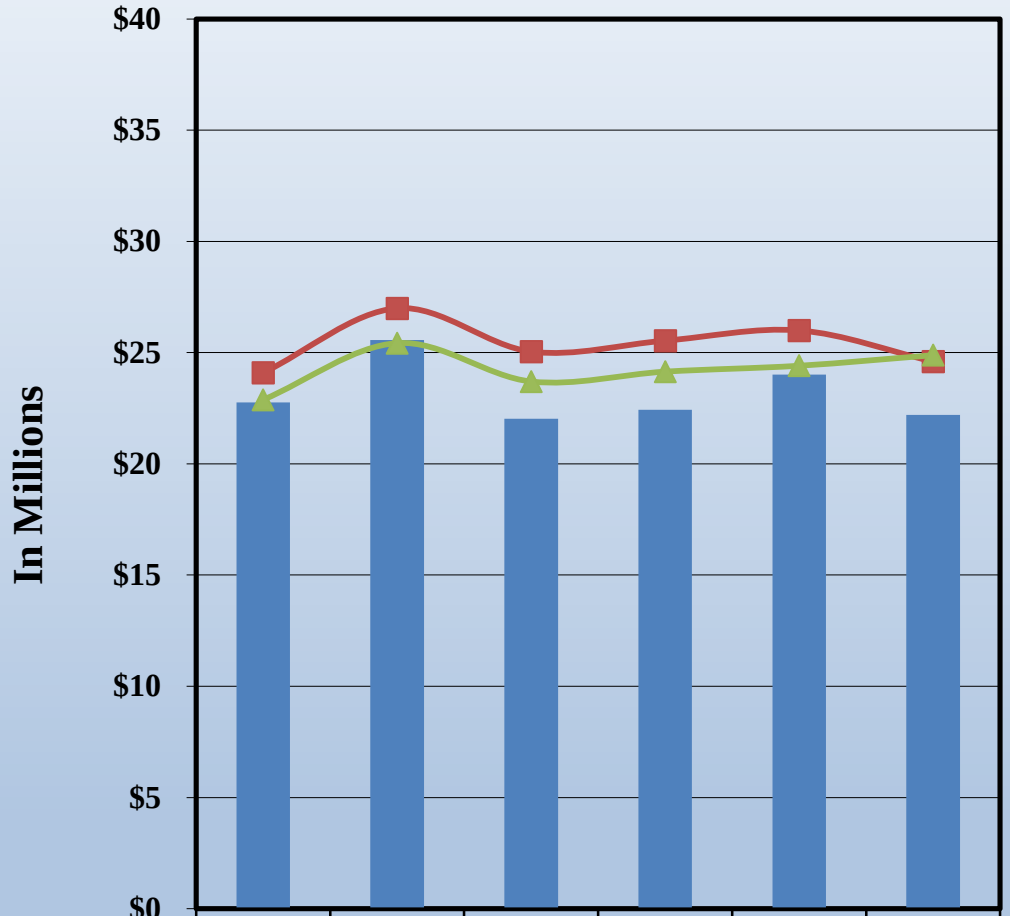
(Ector County Hospital District)



	Feb	Mar	Apr	May	Jun	Jul
Act	$102.2	$113.3	$107.2	$104.7	$104.9	$107.3
Bud	$101.0	$114.8	$104.2	$107.3	$109.5	$101.9
Prior	$100.4	$110.4	$105.7	$108.1	$110.9	$111.3

	Actual	Budget	Prior Year
Month	$ 107.3	$ 101.9	$ 111.3
Var %		5.3%	-3.6%
Year-To-Date	$ 1,095.9	$ 1,055.5	$ 1,067.7
Var %		3.8%	2.6%
Annualized	$ 1,325.6	$ 1,266.3	$ 1,268.5
Var %		4.7%	4.5%

Total Net Patient Revenues



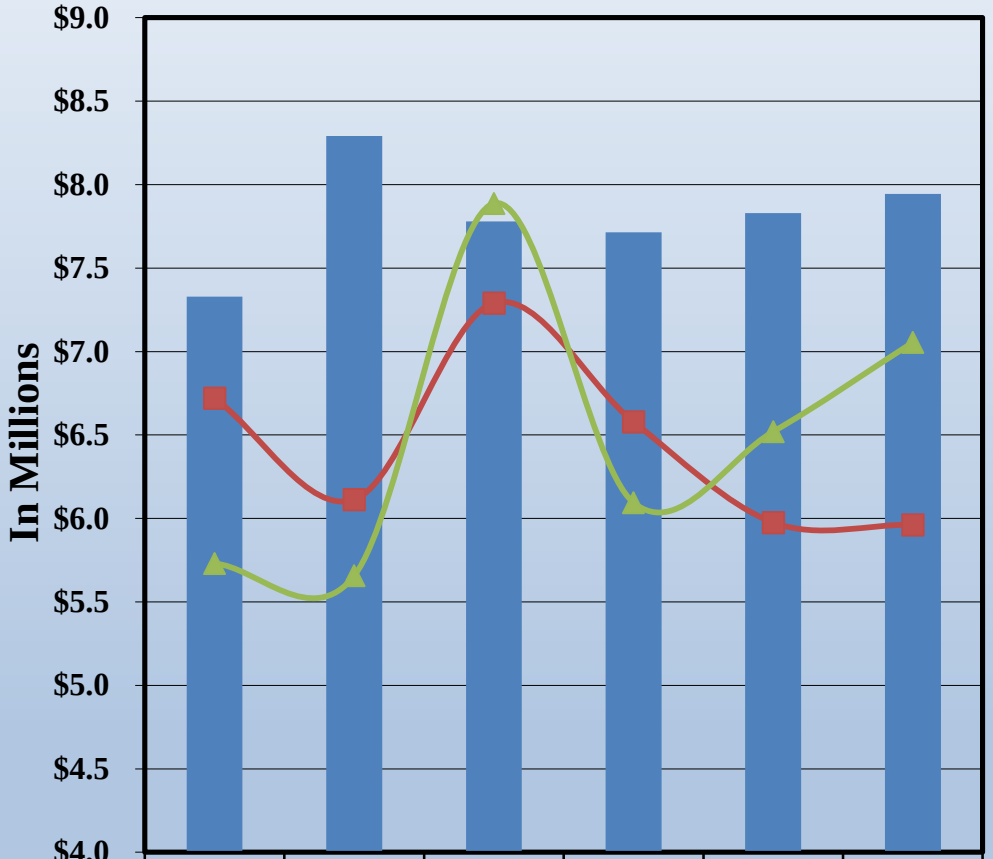
	Feb	Mar	Apr	May	Jun	Jul
Act	$22.8	$25.6	$22.0	$22.4	$24.0	$22.2
Bud	$24.1	$27.0	$25.0	$25.5	$26.0	$24.6
Prior	$22.9	$25.4	$23.7	$24.1	$24.4	$24.9

	Actual	Budget	Prior Year
Month	$ 22.2	$ 24.6	$ 24.9
Var %		-9.8%	-10.8%
Year-To-Date	$ 241.7	$ 251.0	$ 242.9
Var %		-3.7%	-0.5%
Annualized	$ 303.5	$ 298.2	$ 297.1
Var %		1.8%	2.2%

Other Revenue

(Ector County Hospital District)

Including Tax Receipts, Interest & Other Operating Income



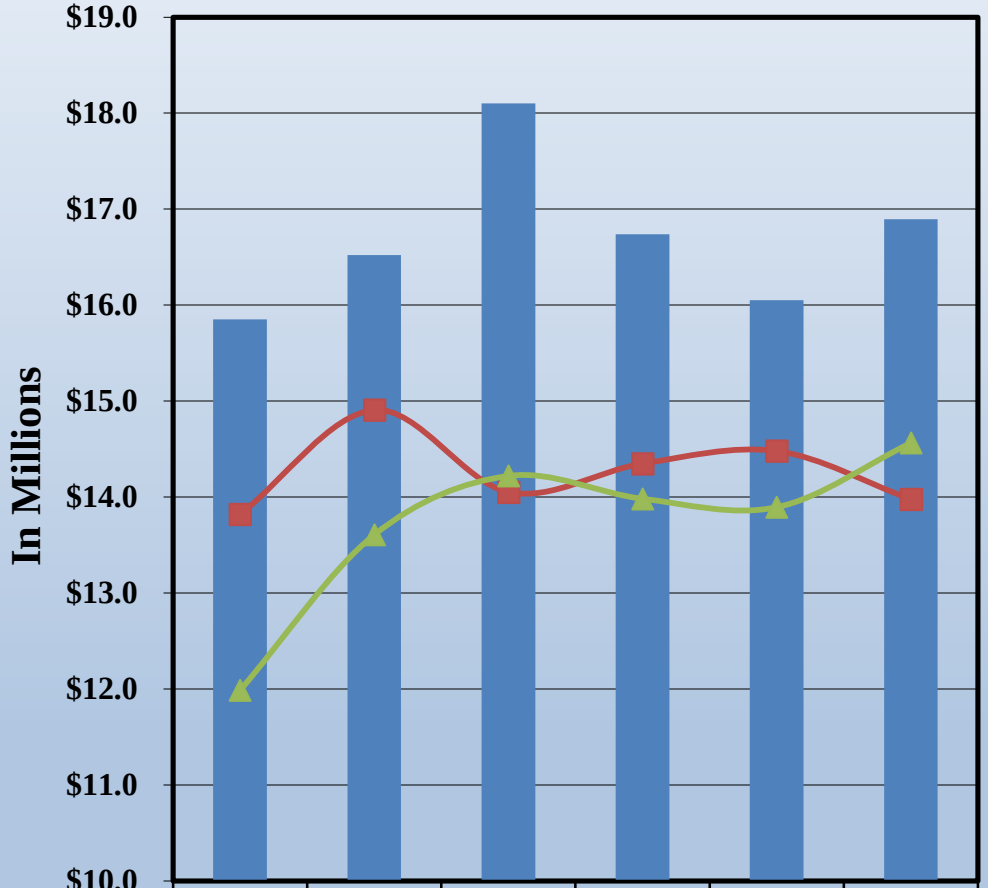
	Feb	Mar	Apr	May	Jun	Jul
Act	$7.3	$8.3	$7.8	$7.7	$7.8	$7.9
Bud	$6.7	$6.1	$7.3	$6.6	$6.0	$6.0
Prior	$5.7	$5.7	$7.9	$6.1	$6.5	$7.1

	Actual	Budget	Prior Year
Month	$ 7.9	$ 6.0	$ 7.1
Var %		33.2%	12.6%
Year-To-Date	$ 80.0	$ 64.0	$ 63.8
Var %		25.0%	25.2%
Annualized	$ 93.1	$ 76.1	$ 75.1
Var %		22.4%	24.0%

Operating Expenses

Salaries, Wages & Contract Labor

(Ector County Hospital District)

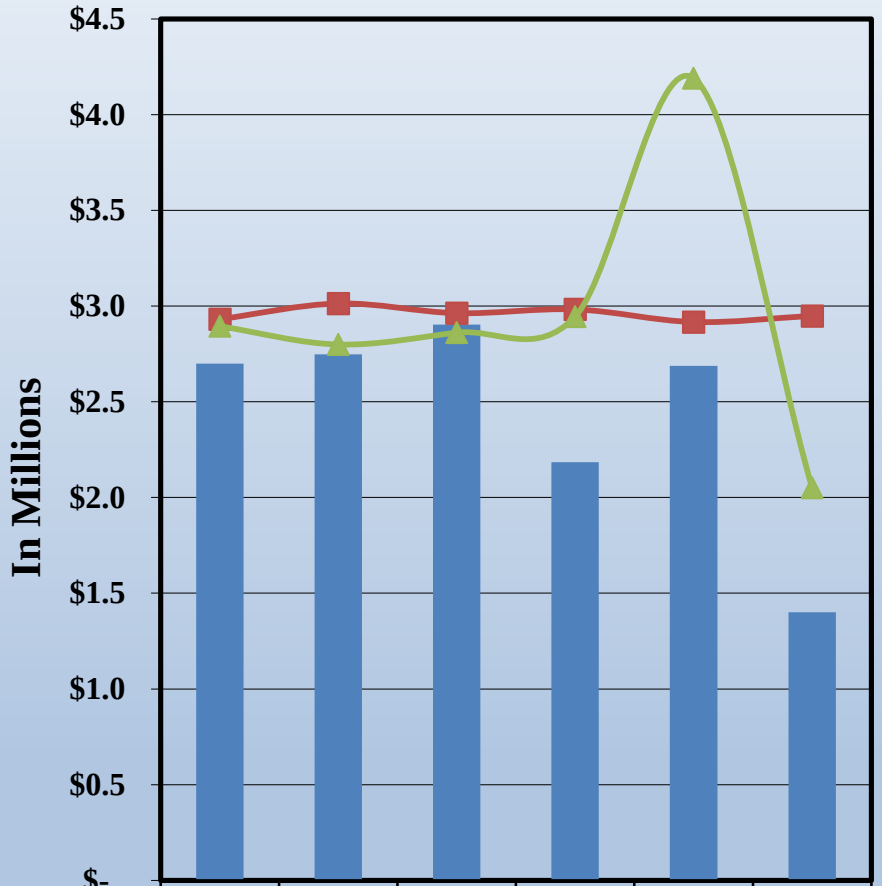


	Feb	Mar	Apr	May	Jun	Jul
Act	$15.9	$16.5	$18.1	$16.7	$16.1	$16.9
Bud	$13.8	$14.9	$14.1	$14.3	$14.5	$14.0
Prior	$12.0	$13.6	$14.2	$14.0	$13.9	$14.6

	Actual	Budget	Prior Year
Month	$ 16.9	$ 14.0	$ 14.6
Var %		20.7%	15.8%
Year-To-Date	$ 165.8	$ 141.5	$ 137.1
Var %		17.2%	20.9%
Annualized	$ 196.1	$ 168.4	$ 163.7
Var %		16.4%	19.8%

Employee Benefit Expense

(Ector County Hospital District)

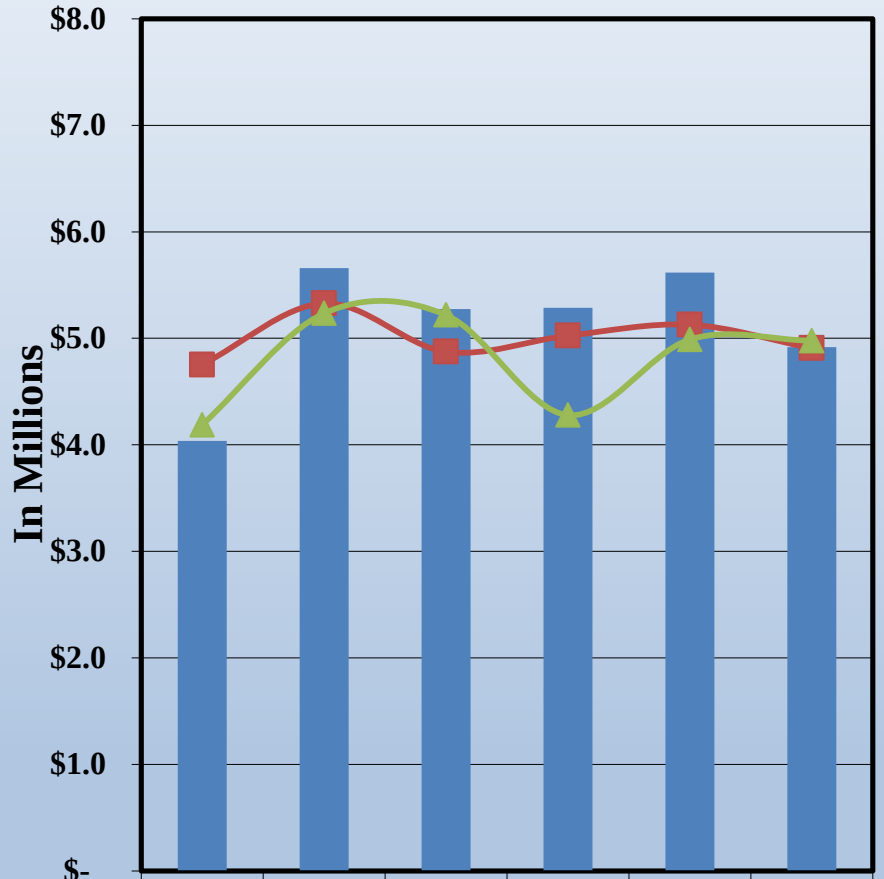


	Feb	Mar	Apr	May	Jun	Jul
Act	$2.7	$2.7	$2.9	$2.2	$2.7	$1.4
Bud	$2.9	$3.0	$3.0	$3.0	$2.9	$2.9
Prior	$2.9	$2.8	$2.9	$2.9	$4.2	$2.1

	Actual	Budget	Prior Year
Month	$ 1.4	$ 2.9	$ 2.1
Var %		-52.5%	-31.7%
Year-To-Date	$ 26.2	$ 29.8	$ 28.4
Var %		-11.9%	-7.6%
Annualized	$ 31.2	$ 35.1	$ 32.1
Var %		-11.1%	-2.8%

Supply Expense

(Ector County Hospital District)

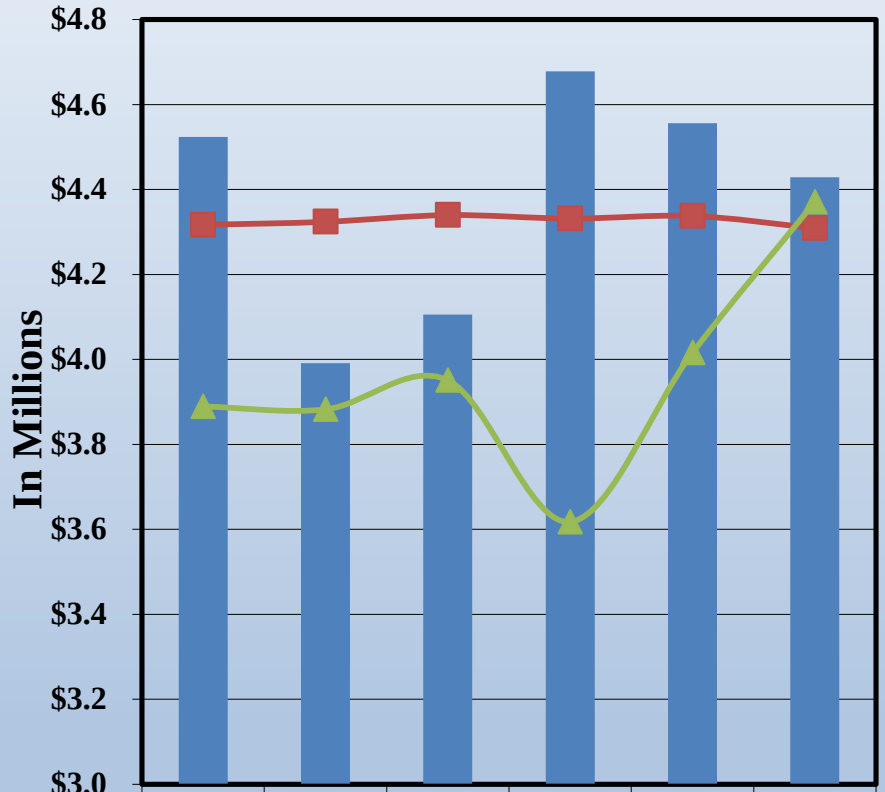


	Feb	Mar	Apr	May	Jun	Jul
Act	$4.0	$5.7	$5.3	$5.3	$5.6	$4.9
Bud	$4.8	$5.3	$4.9	$5.0	$5.1	$4.9
Prior	$4.2	$5.2	$5.2	$4.3	$5.0	$5.0

	Actual	Budget	Prior Year
Month	$ 4.9	$ 4.9	$ 5.0
Var %		0.2%	-1.2%
Year-To-Date	$ 53.0	$ 49.8	$ 49.6
Var %		6.5%	6.9%
Annualized	$ 64.6	$ 59.2	$ 58.4
Var %		9.1%	10.6%

Purchased Services

(Ector County Hospital District)

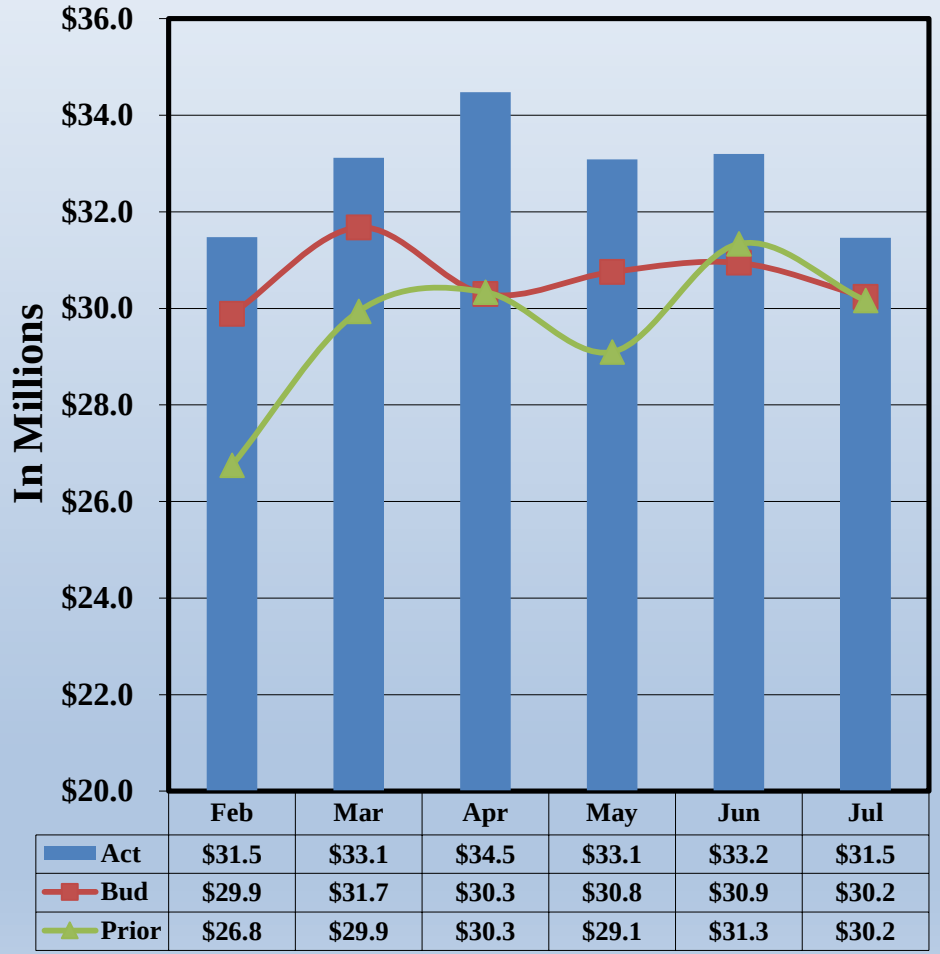


	Feb	Mar	Apr	May	Jun	Jul
Act	$4.5	$4.0	$4.1	$4.7	$4.6	$4.4
Bud	$4.3	$4.3	$4.3	$4.3	$4.3	$4.3
Prior	$3.9	$3.9	$4.0	$3.6	$4.0	$4.4

	Actual	Budget	Prior Year
Month	$ 4.4	$ 4.3	$ 4.4
Var %		2.8%	1.3%
Year-To-Date	$ 43.8	$ 43.2	$ 39.8
Var %		1.3%	10.1%
Annualized	$ 52.3	$ 51.3	$ 46.5
Var %		1.9%	12.5%

Total Operating Expense

(Ector County Hospital District)

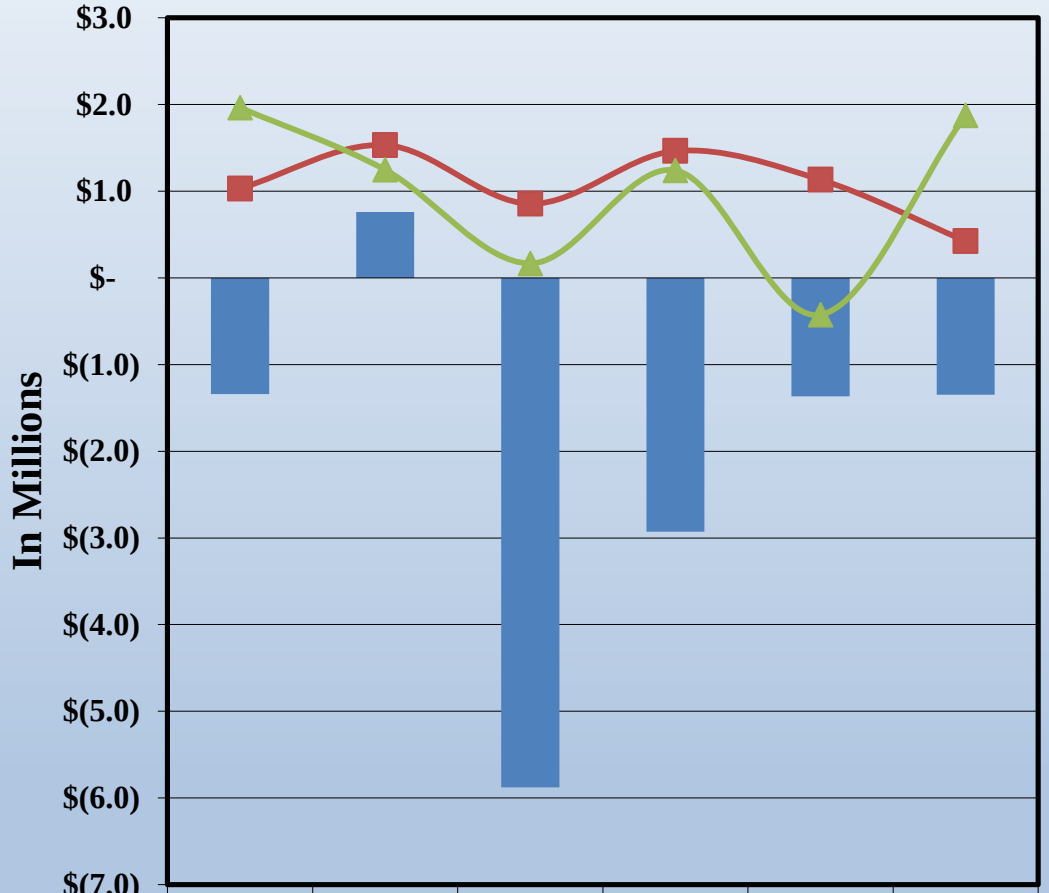


	Feb	Mar	Apr	May	Jun	Jul
Act	$31.5	$33.1	$34.5	$33.1	$33.2	$31.5
Bud	$29.9	$31.7	$30.3	$30.8	$30.9	$30.2
Prior	$26.8	$29.9	$30.3	$29.1	$31.3	$30.2

	Actual	Budget	Prior Year
Month	$ 31.5	$ 30.2	$ 30.2
Var %		4.1%	4.3%
Year-To-Date	$ 331.6	$ 305.2	$ 296.1
Var %		8.6%	12.0%
Annualized	$ 396.8	$ 362.8	$ 350.6
Var %		9.4%	13.2%

Operating EBIDA

Ector County Hospital District Operations



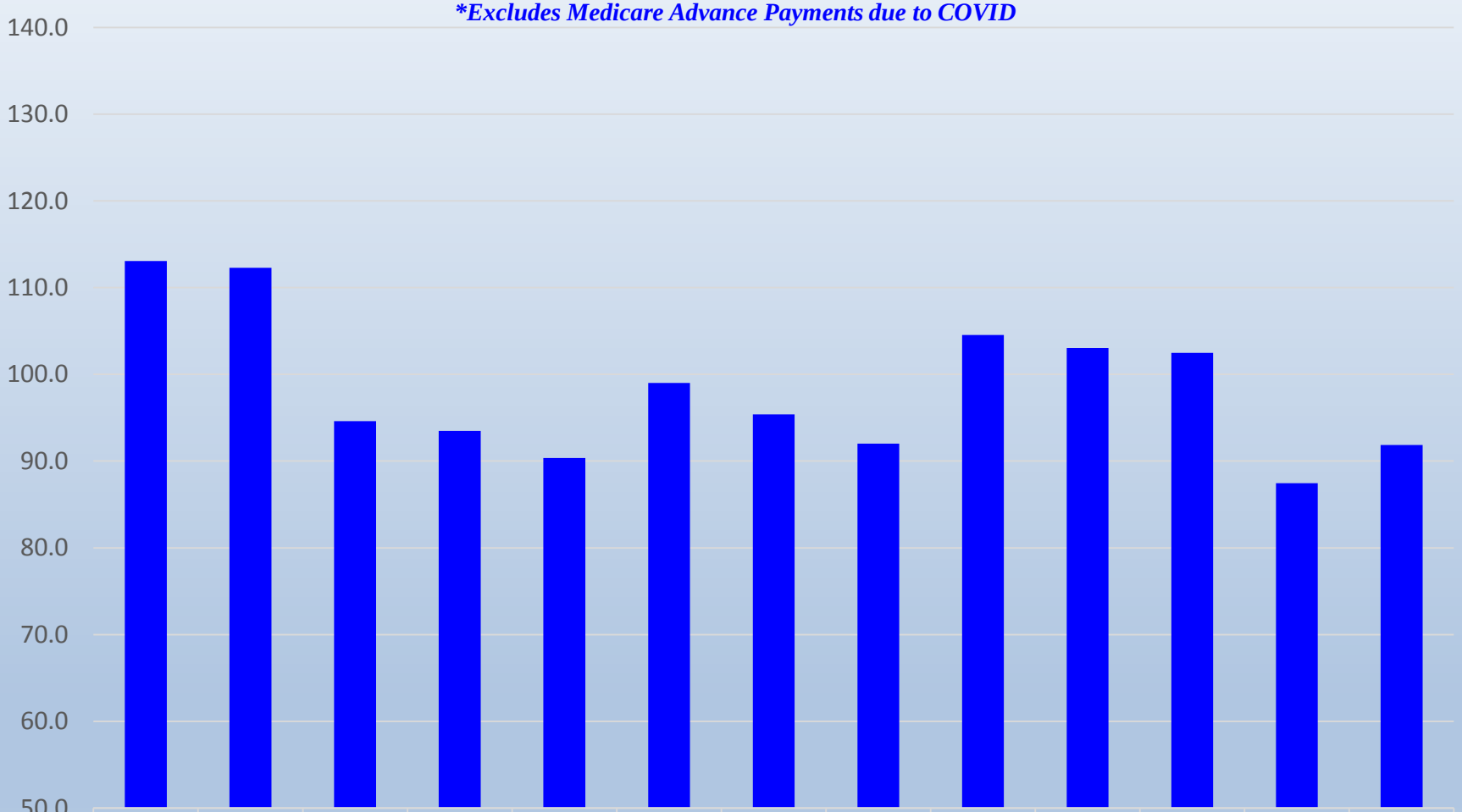
	Feb	Mar	Apr	May	Jun	Jul
Act	$(1.3)	$0.8	$(5.9)	$(2.9)	$(1.4)	$(1.3)
Bud	$1.0	$1.5	$0.9	$1.5	$1.1	$0.4
Prior	$2.0	$1.2	$0.2	$1.2	$(0.4)	$1.9

	Actual	Budget	Prior Year
Month	$ (1.3)	$ 0.4	$ 1.9
Var		(1.70)	(3.20)
Var %		-425.0%	-168.4%
Year-To-Date	$ (10.7)	$ 9.5	$ 10.4
Var %		-212.6%	-202.9%
Annualized	$ 20.8	$ 11.4	$ 21.8
Var %		82.5%	-4.6%

Days Cash on Hand

Thirteen Month Trending

**Excludes Medicare Advance Payments due to COVID*



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Days	113.1	112.3	94.6	93.5	90.4	99.0	95.4	92.0	104.5	103.0	102.5	87.5	91.9


mch
mch

Capital Planning Team

Presentation of Updated Projected Capital Spend for FY 2023

Items to move to Capital FY23 from FY22

Div.	Dept.	MODEL	Loc.	Est. Spend
Facilities - Reno	Facilities	Replace damaged fire doors	Facilities	$ 100,000
Facilities - Reno	Facilities	Elevator Cabs Central Tower	Facilities	$ 75,000
Facilities - Reno	Facilities	***Cancer Center TI's	Facilities	$ 100,000
Facilities - Reno	Facilities	WSMP Parking Garage	Facilities	$ 100,000
IT	IT - Infrastructure	PBX Telecom Upgrade	House wide	$ 1,500,000
Nursing	Housewide	Nurse Call system	House wide	$ 3,086,650
Nursing	Housewide	IV Infusion Pumps	House wide	$ 2,000,000
			Total	**$ 6,961,650**

Updated Expected Capital Purchases FY23

FY 2023 Capital Budget	Tot estimated amount for expected purchases	Outside funding expected (CMN)	Contingency Fund	Total Requested funds for FY 2023 Capital Purchases
Original	$ 22,032,389	$ (81,169)	$ 750,000	$ 22,701,220
Updated	$ 28,982,738	$ (81,169)	$ 750,000	$ 29,651,569

Expected spend for FY 2022 now at $13,240,090* from budget of $20,958,568

* - includes Contingency funded items

MEMORANDUM

TO: ECHD Board of Directors

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

SUBJECT: Culligan Inc. Contract Renewal – RO Water System

DATE: August 23, 2022

Cost:

RO Water System for MCH (05/01/2022 – 04/30/2023) *(Operational Budget)*	$159,311.59
Contract Total	$159,311.59

Background:

This contract renewal will provide equipment and service for RO Water Systems throughout the Medical Center campuses for the next year.

Staffing:

No additional FTE's required

Disposition of Existing Equipment:

N/A

Implementation Time Frame:

N/A

Funding:

Budgeted operational expense

Medical Center Health System
Your One Source for Health

MEMORANDUM

TO: ECHD Board of Directors

FROM: Linda Carpenter, Chief Information Officer

SUBJECT: Breakaway PromisePoint Access/Community Services - (Term Extension)

DATE: September 1, 2022

Cost:

Breakaway PromisePoint Access/Community Services *(1-yr Term Extension)*	$60,000.00

Budget Reference:

Operational Budget	$60,000.00

Background:

Breakaway Adoption Solutions, a Division of Atos, provides Medical Center Health System (MCHS) with PromisePoint access and a suite of online learning simulations for new hires and transfers. This is used to assign specific role based training for the MCHS Electronic Medical Record (EMR). It promotes consistent and effective use of technology, equipment, and processes across MCHS facilities. Along with, customized training to enhance the patient experience and patient outcomes through the most effective use of our clinical applications.

Extending Breakaway contract will retain PromisePoint access and online learning.

Staffing:

No additional FTE's will be required.

Implementation Time Frame:

N/A

Funding:

Breakaway PromisePoint Access/Community Services with annual fee of $60,000 from Atos, will come from operational budgeted funds for this project.

Medical Center Hospital
A Member of Medical Center Health System

FY 2022 CAPITAL EQUIPMENT REQUEST

Date: September 1, 2022

To: Ector County Hospital District Board of Directors

Through: Russell Tippin, President / CEO
Christin Timmons, Vice-President / CNO

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

Re: Invita Healthcare Tissue Tracking System-Extended Warranty

Total Cost	**$22,816/yr. for 3 yr.**
Unbudgeted	$22,816/yr.

OBJECTIVE

Continue software license and service for our Tissue/Implant Tracking system. This will ensure the updating of the computer software appropriately and the equipment is serviced when needed. This also includes one preventative maintenance visit. The tracking system assists to optimize inventory, warranties, expiration dates and receive immediate data on FDA recalls. The Tissue Tracking system is utilized by the Operating Room, Cath Lab, and wound Care.

History

We installed the tissue tracking system in 2019 and had an initial software and license agreement for three years. That agreement expires September 30th, 2022. The tissue tracking systems with integration to the electronic medical record is a valuable tool to assist with compliance with regulatory entities.

PURCHASE CONSIDERATIONS

The lease expires in September, and these are the available options:

- We can buy the Units for $1.00, which the warranty would be out and there would be a Option to buy an extended warranty. (This is the option we chose.)

- We could also trade the old units in for new units and start a new 3-year lease. There would be a 5% increase on the lease price. (The purchase price for the current machines was approximately $166,000 in 2019).

FTE IMPACT
No additional FTE(s) required.

INSTALLATION & TRAINING
None needed

WARRANTY AND SERVICE CONTRACT
3 Year contract

DISPOSITION OF EXISTING EQUIPMENT
No existing equipment presents

LIFE EXPECTANCY OF EQUIPMENT
7-10years

MD BUYLINE INFORMATION
Meets EMTS
and Vizient pricing recommendation.

COMMITTEE APPROVAL
Surgery Dept.
FCC
MEC
Joint Conference
ECHD Board

Medical Center Hospital
A Member of Medical Center Health System

FY 2022 CAPITAL CONSIDERATION

Date: August 22, 2022

To: Ector County Hospital District Board of Directors

Through: Russell Tippin, President / CEO
Matt Collins, COO

From: Brad Timmons, Chief of Police, Director Safety and Emergency Management

Re: Purchase and replacement of 1 Police Patrol Vehicles

Total Cost… **$50,524.55**

OBJECTIVE

Request to replace one police patrol vehicle that's at its end of life.

HISTORY

Safe and reliable patrol vehicles are essential in the day to day operation for police officers responding to emergency calls for service, responding to district properties and clinics, as well as traffic enforcement.

The board approved to replace two vehicles earlier this year. We purchased the two vehicles through the buy board from Caldwell Ford. As of August, we haven't received the vehicles and Caldwell reports that it could be a few more months, due to a back log.

The police department operates with three patrol vehicles. Only one patrol vehicle is safe and reliable to operate. Due to the emergent need to have at a minimum of two reliable vehicles. In August we reached out to Sewell Ford and they had a police package explorer in stock. I submitted to use contingency funds to purchase the vehicle.

Note: We have not replaced vehicles since 2018 when we replaced one vehicle. Once we get delivery of the two vehicles from Caldwell and the one from Sewell, we will be up to date and

can operate for three years until the vehicles will again need to be replaced. We will sell the older vehicles for a fair market value.

WARRANTY AND SERVICE CONTRACT

This purchase will include a 3 year 30K mile warranty.

DISPOSITION OF EXISTING EQUIPMENT

Emergency equipment will be removed and sold

COMMITTEE APPROVAL

N/A

Annual Safety Plans

Emergency Management Plan

- Purpose: The purpose of the Emergency Management Plan is to establish a basic emergency program to provide timely, integrated, and coordinated response to the wide range of natural and manmade events that may disrupt normal operations and require pre-planned response to internal and external incidents.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Facility Management Plan

- Purpose: The Facility Management Plan is designed to provide organizational oversight for the design and maintenance of the physical environment infrastructure and equipment.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Hazardous Materials Management Plan

- Purpose: 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.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Life Safety Management Plan

- Purpose: The fire safety management program is designed to identify and manage the risks of the environments of care operated and owned by Medical Center Health System.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Medical Equipment Management Plan

- Purpose: The purpose of the **Medical Equipment Management Plan (MEMP)** is to support a safe patient care and treatment environment by managing risks associated with the use of clinical equipment technology.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Safety Management Plan

- Purpose: The environmental safety program is designed to identify and manage the risks of the environments of care operated and owned by Medical Center Health System.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Security Management Plan

- Purpose: The security program is designated to identify and manage the risks of the environment of care operated and owned by Medical Center Health System.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Utility Management Plan

- Purpose: 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.
- Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Alignment Room Plan

- Purpose: Through Lean Six Sigma, the Alignment Room supports and facilitates MCH's quality improvement initiatives and seeks to develop improvement capacity throughout the organization’s pillars of finance, quality, experience, growth and people.
- Changes for FY23: Updated types of projects that enter the Alignment Room and the project approval process, roles of the alignment room and committee members.

Infection Prevention Risk Assessment

- Purpose: The risk analysis is conducted / reviewed at least annually and whenever there is a significant change in any of the above factors. The assessment is facilitated by Infection Prevention RN and presented to the Infection Prevention Committee for review and approval as well as QAPI Committee and the hospital board of directors. This risk assessment is organization-wide in scope. It covers inpatient and ambulatory care settings as well as general outpatient care settings.
- Changes for FY23: Updated all High- Risk and Medium-Risk priority areas for FY23

Infection Control Plan

- Purpose: To evaluate the effectiveness of the infection control program to identify those activities that are effective, as well as those activities which require modification so our facilities may continue with Medical Center Health System's commitment to excellence and service.
- Changes for FY23: Updated the effectiveness of significant interventions including CAUTI rates, CLABSI rates and HH Compliance, added conclusion of DSHS 2021 H1 HAI audit and fine tuning of Antimicrobial Stewardship Program.

Pharmacy & Therapeutics Committee Annual Plan

- Purpose: Assist in the formulation of policies, advise the Medical Staff and Hospital's pharm department on matters pertaining to the choice of available drugs; make recommendations concerning drugs, establish standards concerning the use and control of investigational drugs, perform other duties assigned by Chief of Staff or MEC.
- Changes for FY23: The multi-year strategic plan: complete all drug classes by end of FY 2026, moved to Fiscal year plan as we are almost done

QAPI Plan

- Purpose: The organization-wide QAPI Plan encompasses major important aspects of care provided by the hospital in support of the achievement of MCH's mission and strategic goals. This includes continual quality data measurement, assessment and process improvement activities. The Plan describes the overall process for Departments and Services to collaboratively perform QAPI activities in a systematic manner, including the communication of activities and outcomes directed towards improving quality care and services.
- Changes for FY23: Reformatted for easier understanding, detailed out each party's responsibilities, committee role, added facility wide integration areas and how to complete annual evaluation.

Medical Center Health System Emergency Management Plan

Purpose

The purpose of the Emergency Management Plan is to establish a basic emergency program to provide timely, integrated, and coordinated response to the wide range of natural and manmade events that may disrupt normal operations and require pre-planned response to internal and external incidents. Particular attention shall be given to critical areas of concern which may arise during any “all hazards” emergency whether required to evacuate or to shelter in place. The six (6) critical areas of consideration are: Communications, Resources and assets, Safety and security, Staffing, Utilities, and Clinical Activities.

Scope

This is a Medical Center Health System plan that incorporates all services and sites of care provided by the organization and includes Continued Care Hospital located at Medical Center Hospital. This plan applies to staff, licensed independent practitioners, contract workers, and others as appropriate and indicated throughout this document. MCHS uses the calendar year for the purposes of full-scale exercises.

Principles

The fundamental principles of emergency management are based on four phases, mitigation, preparedness, response, and recovery.

Mitigation is the most cost-efficient method for reducing the impact of hazards. A precursor activity to mitigation is the identification of risks. Physical risk assessment refers to the process of identifying and evaluating hazards. The higher the risk, the more urgent the need is to target hazard specific vulnerabilities through mitigation efforts. One example of mitigation at University Hospital is the 96 Hour Business Continuity Plan, which includes mitigation strategies and plans that have been developed to ensure continuity of operations in areas such as utilities, communications, food, water, medication, staffing, and medical supplies when the community is unable to support the hospital due to an external disaster scenario.

Preparedness is a continuous cycle of planning, organizing, training, equipping, exercising, evaluation, and improvement activities that allows Upstate Medical University and Hospital to ensure effective coordination and the enhancement of capabilities to prevent, protect against, respond to, recover from, and mitigate against disaster events that have been identified within the Hazard Vulnerability Analysis (HVA).

In the preparedness phase, the Emergency Management Department develops plans of action to manage and counter risks and acts to build the necessary capabilities needed to implement such plans.

The Response phase includes the mobilization of the identified emergency staff, including first responders, to an internal or external event which could have an impact on patient care operations or the campus. Response procedures are pre-determined by the university and hospital and are detailed in disaster plans during the Preparedness phase. Response to an internal or external incident on campus or in the hospital is directed through the Incident Command System (ICS). Response plans remain flexible in nature due to the varying members of staff available at any given time.

Response procedures and plans are constantly evaluated and changed based on improvements identified during After Action Reviews (AARs), which are held after training exercises and disaster responses. Response actions are also evaluated regularly by the campus and hospital through drills, exercises, tracers, and live events.

The aim of the Recovery phase is to restore the affected area to its previous state. It differs from the Response phase in its focus: recovery efforts are concerned with issues and decisions that must be made after immediate needs are addressed. Recovery efforts are primarily concerned with actions that involve rebuilding destroyed property, re-employment, the repair of other essential infrastructure, as well as the re-opening of essential services in the hospital.

Recovery operations are an extremely important phase in the Emergency Management continuum and yet one that is often overlooked. The Incident Command System team is responsible for the implementation of the Recovery phase.

Objectives

The specific objectives of the Emergency Management Plan are determined by Medical Center Health System. Objectives are specific targets identified by the organization to reduce the risks associated with large and small disaster events. Current objectives are:

- Employ an all-hazards risk-based approach to mitigate, prepare, respond, and recover, from emergencies that overwhelm normal operations of the Health System.
- Support Health System understanding and utilization of the Incident Command System/National Incident Management.
- Continually develop and enhance disaster capabilities through preparing, training, and exercising.
- Address and plan for continuity of operations and sustainability in all practices.
- Work with regional planning partners to ensure seamless operations during any catastrophic event.
- Establish redundant communications within the hospital as well as throughout the community.

- Establish memorandums of understanding with vendors in all areas of the hospital to ensure the best possible care during a catastrophic event.

Program Management Structure

The governing body authorizes the establishment of this plan. The President/CEO has delegated the oversight of this plan to the Emergency Management Coordinator. The senior leadership of the Medical Center Health System – including those of the medical staff – is responsible for actively participating in emergency management planning.

Specialized Department Directors are responsible for ensuring the development and implementation of department specific procedures in coordination with this plan, for ensuring training of staff on their individual roles and responsibilities consistent with the plan and ensuring active participation of their department in the implementation of the plan. Staff is responsible for assuring that their behaviors, work practices and operations are safe, responsible, and in alignment with organizational and departmental procedures, applicable training, and the provisions of this plan.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE6 SR1	**The organization shall provide a comprehensive Emergency Management System to respond to emergencies in the organization or within the community and region that may impact the organization's ability to provide services.** Note: MCHS participates in local and regional planning meetings as well as participates in drills on at least a biennial basis.	-HPP meeting minutes -drill planning meeting minutes
PE6 SR2	**The organization shall meet the requirements set forth in NFPA 99 (2012), Chapter 12, Emergency Management, and the requirements of PE.6, SR.3-5.** Note:	

	MCHS will utilize the guidance and direction from the NFPA chapter 12 to lead the documents, training, development, and maintenance of the Emergency Management Program.	
PE6 SR3	**The organization shall develop and implement emergency preparedness policies and procedures based on the organization's emergency plan as required by 42 CFR Section 482.15(a), a risk assessment as required by 42CFR Section 482.15(a)(1), and the organization's communication plan as required by 42 CFR Section 482.15(c). The policies and procedures shall be reviewed and updated at least annually. At a minimum, the policies and procedures shall address the following:** Note:	- Emergency Operation Plan - Incident Response Guides - Communication Plan
PE6 SR3a	**A process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency, including documentation of the organization's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.** Note: MCHS participates in local and regional planning meetings as well as participates in drills on at least a biennial basis.	-HPP meeting minutes -drill planning meeting minutes
PE6 SR3b	**A system to track the location of on-duty staff and sheltered patients in the organization's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the organization shall document the specific name and location of the receiving facility or other location.** Note: On-duty staff is tracked through our HR department and the paycom system. HR can account for all employees clocked in and on campus.	
PE6 SR3c	**Decision criteria for the determination of protection in place or evacuation of patients in the event of a disaster.**	- Emergency Operation Plan

	Note: The decision to evacuate shall be made by the Incident Commander in collaboration with the senior positions of the Command Center team. In addition, appropriate communication and collaboration with the community-wide EOC shall occur.	
PE6 SR3d	**A means to shelter in place for patients, staff, and volunteers who remain in the facility.** Note: Appropriate resources and supplies will available for patients, staff, and volunteers under the 96-hour plan. Resources and supplies will be monitored carefully and will determine if an evacuation of all will be necessary.	- Emergency Operation Plan - 96-hour Plan
PE6 SR3e	**Safe evacuation includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.** Note: Please refer to the documents	- Emergency Operation Plan - Evacuation Plan - Alternate Care Sites - Communication Plan
PE6 SR3f	**A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.** Note: MCHS utilizes the Cerner EMR System. Through this EMR there are not only backups on campus but also backup servers in other areas of the country. MCHS currently has laptops with the Cerner applications downloaded and are available in the event of an evacuation or the use of an alternate care site.	- Draft IT/Cyber Security Plan
PE6 SR3g	**The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.** Note: MCHS has addressed special precautions to be taken when, for example, there is a regional or local emergency declaration, which necessitates the temporary utilization of unvaccinated	- Emergency Operation Plan p.32

	staff, in order to assure the safety of patients. Upon arrival to the hospital the volunteers will follow the emergency credentialing process set forth by Medical Center Health System to include vaccination status. In immediate disaster times, or times of desperate need, the volunteers will be asked upon arrival of their vaccination status and will be placed accordingly. The vaccinated volunteers will be placed according to the emergency operations plan as any other volunteer. The unvaccinated volunteers or volunteers unable to verify vaccination will be placed in other non-patient care areas of need, examples would be directing traffic outside the building, collecting donations, and others. If available and time permits, testing prior to entering the hospital for unvaccinated volunteers will be attempted. All volunteers will be required to wear the appropriate mask in the building and while performing any duties that may be asked of the volunteers during their time with MCHS. If the volunteer has not fit tested in the past year for an N-95 mask and the request from MCHS requires such PPE, a PAPR (powered air purifying respirator) will be issued for their use. If MCHS works with any disaster volunteer organizations such as a VOAD (Volunteer Organizations Active in Disaster), vaccine status will be required when volunteer's information is requested.	
PE6 SR3h	**The role of the organization under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.** Note: Please refer to document	- MCH 4054 Use of 1135 Waiver
PE6 SR3i	**The development and maintenance of an emergency preparedness communication plan that complies with federal, state, and local laws. The communication plan shall include all of the requirements of NFPA 99 (2012), Chapter 12, Emergency Management and shall also include:** Note: Please refer to document	- Communication Plan
PE6 SR3i1	**Names and contact information for the following:** Note: Please refer to document	- Communication Plan

PE6 SR3i1i	**Staff,** Note: Please refer to document	- Communication Plan
PE6 SR3i1ii	**Entities providing services under arrangement,** Note: Please refer to document	- Communication Plan
PE6 SR3i1iii	**Patients' physicians,** Note: Please refer to document	- Communication Plan
PE6 SR3i1iv	**Other hospitals,** Note: Please refer to document	- Communication Plan
PE6 SR3i1v	**Volunteers,** Note: Please refer to document	
PE6 SR3i1vi	**Federal, state, tribal, regional, and local emergency preparedness staff, and,** Note: Please refer to document	- Communication Plan
PE6 SR3i1vii	**Other sources of assistance.** Note: Please refer to document	- Communication Plan
PE6 SR3i2	**Primary and alternate means for communicating with the following:** Note: Please refer to document	- Communication Plan
PE6 SR3i2i	**Organization staff; and,**	- Communication Plan

	Note: Please refer to document	
PE6 SR3i2ii	**Federal, state, tribal, regional, and local emergency management agencies.** Note: Please refer to document	- Communication Plan
PE6 SR3j	**A means, in the event of an evacuation, to release patient information as permitted under 45 CFR Section 164.510(b)(1)(ii),** Note:	- Communication Plan
PE6 SR3k	**A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR Section 164.510(b)(4).** Note: Please refer to document	- Communication Plan
PE6 SR3l	**If the emergency preparedness policies and procedures are significantly updated, the organization shall conduct training on the updated policies and procedures.** Note: Education and training is completed with all staff through face-to-face training or electronic modules in NetLearning and documentation is kept with the staff members or in their employee training folder	
PE6 SR4	**The organization shall comply with the conditions of participation set forth in 42 CFR Section 482.15(d)(2) regarding exercises to test the emergency plan:** Note: Conditions of participation requirements for exercises are met annually unless the facility is under a waiver. Waivers will be held in the Safety department if applicable	
PE6 SR4a	**Participate in an annual full-scale exercise that is community-based or, when a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or, if the hospital experiences an actual natural or man-made emergency that**	- After Action Report (AAR)

	requires activation of the emergency plan, the hospital is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the actual event. Note: MCHS plans and participates in a community-wide drill on an annual basis. The last community-wide drill after action report can be found in the Emergency Management Office.	
PE6 SR4b	**Conduct an additional annual exercise that may include, but is not limited to the following:** Note: All documentation of exercises is held in the EM office and electronically	- Documentation held in EM office or electronically
PE6 SR4b1	**A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or,** Note: All documentation of exercises is held in the EM office and electronically	- Documentation held in EM office or electronically
PE6 SR4b2	**A mock disaster drill; or,** Note: All documentation of exercises is held in the EM office and electronically	- Documentation held in EM office or electronically
PE6 SR4b3	**A tabletop exercise or workshop is that includes a group discussion led by a facilitator, and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.** Note: Tabletop exercises are completed for build-up for a large-scale event, the recognition of a particular threat or vulnerability, and for education and training purposes of the staff.	- Documentation held in EM office or electronically

PE6 SR4c	**Analyze the organization's response to and maintain documentation of all drills, table top exercises, and emergency events, and revise the hospital's emergency plan, as needed.** Note:	- Documentation held in EM office or electronically
PE6 SR5	**The organization shall comply with the conditions of participation set forth in 42 CFR Section 482.15(e) regarding the implementation of emergency and standby power systems based on the organization's emergency plan:** Note: Please refer to the document	- Utility Failure Electricity
PE6 SR5a	**The emergency generator shall be located in accordance with the location requirements found in the 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), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.** Note: Please refer to the document	- Utility Failure Electricity
PE6 SR5b	**The organization shall implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.** Note: Please refer to the document	- EOC testing schedule
PE6 SR5c	**Organizations that maintain an onsite fuel source to power emergency generators shall have a plan for how it will keep emergency power systems operational during the emergency unless it evacuates.** Note: Please refer to the document	- Utility Failure Electricity
PE6 SR6	**If an organization is part of a healthcare system consisting of multiple separately certified healthcare facilities that elect to have a unified and integrated emergency preparedness program, the organization may choose to participate in the healthcare system's**	**N/A**

	coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program shall do all of the following: Note: Not Applicable	
PE6 SR6a	**Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.** Note: Not Applicable	**N/A**
PE6 SR6b	**Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.** Note: Not Applicable	**N/A**
PE6 SR6c	**Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.** Note: Not Applicable	**N/A**
PE6 SR6d	**Include a unified and integrated emergency plan that meets the requirements of PE.1 and 42 CFR Section 482.15(a)(2), (3), and (4). The unified and integrated emergency plan shall also be based on and include the following:** Note: Not Applicable	**N/A**
PE6 SR6d1	**A documented community-based risk assessment, utilizing an all-hazards approach.** Note: Hospital Preparedness program performs a hazardous vulnerability assessment for the entire region with input from all the hospitals, EMS services, as well as County EMCs.	• Regional HVA

PE6 SR6d2	**A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.** Note: Emergency Management Committee reviews the Hazardous Vulnerability Assessment annually. The HVA assessment for MCHS covers all of our campuses.	• HVA Assessment
PE6 SR6e	**Include integrated policies and procedures that meet the requirements set forth in 42 CFE Section 462.625(b) and a coordinated communication plan, and training and testing programs that meet the requirements of 42 CFR Section 482.15(c) and (d) (see PE.6 SR.1-3).** Note: Not Applicable	**N/A**
PE6 SR7	**If an organization has one or more transplant centers (as defined in 42 CFR Section 482.70):** Note: Not Applicable	**N/A**
PE6 SR7a	**A representative from each transplant center shall be included in the development and maintenance of the organization's emergency preparedness program; and,** Note: Not Applicable	**N/A**
PE6 SR7b	**The organization shall develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.** Note: Not Applicable	**N/A**

Evaluation of Plan

An annual evaluation of the emergency operations plan is completed by the emergency management coordinator and brings any changes to the emergency management committee. With every event, more information is added to the plan to show progression in the ability to plan and prepare for disaster.

Performance Indicators

- **2021-2022 Goals for emergency management**
  - All directors and above must complete the ICS courses 100, 200, 700, and 800 by 12/31/2022.
    - (insert QAPI slides)
- **2022-2023 Goals for emergency management**
  - All executive members must complete ICS 300 and 400 by 12/31/2023.
    - (insert QAPI Slides)
- **2023-2024 Goals for emergency management**
  - All executive members must attend training at the Center for Domestic Preparedness in Anniston for the FRAME course.
    - (insert QAPI slides)

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 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 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 relates to the physical environment
E) Monitor events, occurrences, and impairments to continually improve performance
F) Disseminate appropriate data to QAPI council
G) Maintain Tobacco Free campus policy

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 Safety Committee on a quarterly basis. 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 QAPI Council. The Chief Operating Officer collaborates with the Director of Facilities, Safety Officer and other appropriate staff to address system issues and concerns as well capital infrastructure planning. The Chief Operating Officer also collaborates with the Director of Facilities, and Chief Financial Officer to develop a budget and operational objectives 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), 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 in place to manage staff activities, as required and/or recommended by local, State, and national authorities or**	• See MCHS Policies 4000's • Continuing Education

	related professional organizations, to maintain a safe environment for the organization's patients, staff, and others. 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 process, 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 facility's environmental management system.** Note:	
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 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 needs to be updated • 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 2023
    - 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

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 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.** 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 2023
    - Appropriate location and security of O2 e-cylinders.
        - Monitor: EOC gas cylinder rounding assessment

Medical Center Health System
Life Safety Management Plan

Purpose

Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The fire safety management program is designed to identify and manage the risks of the environments of care operated and owned by Medical Center Health System. The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Medical Center Health System.

The Management Plan for Fire Safety describes the risk and daily management activities that Medical Center Health System 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 the fire safety 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.

The program is applied to the Medical Center Hospital and the hospital-based clinic operations of Medical Center Health System.

Scope

Principles

- All buildings of Medical Center Health System housing patient care services must be designed, operated, and maintained to comply with the 2012 edition of the *Life Safety Code*.
- All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
- All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimizing the potential of loss of life or property in the event of a fire.

- Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

Objectives

- Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.
- Conduct required fire drills in all buildings of Medical Center Health System housing patient care services.
- Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
- Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2000 edition of the *Life Safety Code.*
- Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

Program Management Structure

- The Manager of the FSM program assures that an appropriate maintenance program is implemented. The manager of the FSM program also collaborates with the Safety Officer to develop reports of FSM performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
- The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment 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.

- The Administrative Leadership Team (ALT) receives regular reports of the activities of the FSM program from the Safety Committee. The Administrative Leadership Team reviews the reports and, as appropriate, communicates concerns about identified issues back to the manager of the FSM and appropriate clinical staff. The ALT collaborates with the CEO and other senior managers to assure budget and staffing resources are available to support the FSM program.

- The CEO of Medical Center Health System receives regular reports of the activities of the FSM program. The CEO collaborates with the FSM program manager and other appropriate staff to address fire safety issues and concerns. The CEO also collaborates with the FSM program manager to develop a budget and operational objective for the FSM program.

Definitions

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE2 SR1	**Except as otherwise provided in NIAHO® Accreditation Requirements:**	
PE2 SR1a	**The hospital shall meet the applicable provisions and shall proceed in accordance with the 2012 Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). Outpatient surgical departments shall meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.** Note:	
PE2 SR1b	**Corridor doors and doors to rooms containing flammable or combustible materials shall be provided with positive latching hardware. Roller latches are prohibited on such doors.** Note:	• FIRE DOOR Program SOP in draft form
PE2 SR1c	**In consideration of a recommendation by the state survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in**	

	unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note: All waivers are carefully considered by the EOC committee and MCH administration. If the waiver allows the staff and facility to better serve our patients in times of disaster or need without having adverse effects on the health or safety of our patients, MCHS will prepare the appropriate documentation, and approved waivers will be held in the Safety Office.	
PE2 SR1d	**The provisions of the Life Safety Code do not apply in a state where CMS finds that a fire and safety code imposed by state law adequately protects patients in hospitals.** Note:	
PE2 SR2	RESERVED	
PE2 SR3	**The organization shall maintain written evidence of regular inspection and approval by State or local fire control agencies.** Note: The city of Odessa Fire Marshall's office has an annual assessment. These documents are kept in the Engineering offices.	• Fire Marshall inspection notebook, held in the engineering office.
PE2 SR4	**The organization shall have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel, and guests; evacuation; and cooperation with firefighting authorities. The fire control plan shall provide for training of staff in the following areas (NFPA 101-2012, 18.7.2.2 & 19.7.2.2)** Note: Please see Document	• Fire Response Plan MCH- 4050
PE2 SR4a	**Use of alarms;**	• Fire Response Plan MCH- 4050

	Note: Please See Document	
PE2 SR4b	**Transmission of alarm to fire department;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4c	**Emergency phone call to fire department;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4d	**Response to alarms;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4e	**Isolation of fire;** Note: Please See Document	• Fire Response Plan MCH- 4050
PE2 SR4f	**Evacuation of immediate area;** Note: Please See Document	• Fire Response Plan MCH- 4050 • Evacuation Plan
PE2 SR4g	**Evacuation of smoke compartment;** Note: Please See Document	• Fire Response Plan MCH- 4050 • Evacuation Plan
PE2 SR4h	**Preparation of floors and building for evacuation; and** Note: Please See Document	• Fire Response Plan MCH- 4050 • Evacuation Plan
PE2 SR4i	**Extinguishment of fire** Note: Please See Document	• Fire Response Plan MCH- 4050
PE 2 SR5	**The Life Safety Management System shall include in the elements of SR.4 e a written barrier protection plan for the preservation of the integrity of hospital smoke and fire barriers. The plan shall include:** Note: Please See Document	• SOP Fire Barrier Management

PE2 SR5a	**Name(s) of responsible hospital staff for barrier protection program;** Note: Please See Document	• SOP Fire Barrier Management
PE2 SR5b	**Requirement for written permission for anyone (including all hospital staff, contractors and vendors) to penetrate a smoke or fire barrier wall, ceiling or floor;** Note: MCHS has an Above Ceiling program, where any individuals that will be performing any type of work above the ceiling will be required to obtain a permit for such work. Upon the completion of the work, an engineering department employee will verify the area for no penetrations or complications with the fire suppression system.	• SOW Above Ceiling Permit
PE2 SR5c	**Input from Infection Control and Prevention Practitioner on critical clinical areas prior to issuance of written permit for performing work on barriers; and** Note:	• ALSM and ICRA assessment
PE2 SR5d	**Establishment of monitoring process to ensure all work is completed correctly.** Note: After the above ceiling work is completed at Medical Center, it will be inspected by MCH Engineering Staff. After the inspection is complete the work order will be closed.	• SOW Above Ceiling Permit
PE2 SR6	**Health care occupancies shall conduct unannounced fire drills, but not less than one (1) drill per shift per calendar quarter that transmits a fire alarm signal and simulates an emergency fire condition. When fire drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. (NFPA 101-2012, 18.7.1.7. & 19.7.1.7).** Note:	• Drill Evaluations are kept in the Safety Department • MCH-3003 shifts • Fire Drill Matrix • Aggregated fire drill evaluations

	The safety department conducts quarterly unannounced fire drills on all three shifts. All documentation of the drills and staff evaluations are aggregated and reported to the Quality Committee.	
PE2 SR6a	**Business occupancies shall conduct at least one unannounced fire drill annually per shift.** Note: Safety Department conducts annual fire unannounced fire drills for business occupancies. All documentation of the drills and staff evaluations are held in the Safety department.	• Fire Drill Matrix • Fire Drill evaluations
PE2 SR6b	**Fire drills shall be thoroughly documented and evaluate the organization's knowledge of the items listed in PE.2, SR.4.** Note: All items are listed on the drill evaluation forms and reports of	• Fire Drill evaluations • Aggregated data to Quality Committee
PE2 SR6c	**At least annually, the organization shall evaluate the effectiveness of the fire drills. The report of effectiveness shall be forwarded to Quality Management Oversight.** Note:	• Aggregated data to Quality Committee through consent agenda
PE2 SR7	**The Life Safety Management System shall address applicable Alterative Life Safety Measures (ALSM) that shall be implemented whenever life safety features, systems, or processes are impaired, or deficiencies are created or occur. Thorough documentation is required.** Note: During every type of construction or remodel, an ALSM and ICRA assessments are performed. The results will determine the actions needed for the project.	• ALSM and ICRA assessments • Pre-construction book
PE2 SR7a	**All alternative life safe measures shall be approved by the authority having local jurisdiction. Life safety measures for redundant and/or common minor renovations/repairs/testing may be preapproved for the specific task by the AHJ.** Note:	• ALSM and ICRA assessments • Pre-Construction book

	Our ALSM and ICRA assessments categorize our projects and determine the level of jurisdiction that must provide approvals. All projects in need of a permit will go through the City of Odessa and the Fire Marshall's Division.	
PE2 SR8	**When a sprinkler system is shut down for more than 10 hours, the hospital shall:** Note: MCH will perform an assessment of the area and consult with the Fire Marshall to determine if evacuation or fire watch is necessary.	• ALSM and ICRA assessments • Pre-Construction book
PE2 SR8a	**Evacuate the building or portion of the building affected by the system outage until the system is back in service, or** Note: MCH Safety Officer, Engineering Director, and Chief Operating Officer will determine if the occupants of the affected area will need to be relocated or if a Fire Watch should be initiated	• ALSM and ICRA assessment • Pre-Construction book
PE2 SR8b	**Establish a fire watch until the system is back in service.** Note:	• MCH 4047 – Fire Watch
PE2 SR9	**Buildings shall have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill height shall not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.** Note: With any new construction, all building codes will be followed. All construction before the above-mentioned date will be grandfathered in.	
PE2 SR9a	**The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.** Note: Center for Women and Infants was constructed following the appropriate building code with required sill heights.	
PE2 SR9b	**The sill height in special nursing care areas of new occupancies shall not exceed 60 inches.**	

	Note: Center for Women and Infants was constructed following the appropriate building code with required sill heights.	
PE2 SR10	**The Life Safety Management System shall require that Life Safety systems (e.g., fire suppression, notification, and detection equipment) shall be tested and inspected (including portable systems).** Note: All testing and inspections are per manufacturing specifications and guidance from OSHA and NFPA.	• EOC Committee Testing Schedule
PE2 SR11	**The Life Safety Management System shall require a process for reviewing the acquisition of bedding, draperies, furnishings, and decorations for fire safety.** Note: The material safety review team reviews all bedding, draperies, and furnishings prior to purchase. The team rounds and reviews all holiday decorations as well as special approved events or program décor.	• Material Safety Review Team
PE2 SR12	**All non-patient sleeping rooms shall be equipped with an approved, single-station smoke alarm.** **Note: NFPA 101, 2012 9.6.2.10.1.4: System smoke detectors in accordance with NFPA 72, National Fire Alarm and Signaling Code, and arranged to function in the same manner as single-station or multiple-station smoke alarms shall be permitted in lieu of smoke alarms.** Note: Every sleep room in Medical Center is equipped with a smoke detector and a visual alert.	
PE2 SR13	**Construction, Repair, and Improvement operations shall involve the following activities:** Note:	• ALSM and ICRA assessment • Pre-Construction book
PE2 SR13a	**During construction, repairs, or improvement operations, or otherwise affecting the space, the current edition of the Guidelines for Design and Construction of Hospitals (FGI), shall be consulted for designing purposes.**	• ALSM and ICRA assessment

	Note: All construction projects are subject to a pre-construction assessment which will determine the safety requirements that will be needed for each project. If the pre-construction assessment deems necessary, a full ALSM will be complete and appropriate pre-designed processes will be followed.	• Pre-Construction book
PE2 SR13b	**The organization shall assess, document, and minimize the impact of construction, repairs, or improvement operations upon occupied area(s). The assessment shall include, but not be limited to, provisions for infection control, utility requirements, noise, vibration, and alternative life safety measures (ALSM).** Note: Every project includes a pre-construction assessment is performed. Infection prevention, Safety, and engineering are all responsible to complete the pre-construction assessment.	• ALSM and ICRA assessment • Pre-Construction book
PE2 SR13c	**In occupied areas where construction, repairs, or improvement operations occur, all required means of egress and required fire protection features shall be in place and continuously maintained or where alternative life safety measures acceptable to the authority having local jurisdiction are in place. NFPA 241-2009, Standard for Safeguarding Construction, Alteration, and Demolition Operations, shall be referenced in identifying and implementing alternative life safety measures.** Note: Egress and fire suppression systems are assessed for the level of involvement in the construction project. If the pre-construction and ALSM assessment deem appropriate other procedures are followed i.e. fire watch and other types of education.	• ALSM and ICRA assessment • Pre-Construction book
PE2 SR13d	**All construction, repairs, or improvement operations, shall be in accordance with applicable NFPA 101-2012 standards, and State and local building and fire codes. Should standards and codes conflict, the most stringent standard or code shall prevail.** Note:	• Life Safety Drawings are held in the Engineering Department

	All construction projects utilize architects' groups that ensure the highest level of healthcare safety is used. All safety drawings are kept in the engineering department.	

Evaluation of Plan

On an annual basis, the Safety Department will evaluate the objectives, scope, effectiveness, and performance of the Life Safety 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 Safety Department collaborates with the EOC Committee and other appropriate associates to convey and address any life safety 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 life and fire safety.

Performance Indicators

- Goals for 2023
    - Fire and Life Safety education to all departments on the appropriate response to a fire alarm activation, scavenger hunt for life safety equipment in individuals' areas, and "good to know" life safety information. Responsibility for completion was placed on the department directors and documentation was asked to be placed in the employees' education folder.
    - Improved knowledge of life safety equipment during fire drills by 25% by EOY
    - Development of departmental safety officers so that necessary education will be given at the lowest levels to ensure appropriate understanding of responsibilities and actions during a disaster.
    - Improve preparation time for the ALSM/ICRA assessment process by assessing each project 3 days prior to construction/renovation.
        - Complete 95% of projects assessments 72 hours prior to project start.

Medical Center Health System
Medical Equipment Management Plan

Purpose

The purpose of the **Medical Equipment Management Plan (MEMP)** is to support a safe patient care and treatment environment by managing risks associated with the use of clinical equipment technology. The specific medical equipment risks of the environment are identified by conducting and maintaining a proactive risk assessment plan based on various risk criteria, including risks identified by outside sources such as Det Norske Veritas or other accreditation agencies.

Scope

The MEMP describes the risk and routine management and identifies the policies and procedures activities that have been put in place to achieve the lowest potential for adverse impact on the safety and health of patients, associates, and other people, entering the organization's facilities, and to assure compliance with applicable standards and regulations.

The program is applied to the hospitals, clinics, and operations of Medical Center Hospital, in accordance with the TRIMEDX contract for Medical Equipment Management for the organization.

Principles

- Selection of appropriate equipment is an essential part of providing safe, effective care and treatment.
- Orientation, education, and training of operators of medical equipment are essential parts of the program.
- Assessment of needs for continuing technical support of medical equipment and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that medical equipment is safe and reliable.

Objectives

- Use established criteria and relevant historical information to identify potential equipment risks. The identified risks are minimized through development of appropriate processes for equipment management to ensure that equipment is appropriate for intended use and that associates members are properly trained. It also ensures that equipment is maintained appropriately by qualified individuals.

- Identify and respond appropriately to equipment hazard and recall notices in a timely manner.
- Record, report, and analyze medical equipment problems, failures, and use errors, and implement processes designed to further reduce the risks associated with medical equipment throughout the facility, to improve the overall environment of care.

Program Management Structure

- The authority over the plan and responsibility for the plan development, performance measures, appropriate regulatory compliance, and achievement of the goals has been delegated to the EOC Committee in collaboration with the Safety Officer and Clinical Engineering staff. The Management Plan is approved by the Environment of Care Committee.
- The manager of the program administers the program through the services of the Clinical Engineering department, in conjunction with the clinical care areas as applicable.
- The Clinical Engineering associates manage the schedule and timely completion of the calibration, inspection, and maintenance activities required for safe, reliable performance of medical equipment. In addition, the technicians facilitate necessary repairs and other unscheduled service activities as requested.

Definition

High-Risk Equipment (Life Support & Critical Equipment) **-** Equipment that is critical to patient health and safety. At a minimum such critical equipment includes, but is not limited to, life-support devices, key resuscitation devices, critical monitoring devices, and other devices whose failure may result in serious injury to or death of patients or associates.

Medical Equipment – Fixed and portable equipment used for the diagnosis, treatment, monitoring, and direct care of individuals.

Temporary Equipment – Equipment that is loaned, rented, used for evaluation (demo) regardless of ownership. The time frame that the device is expected to be in and out of the facility is less than the Default PM Inspection time frame.

Computerized Maintenance Management System (CMMS) - TRIMEDX proprietary system for maintaining medical equipment inventory and service records.

Elements of the Program

Standard	Standard Requirement	Evidence of Compliance
PE7 SR1	**The organization shall establish a Medical Equipment Management System that provides processes for the acquisition, safe use, and the appropriate selection of equipment.**	Hospital Policy and Procedure: ___ MCH 4002, RAD-0170, CE 2003, CE 2005, CE 2011, _____

	Note: Clinical Engineering establishes and maintains a current inventory of medical equipment. In accordance with applicable policies and procedures, the manager of the MEMP will keep the inventory up to date as medical equipment is acquired or retired. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory based on contractual or scope of service terms. Trimedx Policy & Procedure: Performance Verification, Retirement.	
PE7 SR2	**The Medical Equipment Management System shall address issues related to the organization's initial service inspection, the orientation, and the demonstration of use for rental or physician owned equipment.** Note: Before initial use and after repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. Trimedx Policy & Procedure: Performance Verification, Retirement of equipment.	Hospital Policy and Procedure: MCH 4002, CE 2003, CE 2005, CE 2011, MCH 4002
PE7 SR3	**The Medical Equipment Management System shall address criteria for the selection of equipment.** Note: The hospital maintains either a written inventory of all medical equipment or written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory.	Hospital Policy and Procedure: Trimedx AEM and Default maintenance plan, MCH 4041, MCH 4025, CE 2003, CE 2005, CE 2011, MCH 4002
PE7 SR4	**The Medical Equipment Management System shall address incidents related to serious injury or illness or death (See SMDA 1990).** Note: Clinical staff develop processes to response to medical equipment failure or disruption. The processes include actions to take in the event of equipment disruption or failure, availability of alternate equipment, and emergency clinical procedures and conditions for when they are implemented. Clinical Engineering may provide technical documentation as needed.	Hospital Policy and Procedure: _____ MCH-4025, CE 2003, CE 2011, MCH 4002_____
PE7 SR5	**The Medical Equipment Management System shall have a process for reporting and investigating equipment management problems, failures, and user errors.**	Hospital Policy and Procedure: MCH 4042, CE 2003, CE 2005, CE 2011, MCH 4002

	Note: Clinical staff develop processes to manage the response to medical equipment failure or disruption. The processes include actions to in the event of equipment disruption or failure, availability of alternate equipment, and emergency clinical procedures and conditions for when they are implemented. Clinical engineering may provide technical documentation as needed. TRIMEDX staff will work with the hospital staff to investigate medical/laboratory equipment management problems, failures, and use errors. The TRIMEDX manager will work with the Quality and Regulatory Department at TRIMEDX when responding to medical/laboratory equipment management problem, failure, and use error.	
PE7 SR6	**The Medical Equipment Management System shall address a process for determining timing and complexity of medical equipment maintenance.** Note: The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance ("AEM") program. Based on risk review devices are assigned to the MRF or AEM program. Criteria used to review medical equipment includes the intended function of the equipment, the physical risks related to the use and/ or failure of equipment, the manufacturer's recommendations, the applicable codes and standards, the repair history of the device, and the patient safety history related to the equipment. For AEM eligible equipment, frequencies are set at a corporate level and are supplemented at a local level to accommodate varying conditions. The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations: • Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be accordance with the manufacturer's recommendations, or otherwise establishes more stringent maintenance requirements. • Medical Laser Device • Imaging and Radiologic equipment (whether used for diagnostic or therapeutic purposes) • New Medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies.	Trimedx Policy & procedure: Preventive Maintenance (PM), AEM and Default Maintenance Program Assignment, PM Schedule Assignment (at Device Level), request for PM Schedule Change, Test Equipment Calibration and Documentation. RAD-0170, RAD-0161, CL-028, Mammo-005, RS-0015, Nuc Med-0018 and 0019, Nuc Med 0041, Rad-0078, Rad-0080, Rad-0074

	If the manufacturers' recommendations are not available, recommendations from like-and-kind equipment are utilized or generic procedures are created by qualified personnel.	
PE7 SR7	**The Medical Equipment Management System shall address the process of receiving and responding to recalls and alerts.** Note: The hospital Responds to product notices and recalls. Documentation of medical alert/recalls is managed in the TRIMEDX Computerized Maintenance Management System and through the hospital's alert tracking program.	TRIMEDX Policy & Procedure: Alerts and Recalls Management, CE Cyber Patch-Vulnerability-Treat Management MCH 4025, MCH 4041

Evaluation of Plan

On an annual basis, the Clinical Engineering Manager will evaluate the objectives, scope, effectiveness, and performance of the Medical Equipment Management Plan. Any changes in objectives will be addressed during the Annual Assessment and incorporated into the updated plan.

The EC Committee receives regular reports of the program activities monthly basis. The program manager collaborates with the EC Committee and other appropriate associates to convey and address medical equipment issues and concerns.

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

The annual Assessment is a year-end summary that is compiled by the Clinical Engineering Manager and presented to the EC Committee and Safety Officer annually for approval. MCH 4025, SSPD 6790-400-022, CE 2003, CE 2005, CE 2011, MCH 4002

Performance Indicators

- Goals for 2022
    - Continue to keep our CNL at 0%

- Continue to keep PM completion at 100%
- Continue to improve Communications with department as far as picked up broken equipment

Medical Center Health System
Safety Management Plan

Purpose

Each environment of care 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 environmental safety program is designed to identify and manage the risks of the environments 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 safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Medical Center Health System.

The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Medical Center Health System has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and all others that visit the organization's facilities. Safety management plan ensures compliance and continued maintenance held to OSHA, CMS, DNV, NFPA, and ASHE guidelines and standards.

Scope

The Safety Management Plan at Medical Center Health System applies to all facilities and to all safety processes, activities, departments, structures and grounds as well as patients, staff, students, and visitors. The Safety Management Plan addresses all elements required to provide a safe and healthy environment free of hazards and to collaborate with department management to provide staff training and monitoring in order to minimize the risk of injuries.

Principles

- The identification of specific risks faced by patients and employees, and others is essential for designing safe work areas and work practices.

- The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work

environments and safe work practices to minimize the potential for adverse impact on them, patients, and all others that are in the environment.

- Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and staff knowledge.

Objectives

The objectives of the Safety Management Plan include:

- Comply with all relevant safety standards and regulations.
- Enforce current safety practices for patients, staff, students, and visitors.
- Provide regular safety education to all staff.
- Monitor the effectiveness of the safety program.
- Identify opportunities and to improve safety performance and develop and implement improvements.

Program Management Structure

- The Chief Operating Officer, Safety Officer, Engineering Director, Risk Manager, and Infection Control Officer work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education, training materials, and manage day-to-day activities of the environmental safety program.

- The Environmental Safety Leadership team coordinates the development of reports to the Environment of Care Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.

- The Environment of Care Committee monitors and evaluates the processes used to manage the environment of care. Members of the committee are by appointed by the Chairman (the Safety Officer). The Environment of Care Committee meets a minimum once per month. During each meeting one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes, and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.

- The Human Resources Staff Development Coordinator and other leadership staff are responsible the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and to job and task specific safety and infection control procedures. The orientation and ongoing education and training emphasis environmental safety.

- Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.

- 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, 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
PE3 SR1	**The organization shall provide a Safety Management System that shall maintain safe and adequate facilities for its services. Diagnostic and therapeutic facilities shall be located for the safety of patients.** Note: Facilities are designed and maintained per applicable building codes and design requirements.	• EOC rounds and assessments • City of Odessa Fire Marshall Inspections • Insurance Risk Assessments
PE3 SR2	**The Safety Management System shall require that facilities, supplies and equipment be maintained and ensure an acceptable level of safety and quality. The extent and complexity of facilities shall be determined by the services offered.** Note:	• EOC Testing Schedule • Clinical Engineering performance reports • EOC safety performance improvement activities (QAPI)
PE3 SR3	**The Safety Management System shall require proper ventilation, light and temperature controls in pharmaceutical, food preparation, and other appropriate areas including where equipment is in use (e.g., computers, sterilizing equipment, refrigerators).** Note: Monitoring, testing, and maintenance of all temperature, humidity, and air balancing is kept in the engineering department.	• Siemens • Versa Trak • ND White testing
PE3 SR4	**The Safety Management System shall require that the organization maintain an environment free of hazards and manages staff activities to reduce the risk of occupational-related illnesses or injuries.** Note:	• ALSM/ICRA assessments prior to and during construction, renovation, and maintenance

		• Minimal lift education and program MCH-4034 • Patient safety event reporting MCH- 4012 • Health and Wellness employee accident and education program
PE3 SR5	**The Safety Management System shall require periodic surveillance of the hospital grounds to observe and correct safety issues that may be identified.** Note: Environmental safety rounds are performed on a weekly basis. Teams members from Environmental Services, Infection Prevention, Quality, Engineering, and Safety perform rounds weekly for observation and identification of improvement areas within the hospital and clinical areas. The findings are recorded and shared with the department directors and engineering department for correction and education.	• MCH Environmental surveillance procedure • Monthly Grounds inspection report
PE3 SR6	**The Safety Management System shall address safety recalls and alerts.** Note: Safety recalls and alerts are tracked and disseminated by our Device Tracker Coordinator in the Material Management Department. The department directors that have said devices in their departments will receive notification of the recall and/or alert along with the options for corrective actions recommended by the manufacturer or the FDA, and templates for documentation for such efforts via the recall tracking system in a timely manner. A list of the recall/alerts and their progress of completion is presented to the Environment of Care Committee every two weeks.	• MCH-4041 Product recall Procedure
PE3 SR7	**All eyewashes and emergency drench showers shall be tested and maintained according to the current ANSI Z358.1 Standard.** Note:	• Eyewash and Emergency drench shower SOP • HEMS work order

	Eyewashes and Emergency drench showers operations are tested on a weekly basis as well as a full inspection annually. Documentation is archived in the Safety Department.	
PE3 SR8	**The organization shall have procedures for the proper routine storage and prompt disposal of trash.** Note:	• MCH 4021 • IC 1042

Evaluation of Plan

On an annual basis, the Safety Department will evaluate the objectives, scope, effectiveness, and performance of the Safety 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 safety department collaborates with the EOC Committee and other appropriate associates to convey and address safety 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 maximizing safety and minimizing risk at MCHS.

Performance Indicators

- Goals for 2023
    - Incorporate an electronic rounding tool to allow for the safety elements in each department to be tracked for compliance and educational opportunities. This program will also graph progress in each department.
    - Continue to work with the materials management department and risk management to better streamline all levels of recalls and follow through in every department in the hospital.
    - Improve the overall safety, security, and cleanliness of the main loading dock and logistics corridors
        - Weekly rounding
        - Implement audit tool

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, and investigation of property losses.** Note:	• MCH-4013 • NADM-0009 • MCH-4015 • MCH-4031 • HPD-1022 • HPD-1003 • HPD-1011
PE4 SR 4c	**Develop a written, comprehensive workplace violence control and prevention program based on guidelines from national authorities such as the OSHA Publication 3148-04R 2015 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 2023
    - As recognized by DNV, enhance the work place violence program and reporting system
        - Hands on training
        - Analysis
        - Education
        - Annual review
    - Improve and sustain campus lighting in designated areas
        - Monthly rounding
        - Report to facilities for repair

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 SR2	**The Utility Management System shall provide for a process to evaluate critical operating components.** 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).** Note:	HEMS work order: Procedure 545
PE8 SR5	**The Utility Management System shall provide for emergency processes for utility system failures or disruptions.**	HEMS work order: Procedure 543

	Note:	
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 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 shall apply to existing healthcare facilities and shall be installed in accordance with NFPA 70, National Electric Code, 2011 edition.** Note:	Installation is in accordance with IBC NFPA occupancy Type 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 2023
    - 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.

FY 2023 Annual Plan Summary

Emergency Management Plan

Purpose: The purpose of the Emergency Management Plan is to establish a basic emergency program to provide timely, integrated, and coordinated response to the wide range of natural and manmade events that may disrupt normal operations and require pre-planned response to internal and external incidents.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Facility Management Plan

Purpose: The Facility Management Plan is designed to provide organizational oversight for the design and maintenance of the physical environment infrastructure and equipment.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Hazardous Materials Management Plan

Purpose: 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.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Life Safety Management Plan

Purpose: The fire safety management program is designed to identify and manage the risks of the environments of care operated and owned by Medical Center Health System.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Medical Equipment Management Plan

Purpose: The purpose of the **Medical Equipment Management Plan (MEMP)** is to support a safe patient care and treatment environment by managing risks associated with the use of clinical equipment technology.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Safety Management Plan

Purpose: The environmental safety program is designed to identify and manage the risks of the environments of care operated and owned by Medical Center Health System.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Security Management Plan

Purpose: The security program is designated to identify and manage the risks of the environment of care operated and owned by Medical Center Health System.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Utility Management Plan

Purpose: 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.

Changes for FY23: Updated dates and goals, reformatted to fit DNV Requirements

Alignment Room Plan

Purpose: Through Lean Six Sigma, the Alignment Room supports and facilitates MCH's quality improvement initiatives and seeks to develop improvement capacity throughout the organization’s pillars of finance, quality, experience, growth and people.

Changes for FY23: Updated types of projects that enter the Alignment Room and the project approval process, roles of the alignment room and committee members.

Infection Prevention Risk Assessment

Purpose: The risk analysis is conducted / reviewed at least annually and whenever there is a significant change in any of the above factors. The assessment is facilitated by Infection Prevention RN and presented to the Infection Prevention Committee for review and approval as well as QAPI Committee

and the hospital board of directors. This risk assessment is organization-wide in scope. It covers inpatient and ambulatory care settings as well as general outpatient care settings.

Changes for FY23: Updated all High- Risk and Medium-Risk priority areas for FY23

Infection Control Plan

Purpose: To evaluate the effectiveness of the infection control program to identify those activities that are effective, as well as those activities which require modification so our facilities may continue with Medical Center Health System's commitment to excellence and service.

Changes for FY23: Updated the effectiveness of significant interventions including CAUTI rates, CLABSI rates and HH Compliance, added conclusion of DSHS 2021 H1 HAI audit and fine tuning of Antimicrobial Stewardship Program.

Pharmacy & Therapeutics Committee Annual Plan

Purpose: Assist in the formulation of policies, advise the Medical Staff and Hospital's pharm department on matters pertaining to the choice of available drugs; make recommendations concerning drugs, establish standards concerning the use and control of investigational drugs, perform other duties assigned by Chief of Staff or MEC.

Changes for FY23: The multi-year strategic plan: complete all drug classes by end of FY 2026, moved to Fiscal year plan as we are almost done

QAPI Plan

Purpose: The organization-wide QAPI Plan encompasses major important aspects of care provided by the hospital in support of the achievement of MCH's mission and strategic goals. This includes continual quality data measurement, assessment and process improvement activities. The Plan describes the overall process for Departments and Services to collaboratively perform QAPI activities in a systematic manner, including the communication of activities and outcomes directed towards improving quality care and services.

Changes for FY23: Reformatted for easier understanding, detailed out each party's responsibilities, committee role, added facility wide integration areas and how to complete annual evaluation.

2023 Alignment Room Plan

Purpose: Through Lean Six Sigma, the Alignment Room supports and facilitates MCH's quality improvement initiatives and seeks to develop improvement capacity throughout the organization's pillars of finance, quality, experience, growth and people.

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

Vision: MCHS will be the premier source for health and wellness

Strategic Plan and Scope: The strategic plan set forth by the executive team will be utilized as a guide to ensure all alignment room projects are aligned with the strategic initiatives. The scope of Alignment Room projects will support the following five pillars: Finance, People, Growth, Experience, and Quality.

Overall Program Effectiveness: The MCH Executive team will oversee the alignment room with the support of the Performance Improvement Officer (PI Officer). Pillar projects will be overseen by the pillar executives and the designated team lead and lean coach. The PI Officer will collaborate with the Alignment Room Committee, Executive Team, Lean Six Sigma coaches, project team leads and all other staff as appropriate to plan, coordinate, and ensure an effective Alignment Room Meeting.

Projects entering the Alignment Room for approval will be vetted for one of the following:

- Process Improvement: A previously established process within the hospital system that is up for review due to needing to be leaned out or changed.
- New Process/Project: Any new process or project idea that if implemented would allow for improvement within the hospital system

Alignment Room Project Approval: To vet a project for approval, the following process must take place: New project proposals will be presented by the pillar executive at the previous month's AR meeting, vetted by the Alignment Room Committee and approved by the executive team upon the first team report out.

Identification of Alignment Room projects can include but not limited to the following:

- Pillar teams – Ran by executives in a collaborate and brainstorming format in alignment to the strategic plan's initiatives.
- Accreditation - Any findings from accreditation surveys, mock surveys, or CMS visits that result in a plan of correction or non-conformity can be brought through the alignment room for support and priority action.
- RCA - (Root Cause Analysis) findings that result in process improvements can be identified by risk management and QAPI Council for alignment room support and priority action.
- QAPI Committees - Committees reporting in QAPI Council that fall below the baseline or identify need for process improvement while working towards their QAPI goal will be reviewed by E-Team and QAPI Council and could be asked to enter the alignment room for support and priority action.
- Kaizen Cards – Any new idea identified through department huddle or a K-card which requires the need and support of the alignment room process.

Roles of the Alignment Room:

Pillar Executive Responsibility: Executive leadership are responsible for the oversight of up to two alignment room projects which may run simultaneously. Projects are based on processes within their pillar that align with strategic initiatives and need process improvement. Through collaboration, the CEO and Executive leadership will allocate necessary resources to support the projects and remove barriers when identified. Executives are responsible for

attending monthly Alignment Room meetings and project specific meetings as requested to discuss all facility project needs, progress and outcomes.

Alignment Room Committee Responsibility: The Alignment Room Committee is an interdisciplinary team chosen to oversee the incoming Alignment Room projects to ensure they are data driven, align with priorities, and serve to support the lean coach and lead throughout their project duration. The committee will provide ongoing guidance to the charters and assist in lean tool recommendation or mentorship when requested.

Team Lead Responsibility: The Alignment Room Team Lead will be a subject expert and serve as the leader of the team. The lead will schedule meetings, prepare an agenda, identify timekeepers, minute takers, track progress, and prepare the team for monthly report out in the Alignment Room.

Lean Coach Responsibility: The Lean Coach will hold either a Lean Six Sigma Green Belt or Black Belt. The Coach, with the lead, will support and facilitate the project team in achieving goals and objectives by utilizing lean six sigma tools and resources for improvement. The Lean Coach will ensure projects and initiatives stay within scope, within the DMAIC structure, and keeps the project timeline on track.

Together the Team Lead and Lean Coach will develop the project charter, identify the fall outs in the process, identify the project scope, meet with the Pillar Executive, Alignment Room Committee, and Project Team as necessary.

Staff Responsibility: The staff at Medical Center Health System will participate on Alignment Room teams as needed. Front-line staff and key stakeholders in the processes are identified on the project charter and will be those who have knowledge of or affect current processes in any way.

Alignment Room Leadership	
Pillar/Support	**Executive**
Growth Pillar	COO, President ProCare
Finance Pillar	CFO
Quality Pillar	CNO
Experience Pillar	CXO
People Pillar	VP of Development & VP of Human Resources
President	CEO
Information Technology	CIO

Alignment Room Committee
AR Committee Chair -Mallori Hutson, Regional Services Manager
Nicole Hays, PI Officer
Tara Ward, Divisional Director of Lab Services
Courtney Look, Associate Chief Experience & Quality Officer
David Graham, Divisional Director of ED, Trauma & SANE Services
Natalie Sandell, Divisional Director of Nursing Administration
Eva Garcia, Divisional Director of Rehab Services
Erica Wilson, Director of Pharmacy

_____

Associate Chief Patient Experience Officer

_____

Chief Nursing Officer

_____

Chief Medical officer

_____

Chief Executive Officer

Medical Center Health System
Infection Control Risk Assessment
FY2023

BACKGROUND
As part of its commitment to quality care and service, *Medical Center Health System*, conducts a periodic assessment of the risk(s) for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.

2. Analysis of surveillance activities and the results of the organization's infection prevention and control data.

3. The care, treatment, and services provided.

SCOPE OF ASSESSMENT
This risk assessment is organization-wide in scope. It covers inpatient and ambulatory care settings as well as general outpatient care settings.

PROCESS
The risk analysis is conducted / reviewed at least annually and whenever there is a significant change in any of the above factors. The assessment is facilitated by Infection Prevention RN and presented to the Infection Prevention Committee for review and approval as well as QAPI Committee and the hospital board of directors.

Once risks are identified, the organization prioritizes those risks that are of epidemiological significance. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided. These risks are outlined on this document as well.

Specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application, and/or duration depending on the specific risk issue, the care setting(s), and environment involved,

ASSESSMENT FINDINGS / MITIGATION STRATEGIES
The table below outlines the prioritized risks identified as the result of the assessment; provides a brief description of those risks, assigns a risk level (low, medium, or high) based on the care setting, outlines – in summary form – actions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of actions taken:

Legend*
I = Inpatient services such as medical surgical, critical care, maternal / child, surgery, behavioral health, and other care units
A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department
O = Outpatient services such as primary and specialty care clinics, wellness centers, infusion centers, rehabilitation clinics, and other services

* For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, pharmacy, clinical laboratory, and all other departments and services of the organization.

Allocation – Enter the Level of Assessed Risk for Each Care Setting:
L = Low Risk
M = Medium Risk
H = High Risk

Prioritized Risk Description	Care Setting / Risk Level (See legend)			Summary of Risk Mitigation Strategies	How Effectiveness of Strategies is Evaluated
	I	A	O		
POTENTIAL FOR TRANMISION OF INFECTIONS					
Potential for transmission of infectious pathogens on healthcare personnel hands due to non-compliance with CDC and/or WHO guidelines and recommendations for hand hygiene	H	M	M	Hand Hygiene (HH) education is provided to all staff during general orientation. Additional secret shopper (SS)/ observers added, and training classes completed. "Just in time" coaching provided by HH observers/ SS. HH unit/ disciple specific education as needed. Ongoing compliance monitoring and modification as needed by HH and IP Committee. Ongoing evaluation of current HH products, location, and availability. Additional hallway sinks, hand sanitizer dispensers and lotion dispensers have been added for HH product availability. HH education to patients and visitors completed during admission/visit to reminding healthcare providers to clean their hands. Added signage for HH reminders throughout facility.	Direct observation and recording of hand hygiene compliance. Sharing HH data with all key stakeholders. Ongoing monitoring and modification as needed by HH and IP committee.
Potential for unprotected exposure to pathogens throughout the organization due to non-compliance with policies addressing category / disease specific isolation and other precautions.	M	M	M	Education of related policies and procedures. Annual PPE donning/doffing education. Revision of Isolation Signage. Isolation orders placed by EMR when infectious pathogen identified, or testing ordered. Daily review of isolation orders by IP. Isolation compliance rounding by IP. Review of isolation needs at daily leadership huddle.	Monitoring of Net Learning annual review of PPE with record of completion reports. Compliance with PPE monitored during EOC and IP rounds
Potential for transmission of infection from medical equipment, and medical devices due to inappropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, or inadequate use of appropriate personal protective equipment for equipment cleaning.	H	L	L	Education on 3 levels of disinfection and appropriate wet/contact times, precleaning instruments and appropriate PPE to use for each is completed on hire and annually. Staff educated on separation of clean and dirty. Low level Disinfection wipes for use throughout MCHS for noncritical "shared equipment". Trimedx cleans and bags IV pumps, SCDs, and feeding pumps. Random monthly ATP testing completed on pumps disinfected by Tirmedx. High level disinfection completed for semi critical items. Cabinets for clean scope storage. All sterile processing completed in SPD. Internal, external, and chemical indicators in use. Limited access to Sterile Processing Department. Re-organized racks at autoclave with color coding for distinction of quarantined items. Two-person validation in place.	Education given through Net Learning on hire and annually, as well as during General Nursing Orientation, with focus on instrument disinfecting, precleaning and reprocessing. Monitor completion of Net Learning education as well as monitoring compliance with processes during EOC and IP rounds.
Potential for infection due to prolonged wait times in common areas and potential exposure to infectious individuals.	L	L	L	Hand sanitizers and PPE available. Seating rearranged to allow for social distancing in waiting rooms. Signs in waiting areas with reminders to cover cough/sneezes, perform hand hygiene and notify staff of potential exposures to infectious diseases. Education given to staff through Net Learning, and	Monitor completion of Net Learning. Evaluation during walk through, observation drills and compliance monitoring during EOC and IP rounds.

Prioritized Risk Description	Care Setting / Risk Level (See legend)			Summary of Risk Mitigation Strategies	How Effectiveness of Strategies is Evaluated
	I	A	O		
				General Orientation on standard and enhanced isolation precautions. Masking as recommended per CDC guidelines. Infectious Disease screening completed on admission. Direct patient bedding process in ED to minimize	
Potential for exposure form Community-wide outbreaks of communicable diseases (such as SARS and influenza) that carry the potential of adversely impacting operations and service capabilities	M	M	M	Developed policies and procedures to manage COVID-19. Employee daily self-monitoring. Universal mask policy per CDC guidance Return to work algorithm in place for high-risk exposures and positive employees. Screen patients for infectious diseases on admission. Collaboration with local and state health departments for management of community outbreaks. Ongoing Emergency Management meetings during times of emergency response. Continued surveillance of CDC community transmission levels. Follow CDC recommendations for Community Level & transmission levels. Links posted on intranet with quick access to COVID-19 updates. Employee Health will complete tracking of exposures and clear when criteria is met to returns to work. Communication on community transition available to staff.	Evaluation and walk-through observations during EOC and IP rounds. Evaluation during drills. Reports from Emergency Management meetings. H&W to report number of employees out due to exposure at IP committee meetings
Potential for a bioterrorism event that would require specific responses from the organization to successfully meet the threat	L	L	L	Developed policies and procedures for Infectious Disease Response Team and designated Highly Infectious Disease Unit. Continued surveillance and screening of patients. Scheduled drills with PPE Donning and Doffing Training	Monitor/evaluate drills and PPE Donning and Doffing. Monitor compliance with policies during walk through observation during IP and EOC rounding.
ACQUISITION AND TRANSMISSION OF MDROs					
Potential for acquisition and transmission of MDROs that carry the potential for increased transmission among patients and staff such as: • **MRSA** • **VRE** • **CDI** • **ESBL** • **CRE**	M	L	L	Follow policy for standard and isolation precautions (MCH-1200), and policy on preventing the introduction and/or transmission of MDROs (MCH- 1201). Staff educated on appropriate HH and PPE use on hire and annually in Net Learning. Daily surveillance by IP of patient isolation orders with recommendations for continuing or discontinuing isolation. Protocol in CPOE for ordering isolation when MRSA, VRE, ESBL, or CRE are identified by lab. Protocol in CPOE for ordering isolation when CDI testing is ordered. CDI surveillance and reporting where applicable. Trend and report CDI rates to stakeholders and complete re-education as needed. Nursing and Provider C diff EBBP Guidelines Education and test interpretation completed. MRSA Bacteremia surveillance and reporting where applicable. Trend and report MRSA bacteremia rates to stakeholders and complete re-education as needed. Collaborate with antibiotic stewardship program to identify and	Monitor for increased incidence of MRSA, VRE, CDI, ESBL, and CRE. Monitor completion of PPE education in Net Learning. Monitoring adherence to isolation precaution, and compliance with PPE and hand hygiene during walk throughs, EOC and IP rounds. Monitor equipment cleaning. Antibiotic stewardship and microbiology reports. Monitor MRSA bacteremia rates. Antibiotic stewardship and microbiology reports.

Prioritized Risk Description	Care Setting / Risk Level (See legend)			Summary of Risk Mitigation Strategies	How Effectiveness of Strategies is Evaluated
	I	A	O		
				control epidemiologically important MDROs and monitor antibiotic use. Collaborate with pharmacy and microbiology to ensure prompt notification of IP when a resistance pattern based on microbiology results is detected. Collaboration with EVS on proper cleaning of isolation rooms. Working on implementing MRSA nasal decolonization process.	
Community Incident of MDRO creating potential for increased transmission among staff and patients	L	L	L	Collaborate with County health department for notification on community transmission of MDROs. Follow policy for standard and isolation precautions (MCH-1200), and policy on preventing the introduction and/or transmission of MDROs (MCH- 1201). Staff educated on HH and appropriate use of PPE completed on hire and annually in Net Learning.	Monitor for increased incidence of MDROs. Monitoring adherence to isolation precaution, and compliance with PPE and hand hygiene during walk throughs, EOC and IP rounds. Monitor Local Health Department reports of community transmission, Antibiotic stewardship, and microbiology reports.
HOSPITAL AQUIRED INFECTION DUE TO INVASIVE DEVICES					
Potential for Central Line Infections (CLABSI)	H	L	L	Device Utilization surveillance and review of medical necessity review during ICU/CCU Patient Safety rounds. Staff education and surveillance of maintenance and insertion bundle. CAUTI/CLABSI Committee team ongoing review of CLABSI rates and working to implement EBP to help reduce/prevent CLABSI. NHSN reporting when applicable. Monitor CL sites during IP rounds.	Monitor NHSN CLABSI SIR and internal rates. Monitor adherence to CL bundle during IP rounds.
Potential for Ventilator Associate Event (VAE) • **VAC** • **IVAC** • **PVAC**	H	N/A	N/A	VAP Bundle Surveillance Increased number of patients requiring long term ventilation due to COVID-19. Increased acuity of vented patients. ICU/CCU Patient Safety Rounds Early Ambulation and Weaning Trials. Monitor oral care of vented patients. VAE ongoing review by key stakeholders VAE HAI Surveillance. Review of VAE Bundle. NHSN reporting when applicable	Monitor NHSN VAE SIR and internal rates. Monitor VAE bundle during IP rounds.
Potential for Catheter Associated UTI's (CAUTI)	H	N/A	N/A	Device Utilization surveillance and review of medical necessity at daily leadership huddle. Staff education of maintenance and insertion bundle. CAUTI/CLABSI Committee team ongoing review of CAUTI rates and working to implement EBP to help reduce/prevent CAUTI. NHSN reporting when applicable. Nurse driven catheter removal protocol implemented. Alternatives to indwelling foley catheters available such as male condom catheter and PureWick. Education completed on alternatives to medicals and nursing staff.	Monitor NHSN CAUTI SIR and internal rates. Device Utilization Review Leader Briefing to discuss possible discontinuation of indwelling urinary device. IP Foley rounds.

Prioritized Risk Description	Care Setting / Risk Level (See legend)			Summary of Risk Mitigation Strategies	How Effectiveness of Strategies is Evaluated
	I	A	O		
Potential for post-op Surgical Site Infections (SSI)	H	L	L	Ongoing SSI Surveillance for NHSN. Monthly letters sent to surgeons for post discharge SSI surveillance of surgical complications and SSI. Report SSI SIR and rates to key stakeholders. Development of SSI Committee to review current SSIs and implement EBP to prevent/decrease SSIs. Mandatory reporting where applicable. Working to implement COLO bundle. Education to staff and patients on SSI prevention. Surgeon education on PATOS documentation completed.	Monitor NHSN SSI SIR and internal rates. IP OR rounding and post op checks.
EMPLOYEE HEALTH					
Potential for lack of staff compliance with Influenza vaccination program goal > 90%	M	M	M	Annual offering of influenza vaccination for all employees. Flu vaccination clinics during day and evening shifts, weekends, and also offered for employee family members. Employee must wear mask if they have not been vaccinated for flu during peak of season and as needed. NHSN reporting as needed.	Monitor employees for appropriate immunization identification during flu season. Flu vaccine compliance rate report out by Health and Wellness to IP committee. NHSN reporting as needed.
Potential for lack of Staff Compliance with COVID-19 vaccination mandate. compliance goal 100% vaccinated or approved medical or religious exemption	M	M	M	Employees must comply with the vaccination mandate per policy MCH- 1016. COVID-19 vaccines are offed free of cost to all MCHS employees. Employees can either receive vaccinations through MCH or receive vaccinations elsewhere and provide proof of such vaccination to health and wellness. If a medical or religious exemption has been legally granted staff must follow all stipulation required.	Health and wellness to report COVID-19 vaccination compliance to IP Committee.
Potential for lack of Compliance with Annual Health requirements per policy	L	L	L	Policy MCH- 3029 Health and wellness program specifies yearly requirements for employees, pre-employment requirements, and requirements for students. Employees will receive an annual TB screening. An annual Respiratory Fit Test is required for those who have direct patient contact/care. Extra N95 fit test offered.	Compliance with TB screen and Fit Test rates reported and reviewed via IP committee.
ENVIRONMENTAL					
Potential for exposure to bloodborne pathogens	M	L	L	Policy MCH-2043 exposure control plan provides guidelines to prevent or minimize occupation exposure of employees to bloodborne pathogens or other potentially infectious material. Engineering controls are instituted whenever and wherever practical to eliminate or minimize employee exposure to blood or other potentially infectious materials. Blood spills are promptly cleaned up with EPA-registered disinfectants. Infectious waste and sharps are disposed in clearly marked, leak-proof receptacles. Handwashing facilities are provided thought the facility. Appropriate sharps containers in work areas where sharps are used. PPE is available. Appropriate disinfectants are available. Education	Monitor sharps containers during IP and EOC rounds. H&W to report number bloodborne exposures to IP committee meetings

Prioritized Risk Description	Care Setting / Risk Level (See legend)			Summary of Risk Mitigation Strategies	How Effectiveness of Strategies is Evaluated
	I	A	O		
				on bloodborne pathogens completed on hire and annually. Hep B vaccine offered free to all staff with potential exposure. H&W to complete work up for exposure.	
Potential for lack of Hemodialysis Monitoring	L	N/A	N/A	Hemodialysis is contracted to Fresenius. Fresenius provides staff and completes machine maintenance and water quality testing. IP completes periodic reviews of water quality testing, hand hygiene compliance, safe injection practices, use of appropriate PPE, compliance with regular and biohazard waste, cleaning and disinfection of environmental surfaces and external surfaces of HD machines during IP and EOC rounds.	Monitored during IP and EOC rounds and water quality reports.
Potential for lack of Sterilizer Monitoring	L	N/A	N/A	Sterilizers tested per manufacturer's recommendations. Logs maintained by SPD and reviewed periodically by IP. All sterile processing completed in SPD. Internal, external, and chemical indicators in use. Re-organized racks at autoclave with color coding for distinction of quarantined items. Two-person validation in place. Temp and Humidity Monitoring of areas with sterile reprocessed instruments. Use of engineered cabinets to control Temp and Humidity for sterile instrument outside of central storage. Limited access to Sterile Processing Department and sterile storage. IP rounding in SPD. SPD report out at IP committee meeting.	Monitoring of process controls with recording of results in logs. Temp and Humidity reports month. Monitoring and evaluation of SPD processes during IP and EOC rounds.
Potential for transmission of infections due to failure to meet environmental cleanliness standards	M	M	M	All treatment areas, equipment and surfaces are to be kept free of blood, mold, and accumulation of dirt or dust and other potentially infectious materials. Emphasize to all staff that cleaning is a shared responsibility involving more than just EVS. Education completed on approved low-level disinfectants on hire with appropriate wet times. EVS has implemented enhanced cleaning of high touch surfaces and waiting areas. EVS to use EPA- registered disinfectants per manufacture's recommendations. Changed to disposable curtains n patient rooms. EVS uses UV light for isolation room cleaning after discharge. EVS participates in bi-weekly EOC rounding. IP collaborates with EVS on room cleaning.	Evaluated during IP and EOC rounds
Potential for failure to identify infection risk associated with construction and renovation (ICRA)	H	L	L	Policy IC- 1054 addresses the infection control risk assessment (ICRA) process. Weekly meeting with Construction team. Collaboration with engineering on ICRAs. ICRA's completed and signed prior to start of Construction. IP completes routine rounding on construction areas. Monitoring of pressure relations. Large scale constructions planned for next few years.	IP rounds on construction sites to ensure ICRA is being followed. Report out at EOC Committee.
Potential for failure to Identify risk from water borne pathogens	L	L	L	Policy MCH-1204 addresses minimizing risk of legionella associated with building water system.	Monitor/evaluate water quality reports

Prioritized Risk Description	Care Setting / Risk Level (See legend)			Summary of Risk Mitigation Strategies	How Effectiveness of Strategies is Evaluated
	I	A	O		
				Monthly and as needed monitory of water system completed, and a copy sent to IP.	
Potential for failure to identify separation of clean and soiled	M	L	L	There is a clear separation of clean and dirty work areas. Clean areas are used for storage and preparation of medications and unused supplies; dirty areas are used for contaminated equipment. Education on separation of clean and dirty completed during new employee education and ongoing as needed. Separate areas designated for clean and solid throughout the facility. Risk assessment completed of high-risk areas as needed. Biohazard waste kept in negative pressure rooms.	Compliance monitoring during IP and EOC rounds.
OTHER					
Potential for failure to meet Blood Culture Contamination Rate Goal is less than 2%	H	L	L	Surveillance and reporting via micro department with report out to clinical leaders. Education offered by lab and unit specific nurse educator. Blood Culture Committee to evaluate current process and implement EBP to decrease blood culture contamination. First meeting 07/20/2022. Mandatory reporting as needed.	Review of products for blood culture collection and technique. Blood culture contamination rates reviewed at IP committee.
Potential for lack of compliance with Antibiotic monitoring through Antibiotic Stewardship Program	L	L	L	Antimicrobial Stewardship Program has become more fine-tuned within the healthcare organization and development of the organizations antibiogram. Antimicrobial Stewardship will meet monthly and collaborate with the Infection Prevention Committee.	Continued monitoring of antibiotic usage and organisms resistance patters in healthcare system. Antibiotic stewardship to reported trends in IP committee.

		Date
Completed by Infection Prevention Officer in collaboration with IP Committee Members	Brenda Dalrymple RN, BSN, CIC	August 3, 2022
Approved by Infection Prevention Medical Director	Dr. Pablo Feuillet	
Approved by IP Committee		August 2022
Approved by QAPI Committee		August 2022
Approved by Board of Directors		August 2022

MEDICAL CENTER HEALTH SYSTEM
ANNUAL EVALUATION OF THE INFECTION CONTROL PROGRAM AND PLAN
FY2023

PURPOSE

To evaluate the effectiveness of the infection control program to identify those activities that are effective, as well as those activities which require modification so our facilities may continue with Medical Center Health System's commitment to excellence and service.

PROGRAM GOALS

The goals of the infection prevention and control program are:

- To identify high priority areas within the Medical Center Health System and the community environment served.
- Evaluate, develop, and implement specific strategies to address the prioritized risks. These strategies may take the form of
    - Policy and procedure establishment
    - Surveillance and monitoring activities
    - Limit the transmission of infections associated with medical equipment, devices, and supplies
    - Education and training programs.
    - Environmental and engineering controls
    - Combinations of the above

PROGRAM SCOPE

The scope of the infection prevention and control program addresses all pertinent services and sites of care within Medical Center Health System.

INFECTION CONTROL RISK ASSESSMENT

The organization conducts a periodic assessment of the risk(s) for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.

    - Medical Center Health System (MCHS) is a 402-bed acute care hospital in the city of Odessa, TX in Ector County, located on Interstate 20 in remote West Texas. The principal industry is oil and gas related service. The population of Ector County is approximately 161,000 (United States Census Bureau). Medical Center Health System (MCHS) serves seventeen (17) counties, is a tertiary referral center, and is the first major healthcare facility encountered when traveling north from Mexico, therefor patients could possibly be from out of the country. MCHS services multiple prisons in Ector and surrounding counties. Patients are received via private transport, ground medical transport, and medical flight services.

2. The results of the organization's infection prevention and control data as evidenced by but not limited to:

    - The CERNER Electronic Health Record was implemented on April 1, 2017 and provides the data base for all patient information. This allows Infection Prevention and other departments to retrieve reports and provide clinical data to assist with management and reporting of infectious diseases.
    - The Cerner system provides customized reports for management of significant hospital trends.
    - These reports require collaboration with the Cerner support team, IT, and Infection Prevention to ensure customization of reports for surveillance and reporting.
    - NHSN Data uploads and reports are also utilized for tracking and trending HAIs.
    - Infection Prevention evaluation and observations during infection prevention and EOC rounds.

3. The care, treatment, and services provided:

    - 20 bed Medical-Surgical ICU2
    - 20 bed Cardiac ICU4
    - 30 bed Level 3 NICU
    - 19 bed pediatric unit
    - Internal and Family Medicine Services
    - Stroke Services
    - In and out-patient Endoscopy
    - Surgical Services on the main campus and at Wheatley Stewart Medical Pavilion
    - Inpatient hemodialysis and peritoneal dialysis
    - In and out-patient Cardiac Rehabilitation
    - Infusion Services
    - Laboratory Services
    - In and out-patient Physical/Occupational/Speech therapy
    - Family Health Clinics
    - MCH Urgent Care sites
    - Extensive Radiology services
    - Laboratory services
    - 24-hour inpatient Pharmacy.
    - Emergency Room
    - The Center for Health and Wellness OB/GYN (In and out-patient services)
    - Women and Infant Services
    - Telehealth Services

The risk assessment is conducted / reviewed at least annually and whenever there is a significant change in any of the above factors. The most recent risk assessment required the following changes in the infection control program (*Any unresolved goals for fiscal year ending September 30, 2022 maybe continued as priorities for Infection Prevention or other departments with periodic evaluation of performance to determine any continued unresolved issues. The following priorities*

are listed by level of assessed risk from the annual risk assessment and not in order of priority in each section.):

FY23 High Risk priority areas identified by the Annual Risk Assessment include:

1. **High potential for transmission of infectious pathogens on healthcare personnel hands due to non-compliance with CDC and/or WHO guidelines and recommendations for hand hygiene:** Additional hand hygiene observers and coaches have completed training classes and are submitting hand hygiene observations. Hand hygiene education for all staff via new employee orientation, yearly in Net Learning and ongoing on the spot training. Hallway sinks have been added for availability. EVS rounding to ensure hand hygiene products are available and soap dispensers and hand sanitizers are functioning properly. Exploring hand hygiene vendor/products for optimal use. Hand hygiene policy revised to include latest Leap Frog standards. Hand Hygiene Committee reinstated and implementing EBBP to improve compliance. Hand Hygiene Compliance has gone from 72.71% in October 2021 to 96.07% for July 2022. Hand hygiene compliance reported regularly to stakeholders.

2. **High potential for transmission of infection from medical equipment, and medical devices due to inappropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, or inadequate use of appropriate personal protective equipment for equipment cleaning:** Disposable equipment is disposed of after each use. All shared equipment is disinfected between patients. Education on 3 levels of disinfection and appropriate wet/contact times, precleaning instruments and appropriate PPE to use for each is completed on hire and annually as well as staff educated on separation of clean and dirty. All sterilization of equipment completed in SPD. CDC guidelines for reprocessing Endo scopes are followed. Endo scopes stored vertically in a way to prevent recontamination and promote drying. Temp and humidity are monitored in sterile equipment storage. Limited access to Sterile Processing Department. Added temp and humidity monitored cabinets for sterile supplies. IUUS reduction by adding more one-of-a-kind sets, and quantity of one-of-a-kind instruments. Daily communication between OR and SPD to prioritize next day instruments. There are separate areas for clean and soiled equipment throughout facility.

3. **High potential for Catheter Associated Urinary Tract Infections:** The CAUTI team achieved sustainment after achieving and sustaining an NHSN SIR below national benchmark in FY20. As CAUTI rates started to trend upward in FY21, the CAUTI committee reconvened and is working on implementing EBBP to decrease CAUTIs including a daily focused review of indwelling urinary catheter device utilization and appropriate indication for use. Nurse driven protocol for foley catheter removal implemented. Education for nurses and physicians completed on nurse driven protocol, CAUTI prevention and foley alternatives. Continue ongoing surveillance for CAUTIs based on NHSN criteria. Monitor NHSN SIR and internal rates and adjust practices as indicated per evidence-based practice. CAUTI rate has gone from 3.47% in October of 2021 to 0.90% in June of 2022. CAUTI rate has maintained below goal for 5 consecutive months.

4. **High potential for Central Line Associated Blood Stream Infections:** Daily focus review of central line utilization and appropriate use. IP will collaborate with providers for appropriate use and appropriateness of culture collection. Continue ongoing surveillance and review central line insertion and maintenance bundles. Provide additional culture collection education for staff biannually and as needed. CLABSI committee is working on implementing EBBP to decrease CLABSIs with focused review of central line utilization and appropriate indication for use. Working on a new policy for CL care and maintenance. Continue ongoing surveillance for CLABSIs based on NHSN criteria. Monitor NHSN SIR and internal rates and adjust practices as indicated per evidence-based practice. Nasal decolonization of Staph aureus for patients with CL approved and will be implemented Aug 2022. CLABSI rate has gone from 3.54% in October of 2021 to 0.0% in June of 2022.

5. **High potential for Ventilator Associated Events:** We experienced an increase in COVID -19 admissions requiring prolonged mechanical ventilation. This resulted in an increase in ventilator utilization days and an increase in VAE in these patients. Our COVID-19 census requiring mechanical ventilation continues to drop. We will continue VAP bundle surveillance during ICU/CCU rounds. Daily review of potential VAE with respiratory and nursing. Continue ongoing surveillance for VAEs based on NHSN criteria. Monitor NHSN SIR and internal rates and adjust practices as indicated per evidence-based practice. Encourage use of VAP bundle and early ambulation and weaning trials.

6. **High potential for Surgical Site Infections**: SSI Committee has reconvened to address and implement EBBP guidelines for prevention of Post-op Surgical Site Infections. Pre-op nasal decolonization of Staph aureus approved and will be implemented Aug 2022. SSI Committee is working on COLO SSI prevention bundle to standardize care. Continue ongoing surveillance for SSIs based on NHSN criteria. Monitor NHSN SIR and internal rates and adjust practices as indicated per evidence-based practice.

7. **High potential to fail to identify construction and renovation risk:** Construction and Renovation plans are an ongoing part of operations, increasing the need for ICRA collaboration, surveillance and monitoring during the construction/renovation activity. Weekly meeting with engineering and construction team. ICRAs addressed and signed prior to start of construction. Ongoing surveillance of construction projects as needed. Open ICRAs reviewed weekly during construction meeting and during EOC Committee meetings.

8. **High potential for failure to meet blood culture contamination goal of <2%:** Surveillance and reporting via micro department with report out to clinical leaders monthly. Additional education to staff on appropriate culture collection. New culture bottle collection system implemented Jan of 2022. New blood culture lab instruments in use. Lab will complete one-on-one education with staff found to have more than 3 contaminated cultures in one month. Trialing alternate blood culture collection systems to help reduce blood culture contamination (Steripath and Kurin). Blood Culture

Contamination Reduction team initiated July 2022 to review and implement EBBP guidelines for prevention of blood culture contamination.

FY23 Medium Risk priority areas identified by the Annual Risk Assessment include:

1. **Medium potential for unprotected exposure to pathogens throughout the organization due to non-compliance with policies addressing category / disease specific isolation and other precautions:** Daily surveillance of isolation patients. Protocol in CPOE for ordering isolation. EMR surveillance and automatic isolation orders placed for patients with C. Diff and TB testing, MDROs or ESBLs positive lab results. Surveillance of hand hygiene and isolation precaution compliance. Additional PPE and Hand Hygiene education to staff.

2. **Medium potential for exposure form Community-wide outbreaks of communicable diseases (such as SARS and influenza) that carry the potential of adversely impacting operations and service capabilities:** Continued ongoing surveillance of CDC community transmission COVID-19 levels. Staff education on community spread, high risk activities, S/S and prevention strategies and expectations completed. Ongoing employee self-monitoring for symptoms. Return to work algorithm in place for high-risk exposures and positive employees. Universal mask policy in place per CDC guidance. Ongoing implementation of CDC guidance for COVID-19 emergency. Ongoing education to staff and updates on CDC guidance. COVID-19 vaccine clinics for community and staff. Mandatory COVID-19 vaccine compliance monitoring/reporting. Collaborate with state and local health departments for management of community outbreaks.

3. **Medium potential for transmission of multi-drug resistant organisms that carry the potential for increased transmission among patients and staff (MRSA, VRE, CDI, ESBL, CRE):** Follow policy for standard and isolation precautions (MCH-1200), and policy on preventing the introduction and/or transmission of MDROs (MCH- 1201). Staff educated on appropriate HH and PPE use completed on hire and annually in Net Learning. Daily surveillance by IP of patient isolation orders with recommendations for continuing or discontinuing isolation precautions. Protocol in CPOE for ordering isolation when MRSA, VRE, ESBL, or CRE are identified by lab. Protocol in CPOE for ordering isolation when CDI testing is ordered. CDI surveillance and reporting where applicable. Trend and report CDI rates to stakeholders and complete re-education as needed. Continue ongoing surveillance of hand hygiene and isolation precaution compliance. Collaborate with antibiotic stewardship program to identify and control epidemiologically important MDROs and monitor antibiotic use. Collaborate with pharmacy and microbiology to ensure prompt notification of IP when a resistance pattern based on microbiology results is detected. Collaboration with EVS on proper cleaning of isolation rooms. Monitor for increased incidence of MRSA, VRE, CDI, ESBL, and CRE. Monitor completion of PPE education in Net Learning.

4. **Medium potential for lack of staff compliance with influenza vaccination program goal of > 90% immunization rate:** Several free influenza vaccine clinics offered by

health and wellness to MCHS employees, medical staff, volunteers, and employee's family members. We will re-evaluate current immunization policy and revise as necessary before each flu season. Strongly encouraging staff to stay up to date with vaccines. Implemented additional mitigation measures for those not up to date with vaccines. Monitor employees for appropriate immunization identification during flu season. Flu vaccine compliance rate report out by Health and Wellness to IP committee. NHSN reporting as needed.

5. **Medium potential for lack of staff compliance with COVID-19 vaccination mandate program goal of 100% vaccinated or approved medical or religious exemption:** Several free COVID-19 vaccine clinics offered by health and wellness to MCHS employees, medical staff, volunteers, and employee's family members. COVID-19 vaccine mandate policy in place with oversight by H&W. We will re-evaluate current immunization policy and revise as necessary. Strongly encouraging staff to stay up to date with vaccines. Implemented additional mitigation measures for those not vaccinated or up to date with vaccines. Employee health to monitor and report out COVID-19 vaccination compliance rates to IP Committee. NHSN reporting as needed.

6. **Medium potential for exposure to bloodborne pathogens:** Policy MCH-2043 exposure control plan provides guidelines to prevent or minimize occupation exposure of employees to bloodborne pathogens or other potentially infectious material. Engineering controls are instituted whenever and wherever practical to eliminate or minimize employee exposure. Appropriate sharps containers in work areas where sharps are used. Infectious or biohazard waste must be placed in biohazard labeled container. Biohazard waste kept in negative pressure rooms. Education on bloodborne pathogens completed on hire and annually. Education on injection safety practices completed on hire and as needed. Hand washing stations, PPE and appropriate disinfectants are available. Monitor sharps injuries through EOC and IP committees and update practices an needed.

7. **Medium potential for transmission of infections due to failure to meet environmental cleanliness standards**: Cleanliness is essential for every healthcare setting. All treatment areas, equipment and surfaces are to be kept free of blood, mold, and accumulation of dirt or dust and other potentially infectious materials. Emphasize to all staff that cleaning is a shared responsibility involving more than just EVS completed on hire and ongoing as well as education on approved low-level disinfectants with appropriate wet times. EVS has implemented enhanced cleaning of high touch surfaces and waiting areas. There is a clear separation of clean and dirty work areas. Clean areas are used for storage and preparation of medications and unused supplies; dirty areas are used for contaminated equipment. Education on separation of clean and dirty completed during new employee education and ongoing as needed. EVS to use EPA approved disinfectants per manufacture's recommendations. Changed to disposable curtains n patient rooms. EVS uses UV light for isolation room cleaning after discharge. EVS participates in bi-weekly EOC rounding. IP collaborates with EVS on room cleaning.

8. **Medium potential for failure to identify separation of clean and soiled:** There is a clear separation of clean and dirty work areas. All treatment areas, equipment and surfaces are to be kept free of blood, mold, and accumulation of dirt or dust and other

potentially infectious materials. Education on separation of clean and dirty completed during new employee orientation and ongoing as needed. Separate areas designated for clean and solid throughout the facility. Risk assessment completed of high-risk areas as needed. Compliance monitoring during IP and EOC rounds.

EMERGING / REEMERGING PROBLEMS IN THE HEALTHCARE COMMUNITY

The organization keeps abreast of infection control related issues occurring in the healthcare community. This is accomplished by the following:

1. Notices from the public health department

    - Located within the Department of State Health Services (DSHS) Region 9/10 with the main office being in El Paso, TX and a satellite office located 30 miles east of Odessa in Midland, TX. Ector County has a county funded Health Department and most notifiable conditions are reported directly to the ECHD (Ector County Health Department) with occasional special surveillances (i.e. seasonal flu) reported directly to DSHS. The Infection Prevention Coordinator(s) are in frequent contact with both DSHS and ECHD. MCH transmits data to DSHS via ECHD by syndromic surveillance or NEDS which is a statewide surveillance system that runs at ECHD.
    - Notices and recommendations from the Center for Disease Control, includes COID-19 emergency guidance, continuation of Influenza Vaccine Administration to support HERD immunity. Identification and control of the spread of Measles and education on vaccination as recommended by CDC. Identification and control of spread of Monkeypox as recommended by the CDC.

2. Current literature and recommendations from professional organization's as well as accrediting and regulatory agencies.

    - The Infection Prevention and Control Department consists of three-FTEs. One FTE is CIC certified and all participate in professional organizations such as TSICP (Texas Society of Infection Control Professionals and/or APIC (Association for Professionals in Infection Control).

SUCCESS OF INFECTION CONTROL INTERVENTIONS

The organization undertook several initiatives to prevent and control infection during the evaluation period of FY22. A summary of the effectiveness of significant interventions is noted below:

- **Significant reduction in CAUTI rates in FY2022**: CAUTI rate has gone from 3.47% in October of 2021 to 0.90% in June of 2022. CAUTI rate has maintained below goal for 5 consecutive months.

- **Significant reduction in CLABSI rates in FY2022**: CLABSI rate has gone from 3.54% in October of 2021 to 0.0% in June of 2022.

- **Significant increase in Hand Hygiene Compliance**: Hand hygiene compliance rate has gone from 72.71% in October 2021 to 96. 07% for July 2022.

- DSHS 2021 H1 HAI audit concluded that MCHS Infection Prevention staff is well prepared and knowledgeable of NHSN definitions and how to use them and stated that the ability to maintain reporting capacity while also responding to the COVID-19 pandemic speaks to the team's tenacity and dedication to infection control.

- IP department will continue with required surveillance and reporting to appropriate regulatory agencies in a timely manner regarding incidence of Texas Reportable conditions, regulatory reporting compliance with Texas HAI Reporting via NHSN for CLABSIs in all in-patient units within the facility, CAUTI in all adult in-patient units, SSI from colon and abdominal hysterectomy procedures, MRSA Bacteremia and C-difficile LABID events facility wide and reporting of H&W Influenza vaccination and COVID-19 vaccination compliance.

- MCHS Infection Prevention and Control Department received commendation from the DSHS for dedication to Influenza reporting.

- Antimicrobial Stewardship Program has become more fine-tuned within the healthcare organization and development of the organizations antibiogram. Antimicrobial Stewardship will meet monthly and collaborate with the Infection Prevention Committee.

MCH's Infection Prevention and Control Department goals for FY23 is to further align with multi-disciplinary team involving participation from individuals across the healthcare organization such as senior leadership, employee health and wellness, frontline staff, pharmacy, engineering, environmental services and physicians in order to review and implement evidence based best practice guidelines to reduce the risk of infection from factors identified in the annual risk assessment as stated above, to decrease device utilization through collaboration with nursing staff and providers, and to improve hand hygiene performance and compliance with additional observations and hand hygiene awareness leading to behavior modifications. IP Department will continue to submit local, state and federal public health reporting in a timely manner.

INFECTION PREVENTION AND CONTROL GUIDELINES

The organization evaluates relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus. This is accomplished by reviewing:

1. Notices from the public health department

2. Notices and recommendations from the Center for Disease Control and Prevention

3. Current literature and recommendations from professional organizations as well as accrediting and regulatory agencies

DETERMINATION OF EFFECTIVENESS

Based on the information noted above, the Infection Prevention and Control Program was determined to be effective in implementing its activities during the evaluation period. Activities which require improvement will be addressed by the program during the upcoming evaluation period.

In the event of outbreaks or other unanticipated developments, the Infection Prevention Department will respond using science based and best practice evidence-based interventions.

This report will be submitted to the organization's entity charged with overseeing the infection prevention and control program, as well as the entity charged with overseeing the organization's patient safety program.

		Date
Completed by Infection Prevention Officer in collaboration with IP Committee Members	Brenda Dalrymple RN, BSN, CIC	August 3, 2022
Approved by Infection Prevention Medical Director	Dr. Pablo Feuillet	August 2022
Approved by IP Committee		August 2022
Approved by QAPI Committee		August 2022
Approved by Board of Directors		August 2022

Pharmacy & Therapeutics Committee
2022 (FY 2023) Annual Plan

Purpose:

The Pharmacy and Therapeutics (P&T) Committee will:

1. Assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs in the Hospital, including review of drug utilization;
2. Advise the Medical Staff and the Hospital's pharmaceutical department on matters pertaining to the choice of available drugs;
3. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
4. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs; and
5. Perform such other duties as assigned by the Chief of Staff or the Medical Executive Committee.

Multi-Year Strategic Plan:

Perform full drug class review of all current formulary medication drug classes (144) by end of FY 2026.

2023 Fiscal Year Organization Priorities:

Complete at least 40 full drug class reviews during FY 2023. Complete optimization of all medication-related powerplans (pending 99) by end of FY 2023

Complete two high-risk medication full medication safety reviews and/or FMEAs.

Scope: All physician groups, nursing, pharmacy, dietary, respiratory therapy and administration or anyone needing to be associated with policy, procedure, or formulary management related to medications may participate in MCHS P&T committee.

Overall Program Effectiveness: The P&T chairmen and P&T Pharmacy representative will assume responsibility for the overall integrity and effectiveness of the P&T committee. The P&T chairmen and P&T pharmacy representative in collaboration with the committee members, Quality Monitoring Committee (QMC), Medical Executive Committee (MEC), department leaders, physicians, and pharmacy and nursing staff will plan, coordinate, and improve medication management at MCHS.

Program effectiveness is ensured by the following:

1. Appropriate formulary and non-formulary medication use maintained
2. Appropriate non-formulary medication request for addition to formulary maintained
3. Standard process followed for medication review for addition or removal to/from formulary

4. Standard process for full formulary drug review established and maintained including evaluating effectiveness, safety, and financial considerations
5. Policies reviewed and approved in a timely manner
6. All improvement actions are evaluated for effectiveness

Medical Staff Responsibility: Medical staff participates as members of P&T, QMC, and MEC and serve as chairs for these committees. Medical staff also participate in initiatives and policy and formulary discussions regarding medications of their areas of expertise. Medical staff will also be asked to attend P&T on occasion to speak regarding topics specific to their areas of expertise.

Pharmacy Staff Responsibility: Pharmacists on staff often play a pivotal role in performing drug class reviews, literature reviews, reviewing and updating policies and procedures and providing this back to Pharmacy Clinical Manager. The Pharmacy Clinical Manager coordinates or participates in the review of all formulary requests, policy review or creation, EMR updates, and patient care initiatives that require medical staff approval. The Pharmacy Clinical Manager is responsible for preparing agenda and minutes associated with all P&T meetings. The Pharmacy Clinical Manager also prepares and presents agenda items at the monthly QMC meetings and prepares agenda for MEC regarding forwarded items from P&T and QMC.

Pharmacy & Therapeutics Committee: The members of P&T consists of at least five members of active medical staff. In addition to medical staff, a representative from pharmacy service, a representative from the nursing service, and a representative from hospital administration will serve as *ex officio* members of the committee. From time to time, other members or representatives of other hospital departments may be appointed to serve as ad hoc members to assist in review of particular issues.

The members of the P&T Committee are responsible for: reviewing agenda items and attachments before meeting starts, attending meetings and providing input and voting on items as appropriate, providing education back to their departments if appropriate

Communication: The Pharmacy and Therapeutics Committee will meet at least quarterly (or more often if necessary to fulfill its duties), will maintain a permanent record of its activities, and will submit reports and recommendations to the Medical Executive Committee. After items are approved at MEC each month, approved items are sent out as updates to appropriate staff via the following means:

- *Pharmacy:* monthly email regarding MEC updates, department newsletter, updates to pharmacy department page, announcement at huddle meetings
- *Physicians:* physician memos via email, individual discussions with providers in person/over email/messaging
- *Nurses or other departments*: email, medication safety committee agenda

Processes and Methodology:

1. Perform drug class review of all medications asked to be added or removed from formulary including (but not limited) to the following: indications, mechanism of action, dosing and administration, storage, pharmacokinetics, safety and tolerability, contraindications, drug interactions, clinical literature review, cost and pharmacoeconomics, recommendations
2. Strive to provide evidence-based medication therapy to MCHS patients
3. Efficacy and safety are top priority but pharmacoeconomics also considered in all medication therapy decisions
4. Use a multi-disciplinary approach to policy and medication therapy and formulary decisions
5. Ongoing formulary and medication ordering procedure improvement

Approved by P&T Committee: __July 14, 2022_____

Approved by QAPI Committee: _____

Quality Assurance, Performance Improvement (QAPI) Plan
FY 2023

PLAN: The organization-wide QAPI Plan encompasses major important aspects of care provided by the hospital in support of the achievement of MCH's mission and strategic goals. This includes continual quality data measurement, assessment and process improvement activities. The Plan describes the overall process for Departments and Services to collaboratively perform QAPI activities in a systematic manner, including the communication of activities and outcomes directed towards improving quality care and services.

Authority & Responsibility: The ECHD Board of Directors has the authority and responsibility to require and support a Quality Assurance and Performance Improvement Program (QAPI) at Medical Center Hospital. The ECHD Board of Directors has delegated the responsibility of implementing an organization-wide QAPI program to the CEO and Quality and Patient Safety Department.

ECHD Board of Directors: The ECHD Board of Directors receives QAPI reports from the council or council designee at minimum annually.

CEO: The CEO oversees the development and implementation of the QAPI activities to assure the integration and coordination of service-specific activities into the organization- program. The CEO delegates authority to the Quality and Patient Safety Department for coordinating and implementing the program.

Medical Staff Responsibility: Medical Staff Members are assigned by the MEC to serve on the Quality Assurance and Performance Improvement Committee (QAPI). QAPI monitors the approved QAPI Plan indicators and reports actions and findings to the MEC and Leadership defined above.

Department Leader Responsibility: Every department, both clinical and non-clinical, within MCHS is responsible for implementing quality assurance and performance improvement projects within their departments. Department Leaders will identify quality indicators, collect and analyze data, develop and implement changes with their frontline staff to impact their identified QAPI goal for the year. Individual department's QAPI goal progress should be reported out to the QAPI Committee as scheduled, at minimum yearly.

QAPI Committee: The QAPI Committee is an interdisciplinary team that oversees the Quality Assurance Performance Improvement activities throughout MCHS.

Committee Role:

- Drive monthly meetings
- Provide QAPI education
- Find ways to remove identified barriers
- Provide and identify cross-functional support needs
- Ensure on-going compliance within the QAPI program

- Annually approve the organizational wide QAPI Plan including individualized department goals or service line specific indicators to improve quality of care utilizing evidence-based practices.
- Receive and act on reports of QAPI outcomes and communicate findings and actions to the Executive team and ECHD Board of Directors.
- Assure QAPI monitoring outcomes are communicated to hospital and medical staff members.
- Assure the effectiveness of sentinel event corrective action through QAPI monitoring.
- Facilitate integration of risk reduction strategies into the QAPI program to reduce medical errors.

The members shall include representation from the following areas: Administration, Nursing, Pharmacy, Ancillary Services, Health Information Management, Information Risk/Safety Management, Quality Facilitator / Management Representative, Physical Environment / Life Safety, Volunteer / Community Member and Medical Staff.

Facility Wide QAPI Integration
Quality Assurance and Performance Improvement is utilized in many areas of Medical Center Hospital, it is important that all areas of performance improvement are integrated into Hospital Wide QAPI plan.

- Departmental Reports
- Accreditation Reports and Corrective Action Plans
- Service Line QAPI Programs
- Risk/Quality Review Outcomes and Action Plans

Quality Improvement Processes and Methodology: Departments/Services should utilize the DMAIC or PDCA processes to benchmark, collect data, trend data, and form action plans to achieve attainable goals. Other lean tools may be utilized as needed.

Outside sources, comparative databases, professional practice standards, national and state benchmarks along with specialty (like stroke, chest pain, cath lab, lab, AIM, etc.) accreditation standards will be utilized to compare outcomes, processes, and to set benchmarks and goals.

PATIENT SAFETY AND MEDICAL ERROR REDUCTION INTEGRATION: Reduction of medical errors and the delivery of safe patient care is a priority. Occurrences are reported through the electronic event management system and overseen by Risk Management and the department Directors. Individual and trended reports are provided to Administration, Medical Staff, and Departmental Leaders for information and follow up. Information related to adverse events, unusual occurrences, medical errors, sentinel events and error reduction is also provided to appropriate Root Cause Analysis teams, QAPI committees and other organizational teams for implementation of risk reduction strategies and monitoring. Aggregate information related to patient safety and the risk management program is reported to the Leadership Team and ECHD Board of Directors on a regular basis by Risk Management.

Additionally, aggregated event data is reported to THA/PSO to facilitate state-wide review and learning about safety issues in the state of Texas.

ANNUAL EVALUATION: An annual report, summarizing outcomes of the QAPI program will be submitted to the Executive Leadership Team for approval at the end of the plan year. The report will contain information regarding opportunities identified to improve care through the QAPI process and the effectiveness of actions taken. The Executive Leadership Team shall forward the annual summary and any recommendations they may have to the Quality Medical Committee, Medical Executive Committee, and The Board of Trustees for final review. The annual report and any recommendations received shall serve as a basis for development of the subsequent QAPI Plan.

_____
Associate Chief Patient Experience Officer

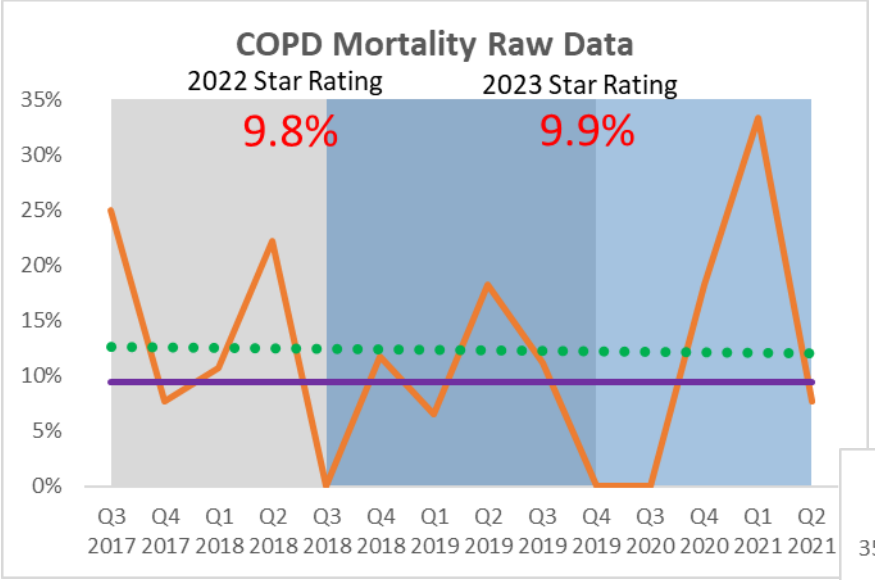
_____
Chief Nursing Officer

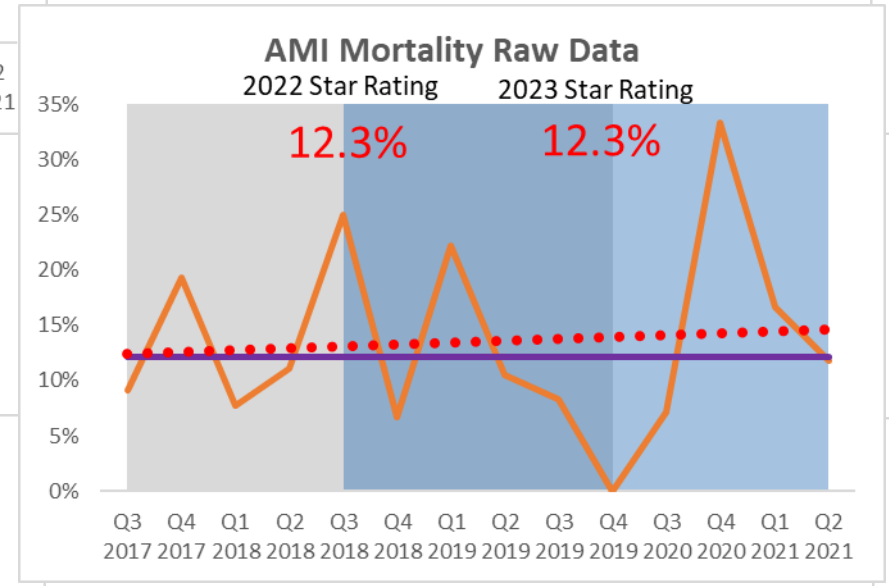
_____
Chief Medical officer

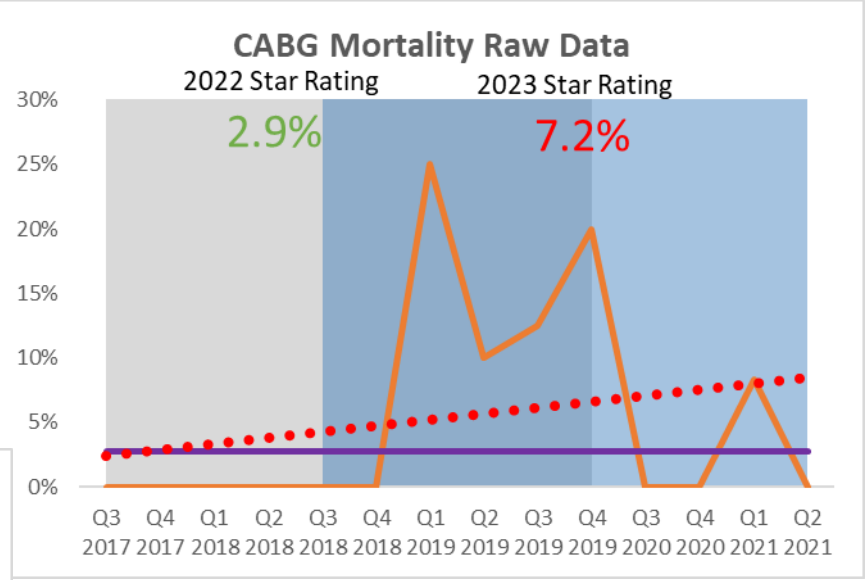
_____
Chief Executive Officer

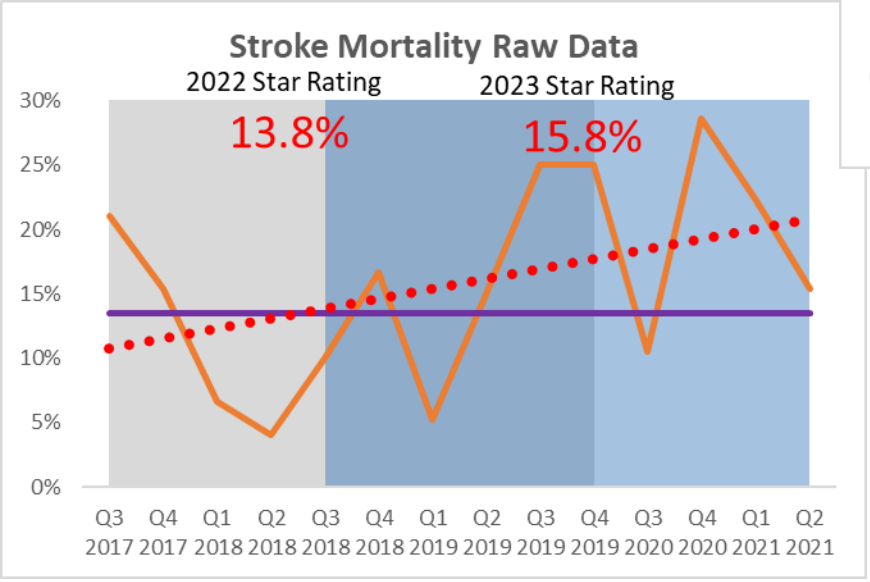
CMS Star Rating Update

Mortality

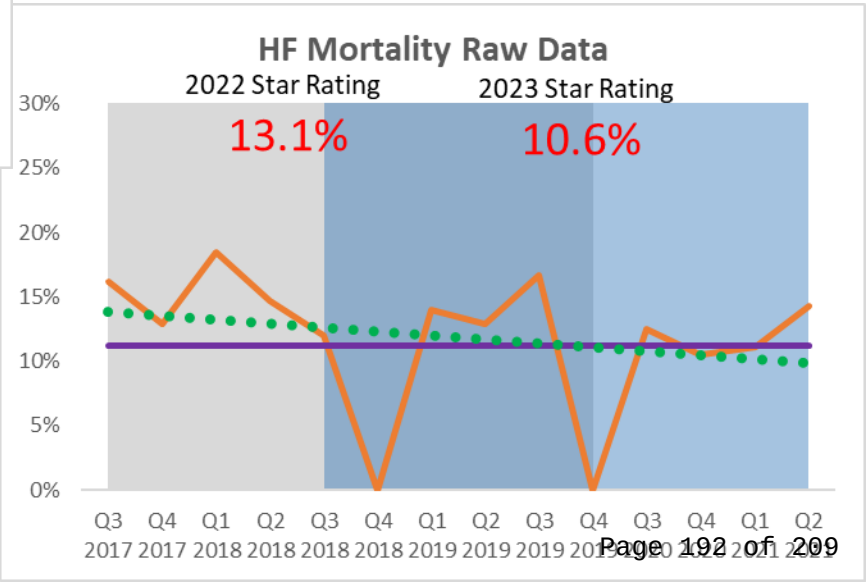








Small adjustments made to overall expected 2023 scoring as well as minor changes to quarterly data based on new CMS Hospital Specific Report.

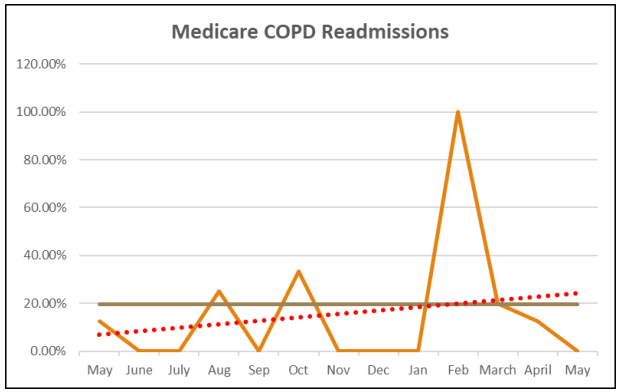


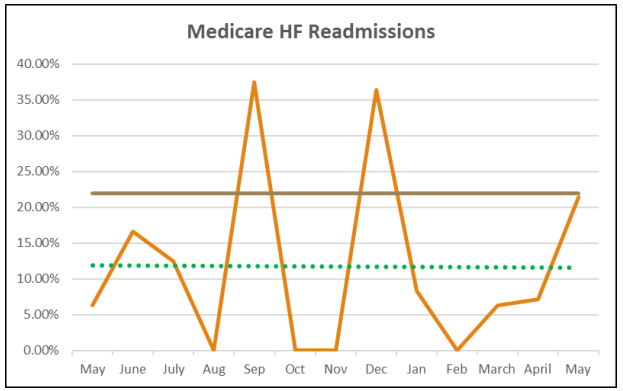
Mortality Action Plan

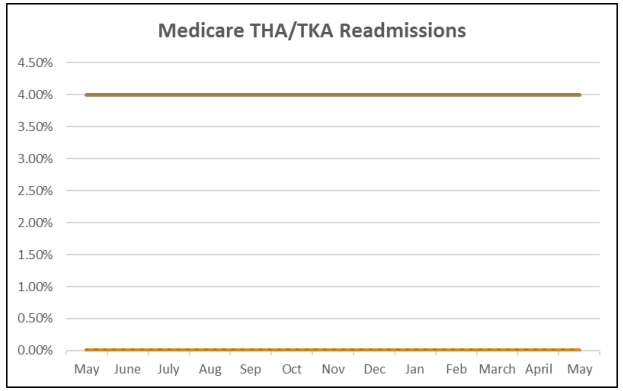
- Peer review coordinator to continue reviewing all deaths and forwarding to peer review if delay of care is noted.
- Patient Safety Officer Position filled and start date of 8/22/22.
- Develop Mortality Review Interdisciplinary Committee lead by PSO.
- Trend Quality Advisor data against Medicare data to have more real time data to drive action.
- Deep dives into mortalities to find trends.

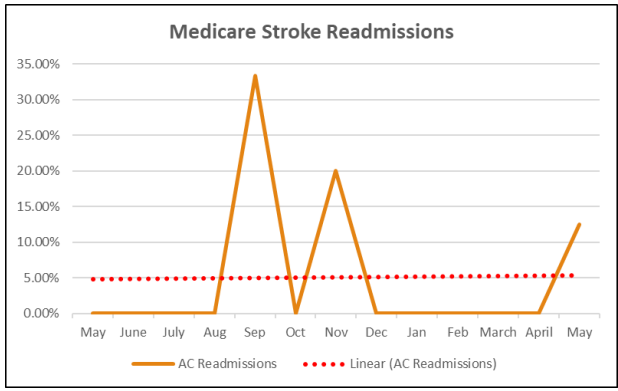
Readmissions Internal Data (12 Month Review)

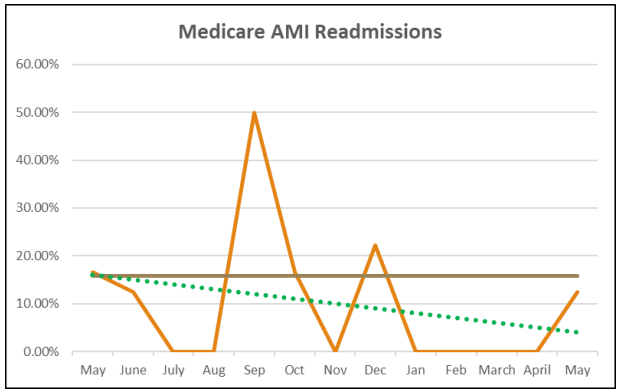
This data only looks at re-admissions into our own hospital.

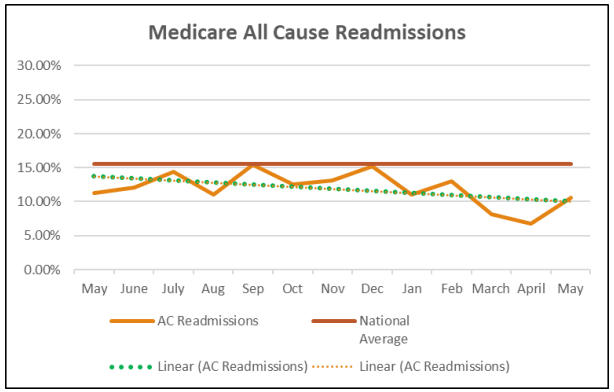


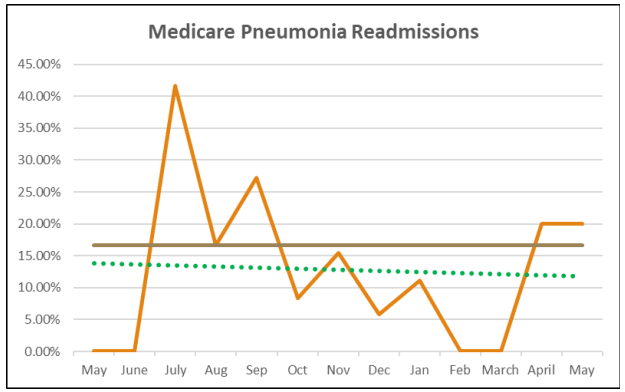


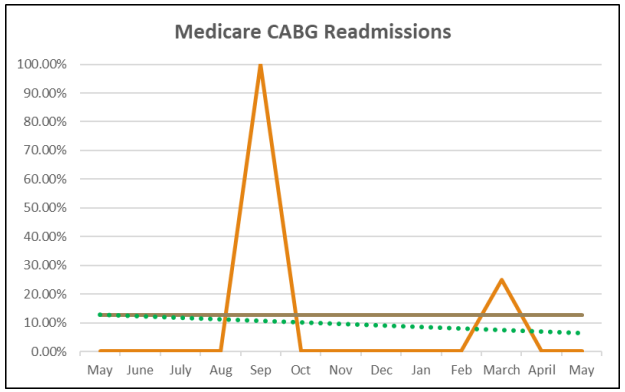










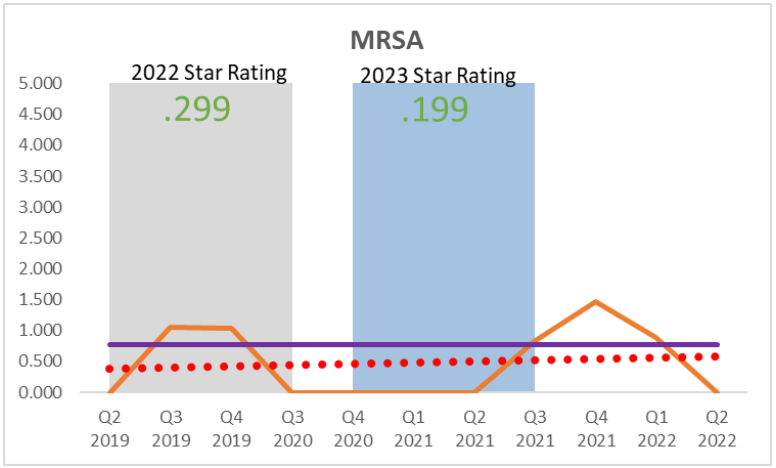


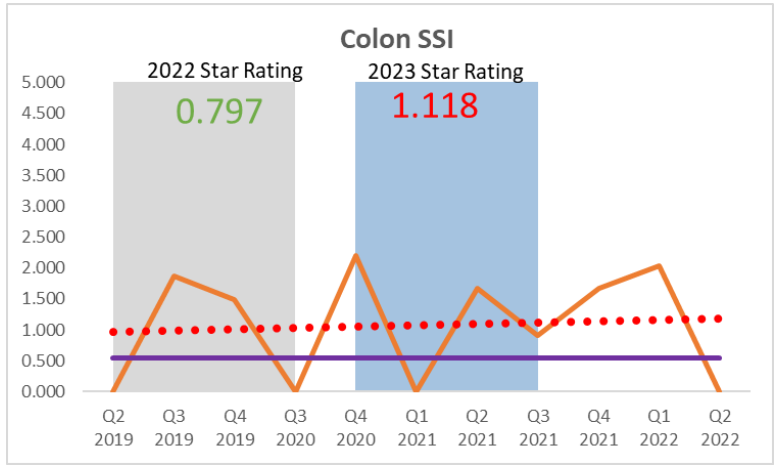
Some areas trending up since last report out, but year to date still below the National Goal for all measures.

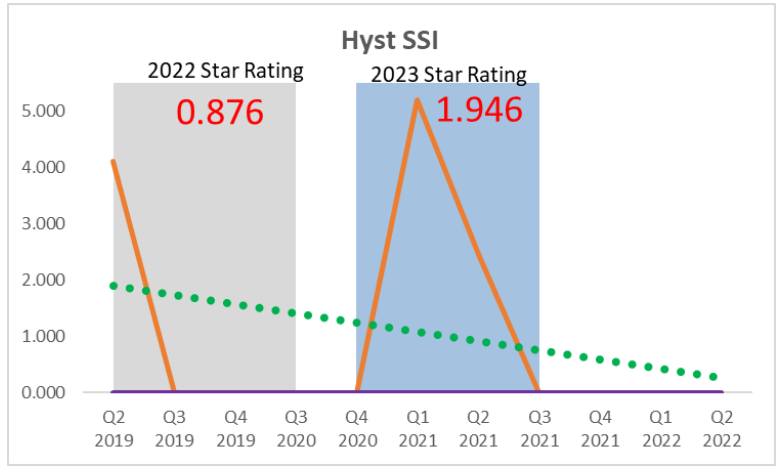
Readmissions Action Plan

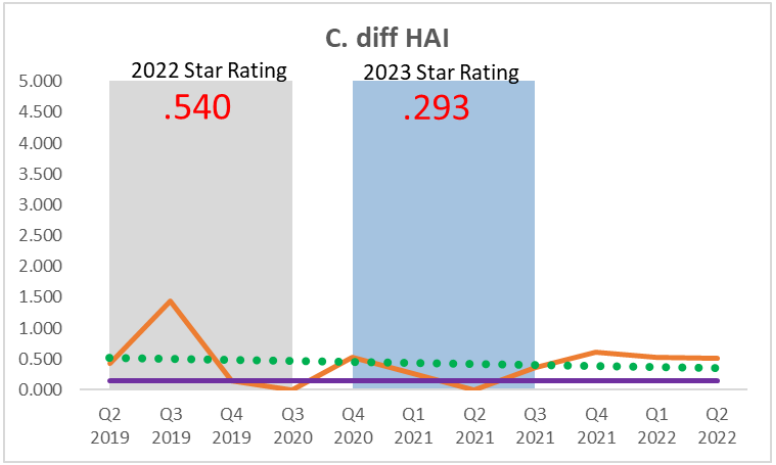
- Readmission Steering Committee – Cohort teams will continue to meet monthly and steering committee quarterly.
- Partner with marketing for cohort specific education through Sonofi.
- Monitor closely those areas with upticks to ensure we continue to stay below the national benchmark.
- New discharge bags being created for CABG patients with all required discharge needs being met. (scale, b/p cuff, dx specific education)
- Consider new trends.

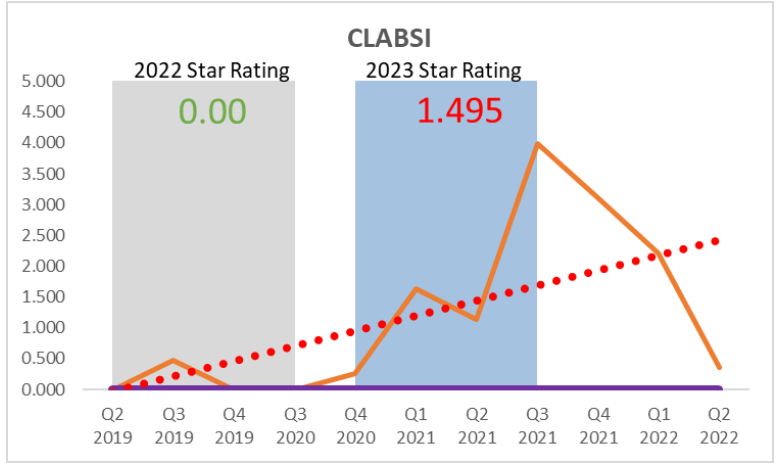
Complications

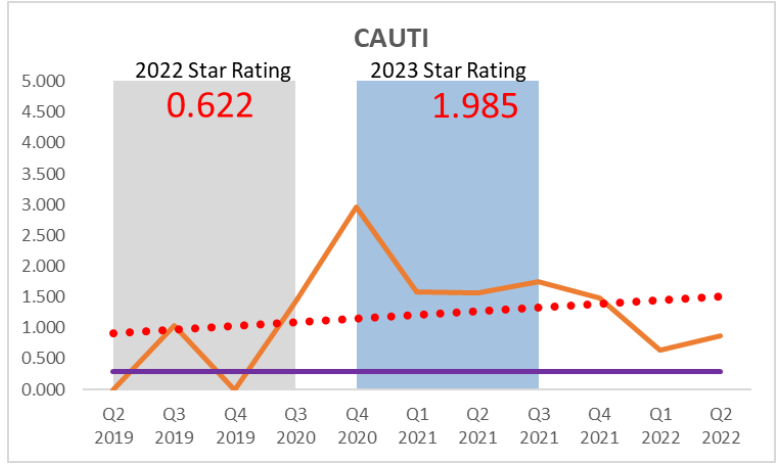












All complications trending down over last 2-3 quarters.

Complications Action Plan

SSI

- Implement Colon SSI bundle – Taking bundle to Surgery Physicians Committee in September.
- Implement De-colonization for CABG, COLO, and Joint Procedures. – Has been implemented in the last week. Will start 6-month trial period starting September 2022.

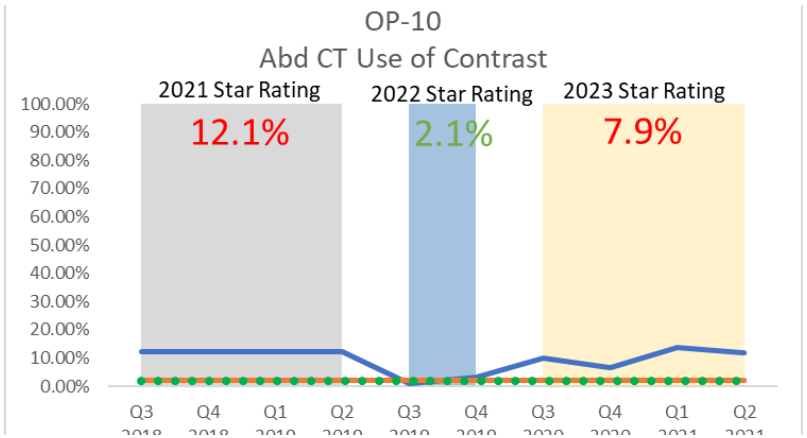
CAUTI

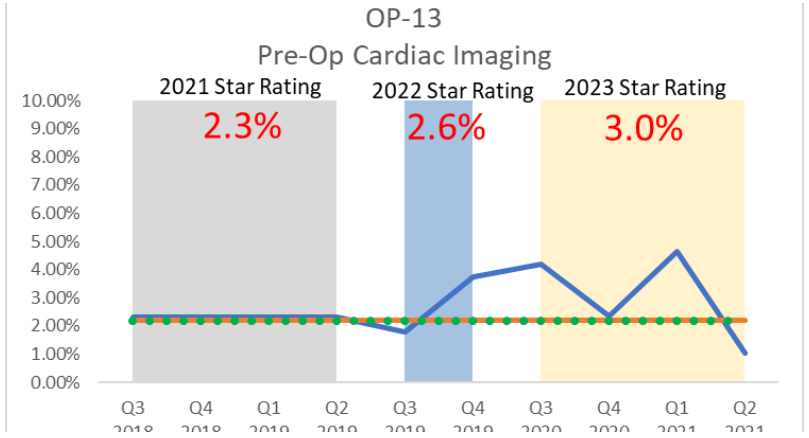
- CAUTI team has done great work in moving these numbers in the last quarter
- New condom catheter trials.
- Physician/Resident education on external catheters.
- Add Foley care onto the travel/agency nursing onboarding education.
- IP Audits

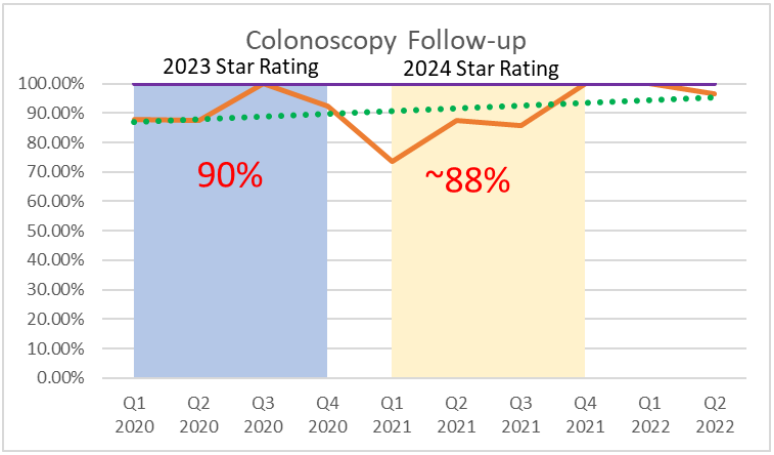
CLABSI

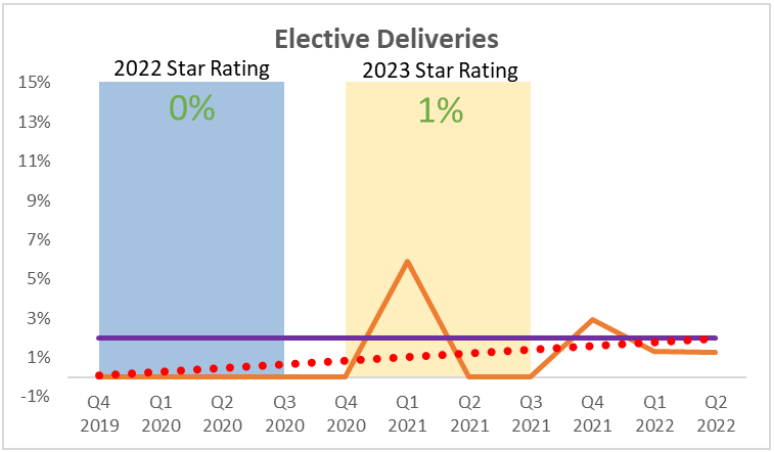
- IP Audits
- Implementation of decolonization process starting mid August.
- Continue to work toward improved hand hygiene numbers house wide.
- Team working to decrease blood culture contamination rates.

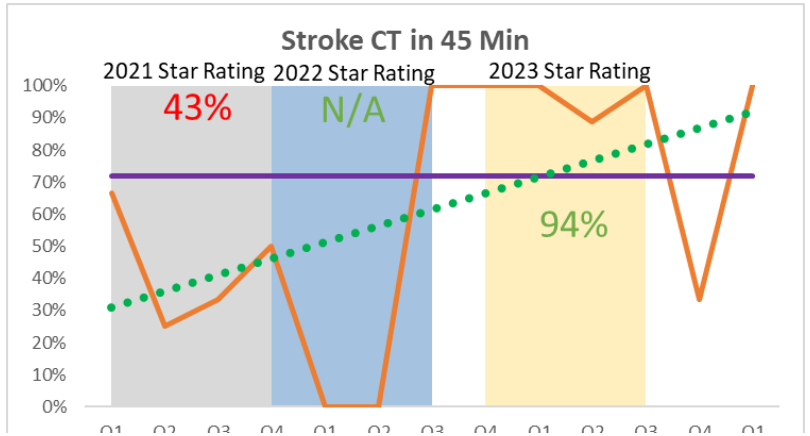
Timely & Effective Care

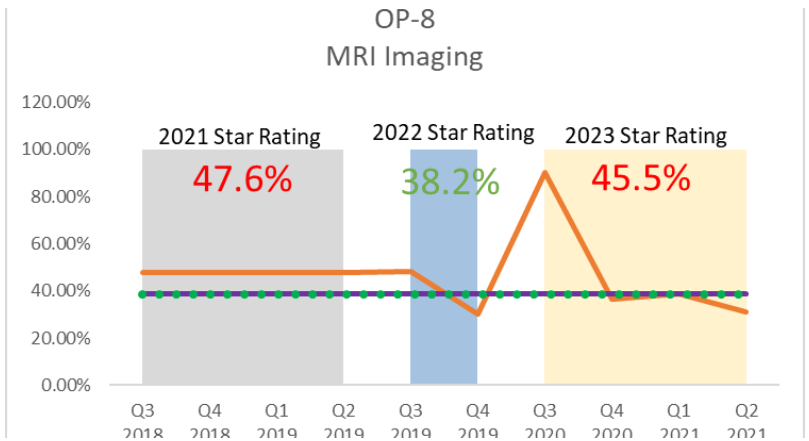


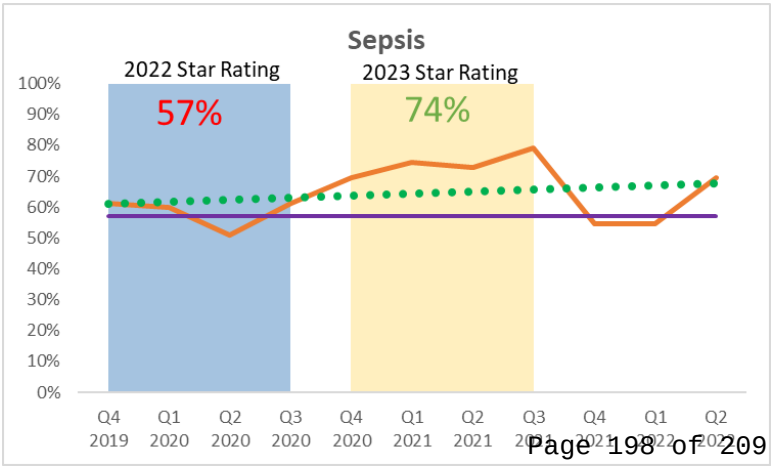












No New Data for these measures.

Timely and Effective Care Action Plan

Outpatient Imaging Measures

- Build internal monitoring program for more up to date data.
- Share data with radiology department and medical staff.

Stroke

- Continue pushing stroke metric education house wide.

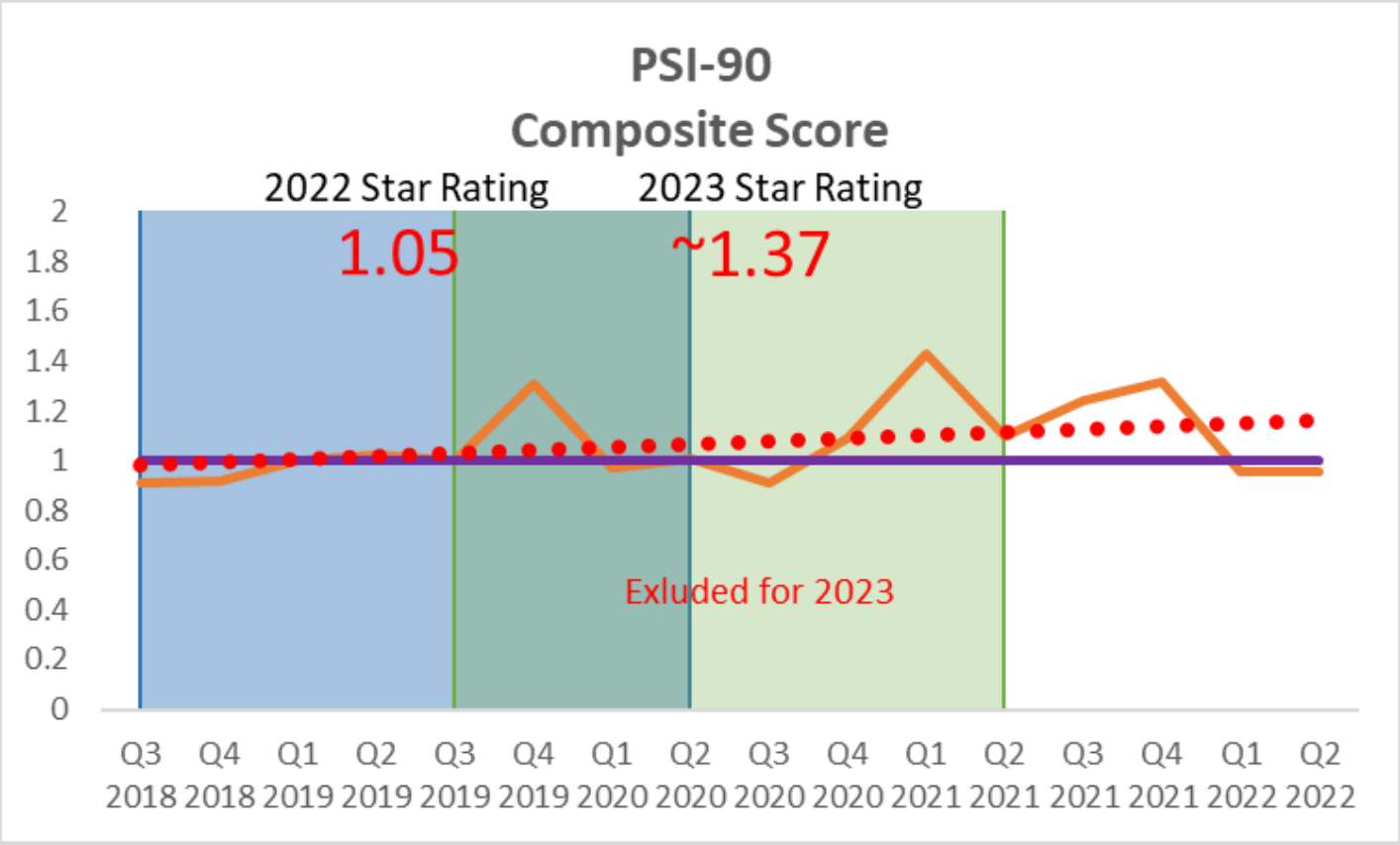
Sepsis

- Continue to push sepsis bundle education house wide in addition to resident training.

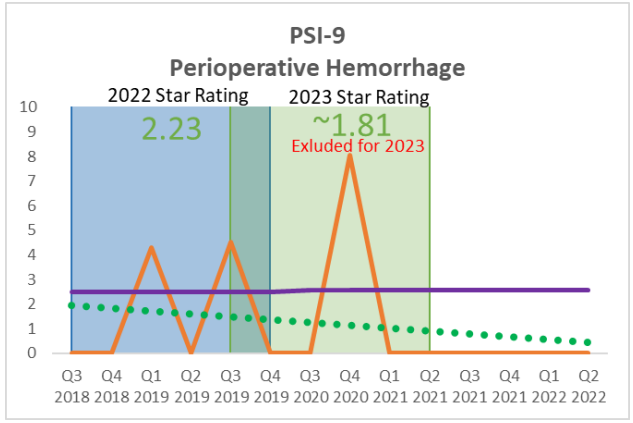
Elective Deliveries

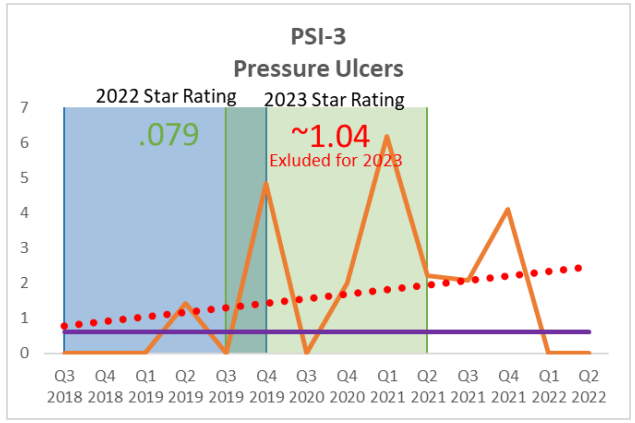
- Re-focus on this metric through Maternal QAPI program.
- Trend by physician

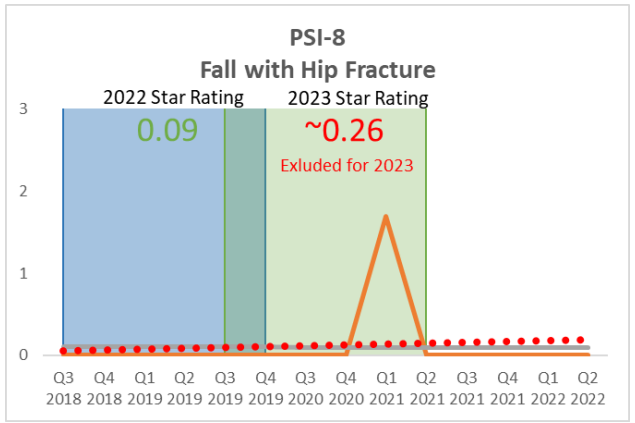
Patient Safety Indicator Composite Score

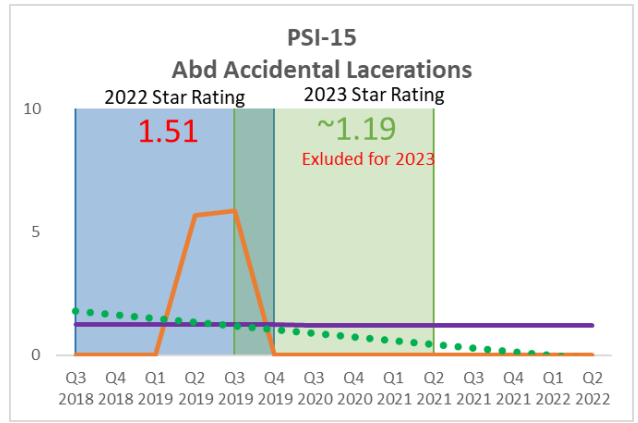


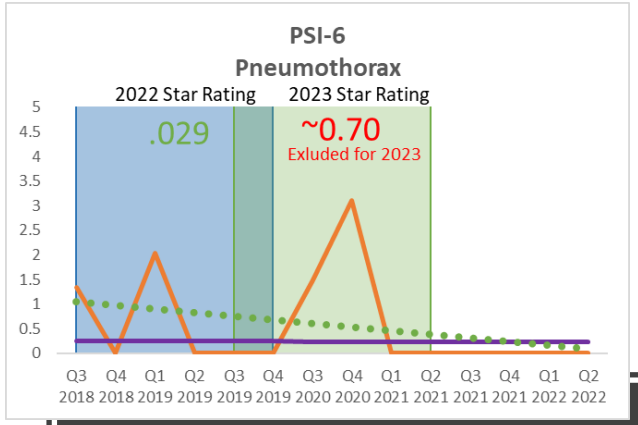
Below goal of observed/expected of 1.0 for the last 2 quarters based on Quality Advisor Data.

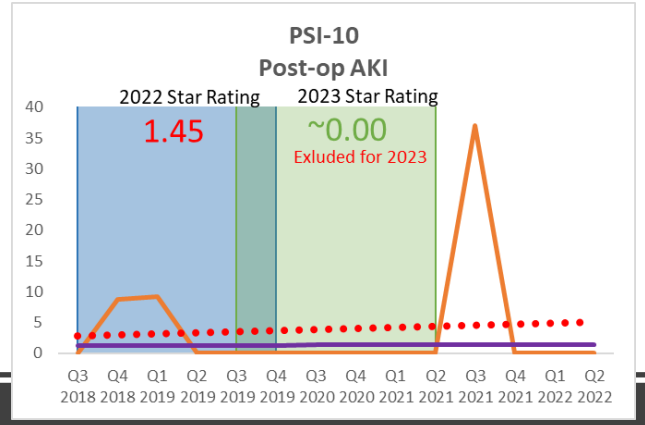


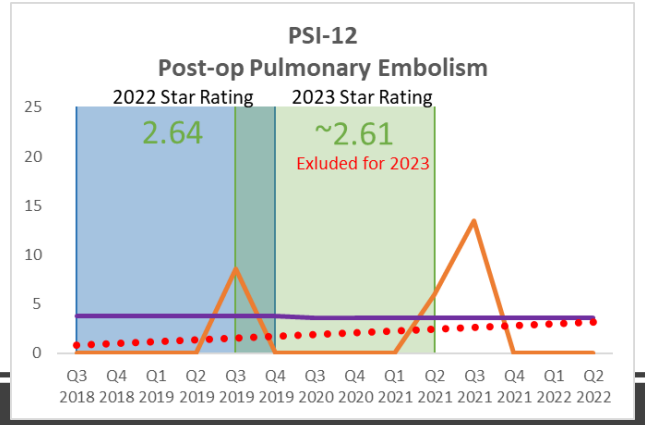


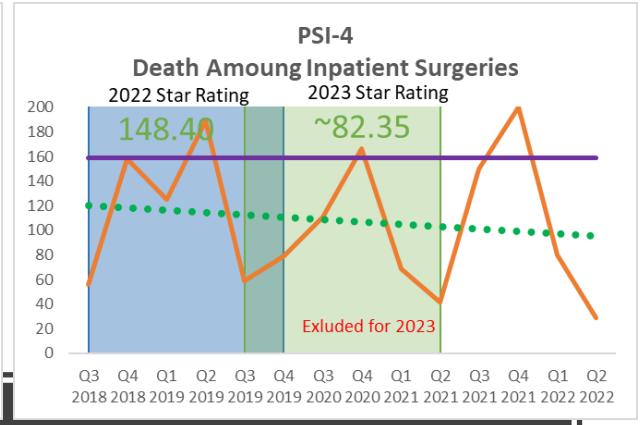






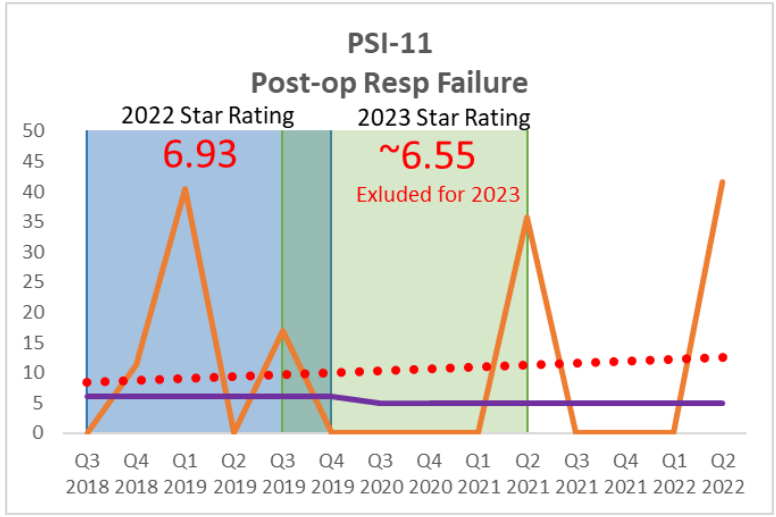


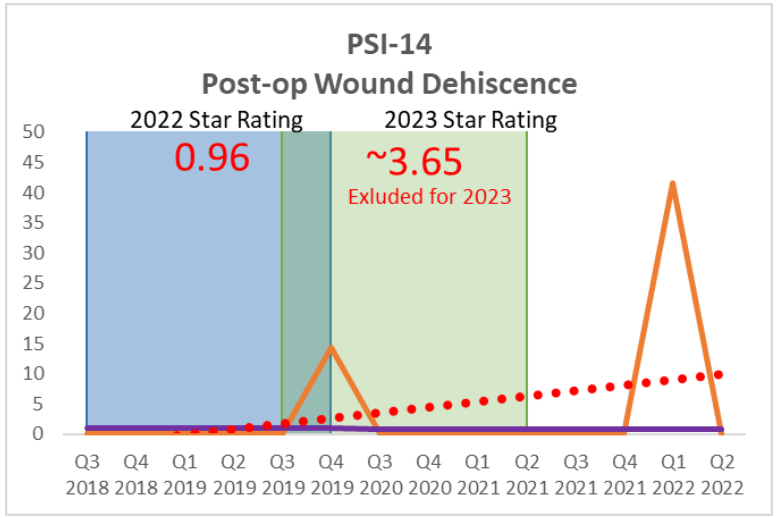


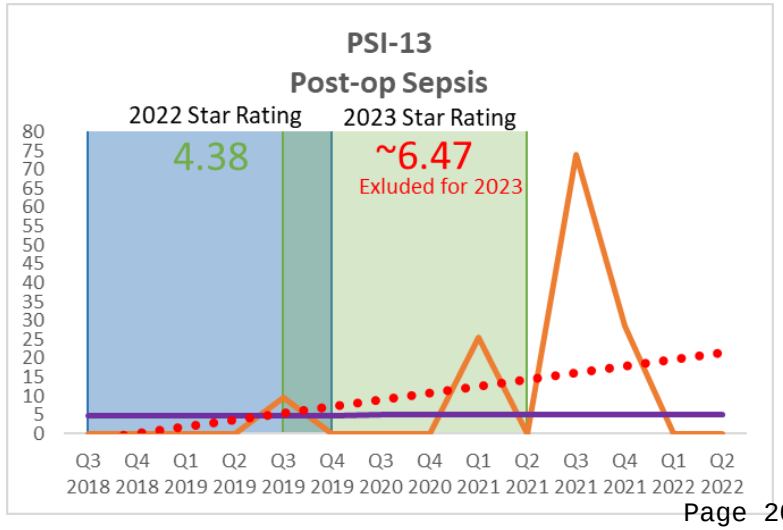


PSI Making Progress

PSI Needing Action







PSI Action Plan

- Utilizing 3M360 Coding/Quality to review each PSI.
- Working with CDI and coding on any findings from quality review.
- In depth Focus Quality Reviews on all PSIs.

New Quality Metrics Coming in 2023

Structural Measures

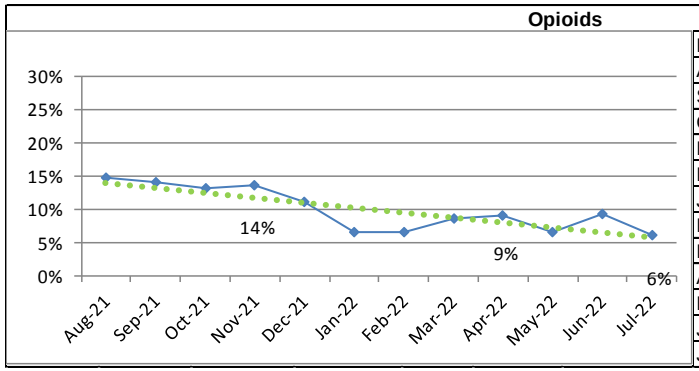
- Hospital Commitment to Health Equity (Required with no penalty)
  - Equity is a Strategic Plan
  - Data Collection
  - Data Analysis
  - Quality Improvement
  - Leadership Engagement
- Screening for social drivers of health (Optional 2023 Required 2024)
- Positive Screening Rate for social drivers of health (Optional 2023 Required 2024)

Hybrid Measures (Claims and eCQM)

- Hospital Wide Readmissions (Optional 2023, Required 2024)
- Hospital Wide Mortality (Optional 2023, Required 2024)

eCQMs

- Safe Use of Opioids (Required)



Month		n	D	%
Aug-21		27	184	15%
Sep-21		26	185	14%
Oct-21		27	205	13%
Nov-21		29	214	14%
Dec-21		26	236	11%
Jan-22		13	199	7%
Feb-22		11	165	7%
Mar-22		18	208	9%
Apr-22		18	197	9%
May-22		14	213	7%
Jun-22		17	181	9%
Jul-22		12	198	6%

- New Maternal Child eCQMs
  - NTSV C-Section Rate (Optional but will be required in 2024)
  - Severe Obstetrics Complications (Required 2024)
  - Elective Deliveries (PC-01) Optional
  - Exclusive Breast Milk (Optional
- Glucose Control

Leap Frog Hospital Survey Update

Leap Frog Updates

- 2022 Survey was submitted 6/30/2022.
- New Grades should be available for review in October 2022. (Expected C)
- Any Survey Updates need to be submitted by November 30, 2022

Leap Frog Kudos

- The following sections are areas we have improved over the past years' performance.

Survey Section	Survey Topic	Scoring
1B	Billings Ethics	Achieved the Standard
3A	Total Knee	Considerable Achievement
4	Cesarean Birth Rate	Achieved the Standard
6D	Hand Hygiene	Considerable Achievement
8B	Medication Reconciliation	Achieved the Standard
10	OP Safe Surgery Checklist	Achieved the Standard
10	Medication Safety for OP Procedures	Considerable Achievement

Quick Improvement Opportunities

- The following sections are areas we have decreased in performance. Covid-19 impacted volumes significantly across many measures. Individual work being completed in each measure for 2023 impact.

Survey Section	Survey Topic	Scoring	Barriers to Success
2	CPOE	Some Achievement	CPOE Alerts
3A	Bariatric Surgery	Considerable Achievement	Low Volume of Procedures
3A	Total Hip	Limited Achievement	Low Volume of Procedures
4	High Risk Deliveries	Some Achievement	Low NICU Volume
7B	CLABSI	Limited Achievement	Covid related spikes
7B	MRSA	Limited Achievement	Covid related spikes
8A	Bar Code Medication Admin	Considerable Achievement	Missed by 1%
9B	Pedi Dosing for Head CT	Some Achievement	Low Volume & CT Protocols

Other Needs to Impact Grade

- The following sections are areas we are in the bottom two tiers of performance and have been over the past 3 years. Priority focus has been requested and teams will be formed for 2023 impact.

Survey Section	Survey Topic	Scoring
5	ICU Staffing	Limited Achievement
6A	Culture of Safety Leadership	Some Achievement
6B	Culture Measurement	Some Achievement
7B	SSI Colon	Some Achievement
7B	CAUTI	Limited Achievement